Quality Assessment and Performance Improvement (QAPI) Program Evaluation

Medicaid and PeachCare for Kids®

Peach State Health Plan - 2017

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Executive Summary for 2017

Since 2006, Peach State Health Plan (Peach State) has provided services for Medicaid, PeachCare for Kids® (Georgia's standalone Children's Health Insurance Program), and Planning for Healthy Babies members in Georgia. Our Quality Assessment and Performance Improvement (QAPI) Program philosophy continues to ensure a systematic, comprehensive, evidence-based, data-driven approach to care. We utilize an annual Quality Strategic Planning Process, including evaluation of lessons learned, an assessment of our member population, environmental scan, DCH goals, strength/weakness/opportunity/threat analysis, and a review of the DCH Quality Strategic Plan for Georgia Families and Georgia 360 to develop annual QAPI Program goals and objectives. Through the QAPI Program, Peach State supports and complies with the DCH Quality Strategic Plan for Georgia Families and Georgia 360. We utilize the Institute for Healthcare Improvement's (IHI) Triple Aim for Health Care Improvement as the framework for evaluating the success of our QAPI Program and ensuring we are improving the Quality of Care and Services rendered to Georgia Families members.
Through evaluation of our 2017 QAPI Program, as documented in this report, Peach State identified the following key achievements and lessons learned during 2017, and priorities for changes in the QAPI Program for 2018.

Achievements in 2017

- Peach State's continuing commitment to quality improvement enabled us to maintain NCQA commendable accreditation status and improve our rate in 46% of the performance measures.
- Peach State's provider recruitment activities succeeded in reducing the number of network access gaps by 15% compared to 2016.
- We continued to align our QAPI Program with the DCH Quality Strategic Plan for Georgia Families and Georgia 360.
- We continued our integration of Quality throughout the organization by conducting training for all managers and above on measuring effectiveness.
- In 2017, Peach State provider network included 305 sites recognized as Patient Center Medical Home practice site which represents 105 in-network providers who provide services to 22% of our membership.
- Peach State increased satisfaction scores in all eight composite areas from 2016 to 2017. Peach State Health Plan also realized an increase in overall Provider Satisfaction compared to 2016.
- Peach State utilized our DRAGG (Diagnosis, Race/ethnicity, Age, Gender, and Geography) analysis methodology and evaluation of cultural attributes and linguistic needs to enhance our understanding of our membership, to identify health disparities in specific populations, and to facilitate development of culturally appropriate interventions that target those disparities.
- In 2017, there were a total of 920 members enrolled in the case management programs. Of the total number of members enrolled, 119 member cases were integrated, requiring that case manager and behavioral health staff to collaboratively develop care plans reflective of goals geared towards both physical and behavioral healthcare.
- During 2017, Peach State implemented new provider analytic tools to assist providers in managing their patients and our members.

Lessons Learned from 2017

- We must strengthen our 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.
- We must better coordinate feedback from providers and members we receive across the organization into the quality management and performance improvement process and activities.
- We must continue to develop the QAPI Program to ensure that it follows the DCH-Required guidelines. Including detailed descriptions on methodologies, data sources, member and provider input, analysis of interventions, and evaluation of the results of QAPI activities.
- Our interventions need to be scalable and sufficiently resourced.
- We need to continue to train key employees on the PDSA cycle specifically measuring the effectiveness of interventions
- Members in PCMHs and/or with providers in incentive programs were more likely to obtain needed services (preventive and routine) than those who were not.
- We need to further improve our ability to assist members to change their health behaviors.

Priorities for Change in 2018

- Continue our commitment to improving member outcomes, evaluated through the Triple Aim Framework, meeting our annual QAPI Program and supporting and complying with the Georgia Families and Georgia 360 strategic plan.
- Implement targeted population-specific outreach and interventions that are culturally appropriate and measurable in order to decrease regional, racial, and ethnic disparities in outcomes.
- Enhance our ability to assess members' readiness to change and to employ techniques such as motivational interviewing to encourage member behavior change appropriate for their level of readiness.
- Strengthen our processes for monitoring, analyzing, and evaluating 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.

Introduction

Overview of QAPI Program

The Department of Community Health (DCH) implemented a full-risk mandatory Managed Care program called Georgia Families for Medicaid and PeachCare for Kids® (the state's standalone Children's Health Insurance Program or "CHIP" program) members in 2006. Peach State Health Plan (Peach State, the Plan) has been one of three Care Management Organizations (CMOs) responsible for covering members required to enroll in Georgia Families since its inception pursuant to its contract with the DCH. In July 2017, DCH implemented a new contract which included the addition of a forth (4th) CMO. As a result, the Plan saw a decrease in our membership and as of December 2017, Peach State provided healthcare coverage for approximately 366,392 people.

Peach State's Quality Assessment and Performance Improvement (QAPI) Program philosophy is to ensure a systematic, comprehensive, evidence-based, data-driven approach to care. The QAPI Program continuously, objectively, and systematically monitors and analyzes performance and implements strategies to evaluate and continuously improve the quality, appropriateness, accessibility, and availability of culturally and clinically appropriate health care for all members, including those with special healthcare needs. Our overarching goal is to improve the health status of members and, where the member's condition is not amenable to improvement, to maintain the member's current health status by implementing measures to prevent any further 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 interventions. Peach State adopted and continues to utilize the Institute for Healthcare Improvement (IHI) Triple Aim for Health Care Improvement as a framework for evaluating the success of its QAPI program. As a quality driven organization, Peach State understands that an effective QAPI Program is critical to meeting goals, improving care and health outcomes for its members, and reducing per capita costs.
Peach State maintained NCQA "Commendable" Accreditation status, as we have since our first year of eligibility. Our QAPI Program continues to use evidence based national and community best practices to respond and adapt to changing member demographics and epidemiological concerns. The Plan's culture, systems, and processes are structured around its Triple Aim: to improve the health of all members and their experience of care at low per capita costs.

Peach State Health Plan's Approach to Quality

The Peach State Health Plan QAPI Program applies a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care, systems and processes. Peach State uses the PDSA methodology which stands for the Plan, Do, Study, and Act process for performance improvement. This methodology, developed by the W. Edwards Deming Institute, is used to monitor performance and measure the effectiveness of the implemented initiatives. The process is based on the scientific approach and includes the following components:

PDSA
PLAN – identify an opportunity and plan for change
DO – implement the change on a small scale
STUDY – use the data to analyze results of the change and determine whether it made a difference
ACT – if the change was successful, implement it on a wider scale and continuously assess results. If the change did not work, begin the cycle again

In specific cases, Peach State Health Plan employs the Six Sigma methodology for performance improvement. This methodology is another commonly applied process for performance improvement and incorporates a rigorous use of data and statistical analysis to measure outcomes using the DMAIC model.

DMAIC
Define a problem or improvement opportunity
Measure process performance
Analyze the process to determine the root causes of poor performance and determine whether the process can be improved or redesigned
Improve the process by attacking root causes
Control the improved process to hold the gains

These systematic approaches provide a continuous cycle for improving the quality of care and service of our members.

Health Information Systems Used to Support the Collection, Integration, Tracking, Analysis and Reporting of Data

Peach State Health Plan collects data from various state resources including the GAHIN, GRITS, the GMCF files, and enrollment files. Peach State has methods for 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. The Plan staff use Centelligence™, a comprehensive family of integrated decision support and healthcare information system to support the collection, integration, tracking, analysis and reporting of data.

The analytic resources below allow key personnel the necessary access and ability to manage the data required to support the measurement aspects of the quality improvement activities and to determine intervention focus and evaluation. Peach State uses multiple information sources and systems to support the collection, integration, tracking, analysis and reporting of data for the QAPI Program. These systems include:

- **Centelligence™ Insight** – Web-based reporting and management KPI Dashboards capability. Includes advanced capabilities for provider practice pattern and utilization reporting – supporting both QI staff and providers with summary and detailed views of clinical quality and cost profiling information. This capability gives providers the practice and peer level profiling information needed for continuous clinical quality improvement.

- **Centelligence™ Foresight** – Predictive modeling (PM) system combines PM applications with predictive modeling and care gap/health risk identification applications to identify and report potentially significant health risks at multiple population, provider, and enrollee levels. Foresight also powers online care gap notification functionality, allowing providers and enrollees to securely access care gaps and health alerts securely via web based provider and member portals.

- **Quality Spectrum Insight (QSI) -** an Inovalon software system used to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns. QSI is an NCQA-certified software; its primary use is for the purpose of building and tabulating HEDIS performance measures. QSI enables the Plan to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.

Additionally, the Inovalon product provides the Plan with an integrated clinical and financial view of care delivery, which enables the Plan to identify cost drivers, help guide best practices, and to manage variances in its efforts to improve performance. QSI is updated on a monthly basis by using an interface that extracts claims, member, provider and financial data. The data is mapped into QSI and summarized. Plan staff are given access to view standard data summaries and drill down into the data or create ad-hoc queries.

Peach State uses software as well as member and provider feedback, plan knowledge/research and best practices from other Centene Plans to determine which interventions to implement to address barriers, opportunities and healthcare disparities. Interventions that are implemented are assessed regularly to determine if the initiatives should be abandoned, adapted or adopted prior to expansion. For additional systems used to support the QAPI Program, please refer to the CY 2018 QAPI Program Description.

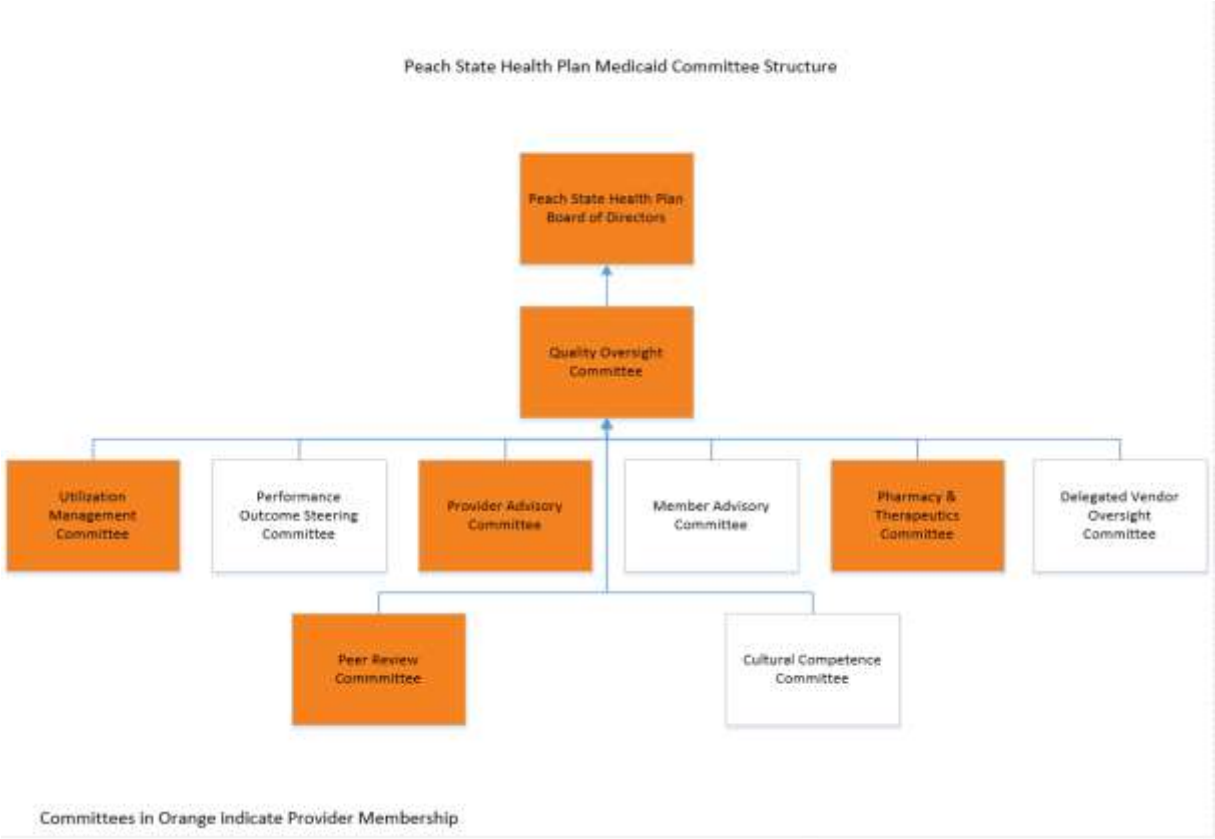
QAPI Program Governance

Peach State Health Plan provides the resources necessary and employs staff that have the expertise necessary to support and effectively carry out the operations of the QAPI Program. The Plan Senior Leadership Team plays a key role in improving quality as they set priorities for the organization and support the structure required to achieve sustainable improvements. By modeling core values, promoting a learning atmosphere, and acting on staff recommendations, senior leadership also fosters an organizational culture that centers on continuous quality improvement (CQI). Senior Leadership and hiring managers work to ensure that Peach State Health Plan recruits and retains employees based on their expertise in quality assessment, utilization management, and continuous quality improvement where applicable.

Peach State incorporates input from clinical and quality improvement staff at both a national and local level by collaborating with Centene corporate staff and its affiliate health plans across other states. The Plan also solicits and incorporates local provider and member input to ensure community involvement in the QAPI Program.

Quality is integrated throughout Peach State Health Plan and represents the strong commitment to the quality of care and services for members. To this end, the Plan has established various committees, subcommittees and ad-hoc committees to monitor and support its QAPI Program. The Board of Directors (BOD) holds ultimate authority for the program and the Quality Oversight Committee (QOC) is the senior management lead committee reporting to the BOD. Additional committees may be developed based on distribution of membership. The Annual QAPI Program Description contains a complete description of the roles of each committee.

Peach State Health Plan QAPI Committee Structure, 2017



Peach State utilizes the annual QAPI Program Description, QAPI Program Evaluation and QAPI Work Plan documents to govern and maintain the structure of the QAPI Program. The QAPI Program Evaluation serves a key role in this process by summarizing and evaluating all quality improvement activities/data of the previous year including outcomes, barriers to improvement and recommendations for the following year, providing methodology for strategic planning for the following year's QAPI Program Description and QAPI Work Plan. The annual QAPI Program Documents are reviewed and approved by the Quality Oversight Committee (QOC) prior to the BOD final review and approval. These entities serve as the foundation for making recommendations based upon identified opportunities for improvement, implementing interventions, and ensuring follow-up for effectiveness of adopted recommendations.

This annual QAPI Program Evaluation was developed with the participation and support of key staff throughout the organization prior to being presented to the Quality Oversight Committee and the Board of Directors for additional recommendations and final approval.

Quality Framework

The Peach State Quality Strategic Planning Process, led by the Senior Leadership Team (SLT), includes an analysis of external driving forces; internal strengths, weaknesses, opportunities, and threats (SWOT); the DCH Strategic Plan; and lessons learned from evaluating the prior

year's QAPI Program and, through a confirmation or revision of our mission, vision, and core values, leads the Plan to adopt high-level goals for improvement.

Elements in the DCH Quality Strategic Plan for Georgia Families and Georgia Families 360° (February 2016) that served as drivers for Peach State's Goals, Objectives, and Strategies for 2017 include, for example:

- Improving access to high quality physical, behavioral, and oral health care for all members
  - Increase and monitor access to health services for members
- Increase appropriate utilization of physical and Behavioral Health services by all members
  - Increase preventive health and follow up care service utilization
- Improve care for chronic conditions for all members
  - Improve care coordination programs
  - Improve evidence-based practices
  - Implement improvement activities focused on chronic conditions
- Decrease LBW and early elective inductions and C-sections
- Use of rapid cycle process improvement/plan-do-study-act principles
- Focus on decreasing healthcare disparities
- Improve appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates
- Reduce the all cause readmission rate

SWOT Analysis

The annual SWOT analysis helped with direction setting for the QAPI Program's 2017 goals and objectives.

Strengths	Weaknesses
• Innovative Programs (NICU CM, ER CM, Healthy • Start, Member Connections, THINC) • Local presence • Member and provider satisfaction with the Plan • Community Medical Director • Tenure and experience of employees (stable leadership)	• Lack of deployment of principles to improve processes by the 25 LSS Certified staff • QAPI Program document integration • Effectively demonstrating the Plan's understanding of the PDSA cycle • Branding/community awareness of PS in certain Georgia Family regions • Effective barrier/root cause analysis to decrease disparities in care and improve outcomes
Opportunities	**Threats**
• Optimization of HIE, GaHIN, Availity • Automation and advancement of IT solutions • Integration and coordination of Behavioral Health and Behavioral Health homes • Implementation of the Value Based Purchasing program • Enhancement of communication and messaging to members and providers	• New Market entrance (CareSource) • Loss of rural healthcare providers-decrease access • Hospital consolidation & physician acquisition • Possible political changes that will impact Medicaid

Program Goals and Objectives for CY 2017

In January 2017, leadership for each Department met to establish goals and objectives or CY 2017. The data used to determine CY 2017 goals were based on review of 2016 monthly:

- Pharmacy data
- HEDIS rates
- Medical management (over/under-utilization, case and disease management)
- EPSDT screening and participation rates

- Member enrollment and demographic data
- Member and provider satisfaction survey and data

In July 2017, departmental leadership met to review established goals and objectives and metrics and determined that a course correction was needed to better align the objectives and metrics of the QAPI Program with the mission and vision of Peach State Health Plan. Along with the data used in January 2017, the Plan incorporated feedback received from members and providers during Q2, 2017 and NCQA accreditation measures into the revised objectives and metrics. Departmental leaders ensured that the revisions continued to align the DCH Quality Strategic Plan for Georgia Families and Georgia Families 360, February 2016 as well as the IHI Triple Aim. The table below reflects the goals established in January 2017 as well as the revised objectives and metrics effective July 2017.

Goal	January 2017 Objective/Metrics	July 2017 Objective/Metrics	Result	Met/Not Met Summary
Improve Member Health **DCH Goal – Improved Health for Medicaid and PeachCare for Kids (CHIP) Members **GOAL NOT MET**	1. Improve access to physical health, Behavioral Health and oral health for members so that select performance metrics for 2017 will reflect a relative two percent increase over 2016 rates. Metrics: HEDIS: W34, AWC, PPC (Prenatal Care) and FPC 81%+, ADV-Total Child Core Set: Dental Sealants; Preventive Dental CMS 416: participation and screening rate **DCH Objective: Improve access to high quality physical health, Behavioral Health and oral health care for all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	1. Improve access to preventive physical and oral health for members so that select metrics for 2017 will reflect a relative two percent increase over 2016 rates. Metrics: HEDIS: W34, AWC, PPC (Postpartum Care) ADV- Total, BCS, WCC (BMI Total) CMS 416: screening rate **DCH Objective: Improve access to high quality physical health, Behavioral Health and oral health care for all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	CMS-416 Screening Rate CY 2016: 71% CY 2017: 73% W34 CY 2016: 72.80% CY 2017: 76.12% AWC CY 2016: 50.00% CY 2017: 54.01% PPC (postpartum) CY 2016: 61.07% CY 2017: 61.56% BCS CY 2016: 66.12% CY 2017: 64.64% WCC- BMI (total) CY 2016: 73.32% CY 2017: 76.43% ADV (total) CY 2016: 63.90% CY 2017: 66.12%	(↑ 2.7%) MET ↑ 4.56% MET ↑ 8.02% MET ↑ 0.8% NOT MET ↓ 2.24% NOT MET ↑ 4.24% MET ↑ 3.5% MET **Objective 1- PARTIALLY MET**

Goal	January 2017 Objective/Metrics	July 2017 Objective/Metrics	Result	Met/Not Met Summary
	2. Increase appropriate utilization of physical health, Behavioral Health and oral health so that select performance metrics for 2017 will reflect a relative two percent increase over 2016 rates. HEDIS ADV (total); PPC (Prenatal & Postpartum Care); FUH -7 day; ADHD-initiation; W34, AWC, CAP Child Core Set: Preventive Visits ** DCH Objective: Increase appropriate utilization of physical and Behavioral Health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	2. Increase appropriate utilization of Behavioral Health and physical health so that select performance metrics for 2017 will reflect a relative two percent increase over 2016 rates. HEDIS: FUH -7 day; ADHD- initiation & continuation, CWP, URI ** DCH Objective: Increase appropriate utilization of physical and Behavioral Health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	FUH- 7 day CY 2016: 50.7% CY 2017: 46.27% ADD - initiation CY 2016: 45.69% CY 2017: 45.48% ADD - continuation CY 2016: .59.84% CY 2017: 57.83% CWP CY 2016: 83.95% CY 2017: 85.06% URI CY 2016: 87.16% CY 2017: 87.59%	↓ 8.73% NOT MET ↓ 0.46% NOT MET ↓ 3.36% NOT MET ↑1.68% NOT MET ↑ 0.5% NOT MET **Objective 2- NOT MET**
	3. Improve care of chronic conditions for all members such that identified measures of effectiveness demonstrate a relative two percent improvement over 2016 rates. Metrics: Quarterly CPG reported rates will meet the overall compliance target of 80% HEDIS: AMM acute and continuation; MMA 75% 5-11 year olds; CDC - Control >9 (lower is better); HbA1c Testing, CDC-Eye Exam	3. Improve care of chronic conditions for all members such that identified measures of effectiveness demonstrate a relative two percent improvement over 2016 rates. Metrics: Quarterly CPG reported rates will meet the overall compliance target of 80% HEDIS: AMM acute and continuation; MMA 75% 5-11 year olds; CDC - Control >9 (lower is better); HbA1c Testing, CDC-Eye Exam	AMM acute CY 2016: 40.76% CY 2017: 44.41% AMM continuation CY 2016: 24.84% CY 2017: 27.69% MMA (75% for 5-11year olds) CY 2016: 20.28% CY 2017: 26.60% CDC (poor) control >9 CY 2016: 61.04% CY 2017: 56.57% CDC- HbA1c testing CY 2016: 83.48% CY 2017: 84.85% CDC – eye exam CY 2016: 59.36% CY 2017: 57.30%	↑ 8.9% MET ↑ 11.5% MET ↑ 31.2% MET ↓ 7.32% MET ↑ 1.64% NOT MET ↓ 3.5% NOT METMET NOT MET NOT MET **Objective 3 - PARTIALLY MET**

Goal	January 2017 Objective/Metrics	July 2017 Objective/Metrics	Result	Met/Not Met Summary
	** DCH Objective: Improve care for chronic conditions for all Medicaid and PeachCare for Kids members so that health performance metrics relative to chronic conditions will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	** DCH Objective: Improve care for chronic conditions for all Medicaid and PeachCare for Kids members so that health	CPG Quarterly compliance ADHD – 94.23% Asthma – 77.64% Diabetes – 73.37%	
Improve Member & Provider Experience with Care **GOAL MET**	Improve member experience with the Plan by decreasing top two grievance reasons from CY 2016 to CY 2017 Metrics: Member Grievance count for CY 2016 and provider satisfaction survey results	1. Improve member experience with the Plan by decreasing balance billing grievances from CY 2016 to CY 2017 2. Improve provider experience with the Plan by increasing overall satisfaction by two percentage points from CY 2016 to CY 2017 Metrics: Member Grievance count for balance billing and provider Satisfaction scores for Overall Satisfaction with Peach State Health Plan	Member Grievance Count Balance billing (provider billing member) CY 2016: 139 CY 2017: 69 Provider Satisfaction CY 2016: 73.1% CY 2017: 80.6%	↓ by 70 grievances- MET ↑ 7.5% - MET **Objective 1 and 2- MET**

Goal	January 2017 Objective/Metrics	July 2017 Objective/Metrics	Result	Met/Not Met Summary
Lower per Capita Cost **GOAL NOT MET**	Have smarter utilization of each dollar by improving select rates associated with appropriate utilization of services/visits by a relative two percent when comparing 2016 rates to 2017 rates Metrics: Child Core Set: C-Section Rate; Nulliparous C-Section Rate; Elective Delivery Rate, Low Birth Weight Rate, Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD). HEDIS: AMBA- ER use Other: All Cause Readmission Rate **DCH Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data. **DCH Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to 9% by the end of CY 2019 as reported in June of 2020.	Have smarter utilization of each dollar by improving select rates associated with appropriate utilization of services/visits by a relative two percent when comparing 2016 rates to 2017 rates Metrics: Child Core Set: (PQI 9)Low Birth Weight Rate (LBW) HEDIS: AMBA- ER use; All Cause Readmission Rate (PCR) **DCH Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data. **DCH Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to 9% by the end of CY 2019 as reported in June of 2020.	Low Birth Weight Rate CY 2016: 8.86% CY 2017: 8.92% AMBA- ER use CY 2016: 48.00% CY 2017: 51.55% All Cause Readmission Rate CY 2016: 11.58% CY 2017: 7.58%	↑ 0.7% - NOT MET ↑ 7.39% - NOT MET ↓ 34.54% MET **Objective- NOT MET**

** DCH Goal and Objectives were taken from the DCH Quality Strategic Plan for Georgia Families and Georgia Families 360, February 2016 (http://dch.georgia.gov/sites/dch.georgia.gov/files/2016-Quality-Strategic-Plan-Final-6.17.16.pdf)

Program Changes for 2017

In 2017 Centene Corporation, the parent company of Peach State Health Plan made a decision to fully integrate Behavioral Health services into the health plans. In 2017, Peach State began the integration process by first integrating Network Management and Provider Relations in Q3 2017. This was followed by Case Management Services in December 2017. The remainder of the Behavioral Health departments and functions will be integrated by June 2018.The was done to streamline activities, better allocate resources and improve effectiveness in achieving program objectives. Further changes implemented in early 2018 are below:

- Grievance and Appeals was moved under Plan Operations.
- Provider Relations restructured to have an internal team focused on provider concerns (claims resolution, change in demographics, etc.) and an external team focused on improving quality scores.
- Outbound call team was relocated to the Quality Improvement Department to focus on education and scheduling appointments for members with care gaps.

The Plan made changes to the QAPI Program in early 2018. This was based on our annual Quality Strategic Planning Process, including lessons from the previous year, an environmental scan and SWOT analysis and review of data such as the population assessment and performance measures.

- Reviewed goal setting for performance measures and determined that comparing administrate rates, versus hybrid, is a better method for assessment. Beginning in 2018, goals for performance measures will be based on administrative rates.
- Provided PDSA and effectiveness training to all Medical Management and Quality Department leadership.
- Increased focus on ensuring coordination of physical and Behavioral Health services and on access to medical/Behavioral Health homes.
- Developed and prioritized strategies and potential interventions that are scalable and sustainable.

Population Served

At least annually, Peach State analyzes key demographic characteristics including race, ethnicity, gender, regional and rural/urban distribution, and disease burden to identify health disparities and to ensure we are addressing the specific needs of our members. The goal is to identify target populations or sub-populations that could benefit from targeted interventions, or care management or disease management programs, as well as to set the direction for the upcoming year's QAPI program.

The findings from the December 2016 population analysis drove the QAPI program during 2017. Peach State conducted another population analysis in December 2017 to determine if any changes occurred. Peach State uses several data sources to complete the analysis including but not limited to:

- Member enrollment data
- Medical claims
- Pharmaceutical claims
- Readmission data
- Providers, members, caregivers
- Health Risk Assessments
- HEDIS® performance reports
- CAHPS® survey results
- Cultural needs and assessment reports
- Utilization data -top inpatient and outpatient diagnoses
- Census Bureau data.

Key Findings

Age, Regional Distribution and Gender

- In 2017, the membership composition based on age, regional distribution and gender was similar to that of 2016 even though the membership decreased by 52,357. The significant decrease in membership during 2017 is attributed to a fourth CMO entering the market.
- Consistent with 2016, over 80% of the Peach State population remained 20 years of age or younger and almost 57% were female.
- The majority of members (over 59%) continued to live in the Atlanta Region, followed by the Southwest Region with 20%, and the Central Region with 13.5%. The North, Southeast, and East Regions continue to have low membership.
- The majority of members in the Atlanta region were males (59.87% compared to 58.32% female). Outside of the Atlanta region, females comprised the majority of the membership in each region.
- Over 80% of the members resided in urban areas.

Race and Ethnicity

- Almost 57% of Peach State members were Black or African American and over 34% were White
- Black or African Americans comprised a greater proportion of all members 21 years or older (62.82%) than of members 20 years or younger (55.83%).
- Black or African Americans comprised a slightly higher proportion of all females (58.60%) than of all males (57.85%).

- The majority of members in four regions (Atlanta, Central, East, and Southwest) were Black or African American. The majority of members in the North Region were White. The East Region had the highest proportion of members in other racial categories.
- Overall membership of members with an ethnicity of Hispanic or Latino decreased by 52.50% from 11.79% in 2016 to 6.40% in 2017. Hispanic or Latino comprised a greater proportion of members 20 years of age or younger (7.30%) than of members 21 years or older (1.86%). A slightly higher proportion of males (7.32 %) than of females (5.70%) were Hispanic or Latino. The Atlanta Region had the highest proportion of Hispanic or Latino members and the East Region had the lowest.

Disease Burden

- Peach State used Major Primary Risk categories, assigned by our predictive modeling suite of applications (ImpactPro) as a means to predict the future risk of healthcare utilization, to analyze the disease burden for our member population.
- The most frequent Major Primary Risk category was No Primary Risk Category, reflecting members who did not have a risk factor identified in 2 or more medical or pharmacy claims, lab results, the enrollment file, or risk assessment data that ImpactPro links to a Primary Risk category and uses to predict future risk. This category includes members with no claims.
- Like 2016, the proportion of members linked to No Primary Risk Category was higher for Black or African American (25.04% in 2016, 30.80% in 2017) and Asian (22.46% in 2016 and 26.55% in 2017) than for White (16.98% in 2016 and 23.57% in 2017) in members 20 years or younger, who are the vast majority of our members. The proportion of members linked to No Primary Risk Category was lower for Hispanic or Latino (18.64%) than for Non-Hispanic or Latino (29.35%) in members 20 years or younger, but no difference was noted for the members 21 years of age or older.
- For members 20 Years and younger:
    - No Primary Risk Category, Pulmonology, and ENT, were in the top three risk categories regardless of race for both 2016 and 2017. BH/MH/SA (the Behavioral Health Primary Risk Category) remained among the top five risk categories for both Black or African American and White. In 2017, 26.55% of the Asian membership also had BH/MA/SA as a Primary Risk Category. No Primary Risk Category, Pulmonology, ENT and Dermatology were in the top five risk categories for both Hispanic or Latino and Non-Hispanic or Latino. BH/MH/SA was in the top five for Non-Hispanic or Latino but was 8th for Hispanic or Latino.
- For members 21 Years or Older:
    - No Primary Risk Category, OB, and Endocrinology were in the top five risk categories for all three races in 2016 and 2017. In 2016 and 2017 the proportion of Asians linked to Endocrinology was almost twice that for Black or African Americans or Whites. No Primary Risk Category, OB, Neurology, Endocrinology and Orthopedic/Rheumatology were in the top five risk categories for both ethnic categories. BH/MH/SA was in the top five for Non-Hispanic or Latino but not for Hispanic or Latino.

Health Disparities

- Peach State's 2016 member demographic analysis identified race for 97.23% of members and ethnicity for 99.86% of members. A high level of identification is critical for valid disparity analysis. In our 2017 analysis, members with identified race increased to 98.51%, and members with identified ethnicity increased to 99.86%.

- Asthma: The number of members with Pulmonology as a Primary Risk Category increased to 39,286 in 2017. These members remained disproportionately male (52.08%) and aged 20 years or younger (95.29%).
- HIV/AIDS: There were 257 members linked with HIV/AIDS as a Primary Risk Category, and remained disproportionately female (85.60%), Black or African Americans (85.21%), and aged 21 years of older (82.88%). These members continued to reside in all regions generally in proportion to the membership.
- Cancer: There were 767 members linked with the Cancer Primary Risk Category. These members continued to be disproportionately female (89.31% compared to 57.12% of all members), and older (81.10% aged 21 years or older compared to 16.60% of all members). Out of all the members linked with Cancer, 50.20% are Black or African American and 34.94% are White. These members continued to reside in all regions generally in proportion to the membership.
- Behavioral Health: The number of members linked to BH/MH/SA Major Primary Risk category decreased to 25,662. This group continued to be disproportionately male (56.32%) and Black or African American (48.72%). They tend to reside in the Southwest and Atlanta Regions.
- Low and Very Low Birth Weight Births: When comparing LBW and VLBW for all deliveries (19,157), members 21 years of age and older had a greater percentage of LBW (8.30%) and VLBW (2.31%) deliveries compared to the 20 and under age category (1.50% and 0.32% respectively). Black or African American mothers tended to have a higher rate of LBW or VLBW babies (8.60%) compared to White mothers (3.30%).

Basic Demographics

According to the Georgia Department of Community Health Fact Sheet dated April 2017 found online (https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/GaFam2017%20-%20Final%20Draft.pdf), the Georgia Families program serves approximately 1.3 million total enrollees in Medicaid, PeachCare for Kids® (PCK, the Children's Health Insurance Program for Georgia), and the Planning for Healthy Babies® (P4HB) Programs.

In December 2016, Peach State provided healthcare coverage to 419,289 members. The vast majority of our members (90.95 %) were enrolled in Medicaid (including P4HB). By December 2017, our overall membership had had decreased to 366,932, and the distribution by product was changed slightly as well with 92.12% of the members being enrolled in Medicaid (including P4HB). The change in membership is directly related to a fourth Care Management Organization (CMO) entering the market and membership being moved to ensure a minimum membership for the new CMO.

Table 1: Membership by Product Type and Year as of 12/31

Year	Medicaid (including P4HB)	% of Total Membership	PCK	% of Total Membership	Total Membership
2017	338,029	92.12%	28,903	7.88%	366,932
2016	381,355	90.95%	37,934	9.05%	419,289

The following section presents a comparison of member demographics between December 2016 and December 2017. Member demographic data is derived primarily from the eligibility file Peach State receives regularly from DCH. We resolved inconsistencies in the data, such as changes in the race identified by a member over time, in a consistent, unbiased manner. The member demographic information collected is self-reported and voluntary, rather than mandatory.

Gender. Female members made up approximately 56% of the membership in 2016 compared to 57.12%. With the addition of the new CMO in 2017, females decreased by 10.69% while males decreased by 14.77%.

Table 2: Membership by gender

Gender	Population by Gender 2016	% of Total	Population by Gender 2017	% of Total	Difference	% Change
Female	234,668	55.97%	209,576	57.12%	1.15	-10.69%
Male	184,621	44.03%	157,356	42.88%	-1.15	-14.77%
Grand Total	**419,289**	**100%**	**366,932**	**100%**		

Age. Over 83% of the Peach State membership was made up of members 20 years of age or younger. A 14.63% decrease when compared to 2016.

Table 3: Membership by Age

Age Category	Population by Age 2016	% of Total	Population by Age 2017	% of Total	Difference	% Change
20 years of age or younger	358,453	85.49%	306,017	83.40%	-2.09	-14.63%
21 years of age or older	60,836	14.51%	60,915	16.60%	2.09	0.13%
Grand Total	**419,289**	**100.00%**	**366,932**	**100.00%**		

Urban/Rural. Although there was an 11.31% decrease members residing in urban areas in 2017 remained above 80%.

Table 4: Membership by Urban/Rural

Rural vs. Urban	Population by Rural/ Urban 2016	% of Total	Population by Rural/ Urban 2017	% of Total	Difference	% Change
Rural	79,766	19.02%	65,523	17.86%	-1.16%	-17.86
Urban	339,118	80.88%	300,773	81.97%	1.09%	-11.31
Unknown	405	0.10%	636	0.17%	0.07%	57.04
Grand Total	**419,289**	**100.00%**	**366,932**	**100.00%**		

Region. In 2017, with the addition of the fourth CMO, all six regions posted a decrease in membership ranging from almost nine percent (8.97) in the Southwest region to over twenty-four point five percent (24.69%) in the East. The Atlanta region continued to be the largest region for Peach State Health Plan with over 59% of the membership. The Southwest region contains the next largest membership with 20.92% of the members. The East region accounts for the smallest number of membership at 1.12% of the total.

Table 5: Membership by Region

Region	Population by Region 2016	% of Total	Population by Region 2017	% of Total	Difference	% Change
Atlanta	242,528	57.84%	216,449	59.09%	1.25	-10.75%
Southwest	84,182	20.08%	76,630	20.92%	0.84	-8.97%

Central	61,719	14.72%	49,418	13.49%	-1.23	-19.93%
North	14,744	3.52%	11,103	3.03%	-0.49	-24.69%
Southeast	10,735	2.56%	8,601	2.35%	-0.21	-19.88%
East	5,381	1.28%	4,095	1.12%	-0.16	-23.90%
Grand Total	**419,289**	**100%**	**366,296**	**100%**		

Race and Ethnicity. The Black or African American race category comprised the majority of members statewide in both 2016 and 2017 (55.68% and 56.99% respectively). White comprised the second highest in both years (36.57% in 2016 and 34.95% in 2017). With the addition of the new contract, Peach State Health Plan recognized a decrease in its Asian population by 20.73%, members identifying themselves as white decreased by 16.37% and Black or African American membership decreased by 10.42%. The number of members who did not specify a race increased by 0.09 percentage points to 4.96% in 2017.As a result of the fourth CMO entering the market, Peach State Health Plan's Hispanic or Latino ethnicity category decreased by 52.50 % and now accounts for 6.4% of the overall membership. The number of members who did not specify an ethnicity remained consistent when comparing 2017 to 2016. The Non-Hispanic/Latino ethnicity category decreased by 7.14% when compared to 2016.

Table 6a: Membership by Race

Race	Population by Race 2016	% of Total	Population by Race 2017	% of Total	Difference	% Change
Black or African American	233,461	55.68%	209,127	56.99%	1.31	-10.42%
White	153,354	36.57%	128,246	34.95%	-1.62	-16.37%
American Indian and Alaska Native	580	0.14%	614	0.17%	0.03	5.86%
Asian	13,116	3.16%	10,397	2.83%	-0.33	-20.73%
Native Hawaiian and Other Pacific Islander	396	0.09%	343	0.09%	0.00	-13.38%
Unknown	17,799	4.24%	18,205	4.96%	0.72	2.28%
Grand Total	419,289	**100%**	366,932	**100%**		

Table 6b: Membership by Ethnicity

Ethnicity	Population by Ethnicity 2016	% of Total	Population by Ethnicity 2017	% of Total	Difference	% Change
Non-Hispanic/ Latino	369,301	88.08%	342,943	93.46%	5.38%	-7.14%
Hispanic or Latino	49,414	11.79%	23,471	6.40%	-5.39%	-52.50%
Unknown	574	0.14%	518	0.14%	0.00%	-9.76%
Grand Total	**419,289**	**100%**	**366,932**	**100%**		

In 2016 and 2017, Black or African Americans comprised the majority of members in both the 20 and younger and 21 and older age groups. The 21 years of age and older category had a higher proportion of Black or African American members (61.39% in 2016 and 62.82% in 2017) compared to the 20 and under age group (54.71% and 55.83% respectively). In 2017, there was a significant increase in the percent of members with an unknown race. Members in the 20 years or younger age category posted an 11.28% increase in members with unknown race (from 4.94% to 5.50%); members 21 years or older with an unknown race doubled going from

1.12% in 2016 to 2.27% in 2017. Members 20 years of age and younger identifying as Hispanic or Latino decreased by 44.28% while those 21 years of age and older decreased by 53.92%.

Table 7a: Member Age by Race and Ethnicity

Race	% 20 years of age or younger 2016	% 20 years of age or younger 2017	% Change	Difference	% 21 years of age or older 2016	% 21 years of age or older 2017	Difference	% Change
Black or African American	54.71%	55.83%	1.12	2.05%	61.39%	62.82%	1.43	2.33%
White	36.99%	35.51%	-1.48	-4.01%	34.14%	32.16%	-1.98	-5.79%
Asian	3.13%	2.91%	-0.22	-6.95%	3.10%	2.44%	-0.66	-21.41%
American Indian and Alaska Native	0.14%	0.16%	0.02	13.44%	0.15%	0.21%	0.06	40.09%
Native Hawaiian and Other Pacific Islander	0.09%	0.09%	0.00	2.39%	0.10%	0.10%	0.00	0.14%
Unknown	4.94%	5.50%	0.56	11.28%	1.12%	2.27%	1.15	102.57 %
Grand Total	**100%**	**100%**			**100%**	**100%**		

Table 7b: Member Age by Ethnicity

Ethnicity	% 20 years of age or younger 2016	% 20 years of age or younger 2017	Difference	% Change	% 21 years of age or older 2016	% 21 years of age or older 2017	Difference	% Change
Non-Hispanic/ Latino	86.78%	92.58%	5.80	6.69%	95.71%	97.87%	2.16	2.26%
Hispanic or Latino	13.10%	7.30%	-5.80	-44.28%	4.04%	1.86%	-2.18	-53.92%
Unknown	0.25%	0.12%	-0.13	-53.47%	0.25%	0.27%	0.02	6.38%
Grand Total	**100%**	**100%**			**100%**	**100%**		

Black or African American comprised the majority of both genders in 2016 and 2017. Black or African American increased from 53.79% males in 2016 to 54.85% in 2017 and females increased from 57.17% to 58.60%. Unlike the Black or African American population where among females represented the highest proportion of membership, a higher proportion of males were White in both 2016 and 2017 compared to females (37.66% and 36.31% compared to 35.72% and 33.93% respectively).

Hispanic or Latino also comprised a slightly higher proportion among males (13.00% in 2016 and 7.32% in 2017) than females (10.83% and 5.70% respectively).

Table 8a: Member Gender by Race

Race	2016 % Among Male Population	2017 % Among Male Population	Difference	% Change	2016 % Among Female Population	2017 % Among Female Population	Difference	% Change
Black or African American	53.79%	54.85%	1.06%	1.97	57.17%	58.60%	1.43%	2.50
White	37.66%	36.31%	-1.35%	-3.58	35.72%	33.93%	-1.79%	-5.02
Asian	3.42%	3.13%	-0.29%	-8.52	2.89%	2.61%	-0.28%	-9.62
American Indian and Alaska Native	0.13%	0.15%	0.02%	18.30	0.15%	0.18%	0.03%	18.33
Native Hawaiian and Other Pacific Islander	0.10%	0.10%	0.00%	-3.40	0.09%	0.09%	0.00%	1.26
Unknown	4.90%	5.46%	0.56%	11.34	3.98%	4.59%	0.61%	15.33
Grand Total	**100%**	**100%**			**100%**	**100%**		

Table 8b: Member Gender by Ethnicity

Ethnicity	2016 % Among Male Population	2017 % Among Male Population	Difference	% Change	2016 % Among Female Population	2017 % Among Female Population	Difference	% Change
Non-Hispanic/Latino	86.89%	92.57%	5.68	6.54%	89.01%	94.13%	5.12	5.75%
Hispanic or Latino	13.00%	7.32%	-5.68	-43.71%	10.83%	5.70%	-5.13	-47.32%
Unknown Ethnicity	0.11%	0.11%	0.00	0.52%	0.16%	0.16%	0.00	2.59%
Grand Total	**100%**	**100%**			**100%**	**100%**		

Regional Analysis

Age and Sex. The proportion of members who were male varied from 59.87% in the Atlanta Region to 1.00% in the East Region during 2017 while the proportion of females varied from 58.32% in the Atlanta Region to 1.21% in the East Region. The proportion of members who were 20 years of age or younger varied from 59.61% in the Atlanta Region to 0.99% in the East Region.

Race and Ethnicity. The majority of members in four regions (Atlanta, Central, East, and Southwest) were Black or African American, with the Central Region having the highest proportion of Black or African Americans (59.47%) and the North Region the lowest (15.68%). The majority of members in the North Region (75.43%) were White. The Atlanta Region had the highest proportion of members in other racial categories, for example 4.33% Asian and 5.82% Some Other Race.

The vast majority of members in all regions were Non-Hispanic/Latino. The Atlanta Region had the highest proportion of Hispanic or Latino members (57.88%); the East Region had the lowest (1.15%).

Table 9a: Member Gender by Region

Race	2016 % Among Male Population	2017 % Among Male Population	Difference	% Change	2016 % Among Female Population	2017 % Among Female Population	Difference	% Change
Atlanta	58.54%	59.87%	1.34	2.29%	57.30%	58.32%	1.03	1.79%
Central	14.41%	13.12%	-1.29	-8.93%	14.96%	13.73%	-1.24	-8.27%
East	1.21%	1.00%	-0.21	-17.72%	1.34%	1.21%	-0.13	-10.03%
North	3.42%	2.85%	-0.57	-16.67%	3.59%	3.16%	-0.43	-12.08%
South East	2.42%	2.09%	-0.33	-13.73%	2.67%	2.53%	-0.13	-5.01%
South West	20.00%	20.89%	0.89	4.45%	20.14%	20.88%	0.74	3.68%
Unknown	0.00%	0.18%	0.18	100.00%	0.00%	0.17%	0.17	100.00%
Grand Total	**100%**	**100%**			**100%**	**100%**		

Table 9b: Member Age by Region

Region	% 20 years of age or younger 2016	% 20 years of age or younger 2017	Difference	% Change	% 21 years of age or older 2016	% 21 years of age or older 2017	Difference	% Change
Atlanta	57.59%	59.61%	2.03%	3.52	58.12%	55.86%	-2.26%	-3.89
Central	14.65%	13.24%	-1.42%	-9.66	14.79%	14.62%	-0.18%	-1.19
East	1.27%	0.99%	-0.27%	-21.45	1.30%	1.73%	0.42%	32.52
North	3.67%	2.83%	-0.85%	-23.05	3.35%	4.03%	0.69%	20.49
South East	2.58%	2.08%	-0.50%	-19.39	2.54%	3.67%	1.13%	44.48
South West	20.24%	21.08%	0.85%	4.18	19.90%	19.88%	-0.02%	-0.12
Unknown	0.00%	0.16%	0.16%	100.00	0.00%	0.22%	0.22%	100.00
Grand Total	**100%**	**100%**			**100%**	**100%**		

Table 9c: Member Ethnicity by Region

	% of Population 2016	% of Population 2017	Difference	% Change
Atlanta				
Non-Hispanic / Latino	55.07%	57.88%	2.81%	5.09
Hispanic / Latino	76.72%	75.40%	-1.32%	-1.72
Unknown	59.75%	52.12%	-7.62%	-12.76
Central				
Non-Hispanic / Latino	16.44%	14.21%	-2.23%	-13.59
Hispanic / Latino	4.25%	2.74%	-1.51%	-35.48
Unknown	12.01%	8.88%	-3.12%	-26.03
East				
Non-Hispanic / Latino	1.22%	1.15%	-0.06%	-5.17
Hispanic / Latino	0.56%	0.49%	-0.07%	-13.24
Unknown	2.76%	4.83%	2.07%	75.14
North				
Non-Hispanic / Latino	3.06%	3.04%	-0.02%	-0.64

Hispanic / Latino	4.19%	2.61%	-1.58%	-37.71
Unknown	6.80%	14.67%	7.87%	115.62
South East				
Non-Hispanic / Latino	2.40%	2.40%	0.00%	0.11
Hispanic / Latino	1.37%	1.39%	0.02%	1.39
Unknown	5.45%	8.49%	3.04%	55.77
South West				
Non-Hispanic / Latino	21.82%	21.15%	-0.66%	-3.04
Hispanic / Latino	12.90%	17.19%	4.29%	33.23
Unknown	13.23%	10.23%	-3.00%	-22.69
Unknown				
Non-Hispanic / Latino	0.00%	0.17%	0.17%	100.00
Hispanic / Latino	0.00%	0.18%	0.18%	100.00
Unknown	0.00%	0.77%	0.77%	100.00

Table 9d: Member Race by Region

	% of Population 2016	% of Population 2017	Difference	% Change
Atlanta				
Black or African American	51.11%	58.91%	7.80%	15.27
White	27.86%	30.62%	2.76%	9.89
Asian	4.22%	4.33%	0.11%	2.60
American Indian and Alaska Native	0.16%	0.20%	0.04%	23.02
Native Hawaiian and Other Pacific Islander	0.11%	0.12%	0.02%	14.22
Unknown	16.54%	5.82%	-10.72%	-64.80
Central				
Black or African American	53.30%	59.57%	6.27%	11.77
White	33.87%	35.73%	1.86%	5.49
Asian	0.72%	0.80%	0.07%	10.30
American Indian and Alaska Native	0.08%	0.11%	0.03%	37.14
Native Hawaiian and Other Pacific Islander	0.05%	0.07%	0.02%	37.38
Unknown	11.98%	3.73%	-8.25%	-68.90
East				
Black or African American	46.27%	58.85%	12.58%	27.18
White	28.43%	33.09%	4.66%	16.37
Asian	1.47%	0.76%	-0.71%	-48.44
American Indian and Alaska Native	0.15%	0.34%	0.19%	129.96
Native Hawaiian and Other Pacific Islander	0.32%	0.05%	-0.27%	-84.54
Unknown	23.36%	6.91%	-16.45%	-70.42
North				
Black or African American	15.36%	15.68%	0.33%	2.12
White	60.94%	75.43%	14.49%	23.78
Asian	1.44%	1.65%	0.21%	14.63
American Indian and Alaska Native	0.18%	0.32%	0.14%	77.06
Native Hawaiian and Other Pacific Islander	0.07%	0.08%	0.01%	19.51
Unknown	22.02%	6.84%	-15.18%	-68.95
South East				
Black or African American	37.09%	44.77%	7.68%	20.71
White	38.57%	47.73%	9.15%	23.73
Asian	1.06%	0.78%	-0.28%	-26.65
American Indian and Alaska Native	0.14%	0.29%	0.15%	108.02

Native Hawaiian and Other Pacific Islander	0.11%	0.08%	-0.03%	-27.19
Unknown	23.02%	6.35%	-16.67%	-72.42
South West				
Black or African American	52.90%	57.23%	4.33%	8.18
White	37.12%	39.49%	2.37%	6.37
Asian	0.47%	0.43%	-0.04%	-8.87
American Indian and Alaska Native	0.06%	0.07%	0.01%	15.96
Native Hawaiian and Other Pacific Islander	0.03%	0.04%	0.01%	38.51
Unknown	9.42%	2.75%	-6.67%	-70.85
Unknown				
Black or African American	0.00%	51.42%	51.42%	
White	0.00%	36.01%	36.01%	
Asian	0.00%	2.36%	2.36%	
American Indian and Alaska Native	0.00%	0.00%	0.00%	
Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.00%	
Unknown	0.00%	10.22%	10.22%	

Disease Burden

Peach State used our predictive modeling suite of applications (Impact Pro) as a means of segmenting the population into mutually exclusive population health categories representing the members' health status to predict the future risk of healthcare utilization and to analyze the disease burden for our member population. They are designated using condition identification, utilization, acute events, and predictive risk score for both future costs and likelihood of being admitted to a facility. Population health categories use the member's most recent 12 months of claims history and care opportunities (i.e. gaps in care) and are the basis to determine the Primary Risk category. The Primary Risk category is the risk marker with the highest percentage of total predicted cost. The Primary Risk categories are then grouped into Major Primary Risk categories representing major health conditions. The approach of this methodology requires that a member have at least 2 or more claims in the most recent 12 months to be considered as having a condition. Due to this conservative approach, there may be situations where a member had an episode of care for an indicated condition but did not qualify for the condition category. In this case they would be placed in the Healthy, Healthy at Risk, or Acute Episodic population health categories, as appropriate, within the Primary Risk category of unknown/demographics.

The following table presents the Primary Risk categories (conditions and therapies) and the member counts and percentages associated with each Primary Risk category within each Major Primary Risk category.

Impact Pro Primary Risk Categories for CY 2017			
Major Primary Risk Category	**Primary Risk Category**	**Member Count**	**% Total**
NO PRIMARY RISK CATEGORY	Unknown/ Demographics	104,408	28.45%
ENT	Allergic rhinitis/acute & chronic sinusitis	19,079	5.20%
	Other ENT	10,748	2.93%
	Otitis media, T&A, & pharyngitis	12,298	3.35%
	Total	42,125	11.48%
PULMONOLOGY (Asthma, COPD)	Acute bronchitis	4,427	1.21%
	COPD, including asthma	29,810	8.12%
	Other pulmonology	2,166	0.59%
	Pneumonia & bacterial lung infection	2,848	0.78%
	Tuberculosis	35	0.01%
	Total	39,286	10.71%
BH/MA/SA	Anxiety disorders/phobias	837	0.23%
	Childhood-onset psychiatric disorders	16,469	4.49%
	Mood disorder, bipolar	557	0.15%
	Mood disorder, depression	1,813	0.49%
	Other mental health	3,506	0.96%
	Psychotic/schizophrenic disorders	1,573	0.43%
	Substance Abuse	907	0.25%
	Total	25,662	6.99%
DERMATOLOGY	Chronic skin ulcer	76	0.02%
	Other dermatology	24,384	6.65%
	Total	24,460	6.67%
GASTROENTEROLOGY	Other gastroenterology	13,330	3.63%
	Other lower GI inflammation/infection	6,528	1.78%
	Other upper GI inflammation/infection	2,101	0.57%
	Ulcers, gastritis/duodenitis	631	0.17%
	Total	22,590	6.16%
ORTHOPEDIC/RHEUMATOLOGY	Joint degeneration/inflammation	2,767	0.75%

Impact Pro Primary Risk Categories for CY 2017			
Major Primary Risk Category	**Primary Risk Category**	**Member Count**	**% Total**
	Orthopedic trauma, fracture or dislocation	8,776	2.39%
	Other orthopedics	9,488	2.59%
	Rheumatoid arthritis	199	0.05%
	Total	21,230	5.79%
OTHER	Chromosomal anomalies	106	0.03%
	Deficiency/vitamin supplements	6	0.00%
	Electrolyte disorder agents	3	0.00%
	Environmental trauma	791	0.22%
	Isolated signs and symptoms	6,807	1.86%
	Late effects and complications	681	0.19%
	Nutritional deficiency and dehydration	1,443	0.39%
	Obesity	6,259	1.71%
	Parkinson's disease	2	0.00%
	Poisonings and toxic effects of drugs	617	0.17%
	Total	16,715	4.56%
OPHTHALMOLOGY	Cataract	65	0.02%
	Diabetic retinopathy	14	0.00%
	Glaucoma	244	0.07%
	Other ophthalmology	12,640	3.44%
	Total	12,963	3.53%
NEUROLOGY (MS, CIPD, BRAIN, SC)	Alzheimer's disease	1	0.00%
	Epilepsy	1,264	0.34%
	Hereditary degenerative & Congenital CNS disorders	416	0.11%
	Migraine headache	957	0.26%
	Multiple sclerosis & ALS	156	0.04%
	Other neurology	9,034	2.46%
	Total	11,828	3.22%
ENDOCRINOLOGY (DIABETES, CF)	Cystic fibrosis	19	0.01%

Impact Pro Primary Risk Categories for CY 2017			
Major Primary Risk Category	**Primary Risk Category**	**Member Count**	**% Total**
	Diabetes	2,343	0.64%
	Other endocrinology	7,942	2.16%
	Total	10,304	2.81%
GYNECOLOGY	Other gynecology	8,176	2.23%
OB	Obstetrics	7,094	1.93%
CARDIOLOGY	Atherosclerosis	12	0.00%
	Atrial fibrillation/flutter	17	0.00%
	Cardiac congenital disorders	973	0.27%
	CVA	44	0.01%
	Heart and/or lung transplant	1	0.00%
	Heart failure/cardiomyopathy	149	0.04%
	Hypertension	1,165	0.32%
	Ischemic heart disease	64	0.02%
	Other cardiology	3,111	0.85%
	Pulmonary heart disease	20	0.01%
	Valvular disorders	198	0.05%
	Total	5,754	1.57%
UROLOGY	Other urology	5,592	1.52%
HEMATOLOGY (HEMOPHILIA)	Agents used to treat enzyme deficiency states	3	0.00%
	Anemia	1,832	0.50%
	Growth hormones	109	0.03%
	Hemophilia	19	0.01%
	Other hematology	744	0.20%
	Other higher cost hematology	209	0.06%
	Sickle-cell anemia	276	0.08%
	Total	3,192	0.87%
NEONATAL	Other neonatal	1,995	0.54%
INFECTIOUS DISEASE	AIDS/HIV	257	0.07%

Impact Pro Primary Risk Categories for CY 2017			
Major Primary Risk Category	**Primary Risk Category**	**Member Count**	**% Total**
	Immunodeficiency's	36	0.01%
	Other infectious disease	1,460	0.40%
	Septicemia	50	0.01%
	Total	1,803	0.49%
CANCER	Leukemia/neoplastic blood disease	105	0.03%
	Malignant ENT neoplasm	4	0.00%
	Malignant gastrointestinal neoplasm	23	0.01%
	Malignant genitourinary neoplasm	25	0.01%
	Malignant hepato-biliary neoplasm	4	0.00%
	Malignant neoplasm of breast/female genital tract	511	0.14%
	Malignant neoplasm of endocrine glands	12	0.00%
	Malignant neoplasm of skin	3	0.00%
	Malignant neoplasm of the CNS	36	0.01%
	Malignant neoplasm of the eye	9	0.00%
	Malignant neoplasm, bone & connective tissue	26	0.01%
	Malignant pulmonary neoplasm	9	0.00%
	Total	767	0.21%
HEPATOLOGY	Infectious hepatitis	149	0.04%
	Other hepatology	290	0.08%
	Total	439	0.12%
PHARMACY	Antineoplastic, Other Episodes	318	0.09%
	Hemostatic/Thrombolytic Agents	9	0.00%
	Total	327	0.09%
NEPHROLOGY	Acute and chronic renal failure	92	0.03%
	Other nephrology	111	0.03%
	Total	203	0.06%
DME	Durable medical equipment	17	0.00%
GENERAL	Anti-shock vasopressors	2	0.00%

Top 10 Major Primary Risk Categories

In 2016 and 2017 the top 10 Major Primary Risk categories were very similar. However the proportion of members with No Primary Risk increased from 21.90% in 2016 to 28.45% in 2017. In addition, the "Other" category which was not in the Top 10 Major Primary Risk categories in 2016 is now in the top 10 in 2017 and Neonatal which was in the top 10 in 2016 is not in 2017.

Top 10 Characteristics of Major Primary Risk Categories				
Primary Risk Category	**2016 Members**	**2016 % of Total**	**2017 Members**	**2017 % of Total**
NO PRIMARY RISK CATEGORY	91814	21.90%	104408	28.45%
ENT	44187	10.54%	42125	11.48%
PULMONOLOGY (Asthma, COPD)	44667	10.66%	39286	10.71%
BH/MA/SA	39480	9.42%	25662	6.99%
DERMATOLOGY	31344	7.47%	24460	6.67%
GASTROENTEROLOGY	27552	6.57%	22590	6.16%
ORTHOPEDIC/RHEUMATOLOGY	22720	5.41%	21230	5.79%
OTHER	**	**	16715	4.56%
OPHTHALMOLOGY	17320	4.13%	12963	3.53%
NEUROLOGY	19454	4.64%	11828	3.22%
NEONATAL	16415	3.91%	**	**

**Not in top 10 Major Primary Risk categories for given year

No Primary Risk Category

In every member group assessed in 2014, 2015, 2016, and again in 2017, the most frequent Major Primary Risk category was No Primary Risk Category, reflecting members who did not have a risk factor in any medical or pharmacy claims, lab result, enrollment file, or risk assessment data that ImpactPro links to a primary risk category. In 2017, the No Primary Risk category accounted for 28.45% of the membership. This category includes members who had fewer than two claims for the same diagnosis as well as those who may not have had claims at all.

Members with no primary risk fall into one of three categories: 01: Healthy, 02: Acute episodic and 03: Healthy at risk. In 2017, 58,393 (55.93%) members with a risk category of no primary risk fell into the healthy category; 1,255 (1.20%) members were in the acute episodic category in 2017, and 43,189 (41.37%) members were in the Healthy at risk category.

These categories are defined below:

1. Healthy category consists of members who meet all of the following criteria:

- No claims OR
- No chronic conditions
- No Behavioral Health conditions
- Risk of future costs for the next 12 months for age < 65 is less than 2 and for >= 65 is less than 4.
- Risk of an admission in the next 12 months is less than 10%
- No inpatient stays regardless of reason in the last 12 months
- No emergency room visits regardless of the reason in the last 12 months
- No medication adherence gaps
- No 'clinically important' care gap opportunities

- No Drug Safety care opportunities

2. Acute Episodic category consists of members who meet all of the following criteria:

   - No chronic conditions AND either
   - 1 or more emergency department visits regardless of the reason in the last 12 months or 1 or more inpatient stays regardless of reason in the last 12 months

3. Healthy at risk category consists of members who meet all of the following criteria:

   - No chronic conditions AND NOT IN 1: Healthy OR 2: Acute Episodic.

Analysis of Major Primary Risk Categories

By Age. As expected, the top Major Primary Risk categories were different by age group. For example, Pulmonology (likely to be predominantly asthma in the younger age group) and ENT ranked high for 0-20 years, while Obstetrics and Gynecology ranked high for 21 years or older, a population that was 89.5% female.

By Race. This analysis is limited to the three largest race categories because of the small numbers of members in the remaining race categories.

20 Years or Younger: In both 2016 and 2017 No Primary Risk, Pulmonology, and ENT accounted for the top three Major Primary Risk categories for all races in members 20 years of age or younger. Black or African American had the highest proportion of members (25.04% in 2016 and 30.80%) of the three largest races with No Primary Risk. Again in 2017, White had the lowest although there was an increase in the number of Whites with No Primary Risk (16.98% in 2016 and 23.57% in 2017). In 2016, ENT was highest among Asian's (15.60%) followed by White (13.89%). In 2017, this remained the same however, Peach State Health Plan saw an increase in the percent of members in all races who had a primary risk category of ENT (Asian, 17.19%; Whites 14.92% and Black or African American 12.21%.

Pulmonology (asthma) remained one of the top risk categories for all three races, but 12.95% of Black or African American in 2016 were linked to Pulmonology (asthma) compared to only 10.94% of White. In 2017 Black or African American continued to have a higher percentage of members linked to Pulmonology (asthma) 13.34% compared to 11.08% for Asian and 10.92% among White. The top ten risk categories for the three largest races are as follows:

Top 10 Characteristics of Major Primary Risk Categories Ages 20 Years or Younger				
Primary Risk Category	**2016 Members**	**2016 % of Total**	**2017 Members**	**2017 % of Total**
NO PRIMARY RISK CATEGORY	84793	20.22%	87421	28.57%
ENT	41308	9.85%	40597	13.27%
PULMONOLOGY (Asthma, COPD)	40770	9.72%	37436	12.23%
DERMATOLOGY	30015	7.16%	23333	7.62%
BH/MA/SA	33850	8.07%	22298	7.29%
GASTROENTEROLOGY	23993	5.72%	20139	6.58%
ORTHOPEDIC/RHEUMATOLOGY	18985	4.53%	17272	5.64%
OTHER	13973	3.33%	14432	4.72%
NEONATAL	19192	4.58%	**	**
OPHTHALMOLOGY	15559	3.71%	12165	3.98%
NEUROLOGY (MS, CIPD, BRAIN, SC)	**	**	7421	2.43%
Top 10 Characteristics of Major Primary Risk Categories Ages 21 Years or Older				

Primary Risk Category	2016 Members	2016 % of Total	2017 Members	2017 % of Total
NO PRIMARY RISK CATEGORY	16352	26.88%	16987	27.89%
OB	7676	12.62%	5954	9.77%
ENDOCRINOLOGY (DIABETES, CF)	4766	7.83%	5425	8.91%
GYNECOLOGY	3796	6.24%	4539	7.45%
NEUROLOGY (MS, CIPD, BRAIN, SC)	7999	13.15%	4407	7.23%
ORTHOPEDIC/RHEUMATOLOGY	3079	5.06%	3958	6.50%
BH/MA/SA	4424	7.27%	3364	5.52%
CARDIOLOGY	1949	3.20%	2504	4.11%
GASTROENTEROLOGY	2082	3.42%	2451	4.02%
OTHER	**	**	2283	3.75%
PULMONOLOGY (Asthma, COPD)	1271	2.09%	**	**

Top 10 Major Primary Risk Categories By Race Ages 20 Years Or Younger				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
BLACK OR AFRICAN AMERICAN				
NO PRIMARY RISK CATEGORY	49116	25.04%	52627	30.80%
PULMONOLOGY	25403	12.95%	22786	13.34%
ENT	20536	10.47%	20866	12.21%
DERMATOLOGY	16750	8.54%	13194	7.72%
BH/MH/SA	17663	9.01%	10990	6.43%
GASTROENTEROLOGY	12100	6.17%	9599	5.62%
ORTHOPEDIC/RHEUMATOLOGY	10120	5.16%	9418	5.51%
OTHER	7330	3.74%	7561	4.43%
OPHTHALMOLOGY	9063	4.62%	6984	4.09%
NEUROLOGY	**	**	3716	2.18%
WHITE				
NO PRIMARY RISK	22518	16.98%	25612	23.57%
ENT	18418	13.89%	16217	14.92%
PULMONOLOGY (Asthma, COPD)	14503	10.94%	11864	10.92%
BH/MA/SA	15145	11.42%	10012	9.21%
GASTROENTEROLOGY	11037	8.32%	8958	8.24%
DERMATOLOGY	11101	8.37%	8958	5.97%
ORTHOPEDIC/RHEUMATOLOGY	7800	5.88%	6486	5.05%
OTHER	5641	4.25%	5483	3.73%
OPHTHALMOLOGY	5507	4.15%	4057	2.90%
NEUROLOGY (MS, CIPD, BRAIN, SC)	4640	3.50%	3152	23.57%

Top 10 Major Primary Risk Categories By Race Ages 20 Years Or Younger				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
ASIAN				
NO PRIMARY RISK	2523	22.46%	2364	26.55%
ENT	1752	15.60%	1531	17.19%
PULMONOLOGY Asthma, COPD)	1273	11.33%	987	11.08%

DERMATOLOGY	971	8.65%	706	7.93%
GASTROENTEROLOGY	836	7.44%	651	7.31%
OTHER	438	3.90%	560	6.29%
ORTHOPEDIC/RHEUMATOLOGY	661	5.89%	457	5.13%
OPHTHALMOLOGY	720	6.41%	429	4.82%
BH/MA/SA	**	**	294	26.55%
ENDOCRINOLOGY (DIABETES, CF)	360	3.21%	252	17.19%

21 Years or Older. No Primary Risk category, OB, and Endocrinology were in the top five risk categories for all three races in 2016 and 2017 for members 21 years or older. The proportion of members with No Primary Risk category remained similar for Black or African American, White, and Asian in 2017 with over 26% of each race falling into the category. The proportion of Black or African American linked to OB in both 2016 and 2017 (12.02% and 10.16% respectively) was higher than for White (10.63% and 9.05 %) or Asian (10.56% and 10.23%). The proportion of Asian (linked to Endocrinology continues for the third year in a row to be about twice that of Black or African American (18.30% compared to 9.39% for Black or African American and 7.46% for White). Please see the following table. Likewise, both in 2016 and 2017 the proportion of White linked to BH/MH/SA (12.53% and 9.16%) was more than twice that of Black or African American (5.31% and 3.95%). BH/MH/SA was not among the top 10 risk categories for Asian.

Top 10 Major Primary Risk Categories By Race Ages 21 Years Or Older				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
BLACK OR AFRICAN AMERICAN				
NO PRIMARY RISK CATEGORY	8393	22.47%	10083	26.35%
OB	4489	12.02%	3886	10.16%
ENDOCRINOLOGY	3466	9.28%	3592	9.39%
GYNECOLOGY	3080	8.25%	3387	8.85%
ORTHOPEDIC/RHEUMATOLOGY	1964	5.26%	2604	6.80%
NEUROLOGY	4871	13.04%	2448	6.40%
CARDIOLOGY	1571	4.21%	1804	4.71%
BH/MH/SA	1982	5.31%	1512	3.95%
GASTROENTEROLOGY	1438	3.85%	1490	3.89%
OTHER	**	**	1468	3.84%
WHITE				
NO PRIMARY RISK CATEGORY	4794	23.08%	5736	29.28%
NEUROLOGY (MS, CIPD, BRAIN, SC)	3474	16.72%	1841	9.40%
BH/MA/SA	2602	12.53%	1794	9.16%
OB	2208	10.63%	1773	9.05%
ENDOCRINOLOGY (DIABETES, CF)	1464	7.05%	1462	7.46%
ORTHOPEDIC/RHEUMATOLOGY	1111	5.35%	1227	6.26%
GYNECOLOGY	866	4.17%	1005	5.13%
GASTROENTEROLOGY	782	3.76%	854	4.36%

Top 10 Major Primary Risk Categories By Race Ages 21 Years Or Older				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
OTHER	**	**	661	3.37%
PULMONOLOGY (Asthma, COPD)	541	2.60%	610	3.11%
ASIAN				
NO PRIMARY RISK	409	21.70%	402	27.05%
ENDOCRINOLOGY (DIABETES, CF)	366	19.42%	272	18.30%
OB	199	10.56%	152	10.23%
OTHER	64	3.40%	110	7.40%
GASTROENTEROLOGY	122	6.47%	74	4.98%
ORTHOPEDIC/RHEUMATOLOGY	94	4.99%	73	4.91%
NEUROLOGY (MS, CIPD, BRAIN, SC)	130	6.90%	69	4.64%
CARDIOLOGY	50	2.65%	60	4.04%
GYNECOLOGY	64	3.40%	55	3.70%
CANCER	**	**	30	4.04%

By Ethnicity

20 years or younger. In 2017, No Primary Risk Category, Pulmonology, ENT, and Dermatology remained in the top five risk categories for both Hispanic or Latino and Non-Hispanic or Latino. Similar to 2016, BH/MH/SA was in the top five for Non-Hispanic or Latino but not for Hispanic or Latino during 2017. Hispanic or Latino had a somewhat lower proportion of members with No Primary Risk Category (17.70% and 18.64%) than did Non-Hispanic or Latino (22.33% and 29.35%). Both proportions increased in 2017. Please see the following table.

Top 10 Major Primary Risk Categories By Ethnicity Ages 20 Years Or Younger				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
NON HISPANIC OR LATINO				
NO PRIMARY RISK CATEGORY	69446	22.33%	83258	29.35%
ENT	36133	11.62%	36972	13.03%
PULMONOLOGY (Asthma, COPD)	37779	12.15%	34741	12.25%
DERMATOLOGY	26081	8.39%	21407	7.55%
BH/MA/SA	31725	10.20%	20991	7.40%
GASTROENTEROLOGY	20769	6.68%	17878	6.30%
ORTHOPEDIC/RHEUMATOLOGY	16768	5.39%	15927	5.61%
OTHER	11738	3.77%	12761	4.50%
OPHTHALMOLOGY	13553	4.36%	10943	3.86%
NEUROLOGY (MS, CIPD, BRAIN, SC)	**	**	6957	2.45%
HISPANIC OR LATINO				
NO PRIMARY RISK CATEGORY	8311	17.70%	4163	18.64%
ENT	6715	14.30%	3625	16.23%
PULMONOLOGY (Asthma, COPD)	5372	11.44%	2695	12.07%
GASTROENTEROLOGY	4416	9.41%	2261	10.12%
DERMATOLOGY	4191	8.93%	1926	8.62%
OTHER	2716	5.78%	1671	7.48%
ORTHOPEDIC/RHEUMATOLOGY	2751	5.86%	1345	6.02%
BH/MA/SA	3081	6.56%	1307	5.85%
OPTHALMOLOGY	2707	5.77%	1222	5.47%

NEUROLOGY (MS, CIPD, BRAIN, SC)	1248	2.66%	464	2.08%

21 Years or Older. No Primary Risk Category, OB, and Endocrinology were in the top five risk categories for both ethnic categories. For this age group, there was no difference in the proportion of members with No Primary Risk Category for Hispanic or Latino (27.36%) than for Non-Hispanic or Latino (27.90%). Please see the following table.

Top 10 Major Primary Risk Categories By Ethnicity Ages 21 Years Or Older				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
NON HISPANIC OR LATINO				
NO PRIMARY RISK CATEGORY	13010	22.36%	16677	27.90%
OB	6678	11.48%	5870	9.82%
ENDOCRINOLOGY (DIABETES, CF)	5131	8.82%	5321	8.90%
NEUROLOGY (MS, CIPD, BRAIN, SC)	8290	14.25%	4320	7.23%
ORTHOPEDIC/RHEUMATOLOGY	3081	5.30%	3876	6.48%
BH/MA/SA	4548	7.8%	3330	5.57%
CARDIOLOGY	2070	3.56%	2467	4.13%
GASTROENTEROLOGY	2268	3.90%	2395	4.01%
OTHER	**	**	2241	3.75%
PULMONOLOGY (Asthma, COPD)	1454	2.50%	1808	3.02%
HISPANIC OR LATINO				
NO PRIMARY RISK	743	30.23%	310	27.36%
ENDOCRINOLOGY (DIABETES, CF)	208	8.46%	104	9.18%
NEUROLOGY (MS, CIPD, BRAIN, SC)	247	10.05%	87	7.68%
OB	309	12.57%	84	7.41%
ORTHOPEDIC/RHEUMATOLOGY	118	4.80%	82	7.24%
GYNECOLOGY	162	6.59%	77	6.80%
GASTROENTEROLOGY	93	3.78%	56	4.94%
OTHER	**	**	42	3.71%
PULMONOLOGY (Asthma, COPD)	51	2.07%	42	3.71%
CARDIOLOGY	57	2.32%	37	3.27%

By Region

20 years or younger. In 2016, No Primary Risk, Dermatology, ENT, BH/MH/SA, and Pulmonology were in the top five risk categories for all six regions. No Primary Risk, ENT, and Pulmonology, Gastroenterology, BH/MA/SA and Dermatology comprised the top six risk categories in 2017.

In 2017, the proportion of members with No Primary Risk Category was highest in the Atlanta Region (30.66%) followed by the Central Region (25.59%) and Southwest (19.89%). BH/MH/SA was highest in the Southwest Region (10.92%) and lowest in the East Region (5.12%); minimal changes were observed in 2016. In 2015, Pulmonology was highest in the Southwest Region (14.90%) and lowest in the Southeast Region (7.87%), and that pattern continued in 2016. The top 10 Major Primary Risk Categories for members aged 20 years or younger in our three largest regions (Atlanta, Central, and Southwest) are presented in the table below.

Top 10 Primary Risk Categories By Region Ages 20 Years Or Younger				
Primary Risk Category	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
ATLANTA				
NO PRIMARY RISK	50416	24.16%	55939	30.66%
ENT	25019	11.99%	24094	13.21%
PULMONOLOGY (Asthma, COPD)	24800	11.89%	21877	11.99%
DERMATOLOGY	17535	8.40%	13993	7.67%
GASTROENTEROLOGY	13154	6.30%	10701	5.87%
BH/MA/SA	16974	8.14%	10539	5.78%
ORTHOPEDIC/RHEUMATOLOGY	11241	5.39%	10502	5.76%
OTHER	8977	4.30%	9238	5.06%
OPHTHALMOLOGY	10597	5.08%	8413	4.61%
NEUROLOGY (MS, CIPD, BRAIN, SC)	**	**	3902	2.14%
CENTRAL				
NO PRIMARY RISK	9204	17.60%	10369	25.59%
ENT	6686	12.78%	5675	14.01%
PULMONOLOGY (Asthma, COPD)	6392	12.22%	4806	11.86%
BH/MA/SA	6053	11.57%	3666	9.05%
DERMATOLOGY	4734	9.05%	3300	8.15%
GASTROENTEROLOGY	4114	7.87%	2885	7.12%
ORTHOPEDIC/RHEUMATOLOGY	3203	6.12%	2455	6.06%
OTHER	1751	3.35%	1749	4.32%
OPHTHALMOLOGY	1957	3.74%	1190	2.94%
NEUROLOGY (MS, CIPD, BRAIN, SC)	**	**	1178	2.91%
SOUTHWEST				
NO PRIMARY RISK	11513	15.90%	12836	19.89%
PULMONOLOGY (Asthma, COPD)	9402	12.98%	9096	14.10%
ENT	8078	11.15%	8739	13.54%
BH/MA/SA	9845	13.59%	7044	10.92%
GASTROENTEROLOGY	6249	8.63%	5568	8.63%
DERMATOLOGY	6108	8.43%	4953	7.68%
ORTHOPEDIC/RHEUMATOLOGY	4039	5.58%	3576	5.54%
OTHER	2972	4.10%	2830	4.39%
OPHTHALMOLOGY	2777	3.83%	2175	3.37%
NEUROLOGY (MS, CIPD, BRAIN, SC)	**	**	2037	3.16%

21 years or older: In 2016 and 2017, for the 21 years or older age group, No Primary Risk Category and OB were in the top five categories in all six regions.
In 2017, the proportion of members with No Primary Risk Category was highest in the North Region (41.43 %), and lowest in the Southwest Region (18.05%). The proportion of members linked to OB varied a bit, highest in the Southeast Region (10.52 %) and lowest in the East

Region (8.56 %). Gynecology was highest in the East Region (7.90 %) and lowest in the North Region (4.35 %) during 2017.
The top ten Major Primary Risk Categories for members aged 21 years or older for our three largest regions (Atlanta, Central, and Southwest) are shown in table below.

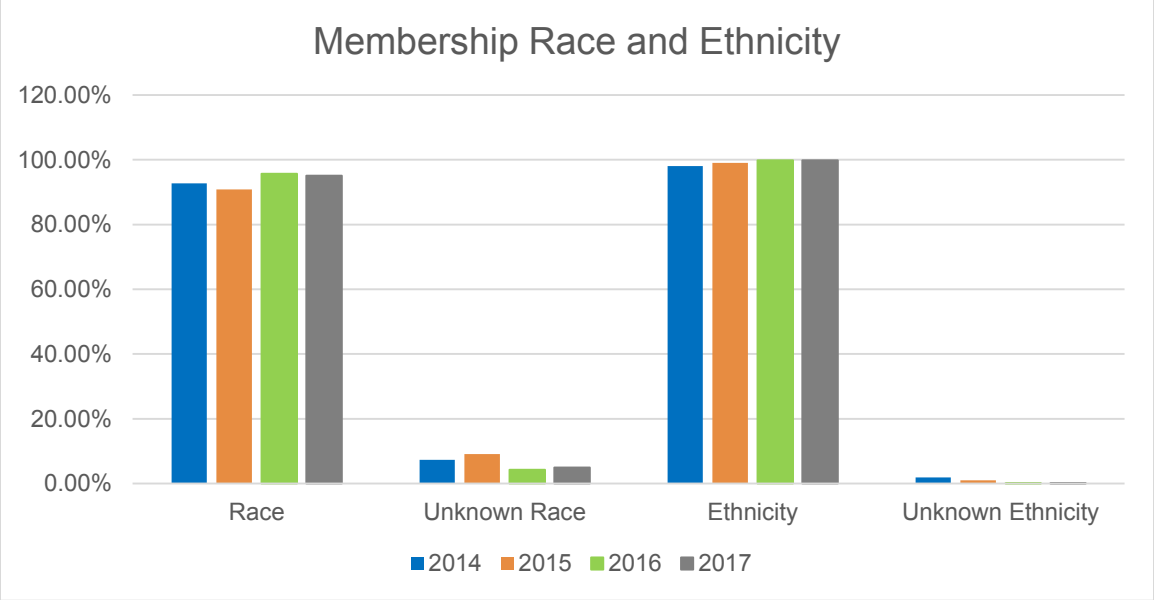
Top 10 Major Primary Risk Categories By Region Ages 21 Years Or Older				
Region	**2016 Members**	**% Of Total**	**2017 Members**	**% Of Total**
ATLANTA				
NO PRIMARY RISK CATEGORY	8670	25.58%	10301	30.27%
OB	4117	12.15%	3383	9.94%
ENDOCRINOLOGY (Diabetes, CF)	2822	8.33%	2763	8.12%
GYNECOLOGY	2402	7.09%	2643	7.77%
ORTHOPEDIC/RHEUMATOLOGY	1704	5.03%	2247	6.60%
NEUROLOGY (MS, CIPD, BRAIN, SC)	4108	12.12%	2204	6.48%
BH/MH/SA	2218	6.54%	1457	4.28%
CARDIOLOGY	1121	3.31%	1356	3.99%
OTHER	**	**	1312	3.86%
GASTROENTEROLOGY	1176	3.47%	1177	3.46%
CENTRAL				
NO PRIMARY RISK	1722	18.28%	2109	23.69%
ENDOCRINOLOGY (DIABETES, CF)	794	8.43%	854	9.59%
OB	1018	10.81%	844	9.48%
GYNECOLOGY	590	6.26%	696	7.82%
NEUROLOGY (MS, CIPD, BRAIN, SC)	1463	15.53%	674	7.57%
BH/MA/SA	937	9.95%	618	6.94%
ORTHOPEDIC/RHEUMATOLOGY	533	5.66%	607	6.82%
GASTROENTEROLOGY	415	4.41%	431	4.84%
CARDIOLOGY	407	4.32%	428	4.81%
OTHER	**	**	331	3.72%
SOUTHWEST				
NO PRIMARY RISK	1789	15.21%	2186	18.05%
ENDOCRINOLOGY (DIABETES, CF)	1335	11.35%	1391	11.49%
NEUROLOGY (MS, CIPD, BRAIN, SC)	2226	18.92%	1191	9.84%
OB	1153	9.80%	1138	9.40%
BH/MA/SA	1050	8.92%	950	7.85%
GYNECOLOGY	778	6.61%	893	7.37%
ORTHOPEDIC/RHEUMATOLOGY	667	5.67%	827	6.83%
GASTROENTEROLOGY	548	4.66%	630	5.20%
CARDIOLOGY	452	3.84%	554	4.58%
OTHER	**	**	487	4.02%

Health Disparities

As defined by the Kaiser Family Foundation (KFF)[1] a "health care disparity" typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. Disparities in health care not only affect the groups facing disparities, but also limit overall improvements in quality of care and health for the broader population and result in unnecessary costs. The KFF further stated that many groups face significant disparities in access to and utilization of care. People of color generally face more access barriers and utilize less care than Whites.

The Georgia Department of Community Health through the contract with Peach State Health Plan and the DCH Quality Strategic Plan for Georgia Families and Georgia Families 360 holds Peach State accountable for reducing health care disparities. Peach State is required to identify the population we serve, including race and ethnicity, gender, rural and urban characteristics and to implement population specific outreach activities.

In order for Peach State Health Plan to better understand the needs of our membership, identify health care disparities, and appropriately tailor programs to address these needs and disparities, we followed a deliberate and structured process to identify and assess health disparities across racial and ethnic groups. The plan's first priority was to obtain accurate and complete demographic data for its members. Peach State's 2014 member demographic analysis identified race for 92.70% of members and ethnicity for 98.06% of members. In our 2015 analysis, members with identified race decreased to 90.85%, but members with identified ethnicity increased to 99.04%. In 2016, the number of members with identified race increased to 95.64% and members with identified ethnicity increased to 99.87%. In 2017, the number of members with identified race decreased to 95.04% and members with identified ethnicity slightly decreased to 99.86%



1. http://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

In 2014, Peach State implemented data analytic and reporting tools that enabled us to report on all datasets, including Healthcare Effectiveness Data and Information Set (HEDIS) measures and Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit use; focused on individual member, provider and population levels; and stratified by Diagnosis, Race, Age, Gender and Geographic location (DRAGG). This was done in order to identify populations that experienced obstacles to health care access based on their race, ethnicity, or geographic area and to target member and provider interventions to correct those disparities.

Addressing health care disparities in the Plan's population aligns with the Plan's goals to improve member outcomes; improve provider and member experience with care and lower per capita cost. The increased prevalence in several conditions noted by the Plan based on HEDIS 2018/CY2017 data follow.

Asthma

- In 2014, data showed that the subpopulation of 21,993 members linked with the Pulmonology Major Primary Risk Category were disproportionately male (56.5%) compared with the percentage of males (43.9%) in our entire membership. They were also disproportionately Black or African American (62.4% compared to 54.9% of all members), disproportionately under the age of 20 (96.5% compared to 84.5% of all members), and resided disproportionately in the Atlanta and Southwest Regions. For this age mix, Pulmonology is likely to be predominantly asthma.
- In 2015, the number of members linked with Pulmonology decreased slightly to 20,364. These members remained disproportionately male and aged 20 years or younger. Though still disproportionate, only 61.0% of these members were Black or African Americans, a decrease of 1.4 percentage points from 2014. The Atlanta Region had the highest share of members linked with Pulmonology at 60.0%.
- In 2016, the number of members in the Asthma subpopulation (Primary Risk Category of COPD), increased to 22,100. These members remained disproportionately male and aged 20 years or younger. Though still disproportionate, only 65.19% of these members were Black or African Americans. The Atlanta Region had the highest share of members linked with Asthma at 59.10%.
- In 2017, 39,286 members were linked with the Pulmonary Major Primary risk category. These numbers remained disproportionately male (52.08%) and aged 20 or under (95.29%). The number of members in the Asthma subpopulation increased to 29,810. These members remained disproportionately male and aged 20 years or younger.

HIV/AIDS

- In 2014, data showed that the 197 members linked with the HIV/AIDS Major Primary Risk category were disproportionately female (88.3% compared to 56.1% of all members). They also were disproportionately Black or African American (88.3% compared to 54.9% of all members), and 21 years of age or older (79.2% compared to 15.5% of all members). The members resided in all regions generally in proportion to the membership. Only 1.5% of these members were Hispanic, compared to 11.3% of all members.
- In 2015, 203 members were linked with the HIV/AIDS Major Primary Risk category, and remained disproportionately female (81.28%), Black or African Americans (84.73%), and aged 21 years or older (71.43%). These members continued to reside in all regions generally in proportion to the membership.
- In 2016, 250 members were linked with the HIV/AIDS Major Primary Risk category, and remained disproportionately female (82.40%), Black or African Americans (87.60%), and aged 21 years of older (78.00%). These members continued to reside in all regions generally in proportion to the membership.

- In 2017, 257 members were linked with the HIV/AIDS Major Primary Risk category, and remained disproportionately female (85.60%), Black or African Americans (85.21%), and aged 21 Years or older (82.88%). These members continued to reside in all regions generally in proportion to the membership.

Cancer

- In 2014, data showed the 822 members linked with the Cancer Major Primary Risk Category identified were disproportionately female (91.36% compared to 56.21% of all members). They also were disproportionately White (38.44% compared to 34.55% of all members), and 19 years of age or older (86.01% compared to 15.5% of all members) as expected due to enrollment of women in the Medicaid Breast and Cervical Cancer Program category of aid. They resided in all regions generally in proportion to the membership.
- In 2015, there were 815 members linked with the Cancer Major Primary Risk category, similar to 2014. These members continued to be disproportionately White (36.07% compared to 34.00% of all members), female (89.08% compared to 56.09% of all members), and older (83.56% aged 21 years or older compared to 14.71% of all members). These members continued to reside in all regions generally in proportion to the membership.
- In 2016, there were 949 members linked with the Cancer Major Primary Risk category. These members continued to be disproportionately female (87.88% compared to 55.97% of all members), and older (80.82% compared to 14.51% of all members). Out of all the members linked with Cancer, disproportionately 48.05% are Black or African American and 36.57% are White. These members continued to reside in all regions generally in proportion to the membership.
- In 2017, there were 767 members linked with the Cancer Major Primary Risk category. These members continued to be disproportionately female (89.31% compared to 57.12% of all members), and older (81.10% aged 21 years or older compared to 16.60% of all members). Out of all members linked with Cancer, disproportionately 50.20% are Black or African American and 34.94% are White. These members continued to reside in all regions generally in proportion to the membership.

Behavioral Health

- In 2014, data showed that the 30,083 members linked with the BH/MH/SA Major Primary Risk category (7.8% of our membership) were disproportionately male (55.6% compared to 43.9% of all members). The age distribution of these members was similar to that for all members (86.1% aged 20 years or younger compared to 84.5% of all members). They also were disproportionately White (45.5% compared to 34.7% of all members), and resided disproportionately in the Southwest and Central Regions. Only 6.5% of these members were Hispanic, compared to 11.3% of all members. Data also showed that Attention Deficit Hyperactivity Disorder (ADHD) constituted 20.9%, and depression 15.4%, of all Behavioral Health diagnoses given to these members. The BH/MH/SA Major Primary Risk Category includes: Anxiety disorders/phobias, Mood Disorders including Bipolar disorder, Depression, Substance Abuse, Childhood Psychiatric disorders, and Psychotic/Schizophrenic disorders.
- In 2015, the 35,023 members linked to the BH/MH/SA Major Primary Risk Category continued to be disproportionately male (54.98%) and Black or African American (47.83%) and to reside in the Southwest and Atlanta Regions.
- In 2016, the 39,480 members linked to the BH/MH/SA Major Primary Risk category continued to be disproportionately male (55.13%) and Blacks/African American (49.76%) and to reside in the Southwest and Atlanta Regions.
- In 2017, the number of members linked to BH/MH/SA Major Primary Risk category decreased to 25,662. This group continued to be disproportionately male (56.32%) and Black or African American (48.72%) and to reside in the Southwest and Atlanta Regions.

Data also showed that this group is disproportionately aged 20 years or younger (86.98%) with the prevalent behavior health diagnosis given Childhood-onset Psychiatric Disorders (64.18%).

Low and Very Low Birth Weight Births

- In 2014, data showed 9.0% of pregnant mothers delivered a low birth weight (LBW – between 1500g and 2500g) baby and another 1.9% were very low birth weight (VLBW - <1500g). The LBW and VLBW birth rates were higher for mothers 21 years or older than for younger mothers. In addition, the rates for Black or African American mothers (11.2% of live births) were 72.6% higher than White mothers (6.5% of live births) for LBW births and 123.1% higher for VLBW births. The rate for LBW births was 23.3% lower for Hispanic than Non-Hispanic mothers. The Southwest Region had rates of LBW births 72.6% higher, and VLBW births 515.7% higher, than the Central Region.
- In 2015, 9.1% of pregnant mothers delivered a low birth weight baby and another 2.9% were very low birth weight. The VLBW birth rate remained higher for mothers 21 years or older than for younger mothers, but the LBW birth rates were similar. In addition, the rates for Black or African American mothers (10.8% of live births
-) were only 64.1% higher than White mothers (6.6% of live births) for LBW births (an improvement over 2014) and 131.2% higher for VLBW births (an increase from 2014). The rate for LBW births was 38.5% lower for Hispanic than Non-Hispanic mothers. The Southwest Region had rates of LBW births 13.5% higher, and VLBW births 66.7% higher, than the Central Region, an improvement for both rates over 2014).
- Peach state had 20,588 members who gave birth during 2016. Members 21 years of age and older accounted for 84.33% of the deliveries (17,362). Those members 20 years of age and under accounted for delivered 15.67% of all deliveries (3,226). Of all pregnant members in 2016, 9.33% delivered a low birth weight baby and another 2.25% were very low birth weight. When comparing the LBW and VLBW for all deliveries (20,588), members 21 years of age and older had a greater percentage of LBW (7.89%) and VLBW (1.88%) deliveries compared to the 20 and under age category (1.44% and 0.37% respectively). However, when comparing LBW and VLBW deliveries between both populations, LBW and VLBW birth rate were almost equal for mothers 21 years or older (11.6%) and for mothers under age 21 years old (11.5%). In addition, the rates for Black or African American mothers who delivered a LBW baby (6.06%) higher than White mothers (2.56%). The Black or African American mothers who delivered a VLBW baby was higher than for White mothers (Black or African American mothers 1.52%; White mothers 0.45%). The rate for LBW births was 8.80% for Non-Hispanic mothers and 0.35% for Hispanic mothers. Of the mothers who delivered a LBW and VLBW baby, Atlanta had the highest percentage (48.78% and 49.03%, respectively).
- Peach State had 19,157 members who gave birth during 2017. Members 21 years of age and older accounted for 85.59% of the deliveries (16,398). Those members 20 years of age and under accounted for 14.40% of all deliveries (2,759). Of all pregnant members in 2017, 9.80% delivered a low birth weight baby and another 2.67% were very low birth weight. When comparing LBW and VLBW for all deliveries (19,157), members 21 years of age and older had a greater percentage of LBW (8.30%) and VLBW (2.31%) deliveries compared to the 20 and under age category (1.50% and 0.32% respectively). However, when comparing LBW and VLBW deliveries between both populations, LBW and VLBW birth rate were almost equal for mothers 21 years or older (12.70%) and for mothers 20 years of age and under (12.65%). In addition, the rates for Black or African American mothers that delivered a LBW or VLBW baby (8.60%) was higher than the rate for White mothers (3.30%). Of the mothers who delivered a LBW or VLBW baby, Atlanta had the highest percentage (49.75%).

Child Preventive Services. Through the (DRAGG) analysis, the data revealed significant regional variation in the percentage of members receiving recommended preventive care services. The Southeast Region continues to have the lowest performing of all regions in three of five key child preventive service measures in 2017. It has more poverty, lower health literacy, and less access to healthcare compared to the other regions. Please see the Effectiveness Section of this Evaluation for a description of related activities such as targeted outreach and incentives for members due for 12 and 15 month well visits.

Note—the tables below use the following abbreviations.

- W15—Percentage of eligible children who received six or more well-child visits in the first 15 months of life
- CIS10—Percentage of eligible children who received all recommended immunizations by age two
- AWC—Percentage of eligible adolescents 12-21 years of age who had one comprehensive well-care visit with PCP or OB/GYN in the measurement year
- IMA – CO1 and CO2 – Percentage of adolescents 13 years of age who had all recommended immunizations (CO2 – Incudes HPV)

Regional Performance on Three Childhood Preventive Care Service Measures

2016	W15	CIS10	AWC	IMA – All Sub-measures
Highest Performing Region	Southwest (57.5%)	Southwest (26.0%)	Atlanta (50.0%)	Southwest (91.92%)
Lowest Performing Region	East (40.2%)	Central (15.6%)	Southeast (30.3%)	North (85.64%)
Statewide Totals	**53.6%**	**20.2%**	**48.2%**	**88.38%**

2017	W15	CIS10	AWC	IMA – CO1	IMA- CO2
Highest Performing Region	Southwest (58.9%)	Southwest (27.5%)	Atlanta (48.4%)	Southwest (92.86%)	Southwest (36.75%)
Lowest Performing Region	Southeast (37.9%)	East (18.7%)	Southeast (30.7%)	Atlanta (88.52%)	Southeast (19.28%
Statewide Totals	**52.3%**	**23.2%**	**47.5%**	**90.20%**	**32.29%**

The analysis of regional distribution of child preventive services by race and ethnicity is limited to those regions with large enough populations for the findings to be statistically valid (Atlanta, Central, and Southwest). In 2015 (and again in 2016) the ethnicity categories show similar patterns for all regions with Hispanic/Latino having higher levels of performance for CIS10 and AWC but lower levels of performance for W15 than Non-Hispanic/Latino.

Regional Performance on Three Childhood Preventive Care Service Measures by Ethnicity

2016	W15		CIS10		AWC	
	Hispanic/ Latino	Non-Hispanic/ Latino	Hispanic/ Latino	Non-Hispanic/ Latino	Hispanic/ Latino	Non-Hispanic/ Latino
Atlanta Region	35.6%	53.9%	30.2%	17.0%	63.5%	47.2%
Central Region	43.9%	55.6%	20.8%	15.4%	54.7%	46.2%
Southwest Region	43.7%	58.4%	29.7%	25.6%	52.3%	46.7%
Statewide Totals	**36.7%**	**55.1%**	**29.5%**	**18.8%**	**60.9%**	**46.4%**

2017	W15		CIS10		AWC	
	Hispanic/ Latino	Non-Hispanic/ Latino	Hispanic/ Latino	Non-Hispanic/Latino	Hispanic/ Latino	Non-Hispanic/Latino
Atlanta Region	28.60%	51.97%	32.15%	20.73%	61.39%	58.09%
Central Region	30.00%	55.74%	32.26%	20.39%	54.69%	46.52
Southwest Region	38.75%	69.55%	27.17%	27.58%	55.17%	46.89
Statewide Totals	**30.03%**	**56.99%**	**31.31%**	**22.22%**	**59.49%**	**52.76%**

Regional Performance on Three Childhood Preventive Care Service Measures by Race

2016	W15		CIS10		AWC	
	Black or African American	White	Black or African American	White	Black or African American	White
Atlanta Region	52.2%	47.4%	13.5%	25.8%	45.9%	54.1%
Central Region	51.3%	61.6%	14.7%	16.3%	46.6%	46.0%
Southwest Region	56.9%	58.9%	25.8%	25.9%	48.0%	45.7%
Statewide Totals	**52.8%**	**53.3%**	**16.7%**	**23.9%**	**46.3%**	**49.3%**

2017	W15		CIS10		AWC	
	Black or African American	White	Black or African American	White	Black or African American	White
Atlanta Region	50.70%	43.15%	15.67%	28.62%	43.78%	53.64%
Central Region	53.45%	58.44%	18.13%	26.20%	45.74%	47.51%
Southwest Region	58.17%	60.78%	26.67%	29.21%	48.0%	46.01%
Statewide Totals	**52.51%**	**50.39%**	**18.80%**	**28.02%**	**44.89%**	**49.67%**

The analysis of regional distribution of child preventive services by race showed a higher level of performance for White members versus Black or African American members. Black or African American members scored higher only in the Atlanta Region for W15 and in the Southwest Region for AWC.

Staff combined results such as these with other operational data including GeoAccess Reports, Call Center volumes, and call categories including translation requests in order to obtain a nuanced understanding of Peach State's membership and the factors leading to disparities.

Collecting Provider, Member, and Community Perceptions

Peach State continues to collect and analyze data gathered regarding providers', members', and communities' experiences and perceptions concerning obstacles to health including racial and ethnic treatment disparities. Sources of this information include:

- Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results
- Peach State's Provider Advisory Committee (PAC) and other committees with provider membership. The Provider Advisory Committee (PAC) is a Plan committee comprised of physician providers and Peach State staff. The providers represent all Georgia Families regions and are either primary care or specialty doctors. At least two providers on the Committee maintain practices that predominantly serve Medicaid beneficiaries. This group has at least quarterly meetings to discuss a wide range of topics related to health plan

operations, initiatives, barriers to care and opportunities, and provides input and recommendations to inform and/or direct the QAPI Program.
- Member Community Advisory Board (MCAB)– The Member Community Advisory Board provides an active forum for Plan members to become personally involved and to connect with the health plan, advocate for our community worth & value and ensure members know the Plan has an expressed and vested interest in maintaining the health and wellness of their community and improving outcomes.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

In CY 2017, Peach State Health Plan contracted with Morpace, an NCQA certified vendor, to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys. The purpose of the CAHPS Health Plan Survey (CAHPS Survey{s}) is to assess the member experience, which encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. The CAHPS Surveys cover topics that are important to members and focus on aspects of quality that they are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

In CY 2017, Peach State conducted both the Medicaid Adult and Child CAHPS Surveys as required by the Plan's contract with DCH. Conducting CAHPS Surveys align with goals identified in the DCH Quality Strategic Plan for Georgia Families and Georgia 360 (February 2016). Peach State did not exclude any members and included members (children) with special health care needs.

The CAHPS Health Plan Survey generates two types of results for reporting purposes. Rating measures are based on items that use a scale of 0 to 10 to measure respondents' assessment of their health plan and the quality of care received over a specified period of time. This measure is sometimes referred to as the "global rating" or "overall rating." Composite measures (also known as reporting composites) combine results for closely related items that have been grouped together.

The CAHPS Survey performed in CY 2016 and CY 2017 (Health Plan Survey 5.0) produced the following measures:

- Getting needed care (composite of 2 items)
- Getting care quickly (composite of 2 items)
- How well doctors communicate (composite of 4 items in the Adult Survey; composite of 5 items in the Child Survey)
- Health plan customer service (composite of 2 items)
- Enrollees' rating of their health plan (1 item)
- Enrollees' rating of their health care (1 item)
- Enrollees' rating of their personal doctor (1 item)
- Enrollees' rating of their specialist (1 item)

In addition, the CAHPS Adult survey includes three performance measures: Flu Shot for Adults ages 18-64; Medical Assistance with Smoking Cessation and Aspirin Use and Discussion. For additional information on the CAHPS survey findings and initiatives, refer to the "Effective Member Communication Strategies" section of this document.
The Plan's CAHPS survey methodology captures member characteristics such as race and ethnicity allowing us to trend satisfaction results in a way that aligns rates with racial and ethnic

health disparities. A comparison of year over year data from 2016 to 2017 Child CAHPS survey results identified some changed over the period. The results shown represent the percentage of members who provided a rating of 8, 9 or 10. The data obtained is used to identify and develop improvement efforts for the areas that do not meet goal.

Customer Service Composite Score

The Customer Service composite score for Hispanic/Latino members in CY 2017 was 88%, slightly higher than the 2016 survey results of 87.3%. Customer Service scores for Non-Hispanic/Latino members was 91%, which was an increase from the CY 2016 of 1.5 percentage points. Customer Service scores for Hispanics/Latinos were three percentage points lower than Non-Hispanic/Latino members in CY 2017 and 2.2 percentage points lower in CY 2016.

CY 2016		CY 2017	
Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
87.3%	89.5%	88%	91%

The Customer Service composite score for White members in CY 2017 as 91% (1.8 percentage points higher than the score in CY 2016 – 89.2%) and for Black or African American members, it was 93% (2.6 percentage points higher than the score in CY 2016 – 90.4%). The CY 2017 scores for White members was two percentage points lower than scores for Black or African American members. The difference was higher than the 0.9 percentage difference in CY 2016. Customer Service scores for 'Other' members increased from 78.7% in CY 2016 to 83% in CY 2017, a difference of 4.3 percentage points.

CY 2016			CY 2017		
White	Black or African American	*Other	White	Black or African American	*Other
89.2%	90.4%	78.7%	91%	93%	83%

"Other" includes Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native and respondent who answered "Other".

Rating of Health Care Composite Score

The CY 2017 Rating of Health Care composite score for Hispanic/Latino members was 89%, which decreased by 5.9 percentage points when compared to CY 2016 results. The Rating of Health Care composite score for Non-Hispanic/Latino members was 89% which was 19 percentage points lower than CY 2016 scores. In CY 2017, the Rating of Health Care score was 1.99 percentage points higher than Non-Hispanic/Latino members. In CY 2017, the Rating of Health Care composite score for both the Hispanic/Latino and Non-Hispanic/Latino members was the same (89%).

CY 2016		CY 2017	
Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
94.9%	87.1%	89%	89%

The Rating of Health Care composite scores for 'Other' members decreased by 3.9 percentage points from CY 2016 (86.9%) to CY 2017 (83%). The Rating of Health Care scores for White members increased by 1.4 percentage points from CY 2016 (89.6%) to CY 2017 (91%). The Rating of Health Care composite scores for Black or African American members increased by 1.1 percentage points from CY 2016 (87.9%) to CY 2017 (89%). The score for Black or African American members was 1.1 percentage points lower than White members' scores in 2016. The difference in scores increased by 2 percentage points in CY 2017.

CY 2016			CY 2017		
White	Black or African American	*Other	White	Black or African American	*Other
89.6%	87.9%	86.9%	91%	89%	83%

Rating of Specialist

The CY 2017 Rating of Specialist composite score for Hispanic/Latino members was 85%, which was 5.5 percentage points lower than CY 2016 results (90.5%). The CY 2017 Rating of Specialist score for Non-Hispanic/Latino members was 85%, which was 0.3 percentage points higher than CY 2016 (85.3%). The rate difference between Hispanic/Latino and Non-Hispanic/Latino members Rating of Specialist decreased in CY 2017 when compared to CY 2016, from 5.2 percentage points to one percentage point.

CY 2016		CY 2017	
Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
90.5%	85.3%	86%	85%

Black or African American member's Rating of Specialist increased by 18.7 percentage points from CY 2016 (64.3%) to CY 2017 (83%) while White members ratings increased by 17.2 percentage points during the same time period. The Rating of Specialist scores for 'Other' members increased by 4.4 percentage points from CY 2016 (69.6%) to CY 2017 (74%).

CY 2016			CY 2017		
White	Black or African American	*Other	White	Black or African American	*Other
73.8%	64.3%	69.6%	91%	83	74%

Overall Rating of the Health Plan

The CY 2017 Overall Rating of the Health Plan score for Hispanic/Latino members was 95%, which was 4.5 percentage points higher than CY 2016 (90.5%). The CY 2017 Overall Rating of the Health Plan score for Non-Hispanic/Latino members was 89.5%, which was 0.8 percentage points higher than CY 2016 (88.7%). The rate difference between Hispanic/Latino and Non-Hispanic/Latino members on Overall Rating of the Health Plan increased in CY 2017 when compared to CY 2016, from 1.8 percentage points to 5.5 percentage points.

CY 2016		CY 2017	
Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
90.5%	88.7%	95%	89.5%

The CY 2017 Overall Rating of the Health Plan scores for White members remained unchanged from CY 2016 (90.2%). The CY 2017 Overall Rating of the Health Plan results for Black or African American members (89.7%) decreased by 0.4 percentage points when compared to CY 2016 (90.1%). The Overall Rating of the Health Plan scores for 'Other' members increased by 6.7 percentage points from CY 2016 (85.8%) to CY 2017 to (92.5%).

CY 2016			CY 2017		
White	Black or African American	*Other	White	Black or African American	*Other
90.2%	90.1%	85.8%	90.2%	89.7%	92.5%

"Other" includes Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native and respondent who answered "Other".

Population-Specific Outreach Activities Implemented in CY17 to Assist in Achieving QAPI Goals and Objectives

In 2017, Peach State conducted several population-specific outreach activities primarily focused on preventive health services (well visits) that addressed potential regional disparities

Region Focused

- Peach State noted that the Southeastern Georgia Families region had lower compliance rates for HEDIS well visits than other regions. Peach State determined that Plan education to supplement practitioner efforts in getting members to obtain well visits may improve well visit rates in this area. The Plan sent 1,162 mailers to non-compliant members in the Southeast Region encouraging them to receive their preventive health visit for a nominal incentive. One hundred eight members (9.3%) completed their preventive health visit within 90 days of the email.

The preceding examples correlates to a detailed description in the Effectiveness of Care section of this Program Evaluation.

Network Resources

Network Resources Compared to Population Served - Assessing Network Needs

Peach State has a mature provider network; maintaining a comprehensive statewide system of primary care providers, specialists, and facilities to meet the health needs of its populations. Peach State evaluates network adequacy in accordance with established standards for distance, specialty distribution, provider to member ratios, and provider quality. The Plan submits quarterly reports to DCH and utilizes the results of the network assessments and audits to monitor the effectiveness of the recruitment work plan in addressing coverage gaps and ensuring members received needed care.

Finally, understanding that Georgia has many rural and underserved areas, the Plan continues its emphasis on meeting members' needs in rural and Health Provider Shortage Areas (HPSAs). In doing so, Peach State continued to close gaps with the addition of new providers, engaging in single case agreements, the use of telemedicine sites and providing access to out of county providers. In 2017, Peach State's provider recruitment activities succeeded in reducing the number of network access gaps by 15% compared to 2016.
Routine assessments conducted throughout 2017 to identify and respond to new and emerging network deficiencies, and monitor the effectiveness of the work plan, included analysis of:

- County level GeoAccess reports
- Network Adequacy and Capacity Reports, including availability of PCPs and key specialty types
- Provider profiling to evaluate the quality of the existing network
- Utilization trends by region and county and the attributable causes as a means of anticipating and promptly responding to network needs
- Out of network utilization and requests for Single Case Agreements as a mechanism for identifying gaps as well as providers to target for recruitment
- Member complaint and grievance reports to identify issues related to access and provider quality
- Provider complaint reports and provider exit survey feedback related to access
- Provider satisfaction survey results to identify opportunities for improvement in Provider satisfaction and retention
- Closed Panel reports and Appointment Availability audits to identify and resolve access issues
- Credentialing data to identify providers able to meet identified needs such as specific area of clinical expertise, cultural competence, or non-English language capabilities
- Input and Oversight. The Quality Oversight Committees (QOC), which includes Providers who are currently participating in the Peach State network is responsible for the oversight and monitoring of quarterly network adequacy assessments and audits and reporting findings to the Board of Directors. The QOC, Provider Advisory Committee (PAC), and Joint Operating Committee (JOC) meetings, meetings held with our key providers and subcontractors on a monthly basis, provided meaningful insight into the 2017 Provider Recruitment Strategy and Work Plan.
- The PAC and JOCs helped identify access issues at the local level and recommended certain providers and/or provider groups to approach to help close access gaps.
- These groups also help us identify areas of health deserts within Georgia where there are no providers. These areas tend to be very rural and are located in less densely populated agricultural areas of the state.
- Maintaining Access and Addressing Identified Deficiencies

Peach State Health Plan's Provider Services staff engaged in ongoing activities to support the existing network; retaining and incentivizing providers to ensure timely access. Equally important were the efforts made to maintain strong relationships with specialized providers such as Emory Medical Care Foundation, Grady Memorial Hospital and Health Centers (the region's premier level 1 trauma center), Wellstar Health Systems, CHOA (Children's Healthcare of Atlanta) and Morehouse Medical Associates (whose physicians are world-renowned for their clinical expertise and compassion in serving diverse populations) to ensure that the network continued to adequately meet the needs of members with complex healthcare requirements. Peach State continued to require providers who wished to participate in the provider incentive programs to maintain an open panel for our members.
Actions taken in 2017 to resolve network deficiencies identified in the quarterly GEO reports and/or improve access to care included:

- Use of the State 7400 file to identify and attempt to recruit non-participating providers
- Provider Relations staff continued to conduct outreach to PCPs in identified shortage areas to encourage them to offer non-traditional hours by educating them on the additional reimbursement available when billing the after-hours add-on CPT codes.
- Peach State Health Plan used the Georgia Health Partnership (GHP) Portal, hospital websites, other CMO provider directories and targeting providers who were recently approved through the state's new credentialing process and who appear on the weekly roster of approved providers were tactics used to identify available providers for recruitment in shortage areas. The Plan continued funding partnerships to expand access in underserved rural areas.

Availability of Primary Care Services

In 2017, Peach State evaluated the availability of primary care services using multiple methods described in detail below.

Regional Geographic Access Analysis

Peach State's provider network includes more than 28,000 providers in over 50,000 locations across all six regions of the state. The Plan's overall statewide network of approximately 5,600 PCPs met or exceeded the DCH access standards of 90% of members having access to a PCP within the distance standards set by DCH in combined urban and rural areas of all regions for 2017.

Percentage of Members with Required Geographic Access to PCPs (as of Q4, 2017)
Adult PCP, Q4 2017

	Atlanta	Central	SW	North	East	SE
URBAN	99.4%	99.6%	96.0%	94.6%	96.7%	95.7%
RURAL	100.0%	99.5%	98.7%	99.8%	97.7%	98.5%

Pediatrics, Q4 2017

	Atlanta	Central	SW	North	East	SE
URBAN	99.4%	99.4%	95.4%	94.7%	95.0%	94.9%
RURAL	100.0%	97.9%	97.3%	99.8%	87.1%	98.2%

County-Level Analysis

During 2017 period, Peach State saw changes from our 2016 data in our overall regional coverage percentages for PCP, Pediatric providers and specialists. This can be attributed to a data validation and continued "clean-up" projects throughout 2017 as well as multiple recruitment exercises. As a result of the provider validation and clean-up projects, as well as the addition of large groups the total number of PCPs and pediatricians year over year increase of

practitioners. We contribute the change to the provider validation process as well as continuous cycle of providers who exit our network because they are deceased, have retired or who have left the service areas. The change in PCPs and Pediatricians by region can be seen in the table below:

Change in Pediatricians and PCPs from 2016 to 2017

Region	Q4 2016 Pediatrician County	Q4 2017 Pediatrician County	Difference	Q4 2016 PCP Count	Q4 2017 PCP Count	Difference
Atlanta	671	1080	409	1368	2335	967
Central	156	200	44	336	527	191
East	73	93	20	170	259	89
North	133	195	62	387	648	261
SE	77	101	24	274	466	192
SW	99	99	0	373	593	220
Total	1209	1768	559	2905	4828	1920

Quarterly, the Plan conducted drill down analysis to identify any gaps at the county level. The tables below show, the counties in each region with an access gap (under the 90% target) for either adult and family PCPs or pediatricians (PED), the percentage of members in the county with required access as of December 31, 2017, and the status of closing the gaps as of submission of this Evaluation. All Medicaid enrolled providers within the counties described below are currently participating in the Peach State network. Practitioners located within the county or adjacent areas provide needed services while the Plan continues to identify and recruit available providers. Peach State uses the state's weekly Credentialing Verification Organization (CVO) file to recruit newly enrolled Medicaid providers to continue to close gaps on an ongoing basis.

Atlanta Region:

There were no PCP or Pediatric gaps identified for the Atlanta Region.

Central Region:

In 2017, Peach State noted a small increase in membership and with a reduction in two pediatric gaps in Marion and Wilcox Counties. The PCP and Pediatrician gaps for the Central Region are noted in the table below.

CENTRAL			
Provider Type	**County**	**% With Access**	**Providers Being Recruited**
PCP	Laurens	78.3%	There are no additional providers in Laurens County. Our members receive care from Reese Family Healthcare and Community Health Systems
Pediatrics	Laurens	76.1%	There are no additional providers in Laurens County. Our members receive care from Southeast Georgia Healthcare and Dr. Bill's Practice.
Pediatrics	Talbot	55.8%	A gap was created during 2016 due to population changes within the county. This deficiency was closed as of the 03.31.17 Q1 2017 quarterly GEO submission.
Pediatrics	Twiggs	85.0%	A gap was created during 2016 due to population changes within the county as well as the resignation of a network pediatrician. There are no additional providers to recruit. Our members receive care from Southeast Georgia Healthcare and Dr. Bill's pediatric practice.

East Region:

In the east Region we saw the closure of a previous gap in Glascock and Wilkes County. While continued to see gaps in Burke and Taliaferro Counties, the percentage of membership with access increased by nearly 20% points. The PCP and Pediatrician gaps for the East Region are noted in the table below.

EAST			
Provider Type	**County**	**% With Access**	**Providers Being Recruited**
Pediatrics	Burke	86.1%	Increased membership in the East region have created gaps in Burke County. There are no additional providers to recruit. Our members may receive care from Pediatric Partners of Augusta. Peach State has recently entered in to an agreement with University Health Link in Augusta, Ga. This contract will greatly increase our service footprint within the region.
Pediatrics	Taliaferro	20.0%	There are no additional providers to recruit. Our members may receive care from Pediatric Partners of Augusta. Peach State has recently entered in to an agreement with University Health Link in Augusta, Ga. This contract will greatly increase our service footprint within the region.

North Region:

In 2017, Peach State Health Plan closed the pediatric gap in Morgan County. The PCP and Pediatrician gaps for the North Region are noted in the table below.

NORTH			
Provider Type	**County**	**% With Access**	**Providers Being Recruited**
PCP	Murray	78.8%	Peach State is pursuing an agreement with Hidden Valley Physician Group and Harbin Clinic which will increase our overall geographic footprint in the northern region. Our members receive care from Floyd Primary Care and Gordon Physicians Group
PCP	Walker	86.1%	Peach State Health Plan is pursuing agreements with Hidden Valley Physicians Group and Harbin Clinic which will increase our overall geographic footprint in the northern region. Our members receive care from Floyd Primary Care and Gordon Physicians Group
Pediatrics	Murray	84.5%	Peach State Health Plan is pursuing agreements with Hidden Valley Physician Group, Fannin Regional Medical Center, and Harbin Clinic which will increase our overall geographic footprint in the northern region. Members treated by providers from Whites Pediatrics (Whitefield County) and AGC Pediatrics (Gordon County)
Pediatrics	Walker	85.6%	Peach State Health Plan is pursuing agreements with Hidden Valley Physicians Group and Harbin Clinic which will improve access in the northern region. Members treated by providers from Whites Pediatrics (Whitefield County) and AGC Pediatrics (Gordon County)

Southeast Region:

The PCP and Pediatrician gaps for the Southeast Region are noted in the table below.

SOUTHEAST			
Provider Type	**County**	**% With Access**	**Providers Being Recruited**
PCP	Bulloch	83.2%	There are no additional providers in the service area or covering areas to recruit.
PCP	Charlton	76.2%	There are no additional providers in the service area or covering areas to recruit.
PCP	Screven	78.1%	There are no additional providers in the service area or covering areas to recruit.
Pediatrics	Bulloch	78.1%	This gap will be closed with addition of East Georgia Healthcare Center in Q2 2018
Pediatrics	Camden	88.5%	There are no additional providers in the service area or covering areas to recruit.
Pediatrics	Effingham	87.4%	There are no additional providers in the service area or covering areas to recruit.
Pediatrics	Charlton	72.5%	There are no additional providers in the service area or covering areas to recruit.
Pediatrics	McIntosh	78.9%	There are no additional providers in the service area or covering areas to recruit.
Pediatrics	Screven	87.7%	There are no additional providers in the service area or covering areas to recruit.

Southwest Region:

PCP and Pediatrician gaps for the Southwest Region are noted in the table below.

SOUTHWEST			
Provider Type	**County**	**% With Access**	**Providers Being Recruited**
PCP	Coffee	80.9%	There are no additional providers in the service area or covering areas to recruit. Our members may receive care from Coffee Regional First Care (Coffee County) and Phoebe Physician Group, Inc. (Ben Hill County
PCP	Colquitt	84.7%	There are no additional providers in the service area or covering areas to recruit. Our members may receive care from Tift Regional Medical Center (Tift County) and (Colquitt Regional Primary Care)
PCP	Thomas	80.3%	There are no additional providers in the service area or covering areas to recruit. Our members may receive care from Archbold Medical Group Inc. (Grady County) and Phoebe Physician Group (Colquitt County)
PCP	Echols	15.1	There are no additional providers in the service area or covering areas to recruit. Our members may receive care from Bainbridge Medical Associates PC (Decatur County)
PCP	Seminole	87.3%	There are no additional providers in the service area or covering areas to recruit. Our members may receive care from Bainbridge Medical Associates PC (Decatur County)
Pediatrics	Coffee	71.6%	There are no additional providers in the county to recruit. Our members may receive care from Southern Pediatric Clinic LLC (Lowndes County) and Valdosta Children's HC (Lowndes County)
Pediatrics	Colquitt	89.1%	There are no additional providers in the county to recruit. Our members may receive care from Southern Pediatric Clinic LLC (Lowndes County) and Valdosta Children's HC (Lowndes County)
Pediatrics	Thomas	88.4%	There are no additional providers in the county to recruit. Our members may receive care from Southern Pediatric Clinic LLC (Lowndes County) and Valdosta Children's HC (Lowndes County)
Pediatrics	Clay	34.4%	The provider originally identified as a recruitment target declined participation. There are no additional providers in the county to recruit. Our members may receive care from Southern Pediatric Clinic LLC (Lowndes County) and Valdosta Children's HC (Lowndes County)
Pediatrics	Echols	5.2%	There are no additional providers in the county to recruit. Our members may receive care from Southern Pediatric Clinic LLC (Lowndes County) and Valdosta Children's HC (Lowndes County)

* Providers include nurse practitioners and other physician extenders.

Summary

During 2017, Peach State reduced the overall number of gaps in the network from Q4 2016 to Q4 2017 by 17%. While we saw our PCP and Pediatrician network increase, we also added 411 ancillary specialists including Behavioral Health Facilities (347), and Dialysis centers (64).

We also added practitioners with specialties in Dermatology (3), ENT (45), and Ob/GYN (200).

Open Panel Analysis

Peach State also evaluated primary care availability by monitoring the rate of PCPs and Pediatricians accepting new patients by region. The Plan conducted quarterly evaluations and an annual overall analysis to identify any regions in which the percentage of PCPs or pediatricians with open panels fell below 55%. (The Peach State threshold is higher than the US national average of 41.5% of PCPs accepting all or mostly new Medicaid patients.)[1]

If the percentage of PCPs or pediatricians in the region with open panels fell below 55%, Peach State outreached to the practices with capacity to request they open their panels to new members to increase availability. To encourage providers to maintain open panels, Peach State required provider groups to maintain at least 80% open panels to remain eligible to participate in the Plan's incentive programs. The table below indicates that as of Q4 2017, the percentage of adult PCPs and of pediatricians with open panels was well above the 55% threshold in each region.

Percentage of PCPs with Open Panels in 2017

2017 Annual Average		
Region	**PCP**	**Pediatrician**
Atlanta	79.19%	77.99%
Central	86.57%	88.54%
East	92.04%	93.17%
North	81.69%	85.90%
Southeast	87.55%	88.48%
Southwest	81.30%	88.15%
Total	**84.72%**	**87.04%**

Other Methods Used to Evaluate Primary and Prenatal Care Availability

Appointment Availability Audit

Peach State conducts quarterly provider appointment availability audits on Primary Care and Obstetrics providers based on DCH contract requirements and access standards. Peach State contracts with SPH Analytics for the provider surveys and Morpace for the member surveys. Both vendors are an NCQA-certified for provider and member (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) surveys respectively.

Peach State sends SPH Analytics a file in spreadsheet form of all contracted PCPs and Obstetricians and SPH Analytics randomly selects a statistically valid sample (no less than 411 completes) of practitioners to audit. Practitioners are only surveyed once during the year unless they fail the audit. SPH Analytics uses an established survey tool to conduct the survey to ascertain the next available appointment for a routine, sick/urgent, or pediatric health check visit as appropriate. Appointment audits focus on appointment availability for:

- Adult: Primary Care - Routine
- Adult: Primary Care - Urgent
- Child: Primary Care - Routine
- Child: Primary Care - Urgent
- Child: Annual Physical (Preventive Care) Exam
- Pregnant Women: Initial visit

Peach State conducts ongoing monitoring of compliance with appointment access standards to ensure members can obtain appointments within DCH required timeframes 90% of the time. Providers who fail to meet the appointment wait time standard are educated and remain in the audit sample and continue to be monitored/audited until they successfully meet the standards. Providers who fail to meet the standard after the second audit are placed on a corrective action plan, which is submitted to the Plan Medical Director for peer-to-peer discussion and/or Peer Review Committee recommendation. Provider Relations continues face-to-face visits and education with the provider and office staff until the provider meets the appointment availability requirements.

In 2017, no providers progressed to a Corrective Action Plan (CAP). Also note, in Q3 of 2017, the DCH Appointment Availability reporting requirements changed and Peach State was required to monitor twenty-five (25%) of the network per quarter. Therefore, the volume of providers being surveyed increased from a statically valid sample to 25% of the network per quarter

Provider Type	DCH Standard	Q1	Q2	Q3	Q4	2017 Results
PCP Adult Sick	24 hours	100%	95%	94%	96%	96%
PCP Pediatric Sick	24 hours	98%	100%	100%	98%	99%
PCP Adult Routine	14 calendar days	100%	96%	94%	96%	97%
PCP Pediatric Routine	14 calendar days	97%	94%	99%	95%	96%
Initial Pediatric Preventive Care (no more than 90 days)	90 days	100%	100%	100%	100%	100%
OB – pregnant women, initial visit	Within 14 days of enrollment	91%	90%	96%	91%	92%

After-Hours Access Audit

SPH Analytics also monitors after-hours care for primary care services for Peach State by contacting PCPs and Obstetricians after-hours and on weekends to ensure services are available timely. A random sample is selected from the universe of participating PCPs and Obstetricians quarterly. Peach State assesses after-hours access to care through analysis of the responses to the following survey questions:

- If a patient needed to speak with a physician, could Dr. [Name here] or an on-call physician return a call within 1 hour? (Routine call response)
- Can Dr. [Name here] or an on-call physician return a call regarding an urgent matter within 20 minutes? (Sick/Urgent call response)

Call Type	DCH Standard	Q1	Q2	Q3	Q4	2017 Results	Goal
PCP-Urgent calls	Shall not exceed twenty (20) minutes	96%	90%	95%	92%	93%	90%
PCP-Other calls	Shall not exceed one (1) hour	94%	92%	94%	92%	93%	90%
OB-Urgent calls	Shall not exceed twenty (20) minutes	98%	100%	98%	93%	97%	90%
OB-Other calls	Shall not exceed one (1) hour	100%	100%	96%	93%	97%	90%

Providers receive a Pass/Fail for each question based on the standards of routine call response within one hour and urgent/sick call response within 20 minutes. Should a practitioner not pass appointment and/or after-hours time elements, Peach State initiates the following corrective action:

- Practitioners are educated within fourteen (14) days via an onsite face to face visit conducted by the practitioner's Peach State Provider Relations Representative.
- Follow-up audits are conducted during the next quarter and tracked to ensure compliance with the standards.
- Within seven (7) days from the date of notification of failure to pass the follow-up audit, a written Corrective Action Plan (CAP) must be implemented by the provider to address the deficiency.
- Practitioners who do not correct the identified deficiencies are subject to peer review.

In 2017, no providers progressed to a corrective action plan.

Member Grievance Audit:

- In 2017, there was one (1) member grievance (type of service-Primary Care) where the member was unable to access care due to "appointment availability" in the period of January 1, 2017 to December 31, 2017. This measure was less than the number reported in the previous reporting period, at 0.003 grievances per thousand members; which met the established goal.
- The one member grievance related to access to care was determined as unsubstantiated after research.
- The member grievance rate was within range of Peach State's performance goal threshold (established goal of less than or equal to 0.9/1000) for the reporting period January 01, 2017 to December 31, 2017

Member Satisfaction Survey Audit:

- Peach State compared scores from its annual 2016 and 2017 CAHPS Adult and Child Member Satisfaction Surveys to identify trends and areas with opportunity for improvement in 2017. During the review, Peach State identified one area measured through the CAHPS Survey that did not meet the established goal.
- To increase the adult member survey results for "Obtained needed care right away, Peach State selected the following interventions:
    - Member Services will educate adult members as they call for assistance and assist them with scheduling appointments
    - New Member Orientation also includes extensive education on the appointment standards
    - Peach State created the Member Engagement and CAHPS Committees to be implemented in Q1 2018 to improve results

Comparison of 2016 and 2017 CAHPS results showed:

- The adult rate for "Obtained needed care right away increased from 78.6% in 2016 to 83.8% in 2017. However, the increase was below the goal of 84.37%.
- The adult rate for "Obtained an appointment for care as soon as needed" increased from 76, 0% in 2016 to 81.60% in 2017. The goal of 79.39% was met in 2017.
- The child rate for "Obtained needed care right away increased from 88.5% in 2016 to 91.91% in 2017. The goal of 90.58% was met in 2017.
- The child rate for "Obtained an appointment for care as soon as needed" increased from 86.5% in 2016 to 89.9% in 2017. The goal of 87.72% was met in 2017.

Areas of Shortages and Impact on Inappropriate Utilization

To identify any impact that primary care shortages may have had on inappropriate utilization, Peach State compared the percentage of members in each of the shortage counties identified earlier in the County-Level Deficiency Analysis section with at least one PCP visit, ER visit, and Non-Emergent ER visit in 2017 and compared it to Peach State's statewide percentages in all counties. Behavioral Health related ER and Non-Emergent ER visits are included in this analysis since members with BH conditions who are engaged in effective medical homes often demonstrate lower ER/Non-Emergent ER utilization.

Geographic Area		Total Members	% Members with ER Visits	% Members with Non-Emergent ER Visits	% Members with PCP Visits
Atlanta	Newton	6352	47.69%	35.80%	92.93%
Central	Marion	346	33.82%	25.43%	95.66%
	Talbot	331	46.83%	34.44%	93.35%
	Twiggs	1840	55.92%	41.03%	90.65%
	Wilkinson	601	47.59%	35.11%	93.51%
East	Burke	133	53.38%	38.35%	78.95%
	Columbia	814	41.89%	32.43%	87.84%
	Glascock	21	28.57%	19.05%	85.71%
	Taliaferro	18	66.67%	55.56%	94.44%
	Wilkes	51	60.78%	50.98%	76.47%
North	Murray	496	43.95%	32.46%	90.52%
	Walker	948	54.85%	39.77%	89.56%
Southeast	Bulloch	852	49.77%	37.91%	91.55%
	Charlton	144	45.14%	32.64%	95.14%
	McIntosh	123	43.09%	31.71%	91.06%
	Screven	154	46.75%	36.36%	87.01%
Southwest	Clay	316	50.63%	40.19%	92.09%
	Echols	1385	28.52%	22.02%	97.91%
	Seminole	950	43.89%	33.68%	95.79%
Statewide (All PCP Deficient Counties)		**15875**	**46.62%**	**34.97%**	**92.50%**

We identified three main patterns that represents 79% (15/19) of the deficient counties described below in relation to the statewide percentages:

- Higher PCP, Lower ER, and Lower Non-emergent ER (Four counties: Marion, Charlton, Echols, and Seminoles). Of the three patterns, this pattern is the most favorable in the deficient county. Although there is a deficiency in PCPs, the members that are accessing care are accessing at a higher rate than the statewide percentage and their ER and Non-emergent ER utilization is lower than the statewide percentage. This could also suggest that the PCPs are accessible to the members even during after-hours. Also, it may suggest that the PCP is serving as the triage for the member prior to the member accessing ER services.

- Lower PCP, Higher ER, and Higher Non-emergent ER (Seven counties: Bulloch, Burke, Clay, Screven, Twigg, Walker and Wilkes). Of the three identified patterns, this one was most suggestive of a lack of primary care availability and a possibly higher acuity level. These counties had lower than statewide percentage for PCP visit rates and higher than statewide percentage for ER visit rate. Also, higher than the statewide percentage was the Non-emergent ER utilization. This too is suggestive of a lack of PCPs in the county. Also, this may suggest the PCPs are not offering after-hours triage for Non-emergent services. Therefore, the members use the ER for Non-emergencies.

- Lower PCP, Lower ER, and Lower Non-emergent ER (Four counties: Columbia, Glascock, McIntosh and Murray). This pattern could suggest the members in these counties have lower acuity levels because the utilization is lower than the statewide percentages for PCP and ER utilization. This could also suggest that the members in these counties are not engaged.

Peach State has focused its efforts on recruiting Urgent Care providers to address the previous year's patterns of care that suggested higher Non-emergent utilization. In the 2017 analysis of PCP deficient counties, Non-emergent utilization was identified as a large percent of the deficient counties. (Pattern #2).

Proposed for 2018: In 2018, Peach State will continue to recruit available Urgent Care centers in the shortage areas and partner with our primary care offices by offering incentives for extended and after-hours coverage to improve access and thereby reduce the Non-emergent ER utilization. The 2018 recruitment Work Plan will focus on primary care shortage areas in an effort to close gaps and improve access. Peach State will also analyze trends in the third pattern in 2018 to determine if the high ER utilization might be related to PCP effectiveness. Peach State may also explore acuity levels and risk in the 3rd pattern counties to determine if the pattern is attributed to membership versus primary care shortages.

Meeting Cultural Needs of the Population Served

Contracting with Diverse Providers

Peach State continually monitored its network in 2017 using member demographic information (described in more detail below), types of providers needed, historic and projected enrollment, travel distances, regional infrastructure, and special needs of those served. This allowed the Plan to identify specific gaps in linguistic, cultural, or disease or disability-related expertise, such as endocrinology, nephrology and rheumatology, to meet member needs and target network recruitment accordingly.

Traditional Medicaid Providers

Health disparities relate not only to the level of cultural competency in delivering care, but also to sufficient physical access to providers. Peach State continually monitors and maintains the provider network to ensure access for all members including those living in the 138 medically underserved areas of the state designated by the US Health Resources Services Administration. In 2017, Peach State expanded its network to include more Primary Care Providers (PCPs) and included safety net and essential providers that typically serve Medicaid members. By partnering with Federally Qualified Health Centers (FQHCs), Regional Health Centers, County Health Departments, School-Based Health Clinics, and Community Mental Health Centers that typically employ providers with experience in addressing the cultural and health care needs of their communities, the Plan helped ensure regional pools of providers who share its commitment to culturally competent, patient-centered care.

In addition to the activities described above, Peach State ensured its network met the cultural needs of the population through other efforts such as:

- Tracking and analyzing member demographic information, including race, ethnicity and primary language, to identify cultural factors that could impact health status. This included population demographic analysis (see Population Served section, above) as well as Peach State's annual Cultural Competency Assessment to identify where the Plan may need to refine the network based on the specific needs of the membership.
- Collecting and analyzing information about provider, member, and community experiences and perceptions concerning obstacles to health including racial and ethnic treatment disparities. Sources of this information included: Annual CAHPS Survey results; feedback from the Plan's Provider Advisory Committee and other committees with provider membership; the Plan's Cultural Competency Committee; the Plan's Member and Community Advisory Boards; and direct member feedback via New Member Orientations, 1st Birthday parties," Parent Nights, Peach State Days, member focus groups conducted at least every two years (even years) and ongoing analysis of member grievances.
- Providing Cultural Competency training to all providers as a component of the New Provider Orientation as well as additional education throughout the year to ensure providers were sensitive to the cultural differences of its membership. This education included but was not limited to information about compliance with the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964.
- Ensuring diverse provider representation on the Plan's committees to bring a variety of cultural perspectives to Peach State's evaluation and decision-making.

Meeting Language Needs

Annually, Peach State Health Plan analyzes key demographic characteristics including race, ethnicity, gender, regional and rural/urban distribution, and language preference to ensure the current provider network meets the needs of our members.

Member cultural, ethnic, racial and linguistic needs and preferences are assessed through:

- Data supplied on the monthly member enrollment files from the Georgia Department of Community Health
- CAHPS survey results on respondent race and ethnicity
- US census data on resident language preference and race distribution for the health plan's service area
- Data on member linguistic needs based on customer service language translation requests
- Member expressed needs regarding practitioners who meet their ethnic, racial, cultural or linguistic needs through analysis of member complaints

Key Activities in areas of interpretation, partnerships, as well as, community events were maintained in 2017 with continue strengthening and improvement of member outcomes and engagements:

- Notification to all members and providers of the availability of interpretation services and how to access bilingual interpreter service
- Provision of free language interpretation services and cultural awareness information to providers
- Offer of free linguistic services to members as needed with assistance at points of member contact with interpretation services via telephone, face-to-face, and during doctor's office visit
- Distribution of all member communications including educational materials in English and Spanish
- Envolve PeopleCare (Disease and Case Management Vendor) and Envolve Benefits (Dental and Vision Vendor) supported PSHP Community Events in 2017 by attending and presenting at various community events. Vendor offer services in both English and Spanish. Printed educational materials were also offered in both English and Spanish.
- Audit of all Vendor CCP and language assistance capability

Language Spoken by Peach State Health Plan's Population

Language	Count	Mix %
English	323,691	91.60%
Spanish	22,241	6.30%
No Linguistic Content	3,836	1.10%
Unknown	2,142	0.60%
Arabic	598	0.20%
Vietnamese	301	0.10%
Portuguese	150	0.00%
Russian	148	0.00%
French	142	0.00%
Miscellaneous (Other)	139	0.00%
French Creole, Creole and Pidgins	62	0.00%
Italian	12	0.00%
Hmong	11	0.00%
North American Indian Languages	6	0.00%
Polish	5	0.00%

German	4	0.00%
Creole - English	3	0.00%
Urdu	1	0.00%
Tagalog	1	0.00%
Mandarin	1	0.00%
Korean	1	0.00%
Finno-Ugrian (Other)	1	0.00%
Dutch	1	0.00%
Armenian	1	0.00%
Total	**353,498**	**100.00%**

Top Language Service Line Requests for CY2017

Table 5 - Language	2017 # of Requests	**2017 % Total**	2016 # of Requests	**2016 % of Total**	2015 # of Requests	2015 % of Total	2014 # of Requests	**2014 % of Total**
Spanish	4833	**82.2%**	5,261	**72.18%**	3,720	**76.14%**	1912	**70.55%**
Burmese	523	**8.9%**	276	**3.78%**	225	4.60%	165	**6.09%**
Arabic	526	**8.9%**	NA	**NA**	NA	NA	NA	**NA**
Nepali	NA	NA	89	**1.22%**	107	2.19%	107	**3.95%**

Spanish continues to be the most prominent non-English speaking language of PSHP'S membership, and observations continue to show that members have a cultural and linguistic need for competence among practitioners and staff who interact with them. PSHP will continue to reinforce the continuous improvements by monitoring competence of bilingual staff and by continuing to track and monitor the Language Service Line activities.

Other Targeted Network Initiatives That Addressed Cultural/Population Issues or Medically Underserved Areas

In 2017, Peach State established key partnerships designed to expand access to culturally appropriate care or to address medically underserved areas of the state. For example:

- Urban League of Greater Atlanta
  - In Q4 of 2017, Peach State Health Plan established a partnership with this community organization to explore social service value added benefits for Peach State Health Plan members
- Emory School Based Health Clinic
  - Peach State Health Plan continued its partnership with Emory Foundation in 2017 by being a sponsor for two schools in the Atlanta Public School system.

Telemedicine

In 2017, Peach State Health Plan continued to support our existing TeleHealth partnership sites through continued funding, technical support, and joint marketing opportunities. Peach State worked with GPT to identify provider and community champions to promote education of TeleHealth, to highlight the opportunities TeleHealth offers our communities and to support of TeleHealth application and services across Georgia. Peach State Health Plan was actively working with Georgia Partnership for TeleHealth throughout 2017 to identify interested sites, overlaying these sites with geographic access needs and Peach State member populations.

- Peach State identified three potential sites based on the feedback from Georgia Partnership for TeleHealth and an analysis of the access needs of our members.
    - One site that was chosen was a school based health center in Bryan County in Pembroke, Georgia. This county is extremely rural and has no access to primary care other than a health department.
    - The second site chosen was a highly-utilized pediatric provider in Tifton, Kids Care Clinic (Dr. Nandlal Chainani) who specifically uses the equipment to provider specialty and Behavioral Health access to his patients.
    - The third site is a family practice provider located in rural Alma, Georgia. Dr. Rachel Burke (South Georgia Primary Care) had partial equipment already installed at her location and has been a huge proponent of TeleHealth for Behavioral Health patients. Peach State purchased the scope equipment for Dr. Burke so that she could expand her TeleHealth outreach to allow her practice to be a receiving primary care site for Appling County School.

The two new partnership providers, Dr. Chainani and Dr. Burke are both strong supporters of TeleHealth and have proven to be provider champions who will promote and encourage TeleHealth services to their patients and community. The equipment in Dr. Chainani's pediatric practice is also being utilized by his wife, Dr. Navdeepa Chainani in her adult primary care practice in Tifton. Dr. Rachel Burke is located in Alma, Georgia, a very remote location with little access to specialty care. She has used the equipment for children and adults to access specialist and Behavioral Health services that otherwise would not be available locally. Bryan County School are in a rural and underserved area of the state. The TeleHealth equipment donated to this location will allow the school nurses to provide expanded primary care and access to specialty care and Behavioral Health services for the children in their elementary, middle school and high school programs.

In 2017, the TeleHealth Workgroup expanded on the 2016 plans related to development and implementation of a comprehensive redesigned strategy to address barriers incurred during and after installation of the TeleHealth units. The table below indicates the updated 2017 and proposed 2018 strategies.

Location	Launch Date	2017 Status Update	2018 Strategy
Edison Medical Center (Calhoun county)	August 2015	Peach State conducted education with Edison Medical Center providers to encourage and empower TeleHealth utilization and to develop a program to support using the equipment.	In 2018, Peach State plans to market and support the Edison Medical Center site to bring awareness to the membership in the catchment area. Also, we plan to partner with the new state-of-the-art Charter School in Calhoun County to educate parents and teachers on the benefits and value of TeleHealth.

Location	Launch Date	2017 Status Update	2018 Strategy
South Central Primary Care (Irwin County)	August 2015	In 2017, Peach State worked with the South Central Primary Care site to increase awareness of TeleHealth by sending letters to providers in the area describing the service, providing educational flyer for members, and installing outdoor signage for the site announcing availability of TeleHealth services.	In 2018, Peach State will develop a program to highlight the South Central Primary Care's relationship as a receiving site for the Irwin County schools to provide primary care and Behavioral Health services to students and will work with the local schools to educate their staff on LEA process and to promote TeleHealth usage.
Mountain Lakes Medical Center (Rabun County)	November 2016	In 2017, Peach State attempted to increase awareness of TeleHealth by sending letters to providers in the area describing the service, by providing educational flyer for members and outdoor signage for the site announcing availability of TeleHealth services. Unfortunately, due to a change of administration this facility, the equipment was removed in 2017 due to lack of support.	In 2018, Peach State will approach alternate Critical Access Hospitals to partner and to develop TeleHealth programs. At this time, Peach State is considering several locations for the partnership offer.
Bryan County School-Based Health Center (SBHC)	March 2017	Unfortunately, the equipment at this site has only just been installed due to a delay on the School Board's approval of the GPT contract.	The goal for 2018 is to increase awareness of TeleHealth by including an educational flier for students in their school packets, outdoor signage for the site announcing availability of TeleHealth services and facilitating TeleHealth presentation at PTO/new student orientation meetings.

The Peach State 2017 TeleHealth strategy included new and innovative ideas on how to increase access for the membership. The Peach State Health Plan Community Medical Director, Dr. Alan Joffe, continued the role of a Clinical TeleHealth Champion to educate providers and promote the program. Dr. Alan Joffe is a member of the Peach State TeleHealth Workgroup and has spoken with OBGYN physicians across the state about Telemedicine and how it can improve outcomes for high-risk pregnant members. By utilizing the telemedicine equipment, high-risk members in the rural areas are able to connect to maternal fetal medicine providers which increases access while reducing the cost and travel burden. In 2017, the top three providers billing presentation site fees for maternal fetal medicine TeleHealth services were all OB/GYNs that Dr. Joffe encouraged to embrace TeleHealth services. These providers are all located in rural, underserved southwest Georgia.

1. The Shaw Center – Thomasville – 134 Maternal Fetal Medicine TeleHealth Encounters
2. South Health District BOH – Valdosta – 132 Maternal Fetal Medicine TeleHealth Encounters
3. Southern OB/GYN - Valdosta – 122 Maternal Fetal Medicine TeleHealth Encounters

In 2017, Peach State Health Plan:

- Expanded its partnerships with School Based Clinics statewide to include the Local Education Agencies (LEA). Peach State Health Plan began educating and supporting LEAs to encourage submission of test claims and provided operational and educational support on claims and billing requirements.
- Sponsored (March 2017) for the Georgia Partnership for TeleHealth Annual Meeting and School Based Health Conference where the Plan presented on school based telemedicine and how to enroll with Peach State Health Plan as an LEA. Peach State piloted with Ware County School system and Mitchel County School system to ensure proper configuration and claims processing. In 2018, Peach State Health Plan will continue to assist LEAs with load processes and monitor their success.
- Updated Member Web Portal to include TeleHealth education. In 2017, the provider and member secure portals were redesigned to include a specific telemedicine section.
- Incorporated TeleHealth education fliers in new member educational packages. Currently the Georgia Families Medicaid and Peach Care for Kids Member handbook includes a section on Telemedicine. The handbook is mailed to all new members and posted to our website for existing members.
- Collaborated with GPT to identify providers with telemedicine capabilities for display in our online and print directory.
- Marketed TeleHealth Services at the following locations: South Central Primary Care, Edison Medical Center.

Plans for 2018: In 2018 Peach State Health Plan plans to solidify and expand our telemedicine program by:

- The Telemedicine committee will be reaching out to primary care, pediatric, critical access hospitals, school based health clinics and FQHCs in the rural areas to form TeleHealth partnerships and create access to deficient specialties.
- Enhanced member education on TeleHealth through:
    - Presenting TeleHealth videos during parent/teacher conferences. Due to the late installation and training for the TeleHealth equipment, Peach State will be facilitating a presentation with Georgia Public Television on the TeleHealth videos during the parent/teacher conferences in 2018 at Bryan county schools
- Explore options of Video Medicine
- Continue working with the LEAs to promote TeleHealth and assisting with testing and billing claims
- Approach existing partnership locations to provide endorsement videos to assist in promotion of partnership opportunities related to TeleHealth with Peach State.

Other Partnership Programs:

Vision Van/FQHC Partnership: Through our partnership with Albany Area Primary Healthcare, Peach State learned that a significant number of school age children in our most rural areas needed eyeglasses. Peach State took this opportunity to impact the lives of not only our members but of any child needing glasses and sponsored to have a vision van and optometrist perform refractive eye exams and to prescribe glasses for those in need in eight FQHC School-Based Clinics. Peach State then funded 100% of the cost of the glasses for every child that needed a prescription. There were a total of 1,830 eye screenings completed and 440 pairs of glasses distributed to children across the state. The following is a detailed account of these partnerships:

School Based Clinic	Location	Eye Screenings	Eye Glasses
Alice Coachman Elementary	Albany	142	32
Turner Elementary	Albany	157	40
Crisp County Primary	Cordele	203	42
Dooly Elementary & Middle Schools	Vienna	136	33
Terrell Elementary & Middle School	Dawson	121	28
Taylor County Schools	Butler	279	51
Chattahoochee County Schools	Cusseta	143	24
Lake Forest Elementary	Sandy Springs	649	190

Efforts to Address Shortcomings

Peach State continually reviews information and data to identify opportunities for improvement, including opportunities to partner with providers to improve the ability of the network to meet cultural needs.

Planned Network Initiatives to Address Language, Age, Race, Ethnicity, and Medically Underserved Needs of Membership

In addition to the analyses related to language and medically underserved areas, Peach State also identified several cultural/treatment disparities which are being addressed through targeted initiatives. The targeted initiatives to address these disparities were continued and expanded. Some highlights include:

- Innovative Medical Home Solutions to Address Health Disparities: Peach State has implemented a PCMH provider strategy to encourage practices to obtain NCQA PCMH Site Recognition through financial incentives. Peach State also provides incentives for providers to achieve NCQA PCMH recognition through the PCMH incentive program, which has contributed to a 92% increase in PCMH practice sites in the network since 2014. In 2016, the Peach State provider network included 239 Patient Centered Medical Home practice sites covering 20% of our membership. This program incorporates multiple elements that incentivize providers to achieve and maintain NCQA PCMH recognition, which promotes quality, access, and effective coordination of care. In 2017, Peach State provider network included 305 sites recognized as Patient Center Medical Home practice site which represents 105 in-network tax ID numbers covering 22% of our membership.
- In 2017, Peach State Health Plan enrolled 100% of eligible members (under 21 years old) in a primary dental home. The Dental Home is responsible for coordinating all dental care for the Member and is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan.

Provider Utilization of Electronic Health Records

EHRs provide quick access to complete and accurate patient information, which improves patient safety and quality of care by supporting the providers' ability to make well-informed, timely decisions about care. Improving the quality and safety of care delivered by providers is a central purpose of the Plan's QAPI Program. To this end, Peach State encourages all providers to use Electronic Health Records (EHRs).

Percentage of Providers Using EHRs

In 2017, the EMR/HER survey continued to follow the 2016 model and targeted to Peach State Health Plan providers who are registered with the Peach State Health Plan Secure portal. The results of the 2017 survey are below.

- 80% of respondents reporting that they are currently using an EMR/EHR. Of the providers who reported using an EMR/EHR, the vast majority (71%) have submitted Adopt, Implement, Upgrade (AIU) or Meaningful Use attestations and 85% have received incentive payments.
- 2017 results showed a significant increase in the number of EMR/EHR users who are also Patient Center Medical Homes certified. One-fifth (20%) of 2017 EMR/EHR respondents are PCMH certified compared to one-fourth (14%) of 2016 respondents. Four percent (4%) indicated they are in the process of becoming PCMH certified, which is the same as 2016 results. As noted previously Peach State monitors the number of PCMH's on routine basis and by the end of 2017, Peach State's provider network included 305 Patient Centered Medical Home practice sites covering 33% of the membership compared to 289 at the end of 2016.
- In 2017, forty-two percent (42%) of respondents have made use of an electronic Health Information Exchange (HIE), which is a 3% over 2016 results or 9% increase over 2015 results.
- Sixty-five percent (65%) of the providers surveyed reported that they have submitted quality measures via the Physician Quality Reporting System. Additionally, forty percent (40%) reported they have submitted Clinical Quality Measures.

The EHR/EMT survey will be repeated in 2018.

Use of EHRs/EMRs Compared to Rural/Urban Member Demographics

In 2017, 67% of Survey Respondents indicated they have EMR/EHR capabilities in their practice which is slightly lower than 2016 results of 70%. In the most recent survey, the breakdown of rural and urban areas within in each region showed that in areas of highest membership, the percentage of providers using EMR/HER was significantly greater than those without EMR/HER capabilities. Targeted outreach to educate and encourage EMR usage is addressed in the following section: Efforts to Increase provider EHR Usage.

Region	Urban			Rural		
	%EHR Providers	% Non-EHR Providers	Membership in Urban Counties Surveyed	%EHR Providers	% Non-EHR Providers	Membership in Rural Counties Surveyed
Atlanta	46%	9%	188,140	0%	0%	0
Central	12%	2%	25,238	34%	0%	2,816
East	4%	0%	2,638	0%	0%	0
North	6%	0%	5,049	34%	17%	5,884
Southeast	12%	0%	4,488	5%	5%	392
Southwest	10%	0%	30,827	5%	0%	1,838

Efforts to Increase Provider EHR Usage

Over the past several years, Peach State has conducted a variety of provider education initiatives and activities to increase the percentage of the network using EHR technology, including the following:

- Incorporated the DCH Fact Sheet "Medicaid EHR Incentive Program" as a standard tool in the Peach State Provider Tool Kit and education strategy.
- Outreached to all FQHCs to determine utilization. 100% of FQHCs reported using an EHR or electronic medical records (EMR).
- Conducted two Technology Focus Groups with providers in which the Plan educated providers on the benefits of using an EHR.
- Targeted provider education to encourage EMR/EHR usage conducted during Pick Peach State campaign.
- Placed educational articles in the provider newsletter and on the provider website promoting:
  - Benefits of EHR
  - Differences between EHR and EMR
  - Medicaid Incentives available to providers who implement EHR
  - Links to DCH EHR educational material

Peach State is developing additional strategies for 2018 to encourage provider adoption and use of an EHR. In 2018, Peach State will require TeleHealth partnership recipients to use EMR/EHR in order to be eligible for TeleHealth partnerships (School-based clinics are exempt from this requirement.) Peach State will repeat the survey in 2018 to measure the impact of these efforts on network adoption of EHR.

Provider Participation in Quality Improvement Initiatives

Outreach Activities and Resources to Educate Providers on Quality Initiatives

- In 2017, Peach State's Quality Clinical Nurse Liaison (CNL) continued to support the Provider Relations team by visiting provider offices to discuss Care Gap reports, quality initiatives, and HEDIS measures, and to serve as a resource to the practices for questions regarding the quality program. In CY 2017, the number of CNL staff increased from two to six.
- The Provider Relations (PR) team also provided member-specific performance measure compliance summaries, clinical practice guidelines, and tips and tools to help engage the member in primary and preventive care. They also provided education and support on addressing gaps in care; HEDIS measure requirements, and proper HEDIS coding during office visits.
- PR and Quality staff provided education about Plan quality initiatives and performance measures at such events as Practice Management Advisory Group meetings, monthly Joint Operating Committee meetings with key provider groups, provider conferences, and other provider meetings.
- Peach State provided information to PCPs bi-annually and OB/GYNs annually on their performance related to selected metrics compared to Peach State benchmarks and the performance of their peers (described in more detail below in the section on Provider Report Cards). The Plan utilized Provider Report Cards to identify outliers for in-person education and follow-up from the PR Team and Medical Directors. In person sessions included discussion of individual performance as well as education on applicable quality initiatives and related goals.
- Peach State's secure provider portal provided a care gap alert for every member due or past due for required services every time a provider accessed Plan online member health record. PR Representatives educated and encouraged provider office staff to generate lists of all members tagged with care gap alerts to target them for appointments and ensure that care gaps are addressed during any office visit.
- Peach State developed and rolled out two quality reporting tools on the secure Peach State web portal. The Provider and Patient Analytics tools allow providers to
    - Pull reports based on particular care gaps, view member information on prescriptions, ER visits and other specialty provider activity
    - View members loyalty to their practice based on claims data
    - Determine members assigned to provider panel who have no claims activity
    - View member care plan and health records

Strategies to Encourage Provider Participation in QI Activities

All Peach State network providers are contractually required to participate in QI initiatives. However, experience has shown effectively engaging providers in quality activities requires the ability to clearly communicate measurable goals and desired outcomes, solicit provider input into the QAPI, provide education, training, and tools, and reward positive performance with provider incentives. In addition to the education, outreach, and resources described above to engage providers in quality programs, Peach State's strategies for engaging providers in quality during 2017 included:

- Continuing the Provider Advisory Committee meetings. Peach State expanded the Provider Advisory Committee to additional specialties to ensure greater diversity in representation and enable more physicians and other providers to have input into Peach State's continuous quality improvement processes.

- Remediating Quality Outliers. In 2017, Dr. Alan Joffe, the Plan's Community Medical Director, conducted provider remediation with 11 provider groups who were identified as outliers based on Impact Intelligence Software cost and quality indicators. The 11 doctors include some of the Plan's best providers whose costs are explained by their practice circumstances; further, eight of the 11 had excellent Quality scores. Of the 86 providers followed from the inception of the Remediation Program, 79 (92%) have experienced a remarkable improvement in cost.
- Offering Provider Incentive Programs. Peach State has offered provider incentive programs since 2010. The incentive programs actively engage and reward providers for delivering high quality, cost effective patient care. The Plan's incentive programs also align with its goal to optimize member health care outcomes, while effectively managing health care costs.
    - In 2017, 63 provider groups participated in one of Peach State's provider incentive programs, compared to 66 provider groups in 2016. The slight reduction was primarily due to practice consolidations or closures. Overall, these providers served 77% of Plan membership, higher than the 66% served by providers in an incentive program in 2016. As shown in the table below, Peach State achieved improvements from 2016 to 2017 in several measures for which the Plan provided incentives. Peach State attributed some of that success to members attributed to participating incentive providers.

Comparison of CY 2017 Performance Measures Between Incentive Groups and Non-Incentive Groups

HEDIS Measure	HEDIS Incentive Groups (Admin)	Groups without HEDIS Incentives (Admin)	Diff	P-value	Statistically Significant
Adolescent Well care	52.97%	35.27%	17.69%	0.000	Yes
Immunization- Combo 10	30.79%	26.67%	4.12%	0.000	Yes
Diabetes - A1C testing	83.63%	79.66%	3.97%	0.044	Yes
Diabetes- Eye	52.13%	46.69%	5.44%	0.032	Yes
Diabetes- Nephropathy	88.65%	87.21%	1.44%	0.397	No
Comp Diabetes - Poor Control A1c>9 - L*ower is better*	79.85%	67.80%	-12.05%	0.000	Yes
Developmental Screening	57.57%	38.78%	18.78%	0.000	Yes
Follow-up Care for Children Prescribed ADHD medication - Initiation	46.13%	44.76%	1.36%	0.491	No
Follow-up Care for Children Prescribed ADHD medication - Continuation	58.44%	56.41%	2.03%	0.753	No
Medication Management- Asthma 5 to 11 75%	27.50%	23.08%	4.42%	0.073	No
Medication Management- Asthma 12 to 18 75%	24.70%	28.68%	-3.98%	0.182	No
Preventive Dental Services	53.20%	46.93%	6.27%	0.000	Yes

BMI Assessment	65.26%	41.06%	24.20%	0.000	Yes
Nutritional Counseling	61.57%	32.74%	28.83%	0.000	Yes
Physical Activity	34.33%	16.10%	18.23%	0.000	Yes
Well child 15 months	54.58%	41.85%	12.73%	0.000	Yes
Well child 3rd-6th years	72.99%	55.96%	17.03%	0.000	Yes

Of the 17 measures used in the 2017 provider incentive program and comparing Incentive versus non-Incentive groups:

- Fifteen (15) measures were higher for Incentive Groups and eleven (11) of those were statistically significant
- Two (2) measures were lower for Incentive Groups and only one (1) of those was statistically significant (Comp Diabetes – Poor Control)

Awards. Peach State encouraged providers to participate in QI activities by recognizing their achievement through the Peach State Summit Award:

- **Peach State's Summit Award** honors exceptional providers who, compared to their peers, demonstrate the most exemplary care based on performance on several key quality and efficiency metrics. Each practice received an engraved plaque presented by one or more members of Peach State's Senior Leadership Team and a catered lunch for their office staff. The Plan also recognized them in national and local press releases, social media updates, on Peach State's website and in the provider newsletter. There was one Summit Award given in CY 2017. It was presented to Dr. Angela Hutchins of Zaman Pediatrics, for exemplary care based on quality measures in comparison to her peers.

Provider Report Cards

The goal of the Peach State Program and Provider Profiling Reports was to increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. The Peach State Health Plan Provider Profiling Program was designed to analyze data in order to identify provider utilization and quality issues. Provider profiling data continued to be used to identify opportunities to improve communications to providers regarding use of clinical standards of practice.

Peach State developed a provider profiling report that identifies utilization, quality indicators and referral patterns of PCPs and other providers as deemed appropriate. Peach State used multiple clinical, administrative and member satisfaction data sources to develop the provider profiles including but not limited to claims payment and encounter data, authorization data, inpatient and concurrent review data, pharmacy data, quality measures and member complaints and grievances .

The following modes were utilized to distribute the provider profiles

- Impact Intelligence Provider Profiles are mailed to providers along with a letter from the Medical Director.
- Provider Analytic Profiles are available to providers on the provider web portal and discussed with providers during visits with the provider relation representatives.
- Annually, a Comprehensive Provider Profile is mailed to providers including their prior year's utilization, quality outcomes and member satisfaction information.

Reports were generated and reviewed to identify any potential patterns of inappropriate utilization or quality concerns. Reports compared providers against peer (in the same geographical area), the provider's historic data and NCQA and state quality targets. Providers whose utilization results were statistically higher or lower than established benchmarks and/or their peers were flagged for qualitative analysis which was conducted to determine the cause and effect of all data not within thresholds or anticipated outcomes. PCPs identified as having quality issues, received specific feedback and/or on-going education when indicated.

Peach State supports network provider improvement efforts by distributing a PCP Report Card semi-annually and an OB/GYN Report Card annually. These report cards show the current practice performance and the average Peach State Health Plan score for given performance measures. The report cards for PCPs include up to 10 HEDIS measures specific to the practice (i.e. adolescent well care visits, well child visits 3-6 years for pediatricians) The report cards for OBGYNs include several quality metrics specific to the practice area (i.e. 17P utilization and post-partum care). Peach State Health Plan used the information to determine which outlier practices may benefit from an onsite education sessions or which measures require broader education efforts specific to the measure (i.e. coding issues) across practices.

Measures Included in PCP Report Card	Measures Included in OBGYN Report Card
Breast Cancer Screening	Notification of Pregnancy Success
Cervical Cancer Screening	Risk Adjusted C-Section Rate
Childhood Lead Testing	Optimal 17-P Utilization
Comprehensive Diabetes Care Eye Exam	Post-Partum Care
Use of Appropriate Medications for People With Asthma Combined Rate	
Annual Dental Visit – Total 2-21 years	
Well Child Visits in the First 15 Months of Life: 6 or more visits	
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life	
Adolescent Well Care Visits	

Peach State Health Plan also uses a more general physician profiling strategy to improve overall performance. Providers are profiled using Impact Intelligence, a national profiling software tool available through Ingenix to identify high cost, low quality providers. Providers with high Health Benefit Ratios (HBRs) and low quality scores receive a profile report and a remediation appointment is scheduled. The provider's progress is reviewed after the initial peer to peer remediation meeting. If there is no improvement, the Peer Review Committee evaluates the physician practice to determine the appropriate disciplinary action, including probation with a corrective action plan or termination. The committee consists of four external practitioners as well as the Peach State CMO, Community Medical Director and Chief Medical Director. The PPEC is the last step committee review, using practitioners in the same discipline, to review high cost low quality practitioners that Peach State is considering for discipline and/or termination.

2017 Findings. Since 2014, this committee has reviewed seven (7) cases, presented three (3) termination recommendations and four (4) remediation recommendations. There were no meetings required in CY 2017.

Provider Satisfaction

2017 Provider Satisfaction Survey

Peach State's Provider Satisfaction Survey Composite Scores increased over the 2016-2017 period. SPH Analytics conducted the Provider Satisfaction survey and followed a one-wave mail, internet, and phone follow-up survey methodology to administer the Provider Satisfaction survey. The survey was preformed from October to November 2017 and included surveys hand delivered to 1500 providers. A total of 365 surveys were completed (155 mail, 43 Internet, and 167 phone), yielding a response rate of 13.2% for the mail/Internet data component and 22.4% for the phone data component.

For 2017, Peach State Health Plan exceeded scores for eight out of eight composites compared to all other Medicaid health plans in SPH Analytics Book of Business (BOB). BOB is a benchmark based on the results of Provider Satisfaction Surveys conducted by SPH for all of their Medicaid CMO clients. The table below shows the Plan's 2017 rates for each composite, compared to rates for the two years and the BOB.

Peach State Health Plan Summary Provider Satisfaction Ratings, 2016-2017

Composite/Attributes	2016	2017	SPH BOB 2016
Overall Satisfaction with Peach State Health Plan	73.1%	80.6%	64.6%
All Other Plans (Comparative Rating)	37.8%	41.2%	33.6%
Finance Issues	36.7%	39.9%	31.7%
Utilization and Quality Management	32.8%	39.8%	31.7%
Network/Coordination of Care	24.3%	33.2%	28.5%
Pharmacy and Drug Benefits	21.0%	29.5%	20.4%
Health Plan Call Center Service Staff	37.6%	44.9%	37.4%
Provider Relations	49.2%	53.4%	35.6%

Peach State increased satisfaction scores in all eight composite areas from 2016 to 2017. Peach State Health Plan also realized an increase (from 78.7% to 80.6%) in overall Provider Satisfaction compared to 2016. This is the highest satisfaction score to date for Peach State Health Plan. Peach State believes the increase in scores can be attributed to a focused and cross departmental committee whose teams worked on initiatives targeting providers concerns and open ended comments submitted on the 2016 Provider Satisfaction Survey. The Provider Relations department at Peach State Health Plan follows a detailed service strategy and believes the effectiveness of this approach accounts for it being the highest scoring composite for 2017 at 53.4%. The strategy included:

- Enhancing and increasing the training for Provider Relations staff to ensure that PR increased not only the quantity but also the quality of provider interactions
- Mandatory, intensive quarterly training for all Provider Relations staff to ensure more effective provider interactions
- Significantly increasing field activity and provider interaction to visit more than 95% of the network providers in 2017
- Continuing the practice of engaging providers through numerous provider committees, stakeholder meetings and conferences, Practice Manager Advisory Group (PMAG) meetings, Annual State Tours, and large group meetings.
- Hand delivering of 100% of the Provider Satisfaction Surveys in October 2017

- Implementing, as a part of the Provider Satisfaction Performance Improvement Project for 2017, the following additional interventions to increase overall provider satisfaction with the Plan:
- Large group provider meetings in all regions to provide additional education and training opportunities for providers across the state
- Sharing quality performance information during each provider interaction

The correlation analysis from SPH Analytics is used each year to identify areas of highest opportunities for improvement to drive interventions for the subsequent year.

Composite Areas	Attributes most Correlated with Overall Satisfaction	2017 Corr. Coeff.*	2017 Rate
Utilization and Quality Management	Consistency of Review Decisions	0.621	36.6%
	Extent to which UM staff share review criteria and reasons for adverse determinations	0.611	47.2%
	The Health Plans facilitation/support of appropriate clinical care for patients	0.610	45.1%
	Access to knowledgeable UM staff	0.590	40.7%
	Access to Case/Care Managers from this health plan	0.588	44.8%
	Degree to which the plan covers and encourages preventative care and wellness	0.572	57.6%
	Procedures for obtaining pre-certification/referral/authorization information	0.563	50.3%
Finance Issues	Accuracy of claims processing	0.588	54%
Provider Relations	Quality of Provider Orientation Process	0.568	58%

Note: * Correlation coefficients of 0.518 or greater

PCP and Specialist Satisfaction

The overall satisfaction scores increased for PCPs by 5.2%, specialty providers by 10.4% and OBGYNs by 13.5% from 2016 to 2017. The table below shows the overall satisfaction practitioners had with the health plan. One reason Peach State believes these scores increased is due to our Community Medical Director, Alan Joffe, MD and his involvement with providers across the state. Dr. Joffe is very active at Society meetings, organizes and recruits for the Provider Advisory committee and works special initiatives and projects with key stakeholders.

Response by Specialty: Overall Satisfaction with Peach State Health Plan

2017			2016		
PCP	Specialist	OBGYN	PCP	Specialist	OBGYN
80.3%	82.8%	82.1%	75.1%	72.4%	68.6%

Improvement Efforts Based on 2017 Survey Findings

Peach State implemented several additional interventions in 2017 that were designed to improve Provider Satisfaction. The interventions described below were developed using feedback obtained from the open-ended comment section of the 2016 survey, as well as provider feedback at PMAG and Joint Operation Committee meetings.

- Claims
  - Rapid Response Model developed and introduced in February 2017 to revamp claim intake processing to a three day turnaround time

- Contracting
  - Continued expansion of the provider network
  - The survey question for the initiative set by the contracting department did not score highly with providers. Peach State believes that providers are linking the Medicaid, Health Exchange and Medicare products all into one for this Medicaid product survey when thinking of the provider network. To resolve this issue for the 2017 survey, the survey will state "Medicaid Product Only" survey on it to differentiate the product and the letter attached to the survey will indicate this also
- Utilization and Quality Management
  - Restructured and organized Medical Management department by line of business to streamline authorizations and decrease turnaround time.
  - Provider training on how to access members care plans on the Peach State secure portal
  - Introduction of Provider and Patient Analytics tools on the secure Peach State portal which gives providers access to member care gaps, member health records and reporting functions.
- Provider Relations
  - New Provider Representative Audit process developed to measure the providers' satisfaction with provider field visits, follow up and resolution from their assigned field representative.
  - New Online directory of Peach State payment policies

Satisfaction with Provider Services Staff Handling of Claims Issues. During 2017, Peach State developed new initiatives to improve the satisfaction with the call center. The initiatives work by increasing their composite score from 37.6% to 44.9%, an increase of 7.3%. The initiatives included:

- Development of enhanced claims training modules for Customer Service Representatives (CSRs) handling provider claims inquiries
- Mandatory refresher claims training for CSRs assisting with claims inquiries
- Implementation of Instant Message (IM) chat with all provider CSRs and Supervisors to provide immediate assistance for resolution with complex claims inquiries
- Bi-monthly team meetings with Provider Relations staff to identify, address and resolve claims inquiries

2018 Activities: For 2018, Peach State evaluated the comments report provided by SPH Analytics and developed new initiatives around this department. The interventions for 2018 will include:

- New Provider Relations model consisting of Provider Relations Operations team and Provider Relations Engagement team to better serve our providers. The Provider Relations Ops team is internal and the goal is to respond and resolve provider issues more quickly. The Provider Relations Engagement team's primary focus is increased field activity with PCP's on Quality/HEDIS Education.
- Implemented Provider After-Call Survey in Q4 2017. As part of the survey process, call backs are made to any Provider that expresses dissatisfaction to resolve the concern. In addition feedback is tracked to provide any needed coaching or training to staff members.
- On-Demand Webinars being created for New Provider Orientations for all products

What 2017 Findings Suggest About Provider Participation in QAPI Program

As shown in the table below, Peach State increased scores in 2017 by 1.8% for the one question that correlated most directly with educating providers on QI initiatives related to performance measures, "Degree to which the plan covers and encourages preventative care and wellness." While the scores indicate continued room for improvement, they also validate that efforts to educate providers and support their involvement in the QAPI Program has been successful. In 2017, Peach State signed up over fifty groups for HEDIS only incentive and twenty-six groups for our Health Benefit Ratio (HBR)/HEDIS incentive. The plan employed four additional HEDIS field nurses to educate providers on HEDIS measures and other quality initiatives. Additionally, the score for 2017 for the question related to the degree to which the plan covers and encourages preventative care and wellness exceeded the benchmark for SPH's BOB by 11.5%. Although these scores indicated that Peach State out-performed peer health plans on these measures, Peach State recognizes there is still room for improvement.

QUESTIONS CORRELATED WITH ENGAGING PROVIDERS IN QI ACTIVITIES	2017		2016	
	Peach State	SPH BOB	Peach State	SPH BOB
3F. Degree to which the plan covers and encourages preventative care and wellness	50%	38.5%	48.20%	39.60%

Quality Initiatives for 2018 include:

- Development of new P4P program to include all Primary Care Providers in Peach State Health Plan Network
- New Provider Relations Engagement team developed to focus on Quality/HEDIS and Risk Adjustment education for primary care practices
- Addition of Quality reporting tools to Peach State secure portal to assist with providers ability to meet Care GAPs and quality targets

Effectiveness of QAPI Program

Interventions Implemented to Address External Quality Review (EQR) Findings

The Georgia Department of Community Health (DCH) contracts with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO). HSAG performed the three required external quality review (activities as outlined in the Balanced Budget Act (BBA): validation of performance improvement projects (PIPs), validation of performance measures and conduction of a review within a 3-year period, to determine the CMOs' compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g).

EQR: Performance Improvement Project (PIP) Validation and Key Review Results

The Department of Community Health (DCH) and Health Services Advisory Group (HSAG) adopted a modified version of the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement as the methodology for the PIPs. The IHI QI model focuses on accelerating improvement without replacing change models that different organizations may already be using. The core component of the model includes testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory during the course of the improvement project. This framework was selected as it allowed broad flexibility, to build on proven quality concepts and a systematic technique to improvement activities.

For CY 2016, Peach State submitted four PIPs for validation. Peach State was also required to collaborate with WellCare, Georgia to conduct an Asthma rapid cycle PIP during CY 2017The PIPs were validated using HSAG's rapid-cycle PIP validation process. The PIP topics included:

- Avoidable Emergency Room Visits – Confidence
- Annual Dental Visits – High Confidence
- Member Satisfaction – High Confidence
- Provider Satisfaction – Low Confidence

Findings. Peach State's performance across the four PIPs suggests that the CMO has made progress in successfully executing the rapid-cycle PIP process. This progress is demonstrated by HSAG assigning two of the four CY 2016 PIPs the level of *High Confidence* and one other PIP the level of *Confidence*. In each of these three PIPs, the SMART Aim goal was achieved and some or all of the quality improvement activities could be linked to the demonstrated improvement. Only one PIP, *Provider Satisfaction*, was assigned a level of *Low Confidence*.

Interventions: Peach State responded to HSAG recommendations:

HSAG Recommendations Based on CY 2016 PIP	Peach State Response
Ensure detailed and accurate documentation of the SMART Aim statement, SMART Aim measure definition, baseline rate, and goal rate across all modules.	Each Module (1-3) requires HSAG approval prior to continuing to the subsequent module. HSAG will verify accuracy of the SMART Aim statement, SMART Aim measure definition, baseline rate, and goal rate during their review of each module and require corrections to be resubmitted if discrepancies are found. Peach State added a "QI Liaison" to each PIP team to provide oversight of data analysis and results.
Ensure adequate analytical staffing of PIP teams to inform and oversee data analyses and results reporting for all PIPs so that all rates are reported accurately and consistently.	Peach State enhanced its Quality Improvement Data Analytics (DA) team to include a Lean Six Sigma Black Belt certified DA IV

HSAG Recommendations Based on CY 2016 PIP	Peach State Response
As Peach State tests new interventions, the CMO should ensure that it is making a prediction in each Plan step of the PDSA cycle and discussing the basis for the prediction. This will help keep everyone involved in the project focused on the theory for improvement.	Peach State Health Plan will make predictions in each Plan step of the PDSA cycle. HSAG requires that the PIPs started in CY 2018 include a submission and approval of the "Plan" in module 4 prior to testing the intervention.
Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.	
Conduct up-front analyses into the frequency of data points related to the intervention and outcome being studied. The CMO should gather and analyze data prior to initiating intervention testing to estimate, and plan for, a testing cycle length that will yield sufficient data points for determining intervention effectiveness.	
Continue to incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.	Peach State will continue to incorporate detailed, process-level data into the intervention evaluation plan in module 4. The detailed plan will be included to help Peach State fully understand the effects of the implemented interventions. HSAG requires that the PIPs started in CY 2018 include a submission and approval of the "Plan" in module 4 prior to testing the intervention.
Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.	Peach State's PIP teams will continue to be multi-departmental and multidisciplinary as well as included at least one member of the Senior Leadership Team to ensure thoughtful PDSA cycles were conducted to accelerate the rate of improvement. The PIP teams will continue to meet routinely (at least biweekly) to review progress. The PIP initiatives were designed to be conducted in incremental PDSA cycles lasting 3-4 months in order to rapidly identify methods of improvement
For PIPs that did not demonstrate real improvement, the CMO should convene key PIP team members and stakeholders to review the key driver diagram, process map, and FMEA. In light of the PIP results, the team should explore additional barriers, gaps, or failures to address in future improvement efforts.	The Peach State Health Plan PIP teams will conduct multiple sessions to develop and update the key driver diagram, process map, and FMEA. The PIP teams consisted of multidisciplinary, cross departmental staff based on the PIP topic. Each team had an executive sponsor, a data analyst, and each version of the key driver diagram, process map and FMEA will be dated to document when it was last revised. If the PIP does not demonstrate real improvement, the PIP team will explore additional barriers/gaps/failures. Peach State will begin to monitor real improvements made with PIPs beyond the life of the PIP to evaluate sustained improvement. The Plan will spread successful PIP interventions to improve outcomes.
For PIPs that successfully demonstrated real improvement, Peach State should continue to monitor outcomes beyond the life of the PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the CMO to continually refine interventions to achieve and sustain optimal outcomes	

HSAG Recommendations Based on CY 2016 PIP	Peach State Response
For PIPs that identified effective interventions, Peach State should pursue avenues for spreading effective interventions beyond the initial scope of the rapid-cycle PIP. The CMO should identify new populations, facilities, or outcomes that could be positively impacted by the interventions. PDSA cycles should be used to test and gradually ramp up intervention dissemination to broader settings.	

Additional details on the CY 2017 implemented PIPs are included in the section "2017 PIP Summaries and Results".

EQR: Performance Measure (PM) Validation and Key Review Results

HSAG validated rates for the following set of performance measures selected by DCH for validation. All performance measures but one were selected from CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set1), Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set2), or the Agency for Healthcare Research and Quality's (AHRQ's) Quality Indicator measures. Colorectal Cancer Screening, a Healthcare Effectiveness Data and Information Set (HEDIS®) non-Medicaid measure, was also included as part of HSAG's validation.

Performance Measure	Method	Specifications	Results
Antenatal Steroids	Hybrid	Adult Core Set	Reportable
Asthma in Younger Adults Admission Rate	Administrative	Adult Core Set	Reportable
Care Transition—Timely Transmission of Transition Record	Hybrid	Adult Core Set	Reportable
Cesarean Delivery Rate	Administrative	AHRQ	Reportable
Cesarean Section for Nulliparous Singleton Vertex	Hybrid	Child Core Set	Not Reportable
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Administrative	Adult Core Set	Reportable
Colorectal Cancer Screening	Hybrid	HEDIS*	Reportable
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	Administrative	Child Core Set	Reportable
Developmental Screening in the First Three Years of Life	Hybrid	Child Core Set	Reportable
Diabetes Short-Term Complications Admission Rate	Administrative	Adult Core Set	Reportable
Elective Delivery	Hybrid	Adult Core Set	Not Reportable
Heart Failure Admission Rate	Administrative	Adult Core Set	Reportable
Live Births Weighing Less Than 2,500 Grams	Administrative	Child Core Set	Reportable
Maternity Care—Behavioral Health Risk Assessment	Hybrid	Child Core Set	Reportable
Plan All-Cause Readmissions	Administrative	Adult Core Set	Reportable
Screening for Clinical Depression and Follow-up Plan	Hybrid	Adult Core Set	Reportable

[1] The Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, March 2016.

[2] The Centers for Medicare & Medicaid Services. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, April 2016.
HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Findings. Of the 16 PMs reviewed and validated by HSAG:

- Data Integration, Data Control and Performance Measure Documentation received a result of "Acceptable."
- Medical Service Data, Enrollment Data and Provider Data received a result of "No Concerns."
- Peach State passed the Medical Record Review Validation (MRRV) process for all the measures. However, the appropriate eligible population and sample size were not met for reporting the *Cesarean Section for Nulliparous Singleton Vertex* and *Elective Delivery* measures. Since the appropriate eligible population and sample size were not met, these measures were not approved for reporting.

In addition to the AHRQ and the CMS adult and child core set measures audited by HSAG, DCH required Peach State to report a selected set of HEDIS measures to DCH. Peach State was required to contract with a National Committee for Quality Assurance (NCQA)-licensed audit organization and undergo an NCQA HEDIS Compliance Audit. Final audited HEDIS measure results from NCQA's Interactive Data Submission System (IDSS) were submitted to HSAG and provided to DCH.
***Interventions*.** HSAG did not require any Corrective Action Plan or intervention.

EQR: Compliance Standard Validation and Key Review Results

The DCH requires Peach State Health Plan 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.

Findings. HSAG did not conduct a compliance review in CY 2017.

Effectiveness of Required Programs in Achieving QAPI Goals and Objectives

Peach State's 2017 QAPI Goals

Goal	Objective	Met/Not Met
Improve Member Health **DCH Goal – Improved Health for Medicaid and PeachCare for Kids (CHIP) members **GOAL NOT MET**	1. Improve access to preventive physical and oral health for members so that select metrics for 2017 will reflect a relative two percent increase over 2016 rates. Metrics: HEDIS: W34, AWC, PPC (Postpartum Care) ADV- Total, BCS, WCC (BMI Total) CMS 416: screening rate **DCH Objective: Improve access to high quality physical health, Behavioral Health and oral health care for all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	CMS-416 Screening Rate ↑ 2.7% MET W34 ↑ 4.56% MET AWC ↑ 8.02% MET PPC (postpartum) ↑ 0.8% NOT MET BCS ↓ 2.24% NOT MET WCC- BMI (total) ↑ 4.24% MET ADV (total) ↑ 3.5% MET **Objective 1- PARTIALLY MET**
	2. Increase appropriate utilization of Behavioral Health and physical health so that select performance metrics for 2017 will reflect a relative two percent increase over 2016 rates. HEDIS: FUH -7 day; ADHD- initiation & continuation, CWP, URI ** DCH Objective: Increase appropriate utilization of physical and Behavioral Health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	FUH- 7 day ↓ 8.73% NOT MET ADD - initiation ↓ 0.46% NOT MET ADD - continuation ↓ 3.36% NOT MET CWP ↑1.68% NOT MET URI ↑ 0.5% NOT MET **Objective 2- NOT MET**

Goal	Objective	Met/Not Met
	3. Improve care of chronic conditions for all members such that identified measures of effectiveness demonstrate a relative two percent improvement over 2016 rates. Metrics: Quarterly CPG reported rates will meet the overall compliance target of 80% HEDIS: AMM acute and continuation; MMA 75% 5-11 year olds; CDC - Control >9 (lower is better); HbA1c Testing, CDC-Eye Exam ** DCH Objective: Improve care for chronic conditions for all Medicaid and PeachCare for Kids members so that health performance metrics relative to chronic conditions will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	AMM acute ↑ 8.9% MET AMM continuation ↑ 11.5% MET MMA (75% for 5-11year olds) ↑ 31.2% MET CDC (poor) control >9 ↓ 7.32% MET CDC- HbA1c testing ↑ 1.64% NOT MET CDC – eye exam ↓ 3.5% NOT MET CPG Quarterly compliance ADHD – MET Asthma – NOT MET Diabetes – NOT MET **Objective 3- PARTIALLY MET**
Improve Member & Provider Experience with Care **GOAL MET**	1. Improve member experience with the Plan by decreasing balance billing grievances from CY 2016 to CY 2017 2. Improve provider experience with the Plan by increasing overall satisfaction by two percentage points from CY 2016 to CY 2017 Metrics: Member Grievance count for balance billing and Provider Satisfaction scores for Overall Satisfaction with Peach State Health Plan	Member Grievance Count for balance billing (provider billing member) ↓ by 70 grievances-MET Provider Satisfaction ↑ 7.5% - MET **Objectives - MET**
Lower per Capita Cost **GOAL NOT MET**	Have smarter utilization of each dollar by improving select rates associated with appropriate utilization of services/visits by a relative two percent when comparing 2016 rates to 2017 rates Metrics: Child Core Set: (PQI 9)Low Birth Weight Rate (LBW) HEDIS: AMBA- ER use, All Cause Readmission Rate (PCR) **DCH Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data. **DCH Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to	Low Birth Weight Rate ↓ 0.7% - NOT MET AMBA- ER use ↑ 7.39% - NOT MET All Cause Readmission Rate ↓ 34.54% MET **Objectives- PARTIALLY MET**

Goal	Objective	Met/Not Met
	9% by the end of CY 2019 as reported in June of 2020.	

Peach State's 2017 QAPI Program included three goals and four objectives, as shown above. The following narrative identifies key interim metrics used by Peach State to track success and highlights the effectiveness of the programs required by the CMO contract in achieving the QAPI goals and objectives.

Key Interim Metrics to Track Success

Improving Peach State Health Plan requires simultaneous pursuit of three goals: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Peach State uses key interim metrics to measure the impact of its contractually-required programs and their effectiveness in achieving the QAPI Goals and Objectives**.** Metrics specifically related to monitoring attainment of the objectives are highlighted in the narrative that follows.

Goal 1: Improve Member Health- NOT MET

Peach State's goal to improve member health includes objectives to positively affect population health by improving health outcomes for women and children through focused prevention and wellness programs.

Objective 1.1 Improve access to preventive physical and oral health for members so that select metrics for 2017 will reflect a relative two percent increase over 2016 rates.

Results: <u>Objective NOT MET</u>. *The results of the metrics used to assess this objective did not demonstrated a relative two percentage point improvement over 2016 rates*

Measure	Summary
CMS-416 Screening Rate	↑ 2.7% MET
W34	↑ 4.56% MET
AWC	↑ 8.02% MET
PPC (postpartum)	↑ 0.8% NOT MET
BCS	↓ 2.24% NOT MET
WCC- BMI (total)	↑ 4.24% MET
ADV (total)	↑ 3.5% MET

There were seven measures used to evaluate this objective.

- Two- NOT MET
  - One improved by less than two percent
  - One did not improve
- Five – MET

Initiatives used to meet this objective were:

- Gift card offered to members for completing their W34 and AWC
- Mailed all non-compliant members a post card reminding them to receive a dental screening (in Q4, 2017)

- Peach State's Care Gap Alerts notified the plan staff of missed services/screening opportunities so that they could contact members and help them, whenever possible, schedule an appointment with their provider.
- The Plan performed Monday - Saturday live calls and uses MyHealthDirect scheduling system as well as conference (three way) calls to assist members with scheduling an appointment.
- The Plan conducted in-person events such as Peach State Days (Clinic Days) in which members are invited to receive their due/past due services.

The WCC (BMI) measure was impacted by intense provider outreach by Provider Relations and the EPSDT staff.
Further details on interventions conducted during 2017 to achieve this objective are included in the section "Plan Performance" and "Responding to the Unique Needs of the Members"

Objective 1.2: Increase appropriate utilization of Behavioral Health and physical health so that select performance metrics for 2017 will reflect a relative two percent increase over 2016 rates.

Results: Objective NOT MET.
The results of the metrics used to assess this objective did not demonstrated a relative two percentage point improvement over 2016 rates

Measure	Summary
FUH- 7 day	↓ 8.73% NOT MET
ADD - initiation	↓ 0.46% NOT MET
ADD - continuation	↓ 3.36% NOT MET
CWP	↑1.68% NOT MET
URI	↑ 0.5% NOT MET

There were five measures used to evaluate this objective.
- Five – NOT MET
    - Two- improved by less than two percent
    - Three did not improve

Interventions used to impact the measures associated with this objective included:
- CWP/URI- (improved by less than two percent): letters were delivered to all providers by PR staff. The letter included information about the need to avoid prescribing antibiotics and why. A Centers for Disease Control (CDC) attachment was included with the letter to provide the physicians with a reliable and trustworthy information source supporting the information the Plan provided in the letter.
- FUH- In 2017, all members hospitalized in a psychiatric hospital received telephonic outreach from Behavioral Health (BH) Case Management (CM) to assist with coordinating transition to a lower level of care. BH utilization managers referred all members who were admitted to a mental health hospital to BH CM.

Peach State's Quality Improvement, Pharmacy, Care Management, Disease Management, Discharge Planning programs as well as the Envolve People Care (Behavioral Health) and Provider Relations department provided oversight and assistance with improving outcomes for those with chronic conditions. Peach State's approach to CPG audits, audit results, and provider education and support can be found under the Clinical Practice Guidelines Section, "CPG

Implementation and Adherence". Further details on interventions conducted during 2017 to achieve this objective are included in the section "Responding to the Unique Needs of the Members"

Objective 1.3: Improve care of chronic conditions for all members such that identified measures of effectiveness demonstrate a relative two percent improvement over 2016 rates.

Results: Objective NOT MET.
The results of the metrics used to assess this objective did not demonstrated a relative two percentage point improvement over 2016 rates

Measure	Summary
AMM acute	↑ 8.9% MET
AMM continuation	↑ 11.5% MET
MMA (75% for 5-11year olds)	↑ 31.2% MET
CDC (poor) control >9	↓ 7.32% MET
CDC- HbA1c testing	↑ 1.64% NOT MET
CDC – eye exam	↓ 3.5% NOT MET
Clinical Practice Guideline (CPG) Quarterly compliance	NOT MET ADHD – MET Asthma – NOT MET Diabetes – NOT MET

There were seven measures used to evaluate this objective.

- Three- NOT MET
  - One improved by less than two percent
  - One did not improve
  - One (CPGs) did not meet compliance

- Four – MET

Activities used to impact the measures used for this objective include:

- During October 2017, Peach State enlisted the assistance of USMM- a vendor that mailed in-home HbA1c and urine specimen collection kits to members who were non-compliant for testing and monitoring for nephropathy.
- The Medication Therapy Management (MTM) program was continued. The MTM outreach coordinators performed outreach calls to each member based on the real time pharmacy data to encourage them to pick up their medication and explain the importance of medication adherence in reaching diabetes control goals.
- Members with depression were identified and received outreach from a Peach State Depression Disease Management program manager. Members enrolled in the Depression Diseases Management Program receive education on the importance of medication adherence in treating depression and were coached on self-management techniques designed to achieved recovery and wellness.
- The Plan worked with practitioners to improve use and adherence to the Clinical Practice Guidelines (CPGs) for Diabetes and Asthma and ADHD.

Peach State's Quality Improvement, Pharmacy, Care Management, Disease Management, Discharge Planning programs as well as the Envolve People Care (Behavioral Health) and

Provider Relations department provided oversight and assistance with improving outcomes for those with chronic conditions. Peach State's approach to CPG audits, audit results and provider education and support can be found under the Clinical Practice Guidelines Section, "CPG Implementation and Adherence". Further details on interventions conducted during 2017 to achieve this objective are included in the section "Responding to the Unique Needs of the Members"

Goal 2: Improve the overall member and provider experience with Peach State- MET
The purpose of this goal, to improve the overall member and provider experience with Peach State, was to ensure the Plan's members have appropriate access to services. The overarching desire is for the Peach State members to receive safe, effective, patient-centered, timely, efficient, equitable care which enable them to live strong, productive lives.

Objective 1: Improve member experience with the Plan by decreasing balance billing grievances from CY 2016 to CY 2017

Results: Objective MET.
Member Grievance Count for balance billing (provider billing member): ↓ by 70 grievances-MET
Peach State attributes meeting this goal to provider education about balance billing.

Objective 2: Improve provider experience with the Plan by increasing overall satisfaction by two percentage points from CY 2016 to CY 2017

Results: Objective MET.
Provider Satisfaction Survey Results: ↑ 7.5% - MET
Peach State achieved a statistically significant improvement with overall practitioner (provider) satisfaction with the plan. Peach State's Provider Relations, Medical Affairs, Customer Service, and QI Departments collaborated in assessing the needs of Peach State providers, identifying specific areas of dissatisfaction, and developing strategies and interventions to support this objective. Activities in 2017 included:

- Identifying opportunities for improvement and implementing strategies to improve provider satisfaction. Key contract-required programs that also supported provider satisfaction and related Provider Relations efforts include the Utilization Management, the Case and Disease Management, and the Pharmacy Programs. Staff from each of these areas interfaced with providers and their staff on prior authorizations and questions related to benefits and member's care. They worked with providers to assist them in the development of care plans that met the holistic needs of each member, and help them identify and resolve members' barriers to adherence with physician directions and recommended treatments.

Further details on interventions conducted during 2017 to achieve this objective are included in the section "Provider Satisfaction".

Goal 3: Lower Per Capita Cost- NOT MET
Peach State's focus for lowering per capital cost was on finding better ways to ensure that the right care is accessible and delivered to the right person at the right time, every time.

Objective: Have smarter utilization of each dollar by improving select rates associated with appropriate utilization of services/visits by a relative two percent when comparing 2016 rates to 2017 rates

Measure	Summary
Low Birth Weight (LBW) Rate	↓ 0.7% - NOT MET
AMBA- ER use	↑ 7.39% - NOT MET
All Cause Plan Readmission Rate (PCR)	↓ 34.54% MET

There were three measures used to evaluate this objective.

- Two- NOT MET
  - Neither measure improved

- One – MET

Initiatives used to meet this objective were:

- LBW - The 17-P program targeted pregnant mothers who have had a history of a previous preterm birth. The program was intended to improve birth outcomes by offering care coordination services that are aimed at preventing a preterm delivery. The Case Manager worked with the OB and home health agency to provide the 17-P treatment to reduce the members' risk for another spontaneous preterm birth.
- AMBA (ER use) - Peach State's Emergency Room (ER) CM Program was designed to engage members with frequent or inappropriate ER utilization. Peach State partnered with 10 high volume hospitals to receive daily notification of members who visited the ER on the previous day. Case Managers outreached to members within 24-48 hours of the encounter to assist them with obtaining follow-up care and to provide education regarding appropriate use of the ER, the importance of getting primary and preventive care, and the availability of the 24/7 Nurse Advice Line.
- PCR - Peach State's Care Managers, in collaboration with the member, work to improve the overall health outcome of those recently discharged from the hospital. Care Managers and/or CCM designees work in collaboration with hospital discharge planners to ensure effective care coordination, and to stabilize or improve members' health condition who may have been recently inpatient and/or received services through the ER. This is achieved by conducting telephonic follow-up with members enrolled in the CCM program to assist with arranging follow-up appointments (post-discharge) and providing information on community-based services.

Care Management, Disease Management, Medical Affairs, and Utilization Management were the primary programs that supported attainment of this goal and objective. For additional information, refer to the "Effectiveness of Care/Disease Management Programs in Reducing Inappropriate Utilization" section of this document.

Clinical Practice Guidelines

Clinical practice guidelines support providers in the provision of evidence-based care with a goal of maximizing member outcomes. Ultimately, the success of case and disease management programs in improving member outcomes relies as heavily on engaging members on effective self-management and compliance with recommended services and periodicity schedules, as on provider compliance with CPGs. Companion member guidelines provide case and disease management program staff with a structure that supports and aligns their efforts with those of their treating providers. CPGs enable everyone involved with the member's care to provide consistent messaging and support toward common goals. Our asthma and diabetes program staff track member compliance with member companion guidelines through interactions with program participants, during contact with providers, through analysis of claims for recommended services and prescriptions, and provide timely interventions when indicated. Peach State Health Plan is responsible for adopting, disseminating, and monitoring provider compliance with Clinical Practice Guidelines (CPGs) relevant to its population for medical and Behavioral Health (BH) services. Guidelines are evidenced-based and relate to activities included in the Disease and Care Management Programs. Peach State has adopted preventive and clinical practice guidelines (PHGs and CPGs) for the provision of preventive, acute, chronic and Behavioral Health services. The guidelines are based on the health needs and opportunities for improvement identified as part of the quality assessment and performance improvement (QAPI) program and are based on valid and reliable clinical evidence or a consensus of health care professionals in the specific field of practice.

Peach State reviews and updates CPGs and PHGs periodically, as appropriate but at least every two years or upon significant new scientific evidence or change in national standards. CPGs and PHGs are presented to and adopted by the Plan Quality Oversight Committee (QOC) through appropriate physician review, input, and adoption, and are made available to all practitioners and to members upon request. A listing of adopted clinical practice and preventive health guidelines is maintained in the Provider Manual with a notation that the links and/or full guidelines are available on the Peach State Website or via hard copy upon request. Additional mechanisms to distribute guidelines may include, but are not limited to:

- New practitioner orientation materials
- Provider and member newsletters
- Member Handbook
- Special mailings

The Plan utilizes evidence based clinical practice guidelines, preventive health and other scientific evidence as applicable in the development, implementation and maintenance of clinical systems used to support Utilization, Disease and Care Management.

Adopted Clinical Practice and Evidenced Based Guidelines and Protocols

Peach State provided outreach and education to providers (and in some cases, members) to increase the use of these evidence-based guidelines. Peach State posted CPGs on its website, provided information about the guidelines, and described how to obtain hard copies in the Provider Manual and Newsletters. Peach State's member newsletters and the member Handbook explained how members may request a copy of the CPGs by calling Customer Service.

Peach State's information system capabilities, to include systematic predictive modeling and health risk identification heuristics assisted with identifying members' gaps in care. These care gaps were made available on the Provider Portal which supported providers by identifying members in need of recommended screening or follow up care and giving providers periodic feedback related to their compliance. CPGs and PHGs available to providers (and members) include those in the table below.

Condition Specific CPGs		Preventive Health CPGs	
Asthma	ADHD	Pediatric Immunizations	Adult Well Male Exam
Depression	Childhood Obesity	Pediatric Preventive Health	Adult Well Woman Exam
Diabetes	Sickle Cell Disease	Pediatric Oral Health	Adult Immunizations
Hypertension		Perinatal Preventive Health	

Peach State utilized medical record audits to assess whether the provider's medical practices conform to clinical standards of practice for three CPGs (ADHD, Asthma and Diabetes) and Pediatric Preventive Health (EPSDT), as described in the section "Responding to the Unique Needs of Members – Children's Health". The audit gathers information on the use of evidence-based clinical practice guidelines by our providers, in order to measure their level of compliance with guidelines.

Ensuring Consistency with the Guidelines

To ensure guidelines are consistant with Peach State policies and procedures, they are reviewed against utilization management criteria, member education materials, benefit information, and other documents as appropriate. At least annually, a multidisciplinary meeting to review CPG and PHGs is conducted including Vendors/Sister Companies, Quality Improvement, Medical Management, Pharmacy, Medical Affairs, Provider Relations and Member Services. The participants review the CPGs, clinical criteria, and other relevant materials to ensure that decisions, to which the guidelines apply, are consistent with internal policies and procedures and standards of care. Further, the cross-departmental meetings review member and provider facing documents to ensure that distributed content and materials are consistent with the guidelines. If guidelines are updated by the QOC between annual meetings, an ad hoc meeting is held to review and approve the newly adopted guideline, as needed.

At least annually, an assessment of all UM staff responsible for decisions regarding utilization management and coverage of services (physicians and authorization nurses) is conducted to ensure consistency in decisions (as applicable) with the CPGs/PHGs. An overall assessment score >90% for each staff member is required. Staff who do not score at least 90% are remediated and retested.

Lastly, the CPG components are built into the TruCare system which allows CM/DM program staff to track compliance during their interactions with those programs' participants. CM/DM Program staff is monitored through quality control audits, review of TruCare notes and documentation as well as call monitoring to ensure accurate and appropriate use of the CPG companion patient guides.

Role of Clinical Practice Guidelines in Case and Disease Management Program Success

Peach State compared CY2017compliance with Asthma, ADHD and Diabetes metrics (HEDIS) among those members receiving care management versus those not receiving care management. Since specific HEDIS rates are based on the same evidenced based practices

guidelines, the results of this analysis provide a good indication of the contribution of CM/DM to the member compliance with relevant CPGs.

Condition	Measure	2017 CM Members	2017 Members Not in CM	CM vs. Not CM	Statistical Significance
Asthma	MMA 5 to 11 (75%)	25.41%	26.70%	↓	No
Diabetes	A1c Test	90.91%	80.50%	↑	Yes
	Attn. to Nephropathy	94.65%	87.19%	↑	Yes
	Eye Exam	58.82%	48.69%	↑	Yes
	Poor Control*	66.84%	76.35%	↓	Yes
ADHD	Initiation	51.16%	45.43%	↑	No
	Continuation	100.00%	57.73%	↑	N/A (too small of a denominator)

The data on members in CM versus those who are not in CM reveal that Diabetics and members with ADHD have higher (HEDIS) rates. This is opposite for Asthma members ages 5-11 years who remain on their medications at least 75% of the expected time.

Peach State's Disease Management Asthma, Diabetes, and ADHD program staff tracks member compliance with guidelines through interactions with program participants; during contact with providers; and through analysis of claims for recommended services and prescriptions; identification of gaps in care; and provides timely interventions when indicated. The Plan concluded that CPGs played a key role in the success of case/disease management programs by guiding care managers and health coaches in improving utilization of evidence-based services.

CPG Adherence

To determine provider adherence to the CPGs, in compliance with the Department of Community Health (DCH) requirements, Peach State conducted quarterly reviews of medical records for Asthma, ADHD and Diabetes. Peach State collaborated with Amerigroup and WellCare to assign primary care practitioners to each CMO by provider's last name each quarter. Peach State identified all members with a claim with a primary diagnosis of the respective CPG submitted by a provider whose last name started with those letters. Once all members were identified, a random sample of eighty members was pulled. This included an oversample of thirty member records. The oversample is included to ensure at least fifty member records are included in the audit. There are times when the oversample is used because the record(s) selected for audit are not received from the provider (refuse/do not respond to request). There are also times that the records requested are delayed due to request for payment of records. In this instance, the Plan selects members from the oversample to replace the record that is likely to not be received timely.

Each CPG has a unique number of indicators that are assessed to determine compliance with the guideline. Every indicator was weighted in value according to DCH criteria, thus impacting the overall score. An indicator is either met, not met or in a few instances not applicable. When an indicator is determined to be "not applicable" that indicator is removed from the denominator.

The information that follows is a summary of review findings for CY 2017 (January 1, 2017 – December 31, 2017).

CPG	# of Practitioners	# of Records	Number of CAPs	Overall Score	% Practitioners who scored >80% (overall or on 1 element)
Asthma	145	204	91	77.64%	63%
Diabetes	152	202	122	73.37%	80%
ADHD	118	202	26	94.23%	22%

Asthma

There were two hundred-four (204) records reviewed which comprised an assessment of one hundred forty -five (145) providers. The ten indicators assessed for Asthma were:

- History and physical completed
- Spirometry and peak flow measures used to confirm the diagnosis in members >5years of age
- Severity of asthma assessed and episodic signs/symptoms identified
- Evidence of asthma management plan developed with member/parent to include documentation of understanding that plan was provided
- Co-morbid conditions assessed and discussed
- Educated member on recognizing triggers and reducing exposure to environmental risk factors
- Educate member on taking prescribed medications correctly
- Prescribed the appropriate long-term medications
- Evaluated response to medication and control of asthma assessed
- Prescribed rescue inhaler

MRR Practitioner Summary

During CY 2017, one hundred forty-five (145) unique practitioners were audited. The providers selected for the audit were grouped as follow:

Provider Type	Total Number
Family Practice	3
Internal Medicine	2
NP/PA	27
Pediatricians	85
Other	28

*The “Other” provider type consisted of Clinics, Groups and Associations.

Overall Plan Compliance

The Overall Average Provider Compliance rate was 77.64% which was below the DCH goal of 80%.

- Providers met or exceeded the DCH target rate of 80% for seven (7) of the ten (10) indicators.
- The indicator “Prescribed the appropriate long-term medications” results were 99% in CY, 2017.
- The indicator “Spirometry and peak flow measures used to confirm the diagnosis in members ≥ 5 years of age” (44%).
- The “Evidence of Asthma Action Plan” indicator continues to be an area that needs improvement (61%).

Deficiencies and Corrective Action Plans

The top two office review deficits CY 2017 were:

1. Evidence of Asthma Management Plan developed with member/parent. 66 offices

2. Spirometry and peak flow measures used to confirm the diagnosis in members ≥ 5 years of age. 64 offices

Of the one hundred forty-five (145) providers audited, ninety-one (91) or 62.75% were placed on a corrective action plan (CAP) for either an overall score of <80% or at least one indicator rate of <80%.

ADHD

There were two hundred and two (202) records reviewed which comprised an assessment of one hundred and eighteen (118) providers. The nine key components assessed for ADHD were:

- Developmental history
- History and physical
- Rating scale reviewed and used to confirm diagnosis
- Co-existing emotional and behavioral conditions assessed
- Developed management plan with the parent/member
- Parent educated on how to recognize the triggers for inattention impulsivity and hypersensitivity
- Parent educated on how to implement behavior management strategies
- Parent educated on the importance of the follow up visit within 30 days of when the first ADHD medication was dispensed
- Documentation of medication effectiveness

MRR Practitioner Summary

During CY 2017, one hundred and eighteen (118) unique practitioners were audited. The providers selected for the audit were grouped as follow:

Provider Type	Total Number
Family Practice	6
Internal Medicine	1
NP/PA	10
Pediatricians	81
Other	20

*The “Other” provider type consisted of Clinics, Groups and Associations

Overall Plan Compliance

The Overall Average Provider Compliance rate was 94.23%, above the DCH goal of 80%.

- Providers met or exceeded the DCH target rate of 80% for all nine (9) indicators.
- The indicator that scored the highest CY 2017 was documentation of medication effectiveness (98.96%).
- The indicator that scored lowest in CY 2017 was Parent educated on how to recognize the triggers for inattention, impulsivity and hypersensitivity (84.75%).

Deficiencies and Corrective Action Plans

The top two (2) office review deficits CY 2017 were:

1. History/Physical completed (must have a minimum of vitals, height, and weight), represented by fifteen (15) office sites.
2. Parent educated on how to recognize the triggers for inattention, impulsivity & hypersensitivity, represented by eighteen (18) office sites.

Of the one hundred and eighteen (118) providers audited, twenty six (26) or 22% were placed on a corrective action plan (CAP). The CAP was given for either an overall score of <80% or at least one indicator rate of <80%.

Diabetes

There were fifty (202) records reviewed which comprised an assessment of forty (152) providers. The twelve indicators assessed for diabetes were:

- History/physical exam
- Annual neuropathy screening
- Annual diabetes kidney disease screening
- Annual retinal eye exam
- Annual foot exam
- Documentation of HbA1c ordered at minimum twice per year
- Documentation that fasting lipid profile was ordered
- Documentation that an annual urine micro-albumin screening was ordered
- Documentation that influenza vaccine was offered
- Educated member on self-monitoring glucose levels
- Educated member on nutrition/diet/weight management
- Educated member on the use of aspirin (anti-platelet therapy)

MRR Practitioner Summary

During CY 2017, one hundred fifty-two (152) unique practitioners were audited. The providers selected for the audit were grouped as follow:

Provider Type	Total Number
Family Practice	54
Internal Medicine	35
NP/PA	14
Pediatricians	0
Other	49

*The “other” provider type consisted of Clinics, Groups and Associations.

Overall Plan Compliance

The Overall Average Provider Compliance rate was 73.37% and fell short of the DCH target rate of 80%.

- Providers met or exceeded the DCH target rate of 80% for five (5) of the twelve (12) indicators.
- The indicator that scored the highest CY 2017 was history and physical (98.98%).
- The indicator that scored lowest in CY 2017 was documentation that the member was educated on the use of Aspirin (anti-platelet therapy) (36.25%).

There were three indicators that were not assessed in previous years and scored below 55%:

- Annual retinal eye exam (52.76%)
- Documentation that an annual urine micro-albumin screening was ordered (55.54%)
- Documentation that influenza vaccine was offered (54.26%)

This represents an educational opportunity for Peach State to ensure that providers are addressing this with members as well as noting the encounter in their record. As such, this will be included in targeted strategies for 2018.

Deficiencies and Corrective Action Plans

The top three office review deficits were:

1. Annual retinal eye exam, represented by sixty-three (63) office sites.
2. Documentation that annual influenza vaccine was offered, represented by sixty-two (62) office sites.
3. Educated member on the use of Aspirin (anti-platelet therapy), represented by forty-six (46) office sites.

Of the one hundred fifty-two (152) providers audited, one hundred twenty-two (122) or 80.26% were placed on a corrective action plan (CAP). The CAP was given for either an overall score of <80% or at least one indicator rate of <80%.

In Q2, CY 2017, a CNL held a lunch and learn (L&L) in at Americus Family Practice. This office was selected as they received a CAP as a result of their Diabetes CPG audit performed March 31, 2017 and requested additional information/assistance to improve their scores. The L&L was conducted May 11, 2017 and the nine attendees included the physician, front office and back office staff. The CNL walked through the Diabetes CPG, the auditing tool and documentation expectations as well as answered questions. A re-audit was conducted for Americus Family Practice in October 2017 (Q4, CY 2017. The office was not issued a CAP, scoring 90%.

Targeted Strategies and Interventions for Asthma, ADHD and Diabetes CPGs

The below ongoing, revised and new actions will address low compliance with CPG use:

<u>Ongoing</u>

- Educate providers on upgrading their EMRs to have the CPG guidelines embedded into the system to assist with CPG compliance.
- Make CPG and CPG Auditing tool available on the website at PSHP.com.
- Share CPG results and analysis with Quality Oversight Committee for Plan and external provider input and discussion.
- Continue collaborating with the CMO workgroup to ensure consistency with CPG guidelines, consistency with the auditors using the audit tool and completing medical record reviews, consistency with utilization decisions to which the guidelines apply, and creating a plan to reduce provider abrasion.

<u>Revised</u>

- Peach State Health Plan staff discussed the CPG results letter and audit process with two providers and was given feedback for improvement.
    - Based on provider feedback, Peach State Health Plan staff revised the CPG Audit Results letter.
    - To better indicate what members were used during the audit we will add members' full member ID number with first and last name initials.

<u>New</u>

- Peach State Health Plan hired and trained staff specific for CPG audits. The staff performed inter-rater reliability (IRR) testing to provide accuracy with the auditing process.
- Peach State is currently crafting a provider communication to share outcomes of the last four (rolling) quarters of audit information. The Plan determined that the provider communication was needed, and the CPG Audit staff was assigned the task of drafting a provider communication with results and recommendations. *The* draft communication

continues to be refined. The final communication will be sent through the internal process and forwarded to DCH.

- Peach State outreached to DCH and requested a meeting to discuss CPGs prior to meeting with the other CMOs on October 26th and followed up on November 16th, December 14th and December 26th. DCH communicated (December 27th) that CPGs will be a topic during the CMO/DCH QMM meeting. Peach State will discuss the below.
    - *ADHD and Asthma:* Peach State Health Plan will seek clarification from DCH on what vital signs are required (minimum) for History/Physical completed.
    - *Asthma:* Peach State Health Plan outreached to DCH to confirm if spirometry/peak flow is to be conducted annually or to confirm diagnosis. The CPG states a spirometry should be conducted annually; however, the provider audit (Form A) states that spirometry/peak flow testing should be conducted to confirm the diagnosis in members who are ≥ 5 years old.
    - *Diabetes:* Annual Neuropathy Screening - This indicator needs to be discussed with DCH to determine if assessment of hands/feet alone or all elements listed are required.
        - Annual retinal eye exam - The Plan will discuss the CPG reference document with DCH, which states (page S75) that if there is no evidence of retinopathy for one or more annual eye exams, then exams every two years may be considered.
        - Annual foot exam - The Plan will seek further guidance as to if a referral to a podiatrist would be considered compliant for this indicator.
        - Documentation that a fasting lipid profile was ordered - Peach State will discuss the CPG recommendations for Lipid Management and the documentation requirements specified on the Audit Form with DCH. In adults not taking statins, it is reasonable to obtain a lipid profile at the time of diabetes diagnosis, at an initial medical evaluation, and every 5 years thereafter, or more frequently if indicated noted on page S63 of the guideline.
        - Documentation that an annual urine micro-albumin screening was ordered - Peach State will discuss the below elements with DCH:
        - If a urinalysis (dipstick) meets the requirement for this indicator.
        - If indicator 3, Annual Diabetes Kidney Disease screening (order for creatinine) and this indicator can be combined and compliance with either of the indicators would meet intent.
        - If a referral to a Nephrologist will meet with for this indicator (or indicator 3).
        - Documentation that influenza vaccine was offered - he Plan will discuss the below with DCH:
        - If only visits occurring September – March should be included in the denominator for this indicator or should the reviewer look back to the previous flu season.
        - Educated member on self-monitoring glucose levels - The Plan would like clarification from DCH on:
        - If members whose diabetes is being monitored by an endocrinologist would be considered compliant for this indicator.
        - If the provider notes provide documentation of glucose readings received from the member would be considered compliant.
        - Educated member on the use of aspirin {anti-platelet therapy} - Peach State will discuss the documentation of education on aspirin use

requirement with DCH. Although the auditing tool requires documentation of member education ASA therapy, the CPG indicates that ASA therapy is not recommended for certain adults (page S66).

- Consider aspirin therapy (75–162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes who are at increased cardiovascular risk (10-year risk.10%). This includes most men or women with diabetes aged ≥50 years who have at least one additional major risk factor (family history of premature atherosclerotic cardiovascular disease, hypertension, smoking, dyslipidemia, or albuminuria) and are not at increased risk of bleeding.
- Aspirin should not be recommended for atherosclerotic cardiovascular disease prevention for adults with diabetes at low atherosclerotic cardiovascular disease risk (10-year atherosclerotic cardiovascular disease risk, 5%), such as in men or women with diabetes aged ≥50 years with no major additional atherosclerotic cardiovascular disease risk factors, as the potential adverse effects from bleeding likely offset the potential benefits.

Follow Up with Practitioners Who Fail to Implement CPGs

The auditor educated providers on each missed element at the time of the audit. In the first three quarter of CY 2017, Peach State required providers who scored lower than 8% on any one element and/or who scored lower than 80% overall on the CPG audit to complete and submit the DCH designed Corrective Action Plan (CAP) to Peach State within 14 days of the audit. Based on provider feedback and auditor findings, Peach State Health Plan staff revised the (internal) CAP process. The previous process was to conduct a three month check in with providers placed on a CAP. In addition to this check-in, the Peach State Health Plan staff performed a face-to-face 6-week follow-up visit to providers placed on a CAP that scored lower than 40% overall. The internal process effective November 1, 2017 (and QOC Committee approved):

- A provider who receives an overall audit score of 85% or higher will receive a CAP for any indicator scoring under 80% but will be considered 'passed' for the quarter.
- A provider who receives an overall audit score of 50% to 84% will receive a CAP on all non-compliant indicators (below 80%). The provider will be re-audited approximately six months after the MRA quarter.

A provider who receives an overall audit score of <50% will receive a CAP on all non-compliant indicators scoring under 80%. The provider will be reeducated approximately three months after the MRA quarter.

2018 Activities

Further provider input was received in January 2018 was reviewed by Peach State Health Plan leadership and CPG staff. Based on provider and Plan staff input with SLT approval, Peach State concluded that instead of the three month re-audit for providers who scored less than 50% the staff will perform a re-visit via phone call. This will be done to provide re-education on the audit process and allows the practices sufficient time to implement the changes needed to become compliant with DCH guidelines

Peach State Health Plan continues to use data, current knowledge of barriers and challenges, collaborate with practitioners in an effort to identify causes, barriers and opportunities to increase CPG compliance.

Effectiveness of Care/Disease Management Programs in Reducing Inappropriate Utilization

Monitoring Over and Underutilization

Monitoring over and underutilization is an integral part of ensuring access to care, improved quality and lower costs. In 2017, the Plan strengthened its processes for monitoring, analysis, and evaluation over and underutilization of services. This includes preventive healthcare and services for members to include those with special health care needs and with chronic diseases.

Monitoring Underutilization

Adult Preventive Care

Peach State Health Plan monitors member's compliance with utilization of adult preventive care. Peach State follows recommendations made by the United States Preventive Services Task Force (USPSTF) for adult screenings to include colorectal screenings, breast cancer screenings and 20-44 year olds member's access to preventive/ambulatory health. The Plan uses HEDIS measures to review and determine under-utilization patterns that need to be addressed.

- In 2017 over 35% of women eligible* to receive a breast cancer screening did not obtain a mammogram.
- In 2017 50.7% of members who should have received a colorectal screening did not.
- Over 23% of members ages 20-44 years old did not access services in 2017.

Measure	HEDIS 2018 CY 2017	HEDIS 2017 CY 2016	
COL	49.3%	48.8%	50.7%
BCS	64.64%	66.1%	35.36%
AAP (20-44 years)	76.30%	77.22%	23.7

Peach State's results for the HEDIS rates that with adult preventive care also underscore the underutilization of preventive services. For information on interventions implemented in CY 2016 and proposed for CY 2017, please see the section "Responding to the Unique Needs of Members" section.

Members with Diabetes

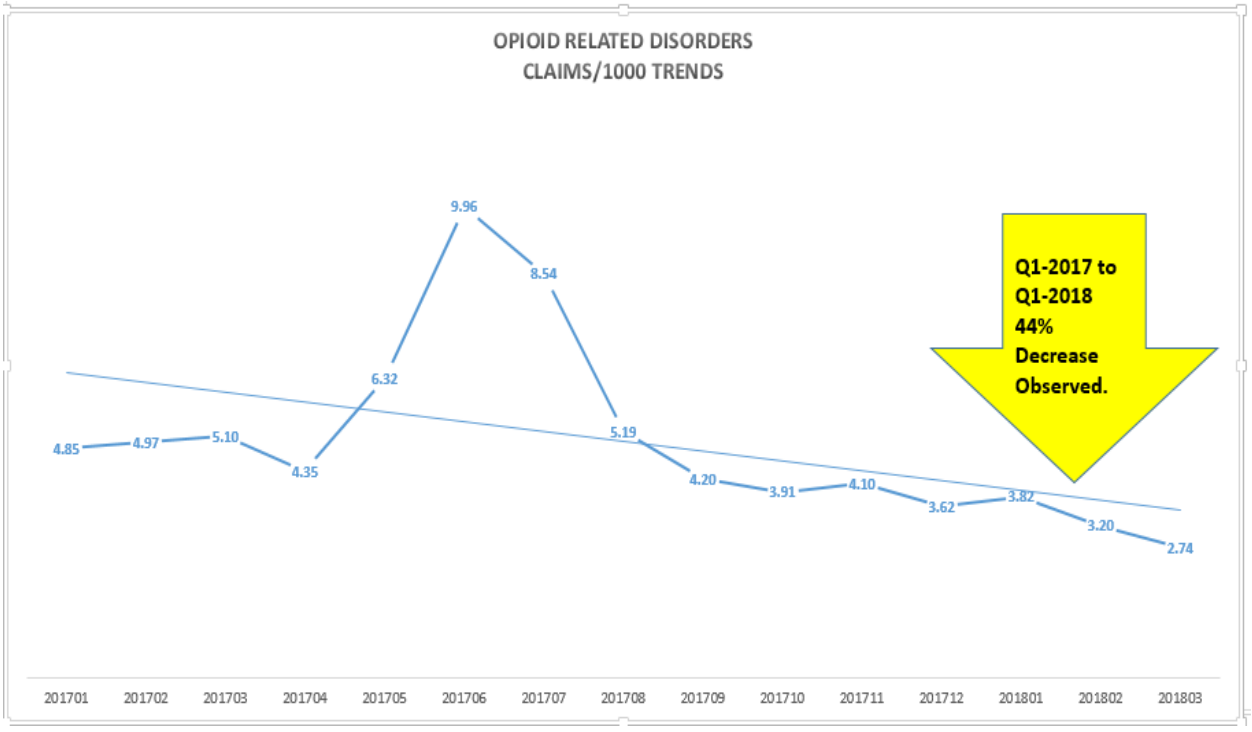
Throughout the year, Peach State monitors our members with diabetes to ensure they are receiving the care they need. We are able to identify, on a monthly basis, those members who have been in for their required lab services, those who are taking their medications appropriately and those whose diabetes is not controlled using data obtained through QSI. During 2017, Peach State identified 1,844 members in the Compressive Diabetes Care HEDIS denominator. Of those members, 15.15% (compared to 16.52% in 2016) did not have an HbA1c test and another 42.70% (versus 2016 - 40.17%) did not receive an eye exam. In 2017, 10.95% (compared to 2016 - 11.30%) did not have a urine micro-albumin screening. This shows many of our members did not have the required services they needed in 20167. Further, greater than 56% of our members with diabetes had an HbA1c >9 and 49% had a blood pressure reading that showed less than optimal control.

In addition, through our clinical practice guideline review, we identified underutilization of required services for members with Diabetes. Less than 55% of the physicians audited, were conducting an annual foot exam or ordering an annual urine micro-albumin screening.

Monitoring Overutilization

Members with Opioid Overutilization

According to the Centers for Disease Control and Prevention, drug overdose deaths and opioid involved deaths continue to increase in the United States. More than six out of ten drug overdose deaths involve an opioid. Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled, yet there has not been an increase in the amount of pain that Americans report. Deaths from prescription opioids have more than quadrupled since 1999[1]. Peach State has seen an increase in Opioid use within the Medicaid population going from in the fourth quarter of 2015 leading the Peach State Pharmacy department to begin an Opioid Overutilization Program (OOP). OOP is a program to identify patterns of inappropriate use of opioids and other potential medication of abuse or medically unnecessary care among health plan enrollees, thereby protecting health plan beneficiaries and reducing fraud, waste, and abuse. Identified members are brought to interdisciplinary adult rounds to provide an avenue for discussion on managing enrollees which may include educating providers and members on evidence based opioid therapies and/or alternative medication management.
In 2017, 60 members were identified for OOP. Of these 60 members, 14 were placed into pharmacy lock-in and referred to BH case management. Efforts have successfully yielded a reduction of opioid utilization as well as reduction in diseases related to Opioids such as Opioid Related Disorders, and Neonatal Abstinence Syndrome. Review of medical claims related to Opioid Related Disorders has shown a 44% reduction when comparing Q1-2017 to Q1-2018.



Overutilization of Antibiotics

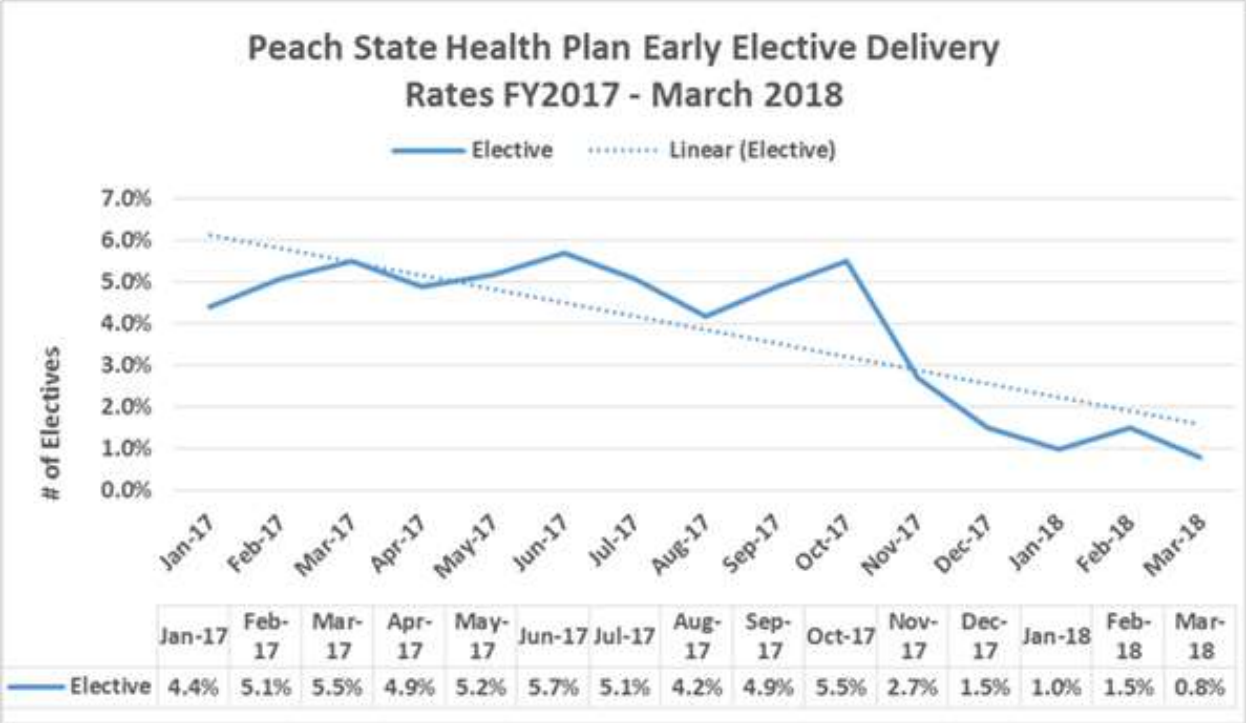
Peach State also uses three HEDIS measures to identify potential overutilization of Antibiotics. The measures include Appropriate Treatment for Children with Upper Respiratory Infection (URI), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) and Appropriate Testing for Children with Pharyngitis (CWP). The results of annual review are used to identify a need for further barrier analysis and interventions. The 2017 results are:

Measure	2017 Rate	2016 Rate	2015 Rate
AAB	28.19%	26.21%	21.73%
CWP	85.06%	83.94%	82.14%
URI	87.59%	87.16%	84.00%

Peach State saw improvement in all three measures however the results indicate there is still overutilization of antibiotic treatment in adults with acute bronchitis. Further, approximately 13% of Peach State members who are ages 3 months to 18 years who are diagnosed with an upper respiratory infection are still receiving an antibiotic which may not be necessary. The CWP measure also shows providers continue to prescribe antibiotics for members with Pharyngitis without conducting a streptococcus test prior.

Early Elective Delivery Reductions

In December 2017, Peach State Health Plan implemented a State coordinated effort to impact early elective deliveries (EEDs) for our members. To achieve a reduction in our EED rate, we required providers to provide a medical necessity diagnosis on any delivery prior to 39 weeks. In addition, we conducted multiple trainings to educate OB/GYN provider network. These efforts has been tremendously successful. Comparing Q1 2017 to Q1 2018, we noted 85% reduction in elective deliveries for our Medicaid population.



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Elective	4.4%	5.1%	5.5%	4.9%	5.2%	5.7%	5.1%	4.2%	4.9%	5.5%	2.7%	1.5%	1.0%	1.5%	0.8%

Peach State has the aforementioned and several other programs in place to monitor the appropriateness of healthcare furnished to members through the use of data.

Peach State Health Plan seeks to improve the health and well-being of all its members through its Case Management (CM) and Care Coordination Programs (CC). The Case Management and Care Coordination Programs provided services to adult and pediatric members with complex medical, psychosocial needs, serious and/or persistent mental illness including those with special health care needs. In the Case Management program, members were assigned to a medical and/or behavioral care manager depending on their primary need for CM. In cases when members have both medical and/or behavioral health needs, the Medical and/or Behavioral Care Manager worked collaboratively, utilizing a holistic approach that addressed the full range of the member's needs. Peach State adopted the DCH definition of children with special healthcare needs: members (adults & children) who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by members (adults and children) generally.

The goal of Case Management and Care Coordination was to coordinate the care of eligible members across all care settings, in efforts to, improve continuity and quality of care including those with special healthcare needs. The CM program emphasized prevention and focused on linking members to the appropriate resources and services that were needed. The CM program assessed, planned, implemented, facilitated, coordinated, monitored, and evaluated services to meet individual's health needs through communication and utilization of available resources that promote quality and cost-effective outcomes**.**

Members enrolled in the Care Coordination program were also assigned to a medical and/or behavioral care manager. Some members were also assigned a health coach. The care managers and/or health coaches worked to assist members obtain skills needed to implement self-care behaviors by offering member-centered, goal-oriented programs focused on whole-health, wellness, and long-term independence. The program interventions chosen for implementation were also culturally relevant to ensure members received services in the most supportive, timely and effective way. Additional information on Peach State Health Plan's Case Management Program is available in the Case Management Program trilogy (Work Plan, Program Description and Program Evaluation).

In 2017, Peach State's Member Connections Department made efforts to further strengthen the relationship with its members. Therefore, the Member Connections team pursued additional educational opportunities, which equipped them with skills required to transition into the Community Health Services Department. As a part of this transition, Peach State's Community Health Services Representatives received over 200 hours of course study, attaining a Community Health Worker certification (CHW). By obtaining this level of training, the Community Health Services and/or Social Workers facilitated early identification of resource needs and provided appropriate community resources to help reduce the risk of medical complications that may have resulted from environmental and/or community factors. Peach State staff worked with the members and providers to arrange for delivery of healthcare services and other community-based services aimed to improve health status in a cost-effective way, encouraging preventive care and shared-decision making. Case Management and Care Coordination activities also included a population assessment, evaluation of member experience with Case Management and Care Coordination, and an analysis of each programs effectiveness.

Effectiveness of Peach State Care Management (CM) Programs

Peach State Health Plan had a comprehensive system to regularly monitor, analyze and evaluate the appropriateness of the services offered through its Care Management and Care Coordination Programs for both medical and behavioral. Through trend analysis reports and utilizing predictive modeling tools that look at inpatient admissions (IP), Emergency Room (ER), and medication utilization data; Peach State Health Plan monitored the over and underutilization of services of its membership. The mechanisms in which this information was monitored and evaluated was by the plan's case management staff and a cross-departmental team, in which, the information was used to determine if current programs and interventions were appropriate and whether further targeted interventions were needed. These interventions were initiated through a PDSA cycle. A series of barrier analyses were completed to identify opportunities to improve performance and the overall health outcomes for our membership. Using these tools, Peach State ensured the delivery and quality of programs offered through our CM and CC programs provided appropriate care to our members, including those with special needs. The table below contains the key metrics that the CM and CC program used to measure effectiveness; which also helps to provide a better understanding into the services that are offered.

Peach State Health Plan helped members identified as having multiple or complex conditions to obtain access to care and services, and coordinated their care. Peach State adhered to the Case Management Society of America's (CMSA) definition of case management as: "A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes." Peach State Health Plan provided both episodic and case management, based on member needs and the intensity of service required. Participation was voluntary and members' decision to decline participation did not result in penalties or reduced benefits.

The purpose of Case Management and Care Coordination was to coordinate the care of eligible members across all care settings, in efforts to, improve continuity and quality of care including those with special healthcare needs. The CM program emphasized prevention and focused on linking members to the appropriate resources and services that were needed. The CM program assessed, planned, implemented, facilitated, coordinated, monitored, and evaluated services to meet individual's health needs through communication and utilization of available resources that promote quality and cost-effective outcomes**.**

Peach State Health Plans' Case Management program identified members who had the greatest need for Case Management, including those who had catastrophic and/or other high-cost or high-risk conditions, such as, women experiencing high-risk pregnancies, infants and toddlers with established risk for developmental delays, and members with special healthcare needs. Members with special health care needs were those members who had the following; serious and chronic physical, developmental, or behavioral conditions that required medically necessary health and related services of a type or amount beyond that typically required by members. Through this identification, Peach State's objective was to:

- Assist members in achieving optimal health, functional capability, and quality of life through improved management of their disease, condition and/or episodic event
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting
- Maximize benefits and resources through oversight and cost-effective utilization management

Peach State used an Integrated Care Management (ICM) Team model that included the most appropriately trained staff to meet a member's identified physical, behavioral, social, and other health needs. Peach State's ICM teams included licensed registered nurses and BH clinician Case Managers, Community Health Workers (CHW), social workers, health coaches (licensed respiratory therapists, certified diabetes educators, registered dieticians, or exercise physiologists), medical and BH medical directors, prior authorization and concurrent review nurses, pharmacists, and non-clinical support staff. The primary Case Manager served as the member's point of contact with Peach State and coordinated the CM and CC team activities.

The CM and CC management team activities included but were not limited to:

- Early identification of members who had special needs (identified disability, health, or mental health conditions requiring early and/or ongoing intervention, special education services, or other specialized services and supports).
- Assessment of member's risk factors such as over or under utilization of services, inappropriate use of services, non-adherence to treatment and/or care plan, lack of education or understanding of current condition, lack of support system, financial barriers, patient safety, cultural or linguistic challenges, and physical, mental or cognitive disabilities.
- Development of an individualized plan of care in concert with the member and/or member's family, Primary Care Provider (PCP), and other treating providers based upon evidence bases guidelines.
- Identification of barriers to meeting goals included in the plan of care.
- Coordination of care to include referrals and assistance to ensure timely access to services and/or providers.
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition or lack of positive response to the plan of care.
- Continuity of care which includes collaboration and communication with other providers involved in the members transition to another level of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/care management activities.
- Addressing the member's right to decline participation in the care management program or to disenroll when the CM or CC goals have been achieved and the member is able to self-manage or the needs and desires of the member change.
- Conducting all care management procedures in compliance with HIPAA and state law
- Integrating behavioral health processes to improve outcomes by encouraging both Physical and Behavioral Health providers to share clinical information.

Peach State's Case Managers and/or designee, in collaboration with the member and provider, worked to improve the overall health outcome of the member through the following:

- Case Managers and/or CM/CC designee conducted a comprehensive assessment of the member's functional, medical, BH, social, and other health needs to identify risk factors and barriers to care. Using results of these assessments and evaluations, the Care Manager, in collaboration with the member, caregivers, and providers, develop an individualized care plan that included measurable goals, to include a schedule for appropriate follow-up.
- Based on the member's level of need, the care manager provided education, care coordination, referrals and linkages to providers and community-based supports and home health agencies. For example, they informed members and their caregivers about their conditions, the importance of obtaining preventive and primary care, how to use their medications, and how to comply with the doctor's prescribed treatment plans. They also coordinated with and/or updated the member's providers as required by the member's

change in health status and conduct periodic telephonic evaluations of members in CM and/or CC.

- Peach State provided continuity and coordination of care by facilitating all care when a member was undergoing active treatment of a chronic/acute medical condition and when a member was receiving care in their second or third trimester of pregnancy. The CM and/or CC team communicated with the member's PCPs and/or other physical/behavioral provider to share assessment results, identify barriers to care or adherence to treatment, care plan recommendations, treatment plans and all other information to support integration of care and improved outcomes.

Key Metrics
Physical Health Case Management
Number of Members identified for Case Management Services
Member CM Satisfaction Survey Results
Fluvention Rate
All Cause 30-Day Readmission Rate
ER Visits/1,000 Member Months
Inpatient (IP) Admissions/1,000 Member Months
Sickle Cell Hydroxyurea Utilization Rate
Provider Follow-up post identification of blood levels above 10 mg/dl
Behavioral Health Case Management
Member Engagement Rate
All Cause 30-Day Readmission Rate
ER Visits/1,000 Member Months
Inpatient (IP) Admissions/1,000 Member Months
Follow-up after Hospitalization for Mental Illness o 7-Days o 30-Days
OB Program Management
C-Section Rate
% Normal Birth Weight Babies
% Low Birth Weight Deliveries
% Very Low Birth Weight Deliveries
NICU Admission Rate
17-P Utilization Rate
High Risk OB o % Normal Birth Weight Babies o % Low Birth Weight Deliveries o % Very Low Birth Weight Deliveries o NICU Admission Rate
Care Coordination
Number of repeat ER Visits after program enrollment
NICU 7-Day Provider Follow-up Rate
Diabetic Post-Hospitalization Follow-up Rate
Post-Partum Provider Follow-up Rate for Members (21-56 days after delivery)
Newborn Provider Follow-up Rate for Members (3-5 days after delivery)
Contraceptive Utilization Rate
Medication Adherence Rate
Health Coaching/Disease Management
% of actively managed prescribed appropriate medication
% of actively managed admitted for a hypertensive crisis or Sequela

Highlights of Care Management Effectiveness

Complex Case Management (CCM) Program

The Complex Case Management Program (CCM) provided services to adult and pediatric members with chronic, complex, high risk, high cost and/or other catastrophic conditions, including those with special health care needs, who did not meet criteria for any other targeted programs. Members were assigned to a registered nurse (RN) or Behavioral Health (BH) Care Manager depending on their primary need for Complex Case Management. Members enrolled in CCM received telephonic or face to face case management to monitor care plan implementation, provide education, and to assist with appointment scheduling and arranging transportation if needed. As an extension of the CCM program, Peach State's Community Health Service Representatives (CHSR) and/or Social Workers facilitated early identification of resource needs and made appropriate referrals to community resources to help reduce the risk of medical complications that could result from social determinants of health.

Peach State provided continuity and coordination of care and integrated physical and behavioral health by collaborating with our fully integrated BH division. Peach State integrated nurse and BH clinician Case Managers to bring a whole person focus to each member's care and services. If a member had both medical and behavioral health needs, the CM and BH Case Manager worked collaboratively in delivering a holistic approach that addressed the full range of member needs. When the Plan staff identified a member with coexisting medical and behavioral health disorders, the identifying staff then notified the Behavioral Health Care Manager. If the member's primary diagnosis was a behavioral health condition, the case was referred for Behavioral Health Case Management.

The BH Case Manager reviewed the member's clinical information to assure the patient received appropriate behavioral health services. If the patient did not appear to be receiving this care, the Case Manager completed the following:

- Contacted the medical provider to ask about a behavioral health consult
- Assisted the member to make arrangements for the behavioral health consult
- Followed-up to make sure a behavioral health consult was conducted

The Medical and Behavioral Health Case Managers also conferred with each other to ensure that the necessary expertise was available to monitor and guide the members' care. Peach State measured effectiveness of CCM no less than annually to assess the process or outcomes of care for members in all of its programs, including those with special healthcare needs. The 2017 results for all programs are provided throughout this section.

CM Enrollment

Peach State used a comprehensive assessment process to determine the appropriateness for enrollment into the CCM services offered for members. Through the utilization of predictive modeling tools which examined utilization trends for members, such as, inpatient admissions, emergency room visits, and medication utilization data, Peach State was able to identify members who were considered to be at-risk of unfavorable health outcomes. Using a detailed assessment, which indicated a new or changed need, Peach State CM staff stratified members by levels of Care Management to ensure we effectively addressed their needs. Services provided at each level were designed to promote access, continuity of care, transition of care support, and discharge planning and follow up, with a goal of improving and maximizing health and wellness.

All members in the Case Management program received education from CM staff regarding preventative measures that could be taken to improve their overall health status. CM staff also encouraged members to adhere to interventions, such as, lifestyle modification recommendations, and active participation in program. Members in the CM program and their families and/or support persons were also encourages to take advantage of opportunities to become engaged with recovery based services, such as, peer support groups. CM staff spoke to members about engaging in healthy lifestyle events, which promoted development of skills needed for self-management of condition and long-term independence.

As a result of the July 1st, 2017 new contract implementation, cases were evaluated and re-stratified into levels (Level I, Level II, and Level III).

- Members appropriate for Level III Care Management typically had unstable conditions and/or were at high risk for an adverse event.
- Members appropriate for Level II Care Management typically had chronic or co-morbid conditions with a recent acute care admission and/or Emergency Department utilization, but were currently stable.
- Members appropriate for Level I Case Management had short term needs or their condition was stable, but they were still at risk for complications

Using this leveling, Peach State Health Plan worked to identify members who qualified for CCM and then worked with them, their families, and their providers to complete a comprehensive assessment of their physical, behavioral health, social and other needs. Peach State used the assessment results to determine which level of care management services was appropriate and the follow-up each member required. The leveling was also used to incorporate interventions that accommodated the needs of each individual member by offering CCM services through traditional and non-traditional methods. When an assessment indicated a new or changed need, Peach State moved members to other levels of case management to effectively address changing needs. The Case Manager reassigned members' contact frequency during the course of Care Management and monitored implementation of the plan of care and progress toward desired outcomes.

Levels of Case Management

2017 Intervention

In 2017, there were a total of 920 members enrolled in the CCM program. Of the total number of members enrolled, 119 member cases were integrated, requiring that CM and BH clinicians collaboratively develop care plans reflective of goals geared towards both physical and

behavioral healthcare. A year-over-year comparison of the CCM membership enrollment data from 2016 (958 enrolled members) to 2017 (920 enrolled members) revealed a 4% decrease in CCM program membership. The CCM program is voluntary, and members were required to provide consent in order to become enrolled. It was discovered that Care Managers and/or CCM designee continued to have difficulty engaging members into the CCM program. In 2017, of the members identified as eligible for the CCM program, 35% were unable to be contacted and 26% refused enrollment. The high unable to contact rate can be attributed to many factors, however, the leading barrier to contacting members remains disconnected phones numbers and/or incorrect addresses. Additionally, the high refusal rate is a major concern for the Plan. CCM staff shared communications from members, which identified member concerns with the time commitment and the follow-up schedule attached to enrollment in the CCM program. Peach State recognizes that more members are working and time was a leading factor impeding the Plan's ability to effectively engage members. As a result, Peach State conducted a needs analysis of its CCM program and in 2018 will implement a restructure of its stratification process. This new stratification process allows for both a high and a low level CCM touch (i.e. face-to-face, care coordination, etc.).

CY 2018 Proposed Interventions:
In 2018, efforts will be made to increase member enrollment and engagement into CCM. This will be done by a restructuring of the Peach State CCM program which will implement different stratification levels of CCM. Using the predictive modeling tool, Impact Pro, Peach State will identify those members with a CM Engagement Score of ≥50, and make them top priority. The score measures how likely a member is to engage in *and successfully complete* care management. Scores range from 0-100, a higher score means more likely to engage. Through this leveling, the plan will incorporate interventions that will accommodate the needs of each member by offering CCM services through traditional and non-traditional methods. The Peach State continues to identify possible interventions to accommodate the needs of each member. Once potential interventions are identified, rapid cycle pilots will be implemented to determine which are most successful.

To ensure that each member enrolled into the CCM program has access to open communicate with their Case Manager, Peach State will continue to offer a free cellular phone through the Connection Plus Program. Members will also have the benefit of additional minutes through the SafeLink Program, if eligible. The Connection Plus Program offers to provide telephones to members enrolled in the CCM program, who do not have access to a telephone. The telephone provided to members through the Connection Plus Program is preprogrammed with the members Primary Care Physician, Case Manager, Health coaches and/or other supports contact information to encourage compliance with any preventive and follow-up care.

Member Satisfaction with Complex Case Management

Satisfaction Survey
Annually, Peach State evaluates satisfaction with the CCM program by obtaining and analyzing feedback from members enrolled in the program. This information is gathered by conducting surveys and most recently the incorporation of a focus study to evaluate enrolled member's perception of:

- Information about the CCM overall program.
- The CCM program staff
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.

Peach State used this information to identify how well the CCM program met the needs of the members enrolled. In turn, data collected also allowed the CCM staff to create various interventions in efforts to improve service delivery and overall member experience.

In 2017, there were a total of 310 CCM surveys administered, of that, 86 were completed. This yielded an overall response rate of 27.7%which is an 11% increase in the overall response rate from CY 2016. This increase can be attributed to a change in the method of how the surveys were collected in 2017A recommendation shared by the Utilization Management Committee in Q1 of 2017, highlighted the benefits incorporating a telephonic option into the survey methodology. There were a total of 79 surveys completed telephonically and seven were mailed back to Peach State. In CY 2017 telephonic surveys accounted for 92% of the collected survey responses.

Peach State analyzed the CCM satisfaction surveys and data reflected that the overall performance goal of 90% was met. An average result of 90% indicated that overall members were satisfied with the services offered through the CCM program, but the program did identify opportunities for improvement. In 2017, members reported lower rates of satisfaction when responding to questions in the area of goal setting. Peach State also identified that member satisfaction with goal setting declined for a second year; therefore, 2018 interventions will be aimed at improving this area.

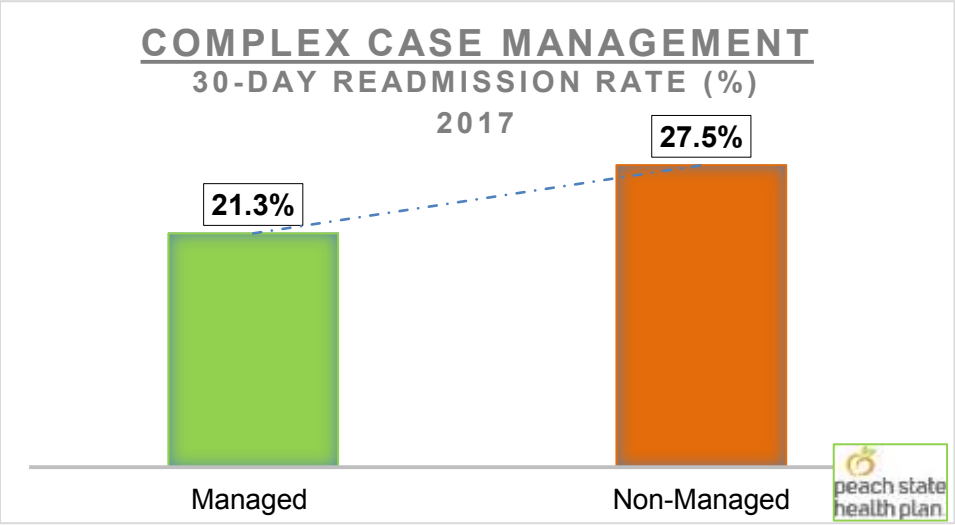
Complex Case Management Satisfaction Focus Study
In an effort to improve member satisfaction and increase enrollment, the CCM and Community Health Services Department, partnered to conduct a Focus Study. The Focus Study targeted members in the Atlanta region that were recently discharged from the CCM program. The purpose of the Focus Study was to survey members to gauge their overall experience with the CCM program and allowed identification of areas for improvement. Peach State chose to target the Atlanta region due to its high percentage of members who were actively enrolled in the CCM program at 60%. There were a total of 39 members identified for this study. Of the 39 members, 12 members participated and provided responses on a series of questions relating to the CCM program. Overall, the members were satisfied with the CCM program. However, the focus study revealed an opportunity for improvement in the area of communication, more specifically, how care managers communicate with the members. Fifty percent of the members participating in the focus study shared their preference of communication was text messages and 50% of the participants responded that emails were the best method of receiving information and communications related to their plan of care.

2018 Proposed Interventions
In response to the member surveys and the focus study, Peach State will conduct quarterly training courses for staff that will focus on effective care planning and appropriate goal setting. These series of training courses will be offered through the Plan's virtual Cornerstone Learning curriculum and also be via face to face for all Case Managers and/or CCM designees. To ensure that members are receiving the required information relating to their care, Peach State will also explore alternative options using the methods suggested through the Focus Study such as the suggested email and/or text options.

Readmission and ER Utilization for Members in Complex Case Management
Analysis reporting, Peach State found that members enrolled in the telephonic level of our CCM program were less likely to adhere to their recommended plan of care, resulting in higher utilization and cost of care.

All Cause 30-Day Readmission Rate

In 2017, members enrolled in the CCM program had a 21.3% readmission rate compared to those not enrolled in the program who had a 27.5% readmission rate.

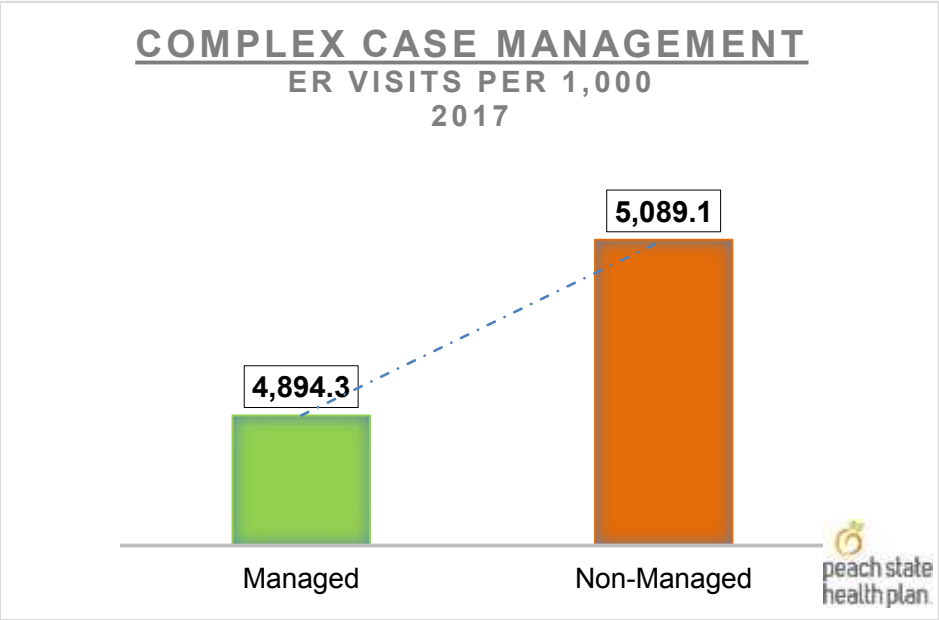


ER Visits/1,000 Member Months

In order to reduce the number of Emergency Room (ER) visits for members enrolled in CCM, Peach State delivered an integrated, member-centric, and innovative coordination and continuity of care program that was rooted in the principles of the system of care approach. Members identified to be at risk were encouraged to participate in specific programs of care that offered various services designed to minimize and/or manage the member's risk factors. This was achieved through varying levels of intensive services which ranged from follow-up telephonic calls, to face to face home visits.

2017 Results

The ER Visits/1,000 for members enrolled in the CCM program was 4,894.3/1,000 and 5,089.1/1,000 for those not enrolled in the program.



2018 Proposed Interventions

In 2017, our Face to Face CM was expanded to cover members in other regions. Additionally, the CM department offered alternate shifts, which included after normal business hours and weekends. This expansion was done to provide appropriate follow-up to members requesting home visits outside the traditional business hours. Peach State recognizes the benefit of providing follow-up with members through face to face interaction; therefore, in 2018, Peach State will enhance its Face to Face CM program by targeting those members, using the predictive modeling tool Impact Pro, with a ≥50 CM engagement score.

Lead Care Management

Peach State's Case Managers worked collaboratively with Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPP) on providing education on lead toxicity and sources, and preventive measures. Through care coordination services, Peach State worked with members whose blood lead levels had been identified as ≥10 g/dl and assisted with reducing their blood lead levels to below 10 g/dl. The Case Manager remained in contact with caregivers, providers/PCP and the health department to assist with arranging any services and/or resources that may have been required to ensure that the member was compliant with appropriate follow-up and treatment plans.

The care manager also developed a care plan to document parent/guardian cooperation and consent and included the following:

- PCP notification and cooperation
- Treatment goals and timeframes
- Periodic screening timeframes for vision
- Hearing and dental services
- Referrals, including developmental and behavioral assessments (if applicable)
- Diagnostic and treatment to correct or ameliorate defects and physical and mental Illnesses (if applicable)
- Early intervention programs and oral health services;
- Social and community support services
- Clinical history

- Appropriate nutrition
- Identification of other linkages such as abatement services (if applicable)

In 2017, there were a total of 37 members that were identified for the Lead Case Management Program. Peach State was able to successfully outreach to 21 members who were subsequently retested and had lead levels less than 10 g/dl. There were 10 members who became ineligible while enrolled in the Lead CM program and were referred back to GHHLPP and the local health department for further follow-up. Peach State had two members who were referred to the Community Health Services Department for a home visit, due to, staff being unsuccessful at telephonic outreach. There were four members who were identified in 2017 that remained in the program in 2018 as additional testing will be required.

In reviewing its data, Peach State recognized a trend in initial test results yielding false positive results. Coordination and follow-up will be needed for members testing greater than 10 g/dl.

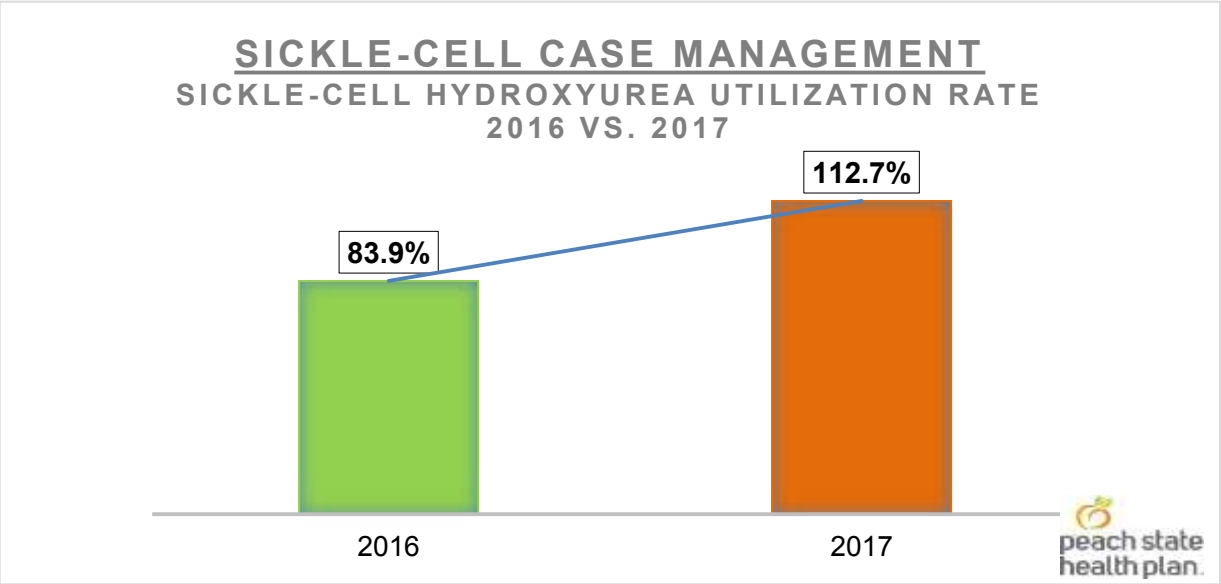
2018 Proposed Interventions

Peach State will continue to work with Georgia Healthy Homes, the Lead Poisoning Prevention Program (GHHLPP) and the local health departments to ensure that its members who test above 10 g/dl have the appropriate follow-up services and care. Peach State will also continue to conduct a home visit on all members who have a confirmed test above 10 g/dl.

Sickle Cell CM Management Program

This program identified members diagnosed with the sickle cell disease who were candidates for the medication Hydroxyurea, but did not show a current prescription within the previous 12 months. The Case Manager worked collaboratively with the provider to coordinate a plan of care to ensure compliance with prescribed medications and appropriate care to reduce ER and IP.

In CY 2017, there were a total of 54 members that received outreach and care coordination services. As a result of these interventions, Peach State achieved a 92.8% decrease in the total medical cost of members enrolled in the Sickle Cell Case Management Program. In 2017, Peach State had a Sickle Cell Hydroxyurea Utilization Rate of 112.7%; in comparison to 2016 when the rate was 83.9%. Peach State attributes this increase to the enhancement in its program to include face to face outreach to newly enrolled members located in the Atlanta region.



2018 Proposed Interventions

In 2018, Peach State will continue to outreach to those members who meet eligibility for the program to offer appropriate care coordination services. The goals of the interventions will be to reinforce the importance of preventive healthcare and to determine the current needs of the member. The care manager will also ensure member has an affiliation with a primary care physician, in efforts to promote medication adherence. Peach State will continue its face to face outreach for all members in the metro Atlanta region to enhance the appropriate management of their disease.

Highlights of OB Program Management Effectiveness

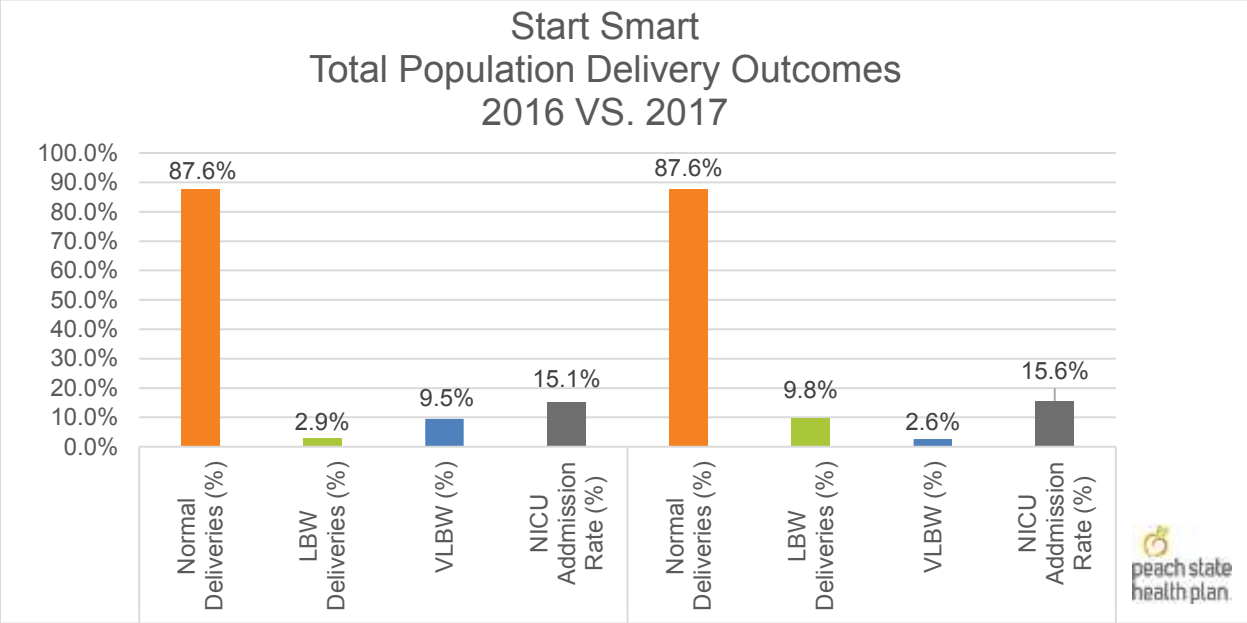
Start Smart Case Management

The Start Smart Case Management Program promoted the early identification and assessment of pregnant members and encouraged appropriate prenatal care and follow-up. The overall goal of the program was to improve birth outcomes. Peach State understands the importance of appropriate prenatal care and how it can reduce the risk of pregnancy complications such as preterm deliveries, unnecessary utilization of services and costly Neonatal Intensive Care Unit births (NICU). In addition to providing case management services, the program educated members on the importance of prenatal and postpartum care and offered incentives for pregnant members who attended their prenatal and timely postpartum follow-up appointments. The Start Smart for Your Baby case management program was an offered benefit for all members who are pregnant. The program offered care coordination services to improve birth outcomes and perinatal health to include the following:

- Outreaching to members to provide education and assistance with accessing needed medical, nutritional, social, educational, and other services, including coordination of referrals to appropriate specialists
- Educating members on the importance of timely preventive visits and immunizations for the unborn/newborn child

- Enrolling members in special programs when indicated including, High Risk OB (HROB), 17-P, and Puff Free Pregnancy Program (a smoking cessation program)
- Providing incentives to members for accessing prenatal and postpartum care
- Utilizing innovative Start Smart mobile technology to help keep pregnant women connected and engaged

The following tables below reflect the delivery outcomes for the entire population of pregnant members who delivered in 2016 compared to 2017:

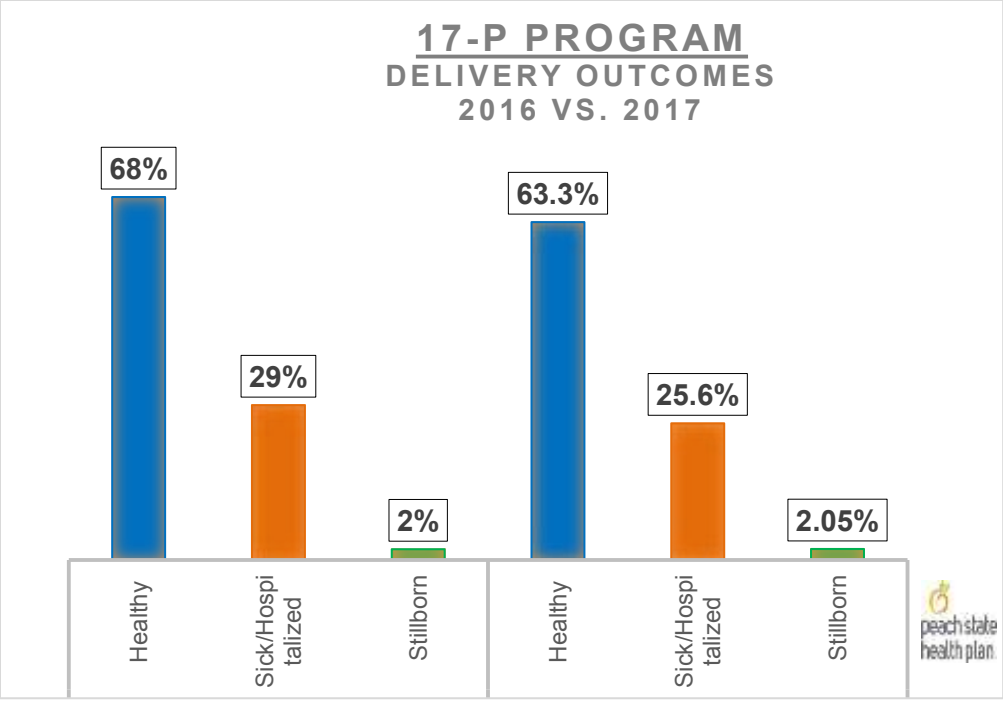


In summary:

- % of Normal Birth Weight Deliveries: The normal birth weight deliveries rate for the total population for both 2017 and 2016 was 87.6%.
- % of Low Birth Weight Deliveries: The low birth weight deliveries rate for the total population for 2017 was 9.8% which was an increase from 2016, in which, the rate was 2.9%.
- % of Very Low Birth Weight Deliveries: The very low birth weight deliveries rate for 2017 was 2.6% which was a decrease from 2016, in which, the rate was 9.5%.
- NICU Admission Rate: The NICU admission rate for the total population in 2017 was 15.6% which was an increase from 2016, in which, the rate was 15.1%.

17-P Program

The 17-P program targeted pregnant mothers who have had a history of a previous preterm birth. The program was intended to improve birth outcomes by offering care coordination services that are aimed at preventing a preterm delivery. The Case Manager worked with the OB and home health agency to provide the 17-P treatment to reduce the members risk for another spontaneous preterm birth. The Case Manager also provided continuous education throughout the pregnancy and the postpartum period, including information about depression, substance use disorders, contraception options and appropriate birth spacing. For members who delivered in 2016 and 2017 the delivery outcomes were as follows:

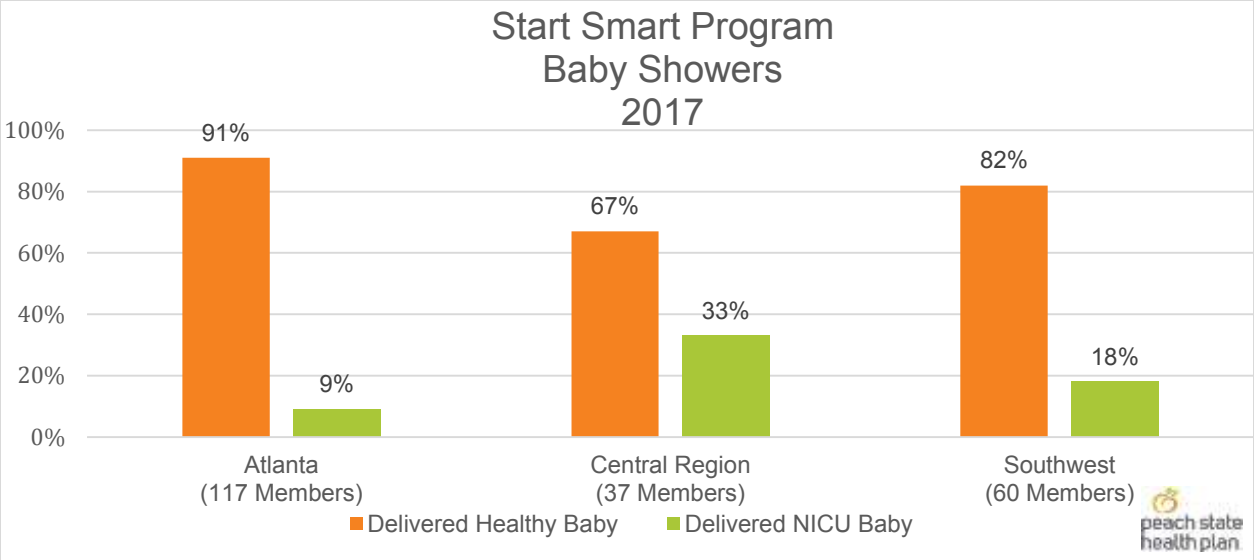


Peach State data reflected a much higher success rate of healthy deliveries for members receiving 17-P. In 2017, there were 390 members enrolled in the 17-P program, this is a 4% decrease from last year, in which 406 were enrolled in the program. In Q4 of 2017, an analysis was conducted to identify providers with a low 17-P utilization rate, but high NICU delivery outcomes. As a result, in 2018 a care manager will conduct targeted outreach to identified providers to educate staff on the benefits of 17-P usage and to encourage providers to refer members earlier to the HROB program for case management and/or care coordination interventions/services.

Start Smart for Your Baby Showers

Peach State continued to place an emphasis on caring for the overall pregnancy population, and therefore increased its member outreach by hosting Start Smart for your Baby Shower Events. The Community Health Services Department hosted a total of 7 Start Smart for your Baby Showers in 2017. In collaboration with the local public health departments and other community partners including (but not limited to) Safe Kids, WIC, and Right from the Start Medicaid, these free events educated members, on the importance of attending prenatal and postpartum appointments, the development of appropriate parenting skills, as well as birth spacing.

For 2017, the Start Smart Baby Showers targeted the high pregnancy regions of Atlanta, Central, and Southwest. The purpose of this targeted outreach was educating and identifying high risk pregnant women and enrolling them in the High Risk Case Management program. There were a total of 214 members who attended the Start Smart for your Baby Showers, all of whom were screened and received follow-up services. As a result of these events, Peach State reports the following birthing outcomes:



Peach state recognized that members who attend the Start Smart for Your Baby Shower events tend to be more compliant with the appropriate care relating to prenatal and post-delivery follow-up visits, resulting in healthier pregnancy outcomes. Peach State was concerned with the timeliness of postpartum care rates for 2017 and after review of data, identified a trend associated with members who delivered by cesarean delivery (C-section) and the completion of their postpartum follow-up appointment. Peach State found that 70% of the members who delivered by C-section were non-compliant with their appointments 21-56 days after delivery. This rendered roughly a 30% post-partum follow-up rate for this population. Further analysis also revealed that members who were ≥37 weeks at time of delivery were at a higher risk for non-compliance.

2018 Proposed Interventions

- Peach State will continue to focus on ensuring members have access to the appropriate prenatal and postpartum care. To encourage the importance of appointments, telephonic outreach will be conducted to newly pregnant members who have not had a prenatal visit within 30 days of enrollment to assist with scheduling a visit and/or selecting an OB/GYN.
- The Community Health Services Department will enhance its face to face outreach by facilitating the early identification of resource needs of members. Outreach will help address barriers resulting from social determinants of health. Addressing barriers will be achieved through the continuation and enhancement of the following interventions and community events:
  - Mutual Approach to Parenting & Partnership (M.A.P.P) Event – These events will target pregnant members and will include topics on bathing, feeding, injury prevention, sleeping and illness while allowing members to participate in interactive activities (i.e. Infant assimilator). Members will also learn the importance of Primary Care Physician (PCP) home, the appropriate use of the ER, and will also encourage preventive care.
  - Start Smart Baby Shower – These events will be enhanced to be hosted throughout the state of Georgia to provide members with information on prenatal and post-delivery care. The Community Health Services Representatives will collaborate with community partners to assist with resolving social determinants of health by connecting members with local physicians, health departments, and community resources. Additionally, as a result of the analysis conducted above, Peach State will identify members who deliver at

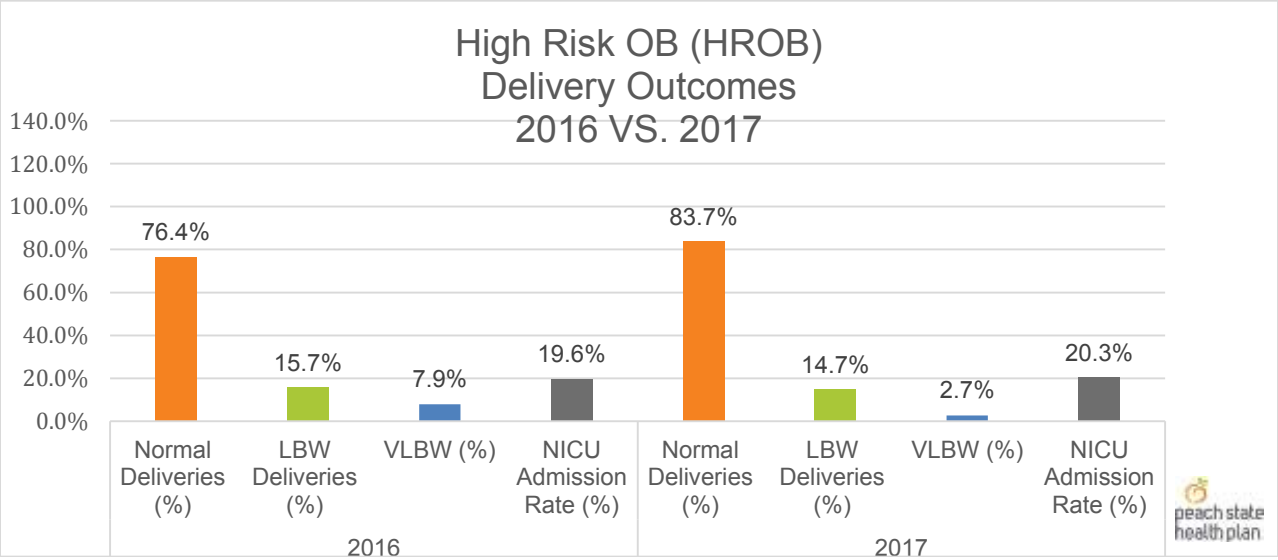
≥37 gestational weeks and conduct telephonic outreach to encourage the importance of postpartum care and to assist with scheduling appointment, if applicable.

High Risk OB (HROB)

The High Risk OB (HROB) Program targeted members who have been identified as having high risk and/or complicated pregnancies. The HROB Program is intended to improve birth outcomes by increasing the number of recommended prenatal care visits received through ensuring access to other needed medical, nutritional, social, educational and other services. The Case Manager worked with the member, family, and OB to complete a comprehensive assessment of health and pregnancy risk factors, and developed and implemented an individualized care plan that addressed the member's full range of physical health, behavioral health, social, and other needs to ensure a healthy pregnancy. The Case Manager provided continuous education throughout the pregnancy and the postpartum period, including information about depression, substance abuse issues, contraception options and appropriate birth spacing.

Peach State understands that certain populations and regions require additional interventions to reduce the likelihood of adverse pregnancy outcomes. Peach State used its data to identify groups of members at risk for a less than optimal pregnancy outcome who were previously stratified as low risk. In 2017, Peach State used data to change its algorithm to identify women with a history of preterm (LBW) deliveries and nulliparous women with risk factors/conditions such as smoking, hypertension and diabetes. Case Managers were provided with lists of these members to attempt to engage and enroll them into the HROB program. Both telephonic and face to face outreach was performed to encourage appropriate prenatal and postpartum visits. In 2017, there were a total of 1,793 members enrolled in the HROB program. This was 10% decrease from 2016; in which 1,994 members were enrolled.

The following tables below reflect the delivery outcomes for the members enrolled in the HROB program in 2016 compared to 2017:

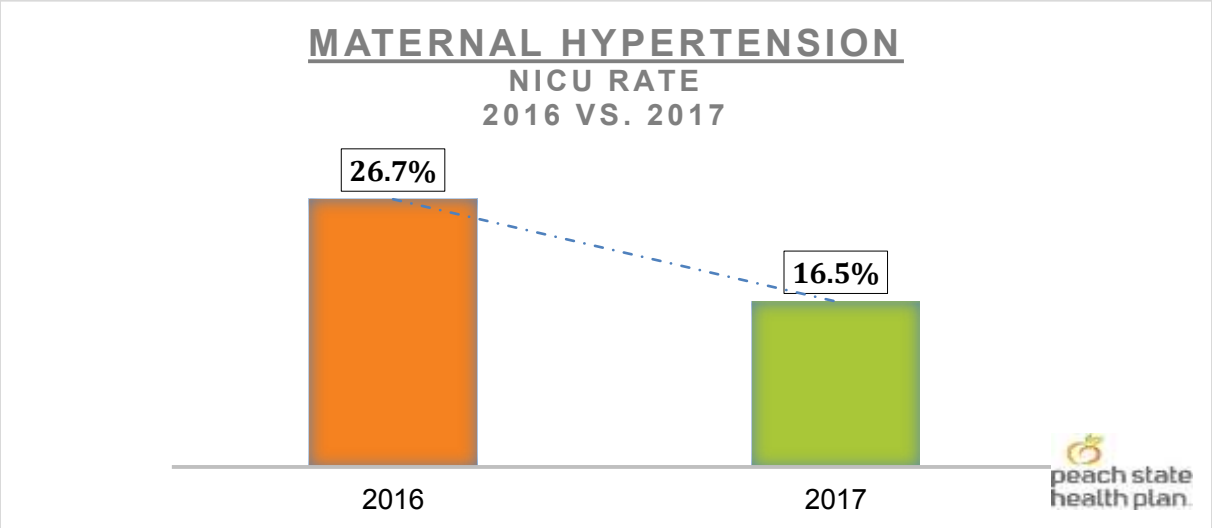


In summary:

- % Normal Birth Weight Deliveries - The 2017 % of members delivering a normal birth weight baby rate was 83.7%, compared to 76.4% in 2016.
- % Low Birth Weight Deliveries - The 2017 % of members delivering a Low Birth Weight was 14.7%, compared to 15.7% in 2016.
- % Very Low Birth Weight Deliveries - The 2017 % of members delivering a Very Low Birth Weight baby (VLBW) was 2.7%, compared to 2016 which was 7.9%. Further analysis showed that the majority of members fell within the age range of 22-34 years old. Also, the members who delivered the most VLBW babies were located in the regions of Atlanta, Central and Southeast.
- NICU Admission Rate - The 2017 NICU admission rate for those members enrolled in the HROB program was 20.3%, compared to 19.6% in 2016, representing a slight increase.

Maternal Hypertension (HTN) Program

The Maternal HTN Program targeted members with a history of chronic hypertension (HTN) and/or pre-eclampsia. The goal of the Program was to reduce the NICU deliveries. Members identified for the Program were assigned to a CM for outreach and to promote enrollment into the Program for education which included signs and symptoms of pre-eclampsia (or superimposed pre-eclampsia with chronic HTN) and assistance with care coordination services. In 2017, the NICU rate for members enrolled in the Maternal Hypertension (HTN) Program was 16.5% which was a decrease from last year's rate of 26.7%.



OB Substance Abuse (Opioid) Program

The OB Substance Abuse Program targeted members with a reported history of Opioid use to reduce the number of babies born with neonatal withdrawal symptoms. Members identified for this program may have been referred to the pharmacy lock-in program and received care collaboration between the Behavioral Health and Physical Health Case Manager. Education about the maternal/fetal effects of opioid abuse during pregnancy was provided. In 2017, the neonatal withdrawal symptom rate was 2.6% which was a slight increase from last year when the rate was 2.3%. Peach State had difficulty with engaging these members in the program but will continue outreach efforts in 2018. The Plan will also use risk based on information received from the public health departments OB assessments and Peach State Health Notification of Pregnancy (NOP) to identify potential members for the OB Substance Abuse Program

Peach State understands that members who have a previous medical history and/or complications within their current pregnancy require more intensive follow-up. Through data analysis, Peach State identified certain regions and/or age groups that were at a greater risk for adverse birthing outcomes as a result of a high risk pregnancy.

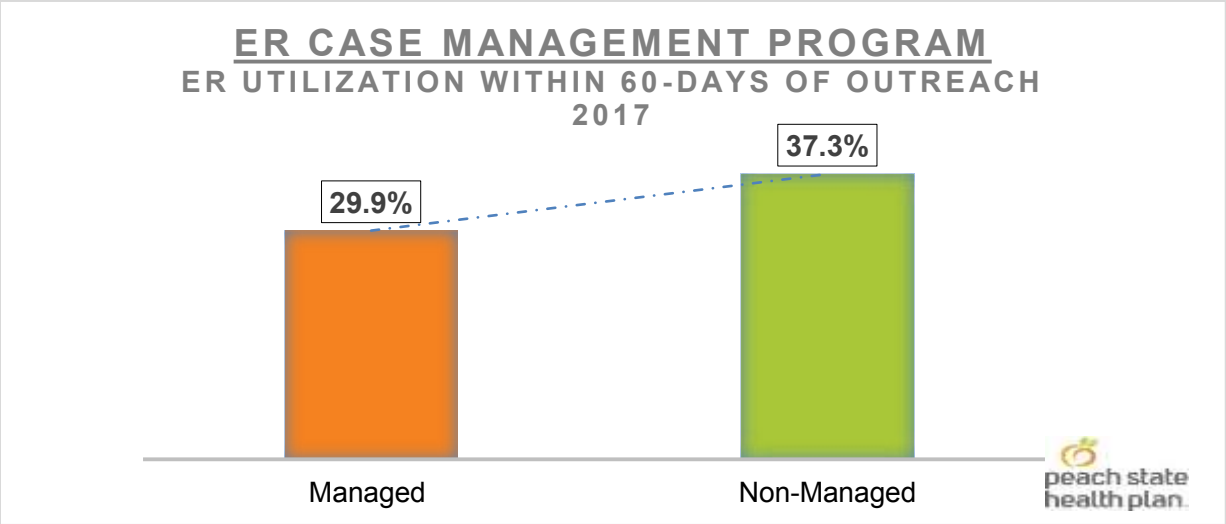
2018 Proposed Interventions

The HROB program will enhance its face to face outreach to target those members identified in level I and level II in an effort to provide education regarding the importance of regular scheduled prenatal visits to increase the potential for a healthy pregnancy and delivery.

Highlights of Care Coordination Management Effectiveness

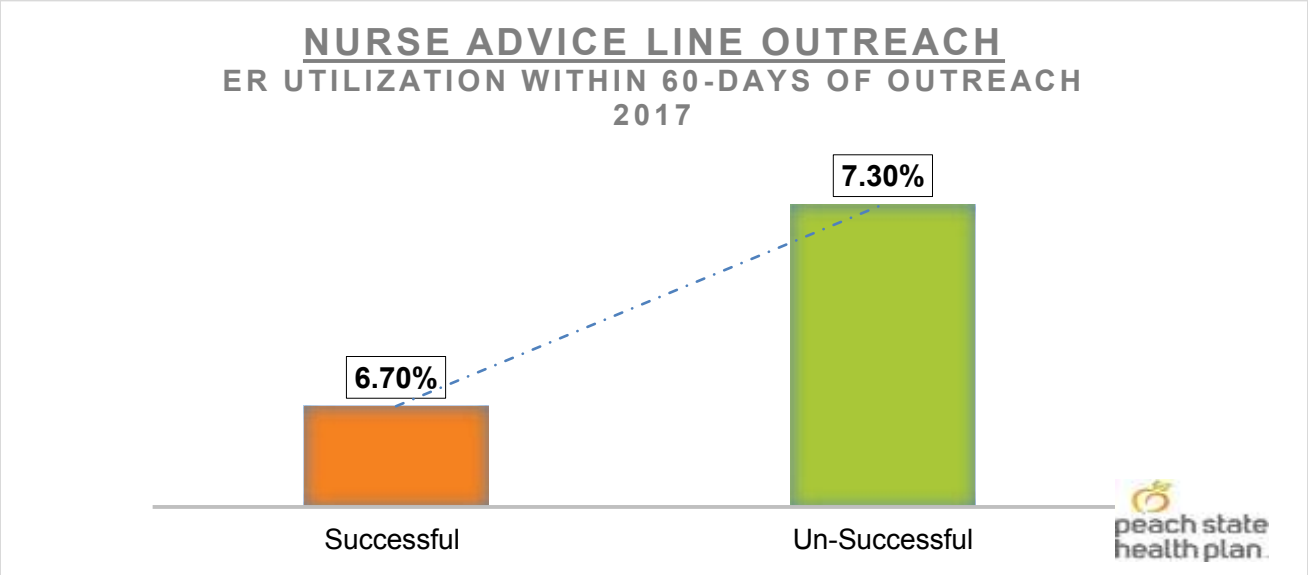
Emergency Room (ER) Case Management Program

Peach State's Emergency Room (ER) CM Program was designed to engage members with frequent or inappropriate ER utilization. Peach State partnered with 10 high volume hospitals to receive daily notification of members who visited the ER on the previous day. Case Managers outreached to members within 24-48 hours of the encounter to assist them with obtaining follow-up care and to provide education regarding appropriate use of the ER, the importance of getting primary and preventive care, and the availability of the 24/7 Nurse Advice Line. There were 210 members enrolled in the ER Case Management Program in which 29.9% of the members had a repeat ER visit within 30 days after program completion when compared to those not in the program at 37.3%.



In 2017, Peach State attempted to implement an ER Diversion Pilot Program to enhance the ER Care Management program by co-locating a staff member in a high-volume ER facility to provide member education and to assist with the selection of a primary care home. Despite the Plan's attempt, no facilities agreed to partner. As a second option, Children's Healthcare of Atlanta at Hughes Spalding agreed to place a staff Member/Patient Navigator in the lobby of the ER department to promote the importance of identifying a PCP, completing annual preventative health screenings, and receiving timely immunizations. Peach State also received notification of members who visited the ER and who are unaware of who their PCP is and required assistance with scheduling appropriate follow-up services.

In addition to the Case Manager Outreach, the 24/7 Nurse Advise Line staff conducted outreach to parents/caregivers of newly enrolled members ages 0-10 years old who were auto-assigned a primary care provider. The Nurse Advice Line staff educated the parent on the appropriate utilization of the ER and assisted with selecting a PCP. In 2017, 11,042 new members received ER educational outreach from the Nurse Advise Line staff. This is a 44% decrease from 2016, in which 19,783 members received ER educational outreach. Of those who received the ER educational outreach, 6.7% did not have an ER visit within 60 days compared to those who did not receive the ER educational outreach at 7.3%.



2018 Proposed Interventions

In 2018, Peach State will enhance its ER Case Management Program to target outreach to member's newly diagnosed with chronic conditions in the ER. Peach State understands that early implementation of interventions with members who are newly diagnosed with medical conditions can prevent inappropriate ER utilization.

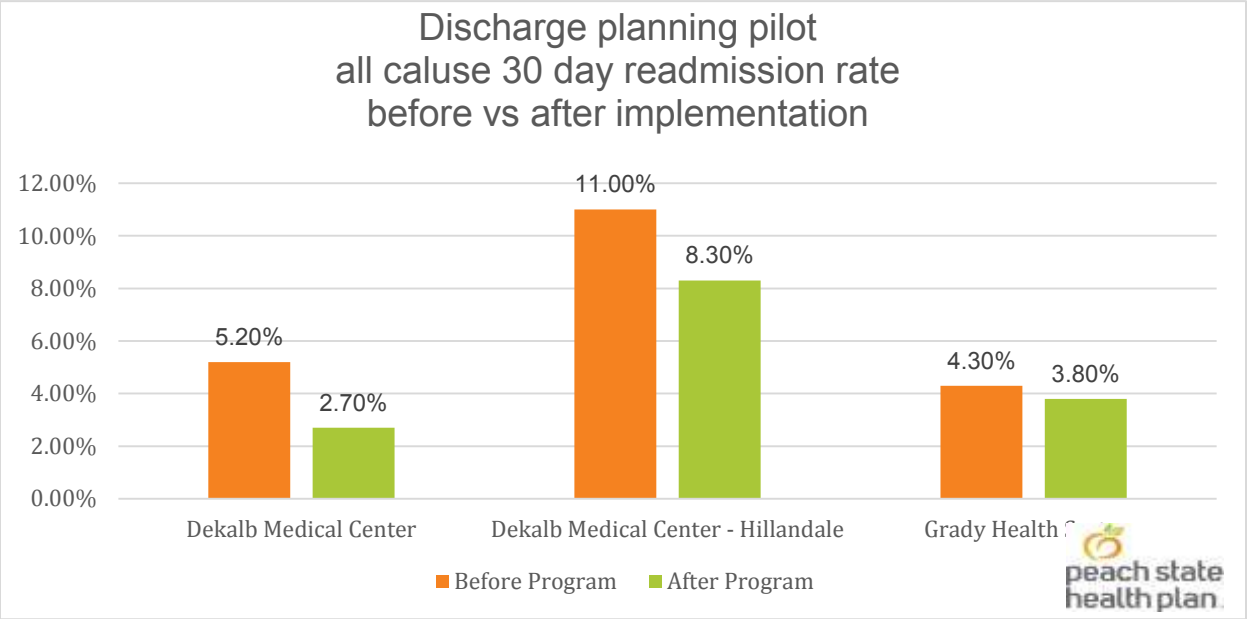
Discharge Programs

Discharge Planning Pilot Program

With the implementation of the new DCH contract, in July of 2017, Peach State implemented a Discharge Planning Pilot Program identifying the top facilities with the highest Readmission Rates, as well as, with the highest number of readmissions. Peach State identified the following facilities based on their readmission rate and agreed to a partnership to place a Peach State staff on-site:

- DeKalb Medical Center
- DeKalb Medical Center (Hillandale)
- Grady Health System

Since program implementation the readmission at these 3 facilities have decreased from 5.3% to 5.0%.



2018 Proposed Interventions

The Discharge Planning Pilot Program is designed to assist the member by implementing timely, appropriate, safe, and cost-effective discharge plans. In 2018, Peach State will continue to the discharge planning efforts with the facilities listed above to ensure the safe transitions of members and appropriate follow-up.

Post-Hospitalization Follow-up

Peach State's Care Managers, in collaboration with the member, work to improve the overall health outcome of those recently discharged from the hospital. The CCM program is designed to provide members with the tools and techniques necessary to manage and control their condition. Care Managers and/or CCM designees work in collaboration with hospital discharge planners to ensure effective care coordination, and to stabilize or improve members' health condition who may have been recently inpatient and/or received services through the ER. This is achieved by conducting telephonic follow-up with members enrolled in the CCM program to assist with arranging follow-up appointments (post-discharge) and providing information on community-based services.

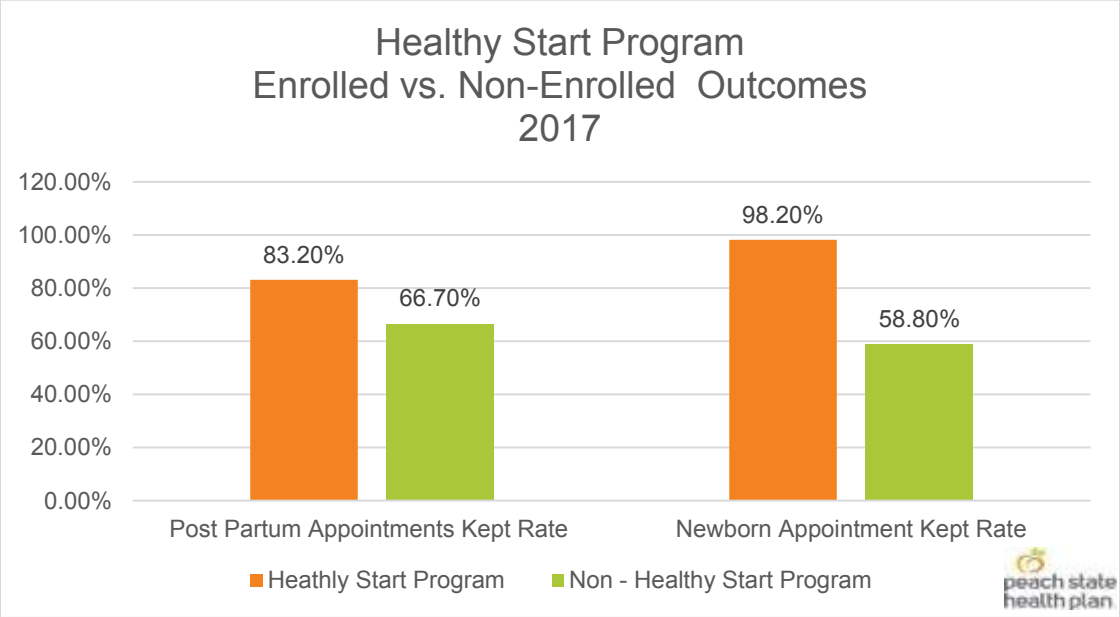
- In 2017, the NICU post-hospitalization follow up rate was 68%. This means that 68% of members discharged from the NICU received a visit with a provider within 7 days after discharge.
- In 2017, the Diabetic Post-Hospitalization Follow-up Rate was 57%.

In 2018, Peach State will continue its follow-up interventions, leveraging the Community Health Services Department to conduct face-to-face coaching services to eligible members to provide short-term, intensive, personal coaching support, and reinforcement on a recurrent basis. The coaching services encompass motivation, education, hands on learning, self-management, goal setting and action plans, breaking through barriers of social determinants of health, advocacy, screenings, empowerment and follow-up. Additionally, Peach State will also continue to conduct post-hospital telephonic calls to assist with scheduling follow-up appointments if applicable.

Healthy Start Program

The Healthy Start Program targets new mothers and newborns to ensure members are linked with an OB/GYN or PCP. The purpose of the program is to increase the total number of members who successfully complete postpartum and newborn well visit appointments. This program provides in person visits while the new mother is still inpatient to ensure the member understood instructions and the importance of follow-up visits for pertinent care. Assistance with scheduling appointments and (non-emergency) transportation is provided, as well as addressing identified barriers.

In 2017, the Healthy Start Program staff was on-site at seven facilities. There were 3,004 members seen through the Healthy Start Program. In 2017, the Healthy Start Program outcomes when compared to those members not visited by staff as part of the Program follow.



In summary:

- The Post-Partum Follow-up rate was 83.2; this is an increase from 2016 rate of 82.6%. The postpartum visit rate for members who were not visited by Healthy Start Program staff was 66.70%.
- The Newborn Provider Follow-up rate was 98.2%; almost 40% points higher than the 2016 rate of 58.80%. This is a slight decrease from 2016 in which the rate was 98.6%.

Peach State (through data) determined that members who were seen at the participating facilities with the Healthy Start Program are more compliant with completion of postpartum visits and newborn well visits.

2018 Proposed Interventions

Peach State will continue the Healthy Start program but enhance the program to follow newborns for the first 6 months up to the first year of life to ensure completion of all recommended preventive appointments and services targeting those members that have been identified at a higher risk for non-compliance.

Other Management Programs

Inter-Pregnancy Care (IPC)/Resource Mother Program

The Inter-Pregnancy Care (IPC)/Resource Mother Program is a program that targets enrollees in an effort to reduce the number of low birth weight (LBW) and very low birth weight (VLBW) births. This Program offered case management and Resource Mother Outreach and support services to the enrollee by educating on appropriate birth spacing and linking them to available community resources.

In 2017, the contraceptive utilization rate for enrollees in the IPC/Resource Mother was 54.5%. Peach State identified that 45.5% of enrollees in the IPC/Resource Mother Program were not reporting use of any form of contraceptive. Peach State also identified an increase in the number of enrollees who become pregnant or who were unable to be reached. In 2018, Peach State will develop targeted member education on contraceptive options and its appropriate use.

PCP Medical Home Steerage Intervention

The PCP Medical Home Steerage intervention provided outreach and care coordination for chronic/high risk members who have been identified as using multiple PCPs. Through this intervention, the Program Coordination team performed outreach and educated chronic/high risk members with multiple PCPs on the importance of establishing a patient centered medical home. For 2017, the PCP Medical Home Steerage intervention targeted a total of 1,300 members who received outreach and care coordination activities. Through this program, Peach State achieved a 77.1% decrease in the total medical cost (inpatient and ED costs).

In reviewing the data, Peach State identified an opportunity to also focus on members who were underutilizing services. In 2018, in addition to continuing to focus on multiple PCP utilization, Peach State will also implement the following initiatives to address the underutilization of services:

- Members who are only using a specialist with no PCP utilization
- Members who are only utilizing the Emergency Room (ER) with no PCP utilization

Effectiveness of Peach State Disease Management Programs

People with chronic conditions generally use more health care services, including physician visits, hospital care, and prescription drugs. Disease management is one approach that aims to provide education and better care while reducing the costs of caring for the chronically ill. Disease management programs are designed to:

- Improve the health of persons with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations;
- Provide targeted interventions to individuals with a specific disease; and
- Reduce inappropriate utilization and improve health outcomes in many ways.

Costly chronic conditions, including asthma, diabetes, HIV/AIDS and tobacco cessation have been the focus of these programs.
Interventions for the Peach State Health Plan Disease Management Program are aimed at providing self-management education, encouraging compliance with a prescribed plan of care as recommended by the individual's physician, and are based on evidence based guidelines. The most significant ongoing interventions of the DM program are the following:

- Conducts initial and periodic in-person or telephonic evaluations of member health status and support needs.
- Educates and coaches members and their caregivers using motivational interviewing techniques that foster positive behavioral change. Education and coaching covers information about the members' conditions and provides support in understanding and adopting healthy behaviors and/or changing or avoiding environmental factors (such as home conditions) that influence the progression of the condition. Diet and exercise are routinely discussed.
- Educates members and their caregivers on the importance of obtaining preventive and primary care, how to use their medications and specific devices, and complying with the doctor's prescribed directions. Medication-related safety factors that are assessed and reviewed include potential drug interactions, contraindications, duplicative treatment, poly-pharmacy and gaps/adherence for chronic condition medications.
- Assists, when needed, in arranging provider appointments, transportation and access to community-based services.

The DM Programs are based on the concept that individuals who are better educated about their condition, and how to manage and control their condition, receive better care and achieve better improved outcomes. This could ultimately result in cost-savings for those enrolled. The DM staff functions in partnership with the CM Team to ensure effective care coordination and to stabilize or improve a member's health condition. These actions help to reduce members' use of inappropriate or unnecessary inpatient admissions/re-admissions and emergency room (ER) visits, including those associated with under/over-utilization of medications.

Key metrics that reflect the effectiveness of the DM programs and that contribute to the achievement of Peach State goals of "Improve member health outcomes through the increased preventive and wellness programs" and "Improve the overall member and provider experience with Peach State", include the following:

Disease Management
Asthma
Medication Management for People with Asthma 75% compliant: 5-11 yrs. (HEDIS)
Medication Management for People with Asthma 75% compliant: Total. (HEDIS)
Diabetes
HbA1c testing
Dilated Eye Exam
Attention to Nephropathy to include Micro albuminuria testing
Blood Pressure (BP) Control <140/90
HbA1c Control (<7, <8, ≥9)
HIV/AIDS
Enrolled
ER utilization per member
Puff Free
Cessation
Cessation after Delivery
Reductions in cigarettes per day
Second Hand Smoke

Overall Disease Management Highlights

Enhancements: Peach State enhanced its DM program in 2017 with the following changes:

DM Programs

In 2017, Envolve People Care (EPC) focused on individual health management through education and empowerment, in a stronger and more unified manner. This allows for the

improvement of the lives of participants by offering health and wellness solutions for the whole person. Envolve People Care Disease Management/Lifestyle Management (DM/LM) is an NCQA and URAC accredited life, health and wellness product dedicated to supporting, encouraging and motivating people to transform their lives.

Asthma DM Highlights

In 2017, Peach State had 1585 asthmatic members actively managed in Disease Management services and an additional 22,368 members passively managed through educational materials being sent routinely. Each year Envolve People Care prepares a claims based analysis of the Disease Management programs and the 2017 results of the analysis determined the majority of the members in the Asthma Disease Management were 0-17 years of age (20,365) while 1,763 were ages to 18 to 29, 875 were between 30 and 49 years of age and 56 were above 50.

2017 Claims Analysis	Gender		Age Range				Intervention Level		
Participant Category	**M**	**F**	**0-17**	**18-29**	**30-49**	**50+**	**Potential Candidate**	**Coaching**	**Mail**
Adult Asthma Non-Participants	1,534	2,504	0	3,019	920	99	4,038	0	0
Adult Asthma Participants	291	1,722	0	1,082	875	56	0	34	1,979
Pediatric Asthma Non-Participants	8,844	6,367	14,590	621	0	0	15,211	0	0
Pediatric Asthma Participants	12,076	8,970	20,365	681	0	0	0	657	20,389

Program participants must meet population selection criteria to be included in the annual claims analysis, therefore the information provided in the table above does not reflect all members that participated in the program.

Peach State used the following performance measure to assess the effectiveness of the asthma program interventions:

HEDIS Measure	2016	2017	Change	Stat. Signif.	DCH Targets
Medication Management for People with Asthma 75% compliant: 5-11 yrs.	20.28%	26.60%	↑	Yes	25.88% (MET)
Medication Management for People with Asthma 75% compliant: 12-18 yrs.	20.25%	25.33%	↑	Yes	34.84% (Not Met)

Peach State set its goal to determine effectiveness of its Asthma program by achieving DCH targets or statistically significant improvement in the rate from CY 2016 to CY 2017. Peach State met the DCH target for 5-11 year olds and the rate showed statistical improvement. The CY 2017 rate for 12-18 year olds showed a statistical significant improvement from CY 2016 but did not meet the DCH target.

Asthma DM Program Outcomes

Readmission Rate - Based on 30 Days for Asthma related diagnosis only	0%
Repeat ER Visit - Total of All Actively Disease Managed Asthmatic Members with Repeat ER Visits for Asthma related diagnosis	47
% of All Actively Disease Managed Asthmatic Members w/ Prescribed Appropriate Asthma Medications (Includes Fills/Refills)	61.64%

% of All Actively Disease Managed Asthmatic Members w/ Documented Asthma Action Plan	100%
% of All Actively Disease Managed Asthmatic Members Managed by a PCP	100.0%

* Please note that the member/member's caregiver, if applicable, needs to agree to participate in the coaching program.

Analysis of Asthma DM Program Outcomes

- The percent of actively managed members with a claims-based asthma related readmission was 3.22% in 2016 and was reduced to 0% in 2017. The trend for readmission has remained very low, which indicated that members are self-managing their condition well. The readmission rate is the total number of actively managed members with an asthma related readmission, defined as an asthma-related diagnosis in the primary thru 5th diagnosis code of J45.20 - J45.998).
- There were 47 members in the asthma disease management program who had a repeat ER visit, which is a reduction of 87.53% from the previous year. A repeat ER visit is defined as an asthma-related ER visit following an initial ER visit, occurring during the same reporting quarter with an ICD-10 code (J45.20 - J45.998).Throughout 2017 Health coaches continued to encourage and provide education to members on:
  - Flu prevention methods and the importance of getting the flu shot.
  - Recognition of early signs and symptoms to prevent an Asthma exacerbation.
  - The importance of maintaining a consistent relationship with the primary health care provider treating their asthma in an effort to avoid acute symptoms and the need for emergency care.
  - Peach State Health Plan and Envolve People Care nurse advice line staff work together to provide an Emergency Room Education Program for members who were not assigned a PCP or who had visited and ER with 30 days are outreached to and education on ER alternatives.

- The total number of 1585 actively managed asthma members with evidence of receiving a prescribed controller medication during 2017 was 61.64 % which is an increase of 1.98% in adherence from 2016 (59.66%). This is claims based evidence for both fills and refills. The managed asthma population includes those members who are actively engaged with a health coach over a period of time. During 2017, the primary health coach educated the member on the importance of appropriate utilization for controller medications, encouraging mediation adherence and self-management.
- The total of actively managed asthma members with a documented asthma action plan during 2017 was 100%. Each member in health coaching for asthma has a documented asthma action plan in the member record. The asthma action plan is designed to be a communication tool with the provider. The action plan documents member self-reported data about a variety of topics including symptoms, condition specific needs and medication use. This action plan may include recommendations to the provider, such as a request for prescriptions or communication about member habits and symptoms.
- All members (100%) within the asthma disease management program were being actively managed by a PCP during 2017.

CY 2017 Barrier Analysis and Intervention:

Barrier: Some members are unable to be contacted due to inaccurate system demographic information.

Barrier: Low number of field services visits accepted by members, parents/guardians to provide in home Asthma education with Asthma Field Health coaches. A total of 67 field service visits were completed for members with Asthma in 2017.

Intervention: Envolve People Care team works to find updated phone information through methods such as directory assistance, contacting provider offices and pharmacies, and internal care management resources such as TruCare and Impact Pro.

Intervention: Envolve People Care health coaches promote the benefits of the field service visit and offer them frequently to members that have reported a recent ER visit or exacerbation, medication compliance issues, need additional instruction on spacer use or medication inhaler devices, and to assist with identification of Asthma triggers in the home by performing an environmental assessment.

It is important to note that field service visits for members participating in the disease management program is outside the 2017 activities outline as part of the PIP as described below.

2017 Activities

The compliance rate for CY 2017 members ages 5-18 years who were dispensed an asthma controller medication that they remained on for at least 75% of their treatment period was significantly lower for both genders of Black or African American members (average of 59.42%) than White members (average of 68.62%). Of the three regions that had more than 50 members who were in the denominator (Atlanta, Central and Southwest) the Atlanta region continued to have the least compliance. The 5-11 year old compliance rate was two percentage points higher than the 12-18 year old compliance rate.

- In CY 2017, Peach State in collaboration with WellCare of Georgia, conducted an Asthma PIP. The Plans used (face-to-face) in-home environmental assessments to assist caregivers with determining and mitigating triggers and educate on the importance of controller medication compliance. There were 124 members that received a home visit and education, 55 (45.08%) of these members did obtain their asthma controller medication after the home visit and education was completed. There were 2 members that received a home visit and education but lost eligibility within 30 days of the home visit and were unable to obtain medication. Of the members who picked up their medication within 30 days and were reached, 29 identified the in-home education as the reason they picked up their medication (90.62%). Although successful for those who participated, the Plans determined that this intervention is not sustainable as it is very resource and time intensive. Modifications and the incorporation of stratification criteria to this intervention was identified as methods to ensure sustainability of the intervention. For additional information on the outcome of the Collaborative Asthma PIP, see '2017 PIP Summary and Report' section of this Evaluation.
- In the summer of 2017, Peach State initiated a collaboration with the Children Healthcare of Atlanta's asthma team and Ronald McDonald House Charities to utilize the **Ronald McDonald Care Mobile®** to provide asthma care at select schools in Atlanta. The Ronald McDonald Care Mobile® helps address barriers to care, like transportation, by bringing a 40 foot vehicle with exam rooms, medical supplies and equipment similar to a doctor's office to these schools. Services are provided to children during school hours. Barriers to completing this intervention included identification of members who attend specific schools and parents completion of the necessary forms/paperwork needed for the member to access the **Ronald McDonald Care Mobile®**. Peach State is discussing methods to implement this initiative within the parameters set by schools.

Diabetes DM Highlights

In 2017, Peach State had 302 members with diabetes actively managed in Disease Management services and an additional 2,951 members passively managed through routinely mailed educational materials. Each year Envolve People Care prepares a claims based analysis of the Disease Management programs and the 2017 results of the analysis determined the majority of the members in the Diabetes Disease Management were 30-49 years of age (918) while 243 were ages 18 to 29, and 185 were above 50. There were 315 members in the program 0 to 17 years of age.

2017 Claims Analysis	Gender		Age Range				Intervention Level		
Participant Category	M	F	0-17	18-29	30-49	50+	Potential Candidate	Coaching	Mail
Adult Diabetes Non-Participants	224	1,057	0	329	746	206	1,281	0	0
Adult Diabetes Participants	181	1,165	0	243	918	185	0	53	1,293
Pediatric Diabetes Non-Participants	68	132	150	50	0	0	200	0	0
Pediatric Diabetes Participants	157	215	315	57	0	0	0	18	354

Program participants must meet population selection criteria to be included in the annual claims analysis, therefore the information provided in the table above does not reflect all members that participated in the program.

Peach State used the following performance measure to assess the effectiveness of the Diabetes program interventions:

HEDIS Measure	2016	2017	Change	Stat. Signif.	CY 2017 DCH Targets
HbA1c test	83.48%	84.85%	↑	No	85.96% (not met)
Eye exam	59.83%	57.30%	↓	No	53.54% (MET)
Attention to nephropathy	88.70%	89.05%	↑	No	91.97% (not met)
BP control <140/90	46.78%	50.55%	↑	Yes	59.61% (not met)
HbA1c Poor >9 (lower rate is better)	61.04%	56.57%	↓	No	43.92% (not met)
HbA1c Control <8	29.91%	35.40%	↑	No	46.72% (not met)
HbA1c control <7	22.46%	25.38%	↑	No	33.82% (not met)

Peach State reviewed its performance metrics for 2017 and compared them to the performance of the prior year and to DCH targets. The Plan saw an improvement in six of the seven HEDIS Comprehensive Diabetes Care (CDC) sub-measures; the DCH target was met for Eye exam. Of note, there was a statistically significant improvement in BP control. The health coaches in the Diabetes program address these HEDIS measures as part of the coaching experience coupled with on-going education with regard to the importance of monitoring/controlling the symptoms and prevention opportunities associated with the disease.

Diabetes DM Program Outcomes

Readmission Rate - Based on 30 Days for Diabetes related diagnosis only	0%
Repeat ER Visit - Total of All Actively Disease Managed Diabetic Members with Repeat ER Visits for Diabetes related diagnosis	25

% of All Actively Disease Managed Diabetic Members w/ HbA1c screening in the past 12 months	83.89%
% of All Actively Disease Managed Diabetic Members with a HbA1c level ≤ 7	26.56%
% of All Actively Disease Managed Diabetic Members with an initial HbA1c level ≥ 9 (Prior to enrollment) , who have had a decrease in the level by 2 points since Enrollment into DM that was documented	6.12%
% of All Actively Disease Managed Diabetic Members with Annual Eye Exam	27.80%
% of All Actively Disease Managed Diabetic Members Admitted for Short Term Complications related to Diabetes	13.79%
% of All Actively Disease Managed Diabetic Members Managed by PCP	100%

* Please note that the member/member's caregiver, if applicable, needs to agree to participate in the coaching program.

Analysis of Diabetes DM Program Outcomes

- The total percent of actively managed members with a claims-based diabetic related readmission was 0% in 2017. The trend for readmission remained low which indicated that members are self-managing their condition well. The readmission rate is the total number of actively managed members with a diabetes related readmission, defined as a diabetes-related diagnosis ICD-10 codes.
- There were 25 members of the diabetes disease management program with repeat ER visits in 2017. This represents a reduction of 86.2% reduction from 2016. A repeat ER visit is defined as a diabetes-related ER visit following an initial ER visit that occurred during the same reporting quarter with an ICD-10 E08.00 - E13.9 & GEM Combination 1-4).
- The total number of actively managed diabetic members with evidence of receiving an HbA1c screening in the past twelve months (2017) 83.89% of the actively managed members. The calculation is based on the managed population which is the number of members identified as being engaged with a health coach over a period of time.
- The total number of actively managed diabetic members with evidence of having an HbA1c result less than 7 during 2017 was 26.56%. This is a decrease of nine percent from the 2016 rate of 29.19%. HbA1c results may be captured via provider information, supplemental lab data or member self-reported. While claims may indicate that a test was completed, not all members in the managed population have a result in the member record. The calculation is based on members who received HbA1c screenings.
- The total number of actively managed diabetic members with an initial HbA1c greater than 9 and evidence of a decrease by 2 points since enrollment into disease management was 6.12%. In 2016 the percentage was 5. 08%. HbA1c results may be captured via provider information, supplemental lab data or member self-reported. While claims may indicate that a test was completed, not all members in the managed population have a result available in the member record. The most significant barrier to reporting on this item is the availability of lab values in the member record for comparison within the appropriate time frames. Health Coaches have been adding goals to have a member remember to have testing results available during each session to help with this issue.
- The total number of actively managed diabetic members with evidence of receiving an annual eye exam was 27.80% which is a decrease by 55% of the actively managed diabetic members. This is attributed to the shift in population after July 1, and 39 members in the Diabetes coaching program were transitioned to other health plans.
- The total number of actively disease managed diabetic members admitted in the current reporting year with short term complications related to diabetes was 13.79% which is an increase of 40% from 2016. An admission related to short term complications of diabetes is defined as claims-based evidence of an admission with an ICD-10 code. This is attributed to

but not limited to the shift in population after July 1 with new members joining the Diabetes program and the transition of 39 members in the Diabetes coaching program that were transitioned to other health plans.
- All (100%) members within the diabetes disease management program were being actively managed by a PCP during 2017.

CY 2017 Barrier Analysis and Intervention:
- Barriers:
  - Some members are unable to be contacted due to inaccurate system demographic information.
  - Although not considered a true barrier, it is important to note that there was a shift the population after July1 and 256 members (39 – Diabetes, 217-Asthma) active participants were transitioned to other health plans throughout the rest of 2017.
- Intervention:
  - Envolve People Care team works to find updated phone information through methods such as directory assistance, contacting provider offices and pharmacies, and internal care management resources such as TruCare and Impact Pro.

2017 Interventions

Medication Therapy Management (MTM) Program: In CY 2016, a Medication Therapy Management (MTM) program was developed. The MTM outreach coordinators accessed CVS Claims system, which provided real time medication information. In addition, MTM outreach coordinators could access on a daily basis to a list of members who are 5 days late or more on expected medication refill. In a targeted approach, the Plan contacted members that were 5 days late in filling their diabetes medications. Each call to the member was preceded (same day) by a real time pharmacy claim review to confirm if the member did, in fact, pick up their medication.
Effectiveness: Calls by the clinical pharmacy team to members began in June 2016 for this MTM program. There were over 4,400 calls to members in 2017. The average fill rate for 2016 (June – December) was 48%. The average fill rate in CY 2017 decreased to 33%.

2016	% of Diabetes Fills After Contact
June	40%
July	56%
August	49%
September	32%
October	52%
November	51%
December	56%

2017	Unique Calls	% of Diabetes Fills After Contact	% of Fills After Outreach
Jan	292	78	27%
Feb	150	68	45%
Mar	277	154	56%

Apr	195	127	65%
May	619	191	31%
Jun	646	161	25%
Jul	672	210	31%
Aug	695	136	20%
Sep	543	142	26%
Oct	81	40	49%
Nov	175	113	65%
Dec	91	34	37%
Totals	**4436**	**1454**	**33%**

2018 Proposed Activities

Peach State developed a Peach Pays Incentive program for members to encourage them to obtain their HbA1c and to maintain an HbA1c result lower than 9. The incentive and initiative was developed based on member feedback during in-person events and the focus group. The diabetes incentive will be implemented in Q3, 2018.

For additional information about the Diabetes DM program, please refer to the sections: "Responding to Unique Needs of the Members" section within this document.

HIV/AIDS DM Highlights

Peach State's Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Care Coordination Program subscribes to the specific needs of the members. The HIV/AIDS Care Coordination Program was initiated by Peach State to promote healthier outcomes for HIV infected members by ensuring and improving access to appropriate health services. This was accomplished by providing education, counseling, advocacy and linking the member with a Case Manager and/or Health Coach. The Case Manager/Health Coach worked alongside the member by encouraging adherence to appropriate ongoing medical treatment and identifying supportive resources within the community to minimize complications and the members' highest level of wellness.

As part of the HIV/AIDS Care Coordination Program, member's medication history was reviewed for medication related safety factors, drug interactions and over/under utilization The Care Coordination (CC) staff outreached to members, their pharmacy and providers to identify the barriers to adherence with prescribed medications. Barriers identified in 2017 included fear of diagnosis being disclosed, forgetting to pick up refills, and inability to afford the copayment. The CC staff collaborated with pharmacies who were able to provide home delivery medications to members and worked with both members and providers to arrange follow up appointments. In 2017, there were a total of 108 enrolled members resulting in a 76.8% decrease in total medical cost (inpatient and ED utilization). In 2018, Peach State will continue the following interventions efforts:

- The Care Coordination staff will collaborate with behavioral health to integrate with members identified with mental health concerns
- The enhancement of the medication adherence program to include other diagnoses to provide appropriate education on medication related safety factors, review of drug interactions and the over/under utilization of prescribed medications

Hypertension Disease Management (HTN) Program
Peach State understands the severity of Hypertension, and recognizes that it is labeled the "silent killer," due to, the likelihood that serious health threats caused by the condition can exist without noticeable symptoms. Therefore, in 2017, Peach State developed a targeted improvement program focused on members diagnosed with hypertension.

Peach State's Hypertension Disease Management Team goals were to reduce hypertension healthcare utilization, improve classification of blood pressure (i.e., from hypertension stage 2 to a lower category) and promote self-management, which includes adherence to appropriate medication regimens if applicable. Goals were pursued by facilitating relationships between members diagnosed with hypertension, caregivers, primary care physicians, providing access to beneficial resources (i.e., blood pressure monitors), delivering tailored education and addressing causes of resistant hypertension (i.e., excess sodium intake, medication).

The Hypertension Disease Management team delivered stratified hypertension management services, including health coaching which focused on medical and social interventions. The team was comprised of health plan care managers, medical directors, pharmacists, health coaches, members, member's families and/or support persons, as well as, community partners. Members with a hypertension diagnosis in the Plan's information system were stratified into three intervention groups.

- **Level I** – Members identified as having no current unmet need for health care services, but may have a history of a condition that places the member at risk for potential problems or complications. Level I also includes members who the Hypertension Disease Management Team were unable to contact (UTC) after numerous telephonic outreach attempts and/or members who successfully completed Health Coaching. These members received quarterly outreach via mail to address member-specific care gaps and education on hypertension.
- **Level II** – Members identified as having many health care needs, but the condition is mostly stable with adequate support. Level II services included Health Coaching only, to members who required outreach/follow-up on a monthly basis. These members required assessments, service plans, collaboration between the Health Educator/Provider and multidisciplinary team approach.
- **Level III** – Members identified as having an episode of serious illness or injury, and are at risk for admission or readmission. Level III included Health Coaching only, to members who required outreach/follow-up every two weeks or more frequently as needed. These members required assessments, service plans, collaboration between the Health Educator/Provider and multidisciplinary team approach. These members may have also required Care Coordination/Care Management referrals.

All members in the Hypertension Disease Management program received educational material that promoted understanding of hypertension, active participation in program and adherence to interventions, lifestyle modification recommendations, and encouraged self-management of condition. Peach State encouraged enrolled members to comply with interventions and recommended preventive care. Peach State also recommended implementation of healthy lifestyle changes such as weight reduction, regular aerobic physical activity, dietary sodium reduction, and moderation of alcohol consumption.

Peach State incorporated clinical practice guidelines (CPGs) in the development of program initiatives and interventions. Clinical data was utilized to stratify members for enrollment based on level of service intensity. The risk level determined the frequency of outreach to the member. In 2017, 86% of the actively managed members were prescribed appropriate medication.

According to the American Heart Association, a hypertensive crisis is when blood pressure values rise quickly and severely with readings of ≥180/120. Studies reveal that various complications can arise from a hypertensive crisis, including but not limited to; loss of memory/consciousness, pulmonary edema, loss of kidney function, stroke, and heart attack. In 2017, there were no members admitted for a hypertensive crisis. Peach State credits the aforementioned interventions for the absence of member inpatient admissions related to a hypertensive crisis.
Peach State has identified that members with hypertension (HTN) are more likely to have other chronic conditions and unlikely to adhere to their treatment regime. In 2018, Peach State will identify members with hypertension (HTN) who have multiple co-morbidities and target them for outreach.

Tobacco Cessation (Puff Free) DM Highlights:
Peach State used the following performance measure to assess the effectiveness of the tobacco cessation program for pregnant women (Puff Free Program) interventions:

Measures for CY 2016 (all measures are self-reported)	Q1 (Jan- Mar)	Q2 (Apr-Jun)	Q3 (Jul- Sep)	Q4 (Oct- Dec)	CY 2016	CY 2017
Cessation	0% (0/5)	0% (0/1)	0% (0/1)	0% (0/1)	33.3%	0%
Cessation after Delivery	0	0	0	0	0	0
Reduction in Cigarettes/day	83.3% (5/6)	100% (1/1)	0% (0/1)	0.0% (0/1)	88.9%	71.4%
Second Hand Smoke	0	0	0	0	0	0

Pregnant members who smoke are offered the *Puff-Free Pregnancy* Program and receive educational materials about the risks associated with smoking during pregnancy and strategies for quitting. Members also receive telephonic coaching from a certified treatment specialist. The tobacco treatment specialist educated the members about accessing all of the resources available through the program, such as the Georgia Tobacco Quit Line where the members will be able to receive instructions about topics such as recovery symptoms, weight control, stress management/relaxation techniques and how to calm the urge to smoke, as well as supplementary materials to help them develop a quit plan.

CY 2017 Activities:

There are many adverse effects of tobacco usage to both the mother and the unborn baby. Due to these increased risks, it is critical for providers to have reliable information regarding their patient's use of tobacco during pregnancy. In an effort to improve birth outcomes by encouraging members to cease nicotine use while, Peach State Health Plan will offer financial incentives to providers who successfully coach and encourage our members to quit and to members who quit. Beginning May 1st, 2017, Peach State Health Plan allowed for all providers to perform a qualitative Nicotine Metabolite Urine Test on all of our pregnant members during their first pre-natal visit, using CPT Code 80307. Providers must use either Quest Diagnostics (test code 14464) or LabCorp (test code 71655) for this testing. Additionally, the Plan will ask providers to retest those members who report tobacco cessation during their post-partum visit using the same test code to confirm their cessation. The results of this second test will be used to reward members who successfully quit tobacco use. Peach State Health Plan will also compensate provider's office $100 for every successful cessation. Our internal data sources will allow the Plan to confirm cessation. Members will be rewarded if they quit smoking.

DM and CPGs

The Envolve People Care (EPC) Disease/Lifestyle Management (DM/LM) Program maintains Standards of Care and Clinical Guidelines to ensure all disease and lifestyle management programs utilize recommendations from the most current evidence-based clinical guidelines. Standards of Care and Clinical Guidelines are:

- Developed, based upon evidence in peer reviewed published clinical or technical literature, evidence-based consensus statements, evidence-based guidelines from nationally recognized professional healthcare organizations and government health agencies.
- Developed with input from clinical content experts involved in active practice treating patients with conditions specific to the clinical programs under review, including at least two physicians who are board certified in an appropriate specialty area.
- Reviewed on an annual (Disease Management) and biannual (Lifestyle Management) basis by the Clinical Specialists, Medical Director(s), and the Quality Improvement Committee, or when updates to the evidence based guidelines are released.

All sources used by the EPC DM/LM Program to develop the disease and lifestyle management programs are continuously monitored through the National Guideline Clearinghouse. Literature searches are conducted to retrieve pertinent abstracts. The Federal Register and FDA Web sites are reviewed for new information on medications pertinent to the disease(s) and/or conditions managed. CPGs that are used by the DM programs and shared with practitioners are: Asthma, Diabetes and Tobacco Cessation for Pregnant Women.

As changes to decision support information are identified, through changes to established guidelines, provider feedback or process improvement activities, updated materials are reviewed by the Medical Director(s), and an actively practicing board certified physician in the appropriate specialty for the condition under review, will be submitted to QOC for approval prior to implementation, and will be distributed to providers via eFax, provider newsletter and the provider portal. The EPC DM/LM Program, continually, monitors feedback from physicians regarding the clinical practice guidelines via the Physician Satisfaction Survey. For additional information, please refer to the CPG section within the Effectiveness of the QAPI Program.

CY 2017 Barriers and CY 2018 Opportunities

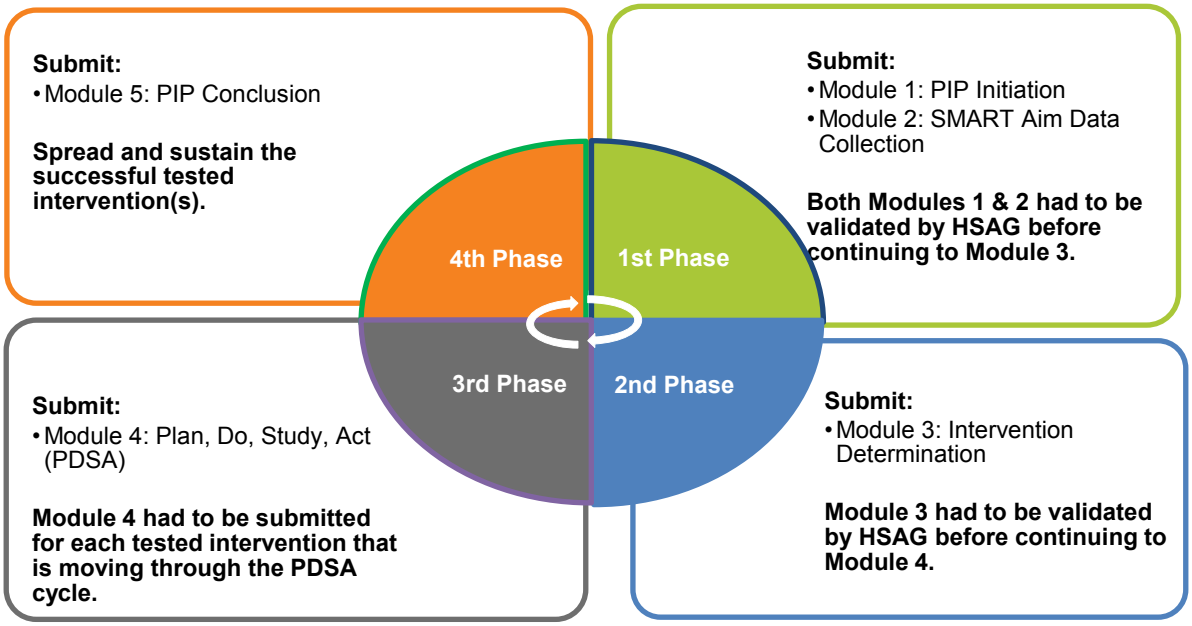
Barriers to members enrolling and/or continuing in the DM program and obtaining needed information as well as opportunities to address the barriers include:

- CY 2017 Barrier: Incorrect or incomplete member contact information
- CY 2018 Opportunity: Utilize the alternate phone report that searches weekly for updated phone numbers in eligibility files

- CY 2017 Barrier: Inadequate incentive designs
- CY 2018 Opportunity: Work to review incentive designs and propose recommendations based on engagement rate

Performance Improvement Projects

Health Services Advisory Group (HSAG), the DCH External Quality Review Organization (EQRO) validates performance improvement projects (PIPs). HSAG placed great emphasis on improving both health care outcomes and processes through the integration of quality improvement science. This approach guided Peach State through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. By piloting on a smaller scale, HSAG determined the Plan would have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale. HSAG developed a series of five modules to guide the MCOs through this new process as they conduct PIP activities.
HSAG's quality improvement framework for PIPs is detailed using five modules. The process flow below illustrates the progression in which the five modules will be submitted and validated throughout the PIP process.



2017 PIP Summary and Results

Peach State Health Plan, in collaboration with WellCare, Georgia, conducted a clinical Performance Improvement Projects (PIPs) during 2017. The PIP was designed to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active DM whose asthma is not well controlled. Following is the summary of the PIP.

Collaborative Asthma Project
SMART Aim Goal
By June 5 2017, 50% of the target population will refill their controller medications within 30 days post one-one/face-to-face education and in-home environmental assessment. Note- all home visits will be completed by May 5, 2017 to allow the member (caregiver) 30 days to refill the medication
Summary of Overall Key Findings and Interpretation of Results

Collaborative Asthma Project

Only one intervention was deployed from March 16-May 5, 2017 with data run out through June 5, 2017 to assess if the intervention was effective. The intervention was first deployed March 16th. The Plans conducted outreach to members telephonically to set appointments to complete in-home environmental assessments using predetermined materials for education. Within the first two weeks the number of home visits scheduled and performed was not yielding the desired outcome. There was concern that if telephonic outreach continued to yield low numbers of completed home visits the Plans would not be able to determine the efficacy of the intervention. To mitigate the low number of member participation in the intervention, Peach State implemented 'cold calls', or unannounced home visits, to member's homes. On April 10th a collaborative Asthma PIP workgroup meeting was held and concerns discussed. Both Plans agreed to move forward with conducting cold calls or unannounced home visits to increase member participation. The run chart above highlights member's participation in the intervention, these members received home visits, education, and obtained medication within 30 days of home visit.

Results showed that of the 124 members that received a home visit and education, 55(45.08%) of these members did obtain their asthma controller medication after the home visit and education was completed. There were 2 members that received a home visit and education but lost eligibility within 30days of the home visit and were unable to obtain medication. Based on the run chart above, the intervention did not meet the goal of obtaining 50% adherence for asthma controller medication. The run chart does show that home visits were found to be an effective means of getting members to obtain their appropriate asthma medication. While the SMART Aim goal was not met, we believe that with some modifications to the identified target membership, this intervention will continue to be an effective tool to motivate members that are non-adherent to become compliant with their asthma controller medication.
The Plans attempted to outreach all 42 members (caregivers) who picked up their medications within 30 days of the in-home assessment and successfully reached 32 members (caregivers). The remaining 10 were unable to be reached due to not answering their phone or their phone being disconnected. Of the members who picked up their medication within 30 days and were reached, 29 identified the in-home education as the reason they picked up their medication (90.62%). Below is a list of the questions asked:

- Was the in-home assessment (information) helpful in assisting you with identifying what asthma triggers a in your home?
- Was the education/ information helpful in assisting you with understanding what an asthma action plan is a is important
- Were the education/ information helpful in assisting you with understanding what long term medications a why it is important for your child to take the medication every day?

Although successful for those who participated, the Plans determined that this intervention is not sustainable as it is very resource and time intensive. A significant number of staff was devoted to carrying out this intervention and large amounts of time were spent conducting telephonic outreach or traveling to and from the member's home. There were times when appointments for in home visits were scheduled and members were not home when staff arrived. For these reasons listed, modifications and the incorporation of stratification criteria to this intervention may assist in our ability to spread and sustain the intervention. Incorporation of stratification criteria would allow resources to be deployed to the most vulnerable and non-compliant members.

Sustainability
While the SMART Aim goal was not achieved, there is opportunity for improvements in medication compliance. The collaborative Asthma PIP team determined that due to the intervention being resource intensive, modifications to identify those members who would receive an environment assessment and medication adherence education must be adjusted. The below change to identify member targets are as follows:

- Enrolled in disease management
- Non-compliant with medication refills for at least 90 days
- Recent (last 30 days) in-patient hospitalization with a primary diagnosis of asthma

With the above list of criteria modifications it is believed this intervention can meet the SMART Aim Goal.

Evaluation
After the new criteria are applied to identify member targets, the intervention can use the same methodology to evaluate outcomes. Once a member has completed a home visit which would include environmental assessment and medication adherence education the Plans will seek to analyze pharmacy data to identify the total number of members who obtained their medication within 30 days of home visit.

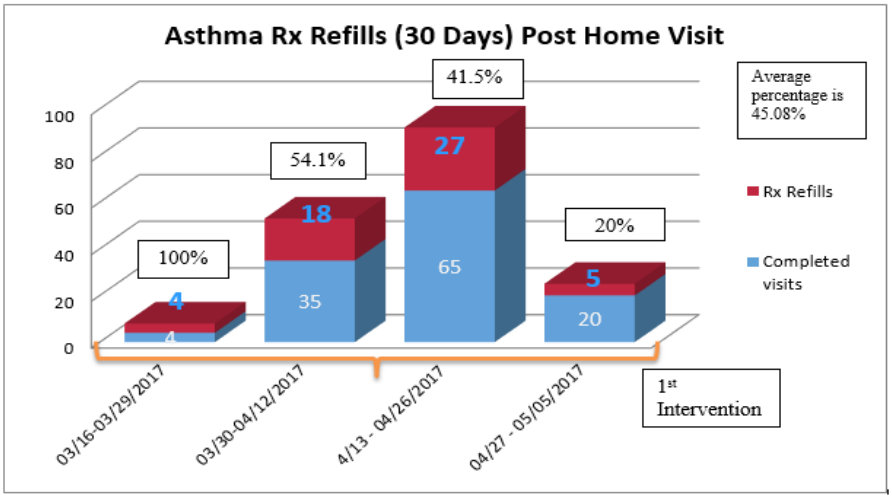
The SMART Aim measure will be calculated every two weeks and displayed in a run chart 30 day medication fills:

Collaborative Asthma Project

- Denominator- members who had an in-home visit
- Numerator- members from the denominator who refilled their medication within 30 days.

Potential Opportunities

- Provide parents with resources to ensure their home is trigger free
- Continued education for the parents and children about asthma and its impact
- Face to Face follow ups to ensure identified triggers were eliminated
- Continue to use unannounced home visits to overcome barriers to reaching members via telephone



2017 HSAG PIP Findings

HSAG reviewed and provided findings for the CY 2017. Overall, Peach State and WellCare appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMOs clearly documented the targeted population, intervention plan, and intervention testing measures. The CMOs also demonstrated strength in developing a robust intervention evaluation plan. Notably, Peach State and WellCare collected extensive process data to guide intervention assessment and refinement during the PDSA cycle. The CMOs tracked data related to scheduling and completion of the home visits and adjusted the intervention plan by adding unannounced home visits to address identified barriers and improve the home visit completion rate. Based on the intervention testing results, the CMOs concluded that the intervention was effective but resource-intensive. The CMOs reported plans to adapt the intervention to focus on a narrower, high-need population, incorporating the strategies into the DM program for members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma in the last 30 days.

Effective Performance Improvement Project Strategies

As a result of the CY 2017 Asthma PIP, the Plan was able to determine that provider education to the member was viewed as more important to the member than the Health Plan's education efforts. The Asthma collaborative Workgroup comprised of Peach State Health Plan and WellCare, Georgia staff reviewed lessons, barriers and feedback from members and assessors. Lessons learned from this intervention that can be applied to other PIPs include the following.

- Some members (caregivers) are likely to comply with Plan's requests (refill medications) when the CMO requests an in- home visit.

- A percentage of members (caregivers) picked up a refill of the controller medication after being contacted by the Plan to arrange an in-home visit (10.45%).
- Provider feedback is more important to parents than the Health Plan.
- Parents are not enforcing medication adherence with their children due to feedback from their child's provider (per caregivers).

Performance Measures

Using Outcomes to Drive Improvement

Achievement of the Triple Aim, an overarching goal shared by both Peach State and DCH, can only be realized through focused administration of an effective QAPI program. Peach State's QAPI program has set its goals and objectives for clearly defined performance measures. Peach State, by improving population health through data driven performance improvement initiatives, identifying opportunities for improvement through data collection and analysis, and successfully engaging members and providers in health care quality is set to achieve those goals and objectives. The following sections highlight Peach State's process to achieve its QAPI goal of "Improve member health outcomes through increased prevention and wellness programs". Those processes describe Peach State's approach to population health management and member and provider engagement through a discussion of the strategies, activities and interventions executed in 2017 to improve outcomes for its Children's and Women's health, Adult Screening and Chronic Conditions.

Real-Time Quality

Some programs, initiatives and interventions in the DCH contract requirements, such as improving member and provider satisfaction, informing members of EPSDT benefits through mail/phone, and ensuring access to Peach State's staff, are not targeted to individual populations but instead are applied to the population as a whole. In addition to annual provider and member satisfaction surveys, Peach State monitors these global issues on a day-to-day basis, identifying and responding to opportunities to improve member and provider experience in real time. Peach State analyzes and promptly responds to trends in member and provider complaints and grievances, closely monitors call center performance, provides ongoing customer service education and training, and ensures that staff has the information and tools necessary to provide high quality service to Peach State's members and providers.

Demographic Analysis

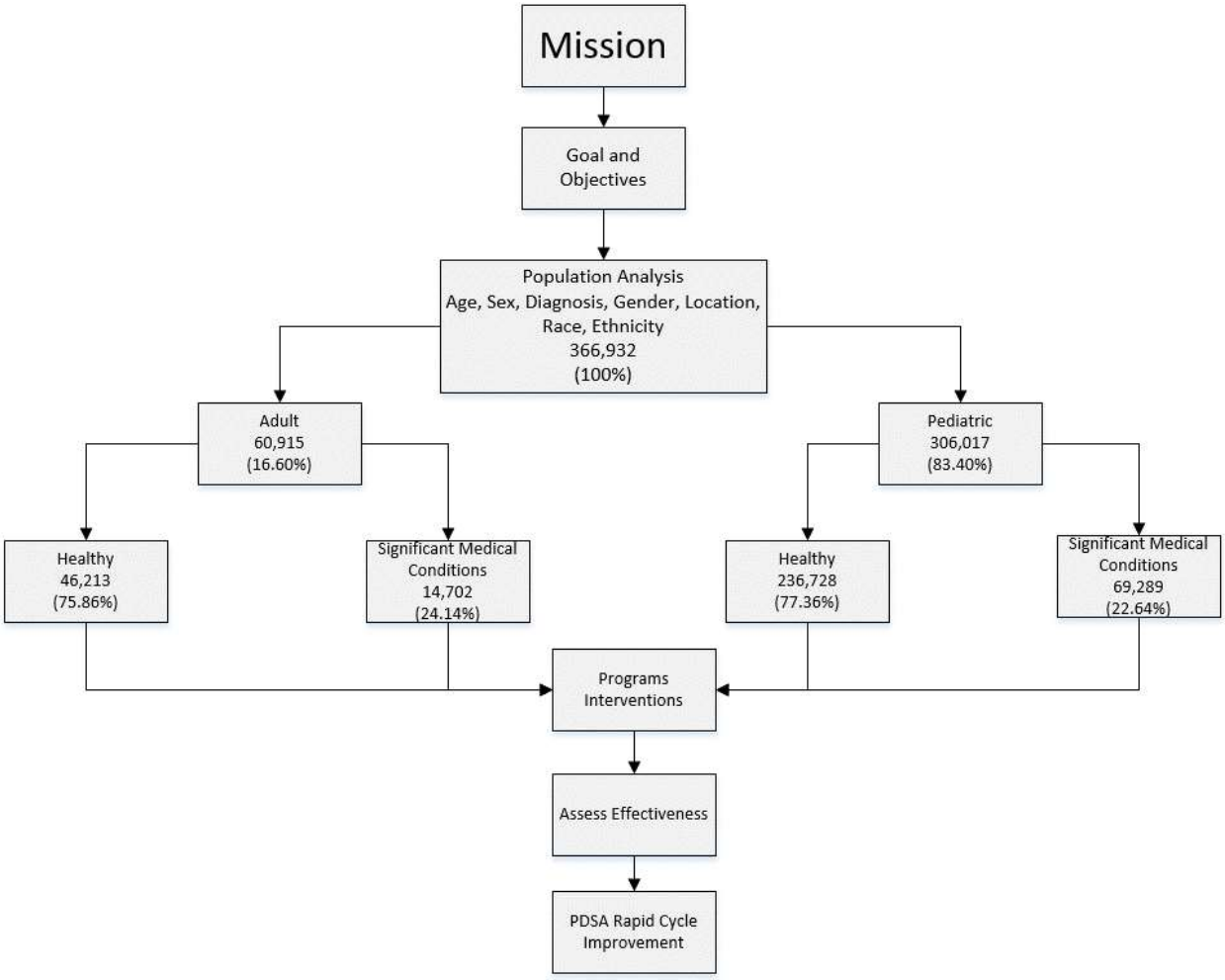
In an ongoing effort to improve the quality of care delivered to its members, Peach State annually analyzes its population demographics, including disease prevalence and healthcare disparities, to identify opportunities for improvement, and trends that indicate potential barriers to care that can potentially affect the results of interventions and initiatives.

Peach State uses demographic analysis to appropriately design its programs and interventions and to evaluate the results of the performance measures. Peach State's approach is to divide the population into adult and children's sections and then to further subdivide these groups into two sections designated as healthy and with chronic conditions. Peach State compares rural and urban outcomes, gender, age, race/ethnicity, and county level performance, analyzes variances and then uses the PDSA model of rapid cycle improvement to achieve desired goals related to member experience, health outcomes, and cost effectiveness. The chart below outlines how Peach State uses the demographic analysis in the population assessment.

Evaluating the Effectiveness of Interventions

Peach State uses performance measures and other process and outcomes results to measure the effectiveness of interventions and activities designed to support the positive interactions between members and providers that drive improved health outcomes and which align with the QAPI program goals and objectives.

In 2017, Peach State examined its populations to determine if their health was improving overall based on performance measure scores. Peach State also reviewed its 2017 program interventions to determine if they were effective in improving performance measures and outcomes, if they were sustainable, and whether they were appropriately targeting health disparities, rural and urban variances, and other population demographics, and determined if changes in processes and interventions needed to be implemented.



Planning for the Future

Using 2017 demographic and outcomes data, Peach State identified high priority areas to be addressed through PDSA rapid cycle improvement in 2018.

2017 Performance Measure Results

Peach State conducted a high level comparison of performance between 2016 and 2017 for the 32 measures that Peach State determined were priority for CY 2017.

- Statistical Significance
  - Improvement: Five (5) measures in CY 2016; Five (5) measures in CY 2017
  - Decrease:; Twelve (12) measures in CY 2016 ; Two measures in CY 2017

The remaining Performance Measures rates did not show a statistically significant change. In addition, Peach State compared its performance measures for 2017 to DCH 2017 targets. In CY

2017, the Plan met 3 out of 25 targets compared to CY 2016 in which Peach State Peach State met twenty (20) out of 31 measures.

The following factors, in conjunction with specific barriers related to individual measures, are being utilized to plan activities to be implemented in 2017 with the purpose of maintaining or improving those measures that reached DCH targets and improving those measures that fell short of the DCH targets.

- A decrease in continuously enrolled memberships as a result of the entrance of the fourth CMO (CareSource) July 1, 2017. The onboarding of a new CMO also lead to staff turnover as Peach State staff chose to move their employment to CareSource.

- Ongoing challenges to receiving accurate demographic data which limited the effectiveness of all outreach efforts. Overall, 40% of calls were not completed due to wrong numbers or failure of anyone to answer the call.

Interventions implemented in 2017, root cause analysis, and proposed 2018 interventions for specific performance measures can be found in the following pages.

Measure Name	CY 2016	CY 2017	Percentage Point Difference	Statistical Significance Change From 2016 to 2017	DCH TARGET for CY 2017
Annual Dental Visits - Total	63.9%	66.1%	2.2%	Yes	N/A
Childhood Immunization Status - Combo 10	26.7%	30.4%	3.7%	No	32.64%
Immunizations for Adolescents - Combo 2	21.9%	31.9%	10.3%	Yes	19.21%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	73.3%	76.4%	3.1%	No	77.78%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	73.7%	73.5%	-0.2%	No	82.25%
Prenatal and Postpartum Care - Postpartum Care	61.1%	61.6%	0.5%	No	67.53%
Breast Cancer Screening	66.1%	64.6%	-1.5%	No	71.44%
Cervical Cancer Screening	66.2%	67.4%	1.2%	No	69.89%
Adult BMI Assessment	85.9%	77.6%	-8.3%	Yes	84.48%
Chlamydia Screening in Women - Total	62.6%	64.1%	1.5%	Yes	61.63%
Asthma Medication Ratio (Total)	72.4%	73.8%	1.4%	No	N/A
Medication Management for People With Asthma: Medication Compliance 75% (Total)	20.3%	26.4%	6.1%	Yes	N/A
Comprehensive Diabetes Care - Eye Exams	59.8%	57.3%	-2.5%	No	53.54%
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	46.8%	50.5%	3.8%	No	59.61%
Comprehensive Diabetes Care - HbA1c Control (<8%)	29.9%	35.4%	5.5%	No	46.72%

Comprehensive Diabetes Care - HbA1c testing	83.46%	84.85%	-1.37%	No	85.96%
Controlling High Blood Pressure - Total	37.8%	32.6%	-5.2%	No	54.80%
Antidepressant Medication Management - Continuation Phase	24.8%	27.7%	2.8%	No	38.06%
Follow Up After Hospitalization For Mental Illness - 7 days	50.7%	46.3%	-4.5%	Yes	55.18%
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment – Engagement (Total)	6.7%	9.1%	2.4%	Yes	9.71%
Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance	59.8%	57.8%	-2.0%	No	67.23%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	31.5%	25.3%	-6.2%	No	59.90%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	23.1%	22.2%	-0.9%	No	N/A
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	57.9%	56.9%	-1.0%	No	N/A
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	26.2%	28.2%	2.0%	No	N/A
Appropriate Testing for Children With Pharyngitis	83.9%	85.1%	1.1%	Yes	86.59%
Use of Imaging Studies for Low Back Pain	73.0%	70.3%	-2.8%	No	N/A
Appropriate Treatment for Children With Upper Respiratory Infection	87.2%	87.6%	0.4%	No	89.93%
Adolescent Well-Care	50.0%	54.0%	4.0%	No	57.66%
Well-child 15 months 6+ visit	63.7%	62.8%	-1.0%	No	67.76%
Well-child 34	72.8%	76.1%	3.3%	No	77.57%
Colorectal Screening	48.8%	49.3%	0.47%	No	50.93%

Responding to the Unique Needs of the Members

Adult Preventive Health Strategy

Adult Screenings

The measures that Peach State uses to monitor the effectiveness of preventive care initiatives and the care that its adult members receive are the Adult BMI Assessment (ABA) performance measures and Colorectal Screenings (COL).

Results:

- ABA: 2016 (85.88%) - vs 2017 (77.6%). Statistical difference
- COL: 2016 (48.84%) - vs 2017 (49.31%). No statistical difference

ABA did not meet the DCH target for 2017; COL did not either.

2017 Interventions and Activities***:***

- **Peach Pays Program:** In 2017, as a result of the information obtained during the MCAB and other member facing meetings, Peach State designed and received approval on the Peach pays Program. The Peach Pays Program is a healthy reward program that incentivizes certain members for completing healthy behaviors. The Peach Pays program includes an incentive for completion on an annual adult physical/well visit. Peach State believes that the more members that an increase in ABA rates will be attained with an increase of well visits. Further, additional education for providers about the importance of obtaining a BMI on members to address potential obesity is crucial to improving overall health of Peach State members. The Plan also shared that obtaining a BMI value can be conducted at 'well' or 'sick' visits.
    - Effectiveness: The original implementation date of Quarter 3, 2017 was modified as a result of the entrance of the fourth CMO, which lead to changes in membership location and a decrease in HEDIS eligible members (due to enrollment). The Peach Pays Program for ABA will be implemented in Q4, 2018.

- **USMM In-Home Mailed Tests**: During October 2017, Peach State enlisted the assistance of USMM- a vendor that provides home services such as health risk assessments (HRAs), BP and BMIs. The vendor mailed stool guaiac test cards which looks for hidden (occult) blood in a stool sample. It is the most common type of fecal occult blood test (FOBT) and can be used to ensure compliance with the COL measures.
    - Effectiveness:

	Total Kit Number Mailed	Kits Resulted	Completion %
FOBT	569	89	16%

This intervention will be conducted in 2018, starting earlier in the calendar year.

Proposed 2018 Interventions and Activities***:***

- The Plan will implement (Q3, 2018) the Peach Pays Program which includes incentives for adult members for obtaining certain preventive health services. The implementation will be piloted in the East and/or Southeast Georgia Families region to allow for the Plan to identify an issues/barriers and implement corrections prior to going statewide.

Women's Health

Preventive Care

The measures that Peach State uses to monitor the effectiveness of programs and interventions designed to improve the rates of women's health preventive care are Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS)).

Results:

- CCS: 2016 (66.19%) vs 2017 (67.4%). No statistical difference
- BCS: 2016 (66.12%) vs 2017 (64.6%) No statistical difference

The DCH targets for CCS and BCS were not met in 2017.

2017 Interventions and Activities

- **Peach Pays Program**: In 2017, as a result of the information obtained during the MCAB and other member facing meetings, Peach State designed and received approval on the Peach pays Program. The Peach Pays Program is a healthy reward program that incentivizes certain members for completing healthy behaviors. The Peach Pays program includes an incentive for completion on breast cancer and cervical cancer screenings.
    - Effectiveness: The original implementation date of Quarter 3, 2017 was modified as a result of the entrance of the fourth CMO, which lead to changes in membership location and a decrease in HEDIS eligible members (due to enrollment). The Plan will implement the Peach Pays Program which includes incentives for certain adult members to obtain their mammogram and cervical cancer screening in the fall of 2018. The implementation will be piloted in the East and/or Southeast Georgia Families region to allow for the Plan to identify an issues/barriers and implement corrections prior to going statewide.

- **Live Outbound Call Campaign**: Peach State called to encourage members to receive their breast cancer screening (mammogram) in October 2017. This month was selected as October is Breast Cancer Awareness month. There were 111 members called and six scheduled appointments to either see their PCP or to have a mammogram at a facility that does not require (MD) orders.
    - Effectiveness: All six members kept their appointments. In discussing reasons for non-compliance with members during the outbound calls, Plan staff compiled member responses to be used for barrier analysis and intervention planning. There were multiple and varied reasons given for non-compliance with the most common being unable to take off work and fear of the outcomes. Peach State shared this information with senior leaders and will implement interventions to address the identified barriers.

Proposed 2018 Interventions and Activities

To address member's desire to obtain screenings and the need for ongoing education on the importance of preventive screenings, Peach State will implement the following interventions/activities for CY 2018:

- Partner with American Cancer Society for
    - Collaborative education and joint outreach to members.
    - Mail collaterals/postcards based on DRAGG analysis findings

- Identify 'walk in' clinics in high member non-compliant areas. This will alleviate the need for members to take off work to first see their PCP then miss another day of work to have the mammogram.

Pregnancy

The measures that Peach State uses to monitor the effectiveness of programs developed to improve pregnancy outcomes are: Timeliness of Postpartum Care (PPC-Post) and Timeliness of Prenatal Care (PPC).

Results:

- PPC – prenatal: 2016 (73.7%) vs. 2017 (73.5%) - No statistical difference
- PPC-Post – postpartum: 2016 (61.07%) vs. 2017 (61.6%) - No statistical difference

Neither PPC prenatal nor postpartum met the DCH target for 2017.

The following table below shows the birth outcomes for Peach State members who delivered in 2017. Of note, babies delivered with a very low birth weight increased and babies delivered with a low birth weight decreased. Both changes were statistically significant.

All Peach State Deliveries Birth Weight Categories	2016	2017	% Change ↑↓	Statistical Significance
Normal Birth Weight	87.6%	87.6%	-	Not significant
Low Birth Weight	9.5%	2.9%	↓69.47%	Significant
Very Low Birth Weight	2.9%	9.8%	↑237.93%	Significant

2017 Interventions and Activities**:** We employed the interventions included in our Start Smart for Babies and High Risk OB Care Management programs to improve rates of PPC-Prenatal and PPC-Post-partum, and reduce the rate of LBW and VLBW deliveries. See the "Effectiveness of Care Management" section within this document.

- **Start Smart Baby Showers**: In 2017, Start Smart Baby Showers targeted the highly populated pregnancy regions of Atlanta, Central, and Southwest. The purpose of this targeted outreach was educating and identifying high risk pregnant women and enrolling them in the High Risk Case Management program. There were a total of 214 members who attended the Start Smart for your Baby Showers, all of whom were screened and received follow-up services.
    - Effectiveness: Of the 214 members who attended the baby showers:
        - Atlanta- 91% delivered healthy babies
        - Central - 67% delivered healthy babies
        - Southwest – 82% delivered healthy babies

- **17P- Program:** The 17-P program targeted pregnant mothers who have had a history of a previous preterm birth. The program was intended to improve birth outcomes by offering care coordination services that are aimed at preventing a preterm delivery. Peach State reflected a much higher success rate of healthy deliveries for members receiving 17-P. In 2017, there were 390 members enrolled in the 17-P program, this is a 4% decrease from 2016, in which, 406 were enrolled in the program.
    - Effectiveness: In 2017, the number babies born sick/hospitalized (25.6%) decreased by 3.4 percentage points from CY 2016 (29%) of delivery outcomes of delivery outcomes were healthy babies.

2018 Proposed Interventions:

- Peach State conducted a data drill down to determine the member demographic less likely to complete postpartum visits. The analysis revealed that members who were ≥37 weeks were at a higher risk for non-compliance. As a result of the analysis, Peach State will identify members who deliver at ≥37 gestational weeks and conduct telephonic outreach to encourage the importance of post-partum follow-up and to assist with scheduling appointment, if applicable.

- Start Smart Baby Shower events will be enhanced to be hosted throughout the state of Georgia to provide members with information on prenatal and post-delivery care. The Community Health Services Representatives will collaborate with community partners to assist with resolving social determinants of health by connecting members with local physicians, health departments, and community resources
- Peach State will continue to promote the Substance Abuse (Opioid) Program. This program targets members with a reported history of Opioid use in an effort to reduce the number of babies delivered prematurely, with neonatal withdrawal symptoms and/or born with low birth weight (LBW) or very low birth weight (VLBW). Peach State recognized the difficulty in engaging members with possible opioid and will continue outreach efforts in 2018. Efforts will be enriched to include early identification of members at risk based on information received from the public health departments OB assessments and Peach State Health Notification of Pregnancy (NOP).

Adults with Chronic Conditions

Common Adult Conditions

The conditions that are most prevalent in Peach State's adult population include the following:

- Diabetes
- Mental Health

***Diabetes*:**

As of December 2017, Peach State Health Plan served 2,343 members identified with Primary Risk Category of diabetes, 28.08% children and 71.92% adults. Of the adult members, 66.94% are African American, 14.88% are male and 85.52% are female. The measures that Peach State uses to monitor the effectiveness of programs and interventions designed to improve rates of diabetes care are the Comprehensive Diabetes Care (CDC) sub-measures listed below.

Results:

- HbA1c Testing: 2016 (83.48%) vs. 2017 (84.85%) - No statistical difference
- Good Control - <8: 2016 (29.9%%) vs. 2017 (35.4%)- No statistical difference
- Eye Exam: 2016 (59.83%) vs. 2017 (57.3%) - No statistical difference
- BP <140/90: 2016 (46.8%) vs. 2017 (50.5%)– Statistical significant decrease

There were no sub-measures that met the DCH target for 2017.

2017 Interventions and Actions**:**

For additional information about the Diabetes DM program, please refer to the sections: "Overall DM Program Highlights" and "Diabetes DM Highlights" within this document.

- **Diabetes Day Partnership in the Southwest**: In Q4, 2017, Peach State's Community Medical Director, Certified Diabetic Educator, Provider Specialist and Community Relations Specialist worked with a large FQHC in southwest Georgia to host a Diabetes Day. The Diabetes Day targeted 30 members who were non-compliant for HbA1c testing, diabetic eye exams and nephropathy screenings and invited them to the FQHC to have needed services completed. PS staff was present to provide information, gift cards and assistance and education about compliance with care, including timely HbA1c, retinal eye exams ,physicals, and medications and nutrition and physical activity information.
    - Effectiveness: Below is a summary of outcomes:
        - 10 members kept their appointment (33% of invitees) and shared that the education and information was beneficial

- Peach State created a repeatable template for future events that focus on chronic condition gap closer. The process will be offered to this and many other clinical sites
- The clinic was so pleased that they agreed to work with the Plan to perform monthly gap closure events.

- **USMM In-Home Mailings:** During October 2017, Peach State enlisted the assistance of USMM- a vendor that provides home services such as health risk assessments (HRAs), BP and BMIs. The vendor mailed in-home HbA1c and urine specimen collection kits to members who were non-compliant for testing and monitoring for nephropathy.
  - Effectiveness

	Total Kit Number Mailed	Kits Resulted	Completion %
HbA1C	525	67	13%
Micro albumin	355	48	14%

This intervention will be conducted again, starting earlier in the calendar year.

- **Peach Pays Program**: In 2017, as a result of the information obtained during the MCAB and other member facing meetings, Peach State designed and received approval on the Peach pays Program. The Peach Pays Program is a healthy reward program that incentivizes certain members for completing healthy behaviors. The Peach Pays program includes an incentive for members to encourage them to obtain their HbA1c and to maintain an HbA1c result lower than 9.

  - Effectiveness: The original implementation date of Quarter 3, 2017 was modified as a result of the entrance of the fourth CMO, which lead to changes in membership location and a decrease in HEDIS eligible members (due to enrollment). The Peach Pays Program for Diabetic members will be implemented in the Q3, 2018.

- **Medication Therapy Management (MTM) Program**: In CY 2017, the Medication Therapy Management (MTM) program was continued. The MTM outreach coordinators accessed medication claims system to identify members who were five or more days late picking up their medications. The coordinators performed outreach calls to each member based on the real time pharmacy data to encourage them to pick up their medication and explain the importance of medication adherence in reaching diabetes control goals.

  - Effectiveness: There were a total of 4,436 calls to diabetic members. The medication refill rate after the calls was 33%. This was short of the program goal of 40%. Although the goal was not achieved, the program was determined to be needed in efforts to assist members with establishing and maintaining lower HbA1c levels. The program will continue

CY 2018 Proposed Activities:

- The MTM Program will include evaluation metrics listed below to better determine the efficacy of the MTM program. Below are metrics that have been considered.
  - The number of members who picked up their medications within 72 hours, 7 days and 14 days of the calls
  - The number of members who picked up their medication the month of the call and did not pick it up the following month
  - The number of members who were called had HbA1c levels of greater than 9%.

- Peach State Health Plan will conduct a formal focus group to assist with further determine barriers to diabetic members controlling their disease state. Once the barriers are identified, the Plan's multidisciplinary, interdepartmental Performance Outcome Steering Committee (POSC) will review the findings. The POSC is Peach State's forum for discussion and delegation of responsibilities to improve outcomes. The Committee will assist with identifying and implementing thought out and innovative initiatives that will impact and improve outcomes. The formal focus groups are scheduled to be conducted in late summer 2018.

Mental Health

Peach State had 2,370 adult members with a mental health diagnosis (Depression, Bipolar, and Mood Disorders) as of December 2017. Of those, approximately 40.04% of members with mental health diagnoses were Black or African American, 56.33% were White, 2.07% were Other Race and 0.80% were Asian. The percentage of members who identified with Latino/Hispanic ethnicity was 3.38%. With regard to gender, 21.05% were male and 78.95% were female. Regionally, members with a mental health diagnosis reside in the following regions: Atlanta 44.35% North 4.43%, East 1.39%, Southwest 28.27%, Southeast 2.49%, and Central 18.82%.

The measures that Peach State uses to monitor the effectiveness of behavioral health related programs and interventions are: Follow-Up after Hospitalization for Mental Illness- 7 day (FUH), Antidepressant Medication Management- continuation (AMM), and Adherence to antipsychotics for individuals with schizophrenia (SAA)

Results:

- FUH – 7: 2016 (50.75%) vs. 2017 (46.3%)- Statistical significant decrease
- AMM – continuation: 2016 (24.84%) vs. 2017 (27.7%) - No statistical difference
- SAA: 2016 (31.53%) vs. 2017 (25.3%) - No statistical difference

Peach State did not met the DCH targets for any of the measures in 2017.

Behavioral Health Care Management Program. Peach State's Behavioral Health Care Management Program supports all of its behavioral health clinical efforts and initiatives. Psychiatric inpatient utilization represents the highest need and acuity in the behavioral health continuum. All members accessing that level of care are automatically outreached for care management. There are many instances when an in-person CM services are needed in order to engage members in outpatient BH providers with whom they might have been treated prior to the hospitalization. This provides an opportunity to engage members in CM and strengthen their ability to self-manage and maintain compliance, in order to improve outcomes. Additional information can be found in the "Effectiveness of CM Program" section.

Follow-up after Mental Health Hospitalization 7/30 Day

For members to regain full recovery after an Inpatient Mental Health stay, following up with a mental health provider within 7 or 30 days of discharge is vital. Peach State understands the importance of discharge planning to ensure members follow up with a mental health provider after discharge which is critical in decreasing readmission rates. Additional information can be found in the "Effectiveness of CM Program" section.

2017 Interventions: In 2017, all members hospitalized in a psychiatric hospital received telephonic outreach from Behavioral Health (BH) Case Management (CM) to assist with coordinating transition to a lower level of care. BH utilization managers referred all members who were admitted to a mental health hospital to BH CM. The BH Care Coordinator received admission notices and contacted the hospital's social services staff to assist in coordinating outpatient services with the member's PCP and/or treating provider. Within 3 days of discharge,

the BH Care Coordinator attempted to contact the member/family/guardian to assess their discharge needs and ensure a meaningful outpatient appointment was scheduled or kept. If the BH Care Coordinator was unable to initially contact the member/family/guardian, they outreached a second time (within 10 days after hospitalization) to ensure the member scheduled and/or a follow-up appointment and referred the member to case management if needed. Members who consented, were engaged with BH CM who addressed their needs beyond discharge planning.

- Effectiveness: Peach State Health Plan outreached to 100% of members who were admitted to a mental health hospital

2018 Proposed Interventions

- Interventions implemented to improve mental health outcomes and performance measure rates were not impactful. In 2018, EPC will complete the full integration of Cenpatico Behavioral Health, LLC, an NCQA accredited managed Behavioral Health organization into Peach State Health Plan. This will provide a high level and seamless physical and Behavioral Health service integration through co-location of staff and shared systems and platforms. EPC will work with Peach State to implement behavioral health homes which may have a positive impact on mental health/behavioral health follow up and outcomes for members.
- In an effort to increase the number of members who follow up within seven days after discharge from a mental health facility, the Plan has selected this topic as an official 2018-2019 performance improvement project (PIP). Peach State will work with Peachford (Mental Health) Hospital to pilot interventions that if successful, can both sustained by Peachford Hospital and be implemented throughout the entire network.

Antidepressant Medication Management

Research has shown up to 68% of patients diagnosed with depression discontinue their antidepressant medications by three months.[1] Failure to adhere to antidepressant medication is one of the leading causes of relapse and recurrence. [2] It is important that providers discuss the importance of antidepressant medicine for successful treatment, schedule follow-up appointments with patients and assist with identification of barriers to medication adherence Through research, member and provider feedback, the Plan determined that common barriers to medication adherence include:

- Fears or concerns about treatment, including side effects
- Feeling medication is not needed once symptoms have subsided
- Not understanding how antidepressants work (e.g., they are not addictive)
- Logistical, economic or cultural barriers

Peach State care managers track members from their initial prescription fill for an antidepressant medication through the 6 months. Additional information can be found in the “Effectiveness of CM Program” section.

2017 Interventions:

Members with depression were identified and received outreach from a Peach State Depression Disease Management program manager. Members enrolled in the Depression Diseases Management Program receive education on the importance of medication adherence in treating depression and were coached on self-management techniques designed to achieved recovery and wellness. Members enrolled in the Depression Disease Management Program that required support with care planning were referred to the BH Care Management Program for more intensive support with reduction of barriers to adherence with their treatment plan.

- Effectiveness: Peach State recognized the opportunity to measure the effectiveness of the Depression Disease Management Program and will establish metrics in CY 2018.

Proposed 2018 Interventions and Activities

- Peach State will determine measures of effectiveness for the Depression Disease Management Program

Children's Health

Approximately 83.40% of the 2017 membership (as reported in December 2017) was 20 years of age or younger. Approximately 50.20% of Peach State members aged 20 years and under were female and approximately 49.80% were male members. Of all Peach State members who were ages 20 years or younger: 55.83 % were Black or African American, 35.51% were White, 5.50% were 'unknown' and 2.91% were Asian. There were 92.58% of members 20 years of age or younger whose ethnicity was reported as Non-Latino/Hispanic; 7.30% reported Latino/Hispanic and 0.12% had an unknown ethnicity. There were 77.36% of members aged 20 years or younger who were considered healthy

Peach State's EPSDT Program is designed to ensure that members access the comprehensive preventive care benefits available. This benefit is designed to assist with the identification and early diagnosis and treatment of conditions which, if undetected, could result in serious illness and/or costly care. The EPS part of the EPSDT benefit provides preventive health screenings that include well visits, immunizations, lead testing, developmental screenings, obesity prevention and preventive dental care. Peach State used nine performance measures to evaluate the quality of care related to children's health.

Results:

Measure Name	CY 2016	CY 2017	Percentage Point Difference	Statistical Significance Change From 2016 to 2017	DCH TARGET for CY 2017
Annual Dental Visits - Total	63.9%	66.1%	2.2%	Yes	N/A
Childhood Immunization Status - Combo 10	26.7%	30.4%	3.7%	No	32.64%
Immunizations for Adolescents - Combo 2	21.9%	31.9%	10.3%	Yes	19.21%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	73.3%	76.4%	3.1%	No	77.78%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutritional Counseling (Total)	68.27%	73.95%	5.68%	No	70.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents –	57.93%	63.52%	5.59%	No	63.47%

Physical Activity Counseling (Total)					
Adolescent Well-Care	50.0%	54.0%	4.0%	No	57.66%
Well-child 15 months 6+ visit	63.7%	62.8%	-1.0%	No	67.76%
Well-child 34	72.8%	76.1%	3.3%	No	77.57%

Of the nine performance measure rates used to evaluate quality of care for children's preventive health:

- 2 measures experienced a statistically significant increase from 2016 to 2017
- 0 measures experienced a statistically significant decrease from 2016 to 2017
- 8 showed an increase in rate from 2016 to 2017
- 1 showed a decrease in rate from 2016 to 2017

In addition to the nine performance measure rates, Peach State also utilizes the CMS-416 screening rate and sealant rate to assess health outcomes of the childhood population. The Combined Medicaid and PCK members CMS-416 screening rate in 2015 was 67%, in 2016 it was 71% and in 2017 it was 73%. The rate demonstrated a statistical significant increase, however it did not meet the DCH target (80%).

In an effort to improve performance measure rates, increase the CMS -416 screening rate and improve overall outcomes for children, Peach state conducted many initiatives in 2017. The initiatives and outcomes are shared in this section.

Preventive Visit Disparities*:* Peach State continued to identify health care disparities and differences in compliance in an effort to appropriately address issues and improve outcomes for all enrolled children. The following information identified significant differences in compliance based on, region, age, race/ethnicity and gender as well as initiatives to address each disparity.

- **Region Focused.**
  Peach State monitored monthly administrative performance measure rates. This monitoring noted that the Southeastern Georgia Families region had lower compliance rates for HEDIS well visits than any other region in Georgia. The Plan's EPSDT staff spoke with members during Peach State Days, health fairs and other in-person events and learned that members believed that practitioners were requesting unnecessary visits and that there was no medical reason to make/keep well visit appointments. Peach State determined that Plan education may supplement practitioner efforts in getting members to obtain well visits and sent 1,162 mailers to non-compliant members in the Southeast Region encouraging them to receive their preventive health visit for a nominal incentive.
    - Effectiveness: One hundred eight members (9.3%) completed their preventive health visit within 90 days of the email.

- Peach State Health Plan EPSDT Coordinators' partnered with Albany Middle School located in Albany, GA (Southwest Region) to complete a community health fair entitled "Girl Talk". There were 199 pre-teen and teenage girls present at this event. The topics of discussion were body image and self-esteem, preventive health visits, puberty, peer pressure and bullying. The Peach State Health Plan EPSDT Coordinators' provided information to all girls on the importance of getting their preventive health visits even if they don't feel ill. The EPSDT Coordinators' provided bags at the end of the event with a fidget spinner, Off the Chain book w/parent guide and an EPSDT (Health Check) brochure. The young ladies were

also given a Peach State Health Plan EPSDT Coordinator business card to take to their parents and were instructed to have their parents call for more important information.

- Effectiveness: There were ten parents who called back to schedule an appointment. All ten members completed their preventive health visit with their primary care doctor.

2017 Interventions

Peach State has continuously analyzed the data and discussed ways to engage, educate and involve members and providers in identifying barriers to care and exploring opportunities to address those barriers. In addition to the interventions included in the Preventive Visit Disparities section, the below interventions were implemented in CY 2017.

- **School Partnership**: Peach State Health Plan partnered with Southside Medical Center (FQHC) which has a school base clinic located at Dobbs Elementary School in Fulton County. Dobbs Elementary is a Title I school meaning that most members are the school received free or reduced lunch and would likely qualify/be enrolled in Georgia Families. By partnering with this school base clinic Peach State Health Plan gained access to schedule non-compliant members for their annual well-child visit. The EPSDT coordinator was able to call members and schedule their appointments at the clinic during school hours where the child didn't have to miss school. Parents that were contacted were very happy to utilize the clinic.
  - Effectiveness: The EPSDT Coordinator called 401 members, 69 appointments were scheduled, 31 completed their scheduled appointment and received a $25 dollar incentive, 25 scheduled without any assistance and 3 completed the appointment and did not call in to receive their incentive. Peach State Health Plan will continue to work with this school base clinic in 2019.

- **General Dental Education:** The Peach State Health Plan's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) team collaborated with the Help a Child to Smile Mobile Dental Program and Decatur Pediatrics to provide preventive health services and dental check-ups for the community of Clarkston, Georgia. Peach State Health Plan invited all non-complaint members assigned to the Decatur Pediatrics facility who were due for a well-child visit and/or a dental check-up to attend the event.
  - Effectiveness: There were 140 people in attendance; 28 were Peach State Health Plan members. The Peach State Health Plan members who attended completed the required service and were entered into a raffle to receive a 32 inch flat screen television. This was a great event for Peach State Health Plan as well as Decatur Pediatrics. Peach State Health Plan did not receive any calls from the parents to assist in scheduling a dental appointment.

- **Partnership to Provide Dental Screenings/Cleanings:** Peach State Health Plan partnered with the Oak Hurst Medical Center for a Dental Day. The purpose of the Dental Day was to provide preventive dental services to Plan members who were ages 5-20 years old. The EPSDT Coordinator called members who were assigned to Oak Hurst Medical Center and who were non-compliant for preventive dental services and to assist in scheduling an appointment. The coordinator called 75 members and offered an incentive to members who attended the Dental Day and completed services.
  - Effectiveness: Twelve (12) Peach State Health Plan children received dental cleanings during the dental day.

Proposed 2018 Interventions and Activities

Barriers identified through EPSDT events and activities include (but are not limited to):

- Lack of importance and understanding of what constitutes a comprehensive a preventive care (well visit)
- Lack of school requirements/school involvement in education about the importance of preventive care
- Convenience/lack of provider flexibility

Peach State proposes implementing the below initiatives/activities to increase compliance and address the above barriers:

- **Member Engagement:** Peach State Health Plan will work with providers to assist with scheduling appointments for non-complaint members as well as members who don't utilize their benefits provided by the health Plan.
- **Children 0 to 21 years old**: Peach Pays Program – To improve outcomes, Peach State will implement the DCH approved healthy reward program, Peach Pays that provides incentives for completion of well child visits.
- Peach State Health Plan will identify practitioner offices who have the highest number of noncompliant members:
    - Mail letters to those members under the provider's name encouraging the member to schedule an appointment
    - Implement a pilot program in East and Southeast regions in which a Plan EPSDT Coordinator will contact members from their provider's office and assist with scheduling appointments.
- **Provider Engagement:** Peach State understands the importance of provider engagement and assistance with encouraging members to schedule and keep preventive screening/visit appointments. The plan will continue education, P4P programs, web based tools such as care gap reports in addition to the initiatives below for CY 2018:
    - Partner with PCP offices and offer incentives for extended and after-hours coverage to improve access and reduce the Non-emergent ER utilization.
- **Improving Dental Visits**: Peach State Health Plan will outreach to members/caregivers to remind them of the importance of dental care.
    - Implement POM calls to remind members of the importance of dental visits
    - Partner with a FQHC that performs dental services to hold a "Dental Day" in which non-compliant members are called by the Plan or FQHC and invited to have the service completed.

Common Conditions in Children

The percentage of children with chronic health conditions is on the rise, and new research being presented at the Pediatric Academic Societies 2016 Meeting shows this is especially true among children who live in or near poverty. The study found more significant increases in asthma and Attention Deficit Hyperactivity Disorder (ADHD) among children living in poverty, as compared to their wealthier counterparts. Poor children with these conditions also were more likely to have two or more additional diseases. Those living in extreme poverty who had asthma and ADHD, for example, were roughly twice as likely to have at least one other chronic medical

condition. Some of the more common co-existing conditions included developmental delays, autism, depression or anxiety, behavioral or conduct issues, speech and language problems, epilepsy/seizure disorders and learning disabilities. Among children who had public health insurance, significant increases were seen among all the chronic diseases studied. This section will include information on Asthma and Mental/Behavioral Health Conditions.

Asthma and ADHD

Peach State had 39286 members identified with Asthma as a Primary Risk Category as of December 2017. These members were majority male (52.08%), Black or African American (60.99%), aged 20 and younger (95.29%), and residing in the Atlanta Region (58.36%).

As of December 2017, Peach State had approximately 9193 children identified with ADHD. This assessment uses the child psychiatric disorders Primary Risk Category of the Major Primary Risk Category of BH/MH/SA. Due to insufficient identification using the major risk categories, Peach State used the Quality Spectrum Insight (QSI) HEDIS measure which indicated that as of December 2016, Peach State has approximately 2937 children identified with ADHD. Of these members, approximately 37.32% of the children were White, 59.75% Black or African American, 0.24% Asian and 2.62% percent all other races. With regard to gender, 69.02% were male and 30.98% were female. Regionally, children reside in the Atlanta Region (38.95%), Southwest Region (41.37%), Central Region (16.44%), North Region (1.40%), Southeast Region (0.85%) and the East Region (0.89%).

Peach State used the Medication Management for People with Asthma 5-11 years old –75% and 12-18 years old – and 75% (MMA) to assess the health status of asthmatics. The follow-up care for children prescribed ADHD medication through the initiation and continuation phases were used to monitor ADHD. Refer to the CM

Results:

- MMA 5-11 yrs. - 75%: 2016 (20.28%) vs. 2017 (26.60%) – Statistical increase
- MMA Total -75%: 2016 (20.3%) vs. 2017 (26.4%) – Statistical increase
- ADD – Initiation: 2016 (45.69%) vs. 2017 (45.48%) - No statistical difference
- ADD – Continuation: 2016 (59.84%) vs. 2017 (57.8%) - No statistical difference

There was a statistically significant increase in the MMA performance measure rates when comparing 2016 to 2017. The ADD rates showed no statistical difference when comparing 2016 to 2017. Only the Asthma medication management rates for 5-11 year olds (75%) met the DCH target.

2017 Interventions

Numerous interventions were in place in 2017. In addition to those listed below, a detailed description of the interventions is included in the section “Asthma DM Highlights.”

- **Asthma PIP**: In CY 2017, Peach State in collaboration with WellCare of Georgia, conducted an Asthma PIP. There were 124 members that received a home visit and education, 55 (45.08%) of these members obtained their asthma controller medication after the home visit and education was completed. Although successful for those who participated, the Plans determined that this intervention is not sustainable as it is very resource and time intensive. Modifications and the incorporation of stratification criteria to this intervention was identified as methods to ensure sustainability of the intervention. For additional information on the outcome of the Collaborative Asthma PIP, see ‘2017 PIP Summary and Report’ section of this Evaluation.

- **Medication Therapy Management:** In a targeted approach, Peach State contacted members that were 5 days late in filling their asthma controller medications. Each call to the member was verified by a real time pharmacy claims review to confirm if the member did, in fact, pick up their controller medication.
    - Effectiveness: There were 8,817 unique calls conducted in 2017 and 3,056 controller medications filled after the outreach (35%). The Plan will continue this intervention in 2018.

Proposed 2018 Interventions and Activities

To address continued difficulty with increasing the number of members newly diagnosed with ADHD who return for initial and continuation follow up visits and to improve Asthma outcomes, Peach State will implement the following initiatives.

- Peach State will implement 14 day initial fill on ADHD medication to encourage members to schedule and keep a follow up visit within 30 days.
- The Plan will continue education on ADHD and Asthma CPGs. The Plan will continue to issue corrective action plans for providers who do not meet minimum standards of use.
- Peach State will continue the Asthma MTM program.
- Please see the “Asthma DM Highlights” for further interventions.

Effective Member Communication Strategies

Member Satisfaction - CAHPS® Scores

Peach State utilizes the results of the national CAHPS survey to obtain information regarding a member's perception of their care which includes assessing the quality of their interactions with their doctors, hospitals and their health plan. In 2017, Morpace, a National Committee for Quality Assurance (NCQA) certified HEDIS Survey Vendor, was selected by Peach State Health Plan to conduct its 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Medicaid Adult and Child Member Experience Surveys.

- Child CAHPS Methodology: The sample size was 3003. Morpace collected 770 valid surveys (293 Mail, 428 Telephone and 49 Internet) from the eligible member population. After adjusting for ineligible surveys, Peach State's survey response rate was 26%. The survey was conducted in Spanish for non-English-speaking members. The total number of completed surveys in Spanish was 48.
- Adult CAHPS Methodology: The sample size was 2727. Morpace collected 429 valid surveys (175 Mail, 219 Telephone and 35 Internet) from the eligible member population which resulted in a 16% response rate after adjusting for ineligible surveys. The survey was also conducted in Spanish for non-English-speaking members with 0 surveys completed in Spanish.

The tables below display the summary rate results for overall ratings measures, composites (collections of the results of several questions) and attributes (results of individual questions) on the 2017 Child and Adult CAHPS Surveys, compared to the 2016 Child and Adult CAHPS Surveys and the Health Plan's Quality Compass percentile ranking as compared to 2016 Quality Compass.

Child CAHPS

Child CAHPS 5.0H	2017 (770 Total Respondents)		2016 (599 Total Respondents)	
Composites, Attributes and Key Questions	**Percentile**	**Rate**	**Percentile**	**Rate**
Getting Needed Care	47th	83.90%	41st	83.60%
Q14. Ease of getting care, tests or treatment child needed		90.42%		89.90%
Q28. Obtained child's appointment with specialist as soon as needed		77.38%		77.40%
Getting Care Quickly	66th	90.89%	33rd	87.50%
Q4. Child obtained needed care right away		91.91%		88.50%
Q6. Child obtained appointment for care as soon as needed		89.88%		86.50%
How Well Doctors Communicate	36th	92.63%	37th	92.40%

Child CAHPS 5.0H	2017 (770 Total Respondents)		2016 (599 Total Respondents)	
Composites, Attributes and Key Questions	**Percentile**	**Rate**	**Percentile**	**Rate**
Q17. Child's doctors explained things in an understandable way		92.64%		92.60%
Q18. Child's doctors listened carefully to you		94.39%		95.60%
Q19. Child's doctors showed respect for what you had to say		95.09%		96.80%
Q20. Child's doctors spent enough time with you		88.42%		84.70%
Customer Service	83rd	90.57%	47th	88.70%
Q31. Getting information/help from customer service		85.52%		83.90%
Q32. Treated with courtesy and respect by customer service staff		95.62%		93.40%
Shared Decision Making	13th	74.33%	32nd	76.90%
Q10. Doctor/health provider talked about reasons you might want your child to take a medicine		92.35%		90.80%
Q11. Doctor/health provider talked about reasons you might not want your child to take a medicine		54.59%		60.00%
Q12. Doctor/health provider asked you what you thought was best for your child when talking about starting or stopping a prescription medicine		76.04%		79.80%
Health Promotion and Education (Q8)	66th	72.34%	52nd	69.70%
Coordination of Care (Q22)	39th	81.78%		83.30%
Overall Rating Measures (Rating 8, 9 and 10)				
Rating of Health Care (Q13)	80th	88.63%	72nd	87.90%
Rating of Personal Doctor (Q23)	69th	89.96%	80th	90.70%
Rating of Specialist (Q27)	38th	84.67%	50th	85.50%
Rating of Health Plan (Q35)	89th	90.29%	50th	88.50%

Key Driver analysis is conducted to understand the impact that different aspects of provider care and plan service have on member's overall experience with their health plan, their personal doctor, their specialist and health care in general and helps to identify high opportunities for improvement. Getting Needed Care and Care Coordination are the measures that highly correlate with the member's overall health plan experience for the Child CAHPS Survey.

Peach State looks to take actions to improve items that are highly correlated to the overall measure and /or currently rate low when compared to the national average. Shared Decision Making is the only measure that falls below the 25th percentile on the Child CAHPS survey.

Highlights from the 2017 Child CAHPS survey results include:

- Customer Service, Rating of Health Care and Rating of Health Plan increased year over year; all scoring at or above the 80th percentile; Health Promotion and Education and Getting Care Quickly also increased and scored at the 66th percentile.
- Shared Decision Making, Care Coordination, Rating of Personal Doctor and Rating of Specialist, all scored lower than in 2016.
- Rating of Specialist and Shared Decision making fell at or below the 38th percentile.

There was no statistically significant difference between the 2016 and 2017 rates for any of these results.

Adult CAHPS

Adult CAHPS 5.0	2017 (429 Total Respondents)		2016 (303 Total Respondents)	
Composites, Attributes and Key Questions	**Percentile***	**Rate**	**Percentile***	**Rate**
Getting Needed Care	32nd	79.17%	46th	80.80%
Q14. Ease of getting care, tests or treatment needed		79.94%		84.50%
Q25. Obtained appointment with specialist as soon as needed		78.41%		76.50%
Getting Care Quickly	67th	82.68%	21st	77.30%
Q4. Obtained needed care right away		83.77%		78.60%
Q6. Obtained appointment for care as soon as needed		81.60%		76.00%
How Well Doctors Communicate	78th	92.57%	30th	89.80%
Q17. Doctors explained things in an understandable way		92.58%		91.90%
Q18. Doctors listened carefully to you		92.97%		89.00%
Q19. Doctors showed respect for what you had to say		94.12%		90.70%
Q20. Doctors spent enough time with you		90.63%		87.80%
Customer Service	39nd	86.93%	73rd	89.20%
Q31. Getting information/help from customer service		81.25%		82.80%
Q32. Treated with courtesy and respect by customer service staff		92.61%		95.60%
Shared Decision Making	31st	78.04%	18th	75.80%
Q10. Doctor/health provider talked about reasons you might want to take a medicine		93.71%		92.00%
Q11. Doctor/health provider talked about reasons you might not want to take a medicine		66.86%		62.50%

Adult CAHPS 5.0	2017 (429 Total Respondents)		2016 (303 Total Respondents)	
Composites, Attributes and Key Questions	**Percentile***	**Rate**	**Percentile***	**Rate**
Q12. Doctor/health provider asked you what you thought was best when talking about starting or stopping a prescription medicine		73.56%		72.70%
Health Promotion and Education (Q8)	72nd	74.62%	11th	66.30%
Care Coordination (Q22)	15th	78.06%	<10th	73.90%
Overall Rating Measures (Rating 8, 9 and 10)				
Rating of Health Care (Q13)	66th	75.61%	84th	77.60%
Rating of Personal Doctor (Q23)	87th	84.09%	36th	79.10%
Rating of Specialist (Q27)	26th	78.31%	25th	78.90%
Rating of Health Plan (Q35)	70th	78.04%	54th	75.70%

The Key Drivers which correlate highly with Overall Rating of Health Plan for the Adult CAHPS includes Getting Needed Care and Customer Service. Care Coordination and Rating of Specialist scored at or below the 26th percentile.
Highlights from the 2017 Adult CAHPS survey results included:

- Getting Care Quickly, Shared Decision Making, Care Coordination, How well Doctors Communicate, Health Promotion and Education, Rating of Personal Doctor and Rating of Health Plan increased year over year; all scoring at or above the 80th percentile except for Shared Decision Making (31st) and Care Coordination (15th) percentile
- Getting Needed Care, Customer Service and Rating of Health Care decreased in 2017, although not significantly
- Getting Needed Care, Customer Service, Shared Decision Making, Care Coordination and Rating of Specialist all fell at or below the 39th percentile.
- There was a statistically significant increase between the 2017 and 2016 rate for Health Promotion and Education.

Member Experience and Provider Satisfaction Workgroup Improvement Activities

Peach State analyzed both composites and individual scores to identify the most meaningful opportunities for improvement. Peach State also assessed member satisfaction by monitoring member grievance and appeals data and through targeted surveys to determine satisfaction with specific programs and/or services such as Care Management, Disease Management, and specific activities such as Baby Shower events that provided health education and risk screening to pregnant members. Peach State's Member Experience and Provider Satisfaction Workgroup reviewed the results of all surveys and member satisfaction-related data and developed initiatives and actions to improve key areas, which correlate to overall member experience.

In 2017, Peach State implemented numerous initiatives to improve the member's experience Peach State enhanced the Personal Advocate program statewide by increasing dedicated resources providing a concierge approach to resolving complex member inquiries and assisting with PCP selection, addressing Getting Needed Care which was identified as an opportunity for

improvement for both the Adult and Child CAHPS surveys. This initiative helped in improving the member's experience within the first 90 days of enrollment. Additional initiatives are included in the table below

2017 CAHPS Initiatives

Intervention	Satisfaction Area Addressed	Implementation Dates
Educate members and providers on identifying in network providers through written materials. At the end of 2017 we identified a 13% decrease in SCA's.	Providers/provider staff are referring members to practitioners or providers that are out of network (laboratories/facilities). Members are unaware of their cost share associated with using out of network providers	Q2 2017
Identify and contract with additional urologists and internal medicine physicians. In 2017, we contracted with the largest urology group in Chatham county.	Lack of urologist and internal medicine providers in Chatham County.	Q3 2017
Mobile App: New Mobile app scheduled to launch at the beginning of Q4 2017. The app will allow members to access information regarding coverage to include contact information for the PCP and the ability to locate other providers and specialist from their mobile device	Got care as soon as needed when care was needed right away	Q4 2017
Implement a concierge approach to resolving complex member inquiries, with increased dedicated resources. These members are assigned to Personal Advocated for Care (PAC) for 90 days to address any questions or concerns	Customer service provided information or help	Q1 2017

In 2017, Peach State also focused on improving customer service, interventions included:

- Re-launched year-round "Providing a Personal Touch on Every Call" training campaign for CSRs to provide personalized service on every call.
- Implemented the Personal Advocate for Care program to provided concierge level customer service to new members for the first 90 days.
  - 125,574 new members were contacted in 2017 in efforts to provide Personal Advocate for Care services.
- Re-launched after Call Survey that is offered to every member at the end of a call to solicit real time feedback and gage members experience with CSR.
  - Based on the after call survey question "Was the team member able to address and resolve your issue" 93% of the members surveyed responded favorably "Yes"
- Enhanced our appointment scheduling process for CSRs that enabled them to more easily offer members assistance with scheduling appointments for needed services.
  - In 2017, 1011 appointments were scheduled for Members via the MyHealthDirect scheduling tool.

Member Communication Activities to Improve Satisfaction

Member engagement through ongoing communication, in the manner preferred by members, is at the heart of Peach State's outreach and communication strategy to improve members' experience with their care and the health plan. Peach State has implemented a variety of customer service, outreach, education and communication initiatives designed to assist its members with understanding their benefits, accessing care and preventive services, engaging in healthy behaviors, and achieving improved health outcomes. An educated and engaged

member is more likely to understand and appropriately utilize services which will improve health outcomes, and will be a satisfied member.

Peach State staff are trained to provide helpful, accurate information during every interaction so that members receive the right information at the right time. Consistent with Peach State's goal of meeting the members where they are, Peach State sponsored, offered and/or participated in a wide range of community outreach and education events in 2017 to communicate with members in their communities. Examples include:

***2017 Initiatives and Activities*:**

- The Member Connections Department transitioned its role into the Community Health Services Department. As a part of this transition, the staff received over 200 hours of course study obtaining a Community Health Worker certification. This transition will allow the Community Health Services Department to continue to work collaboratively with the Care Managers utilizing a holistic approach that addresses the full range of the member's needs. While the Community Health Services Department continues to outreach too hard to reach members; more emphasis was placed on outcomes such as the reduction of use of emergency services, increase in pre-natal service delivery, better health screen compliance rates, and the reduction in care gaps.
    - Effectiveness/Event Highlights: During 2017, the Community Health Services Department were able to meet face to face with a total of 2,938 members who were unable to be contacted by their Care Manager. This yielded a 70% success rate at reaching high risk, hard to reach members through face-to-face outreach interventions.

- Healthy Lifestyle Events: The Community Health Services Department conducted a total of 12 Healthy Lifestyle Events throughout the state of Georgia in 2017. The Healthy Lifestyle Events consisted of helping members to improve their health and wellness by providing community education and activities at local health departments, recreation centers, and FQHC's. There were a total of 71 members who attended the events.
    - Effectiveness/Event Highlights: In February, to bring awareness to Heart Disease, the Community Health Services Department hosted the event, "Canvas to My Heart" to recognize and educate members with heart conditions on ways to reduce stress that included painting a canvas picture, while also receiving beneficial information to aid with an overall healthy lifestyle. There was a total of 25 members who attended this event.

- Baby Showers: The Community Health Services Department hosted a total of 7 baby showers in 2017. The Start Smart Baby Showers targeted the highly populated pregnancy regions (Atlanta, Central, Southwest) with the purpose of educating high risk pregnant women and enrolling them into the plan's High Risk Case Management Program. There were 214 members who attended the Start Smart Baby Showers.
    - Effectiveness/Event Highlights: The Community Services Department is committed to the overall health of its members and understands that a myriad of interventions must be utilized to target those members in high-risk regions and/or populations. As a result, during flu season a "Gift of Love" baby shower was hosted in the Southwest region to focus on increasing flu vaccinations and preventing hospitalization of expectant mothers due to the influenza epidemic. The Community Services Department partnered with the local Walgreens Pharmacy to offer free influenza

vaccinations on-site to members and their family members. The members were also educated on prenatal care, the sign and symptoms of preterm delivery, the stages of development with newborns, and the importance of follow-up care. During this event, 58% of the members who attended the baby shower received the flu vaccination.

- Face-to-Face New Member Orientation: In 2017, the Community Relations Department hosted monthly member orientation sessions across the state to meet, connect with and educate new members about Peach State Health plan. A demonstration of the Peach State Health Plan website was conducted to assist new members with the navigational process.
    - Effectiveness/Event Highlights: In 2017, the Community Relations department hosted 45 events. A total of (83) members completed the HRAs online/or paper. In addition 174 members were educated on benefits, value additions, case management services and completion of health risk assessments were completed.

- Healthy Baby, Bright Future: In 2017, the Community Relations department hosted annual Healthy Baby, Bright Future Birthday Parties for one year old Peach State members in in all regions with the sole purpose of educating their parents or guardians on the importance of Well Checks or Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Community Relations worked with the Quality team on identifying any barriers that would prevent the parent/guardian from keeping their child's appointment.
    - Effectiveness/Event Highlights: In 2017, there were a total of 7 Healthy Baby, Bright Future events held statewide. There were a total of 94 members who attended and were educated on the importance of Well checks or EPSDT services. Additionally, Community Relations, in collaboration with the Quality team assisted member's families with closing of any other care gaps that were present. Additionally, 268 family members were in attendance at these events.

- HOLA/HELLO Event: In 2017, Community Relations department hosted health events for PSHP Hispanic members with the primary focus on educating and connecting members with Plan Services and Out-of-plan services. The event also promoted improving healthy lifestyle choices (i.e. attending doctors apt, compliant with meds, compliant with annual health screenings). Peach State Health Plan worked with our Community Partners, our Translations Services, FQHC, Vision Vans, Dental Vans, Mobile Market, provider offices and faith based partners to make these events a success.
    - Effectiveness/Event Highlights: In 2017, there were a total of 4 HOLA/HELLO events held statewide. There were a total of 136 Peach State Health Plan members who attended and were educated on the available Plan Services (i.e. Case Management, Disease Management, Behavioral Services, etc.). Peach State Health Plan provided free vision exams, general dentistry services, which included x-rays and cleaning. Our community providers provided free high blood pressure, diabetes, and cholesterol screening. Walgreen's was on site to administer flu shots to various family members. Peach State Health Plan worked in collaboration with a number of organizations to include but not limited to: Latin American Association, Partners for Community Action, Ser Familia, Beaver Ruin Road Church, 1st Hispanic Baptist Church, Hispanic Access Foundation, UGA Expanded Food & Nutrition Education Program, Mundo Hispanico, Medical Associates Plus, Richmond Co. Health Department. The Community Relations team worked with Quality to ensure that all applicable care gaps were addressed and assistance was provided with scheduling

appointments, if necessary. Additionally, 405 family members were in attendance at these events.

2018 Proposed Interventions and Activities

In 2018, the Community Health Services Department will continue to seek to improve the health and overall well-being of its members through its community outreach face to face interventions and events. The Community Health Services Department will enhance its face to face outreach by facilitating the early identification of a members resource needs to help reduce the risk of health complications resulting from social determinants of health. This will be achieved through the continuation and enhancement of the following interventions and events:

- **Location Home Visit Services**: The Community Health Services Department will continue to conduct home visits that will target members who are unable to be reached but in a more standardized approach. The Community Health Services Department will use Impact Pro, a predictive modeling tool, to identify members with a Case Management Engagement score of ≥40.
- **Coaching Services**: The Community Health Services Representatives will offer care coordination services to members in the following programs (Readmissions, Diabetes, Asthma) to intervene with short term, intensive, personal coaching support, and reinforcement on a recurrent basis. The coaching services will encompasses motivation, education, hands on learning, self-management, goal setting & action plans, breaking through barriers of social determinants of health, advocacy, screenings, empowerment and follow up visits.
- **Mutual Approach to Parenting & Partnership (MAPP) Events**: These events will target pregnant members and will include topics on bathing, feeding, injury prevention, sleeping, and illness while allowing members to participate in interactive activities. Members will also learn the importance of a Primary Care Physician (PCP) Home, the appropriate use of the ER, and will also encourage preventive care.
- **Healthy Lifestyle Events**: These events will be enhanced to be hosted throughout the state of Georgia. The Community Health Services Department will work collaboratively with community partners to facilitate and offer appropriate preventive services and improve overall health and quality outcomes by identifying potential gap opportunities.
- **Start Smart Baby Shower**s: The Community Health Services baby showers will be enhanced to be hosted throughout the state of Georgia to provide members with information on prenatal and post-delivery care. The Community Health Services Representatives will collaborate with community partners to assist with resolving social determinants of health by connecting members with local physicians, health departments, and community resources.
- **Community Relations**: The Community Relations Department will continue to facilitate the events mentioned above but will expand to additional counties throughout the state of Georgia.
- All of activities are geared towards improving communications between Peach State, its members and providers and have been developed with the member/customer in mind.

Conclusion

Summary of Lessons Learned from 2017 QAPI Program

Peach State Health Plan's evaluation of its 2017 QAPI Program demonstrated both successes and continuing opportunities for improvement within the Plan's strategies and interventions. The Plan's Quality Oversight Committee reviewed the QAPI Program Evaluation findings and recommendations in order to learn from the experience, support the cycle and continue to improve the quality of care and services received by Peach State members. Key lessons learned included:

- We are still on a learning curve for Quality Strategic Planning, and for identifying, prioritizing, and implementing effective interventions. Our goals and objectives need to be more tightly linked to the strategic planning process. Our interventions need to be scalable and sufficiently resourced.
- We need to improve our use of improvement methodology, particularly the planning phase, and rapid cycle tests of change
- We need to focus on improvements in member outcomes for all Plan members, not just those in case/disease management or HEDIS denominators. Once members are identified, the Plan should prioritize who, how, when and where to focus efforts.
- We need to continue to improve our ability to assist members to change their health behaviors.

Other Key Drivers of Changes in the QAPI Program for 2018

Population Assessment

Between 2016 and 2017, Peach State did not experience a significant change in the basic demographics of our membership. The following are examples of findings from these analyses that drove our selection of strategies for 2018

- Regional Analysis:
  - The Atlanta region had the lowest compliance for asthma medication ratio (AMR) for all races and genders.
  - The Atlanta region had the lowest compliance for 7-day follow up after mental health hospitalization for all races and genders.
  - The Southwest region had the highest prenatal and postpartum visit rates.

- Race Analysis:
  - White women had lower compliance rates for preventive services for women compared to their Black or African American counterparts for breast cancer and cervical cancer and chlamydia screenings
  - White adults had lower compliance rates for 7-day follow up after mental health hospitalization compared to their Black or African American counterparts. Conversely, White children had higher compliance rates for 7-day follow up after mental health hospitalization compared to their Black or African American counterparts.
  - Well child compliance rates for Blacks/African Americans were lower than other races for well child 3-6 year olds and adolescent well visits.
  - Black or African American mothers delivered a LBW or VLBW baby over two times more was higher than White mothers.

- Latino/Hispanic children receive preventive care more than non-Latino/Hispanic members (about 14 percentage points more)

- Gender:
  - Female members were more compliant for adolescent well-care visits and well-child visits for 15 month olds; males were more compliant for well-child visits for 3-6 year olds.
  - There were significantly more women than men with prescriptions for antidepressants for the diagnosis of major depression. Overall, females were less compliant with taking their medications consistently for three and nine months.
  - The number of members in the Asthma subpopulation increased to 29,810. These members remained disproportionately male and aged 20 years or younger

DCH Goals

Elements in the DCH Quality Strategic Plan for Georgia Families and Georgia Families 360° (February 2016) that served as drivers for Peach State's Goals, Objectives, and Strategies for 2018 include, for example:

Goal 1 – Improved Health for Medicaid and PeachCare for Kids (CHIP) Members I

- Objective 1: Improve access to high quality physical health, Behavioral Health and oral health care for all Medicaid and PeachCare for Kids
  - Review Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify members' experience with care concerns and work to resolve concerns identified.
  - Encourage co-location of physical health and behavioral health providers.
- Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids members
  - Implement preventive health visits and screening services(interventions) for members aged 21 years and older
- Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids members so that health performance metrics relative to chronic conditions
  - Ensure members with behavioral health conditions are able to access and utilize behavioral health services and monitor these conditions through performance metrics
  - Implement improvement activities focused on chronic conditions

Goal 2– Smarter Utilization of each Medicaid dollar

- Objective : Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations
  - Reduce ER visits for ambulatory sensitive conditions

Environmental Scan and SWOT Analysis

Environmental Scan

We took note of three key trends in our annual scan of our environment for year-end 2017.

- Increased state and national focus on decreasing healthcare disparities
- Increased state and national focus on overall improvement in quality

- Increased state and national focus on improvement in outcomes for members with chronic conditions

The annual SWOT analysis helped with direction setting for the QAPI Program's 2017 goals and objectives.

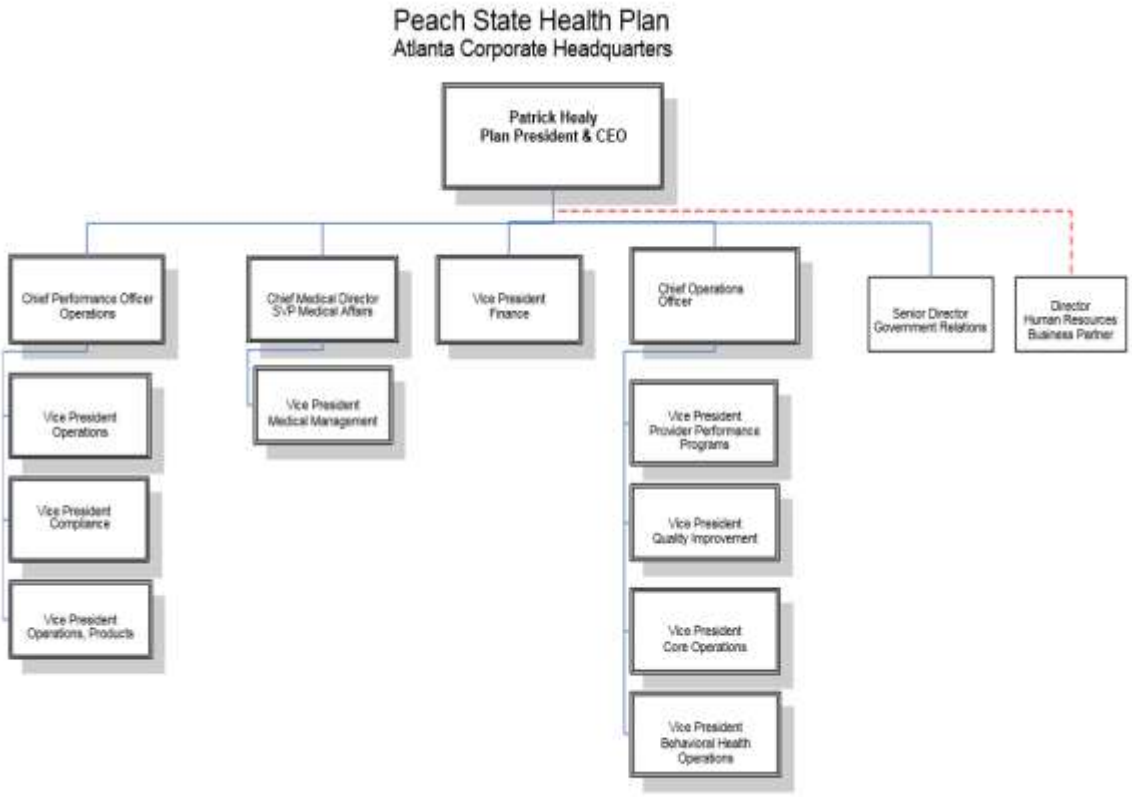
SWOT Analysis at end of 2017:

Strengths	**Weaknesses**	**Opportunities**	**Threats**
A culture of quality throughout the organization from senior leadership to frontline associates Integration and coordination of Behavioral Health and Behavioral Health homes Member and provider satisfaction with the Plan Stable leadership	Effectively demonstrating the Plan's understanding of the PDSA cycle Sustaining improvement initiatives over time Effective barrier/root cause analysis to decrease disparities in care and improve outcomes Provider facing systems that are user friendly	Automation and advancement of IT solutions Enhancement of communication and messaging to members and providers	Diminishing health professional, especially primary care, capacity in Georgia's rural and other shortage areas. Increased prevalence of chronic conditions

Program Changes for 2018

In early 2018, Peach State restructured to improve and streamline roles, responsibilities and functions. The restructure was implemented to improve oversight of programs and outcomes as well as evaluation of activities. Highlights of the changes are below:

- Vice President Chief Operating Officer (COO).
  - Reporting departments include Medical Management, Provider Relations, Behavioral Health Operations, Contracting and Network Development, and the newly formed department called Core Operations, consisting of Claims, Configuration, Provider Data and Contract Management
- Chief Performance Officer (CPO).
  - Reporting departments include Call Center, Community Outreach, Marketing and Communications, Products, Compliance and Regulatory Affairs, and the newly formed department of Information Services, consisting of Data Analytics, Business Systems, and State Reporting.
- Vice President Behavioral Health
  - Collaboration with all Plan staff to assist with integration of Behavioral Health services.



Along with the aforementioned changes, the Plan made other modifications to its structure in an effort to be efficient and effective and member centric.

- Behavioral Health was fully integrated into the Plan
- Grievance and Appeals was moved under Plan Operations.
- Provider Relations restructured to have an internal team focused on provider concerns (claims resolution, change in demographics, etc.) and an external team focused on improving quality scores.
- Outbound call team was relocated to the Quality Improvement Department to focus on education and scheduling appointments for members with care gaps.

The Plan adopted the Centene model to take the lead in challenging ourselves and the world around us to be better and to transform the health of the community. In 2018, Peach State started promoting the model to improve the Quality Strategic Planning Process.

- Encourage talent multipliers. Amplify capabilities by coaching and inspiring people to be better, building an inclusive workplace where individuals have support to learn, generate ideas and problem solve
    - Promote and enable continuous development of staff
    - Value diversity of thought, authenticity and humility

- Moved to a purpose driven model. Align every action with core propose and inspire others to do the same. Working with purpose and vision fosters engagement and stronger execution of strategic priorities.
    - Collaborate cross-functionally to deliver local impact
    - Build strong relationships with customer partners

- Maintain principled agility. Reshape new challenges and opportunities by adapting to frequent changes and approaching problem solving by testing new ideas regularly. Focus on the most important work first to drive the biggest impact.
    - Prioritize quick, iterative changes to drive impact and address shifts in customer needs.
    - Maintain flexibility and exhibit resilience in the face of ambiguity or adversity

- Focus on becoming results-oriented. Act decisively with accountability to drive results. Challenge conventional belief systems to find new opportunities for innovation and growth.
    - Act decisively with a sense of urgency grounded in facts and analysis.
    - Accept personal accountability to exceed expectations and hold other sot the same standard.

In addition to the new model, Peach State's 2018 initiatives will include lessons learned from our 2017 experience, population assessment, environmental scan, DCH goals, and SWOT analysis.

Member and Provider Feedback

Peach State Health Plan obtained member and provider feedback on the 2018 goals, objectives, strategies and intervention. For CY 2018, Feedback from six (6) members and 29 provides was obtained through:

- In-person New Member Orientation (NMO) on June 14, 2018 (members)

- Provider Office visits to call members for Peach State Days June 14, 2018 (members)
- Quarter 2, 2018 Medical Record and Office Review (providers)
- 2018 Pediatrics Conference by the Sea June 13-16 (providers)
- June 21 Provider Advisory Committee Meeting (providers)

General feedback obtained provided during the member events included:

- CY 2018 goals, objectives and strategies:
  - There were five (5) members who believed that the goals set were reasonable with appropriate activities and incentives to meet them
  - One parent believed the goal was set too low and the aim should be higher

- Suggested interventions to meet established goals for CY 2018 included:
  - Make it legal (mandatory) that parents are required to take their children to the doctor
  - Make sure members are aware of incentives offered for completing visits

Provider feedback was obtained during Medical Record and Office Reviews and at the Pediatrics by the Sea Conference. Feedback from the 29 providers included:

- CY 2018 goals, objectives and strategies:
  - There were ten (25) providers who believed that the goals set were reasonable with appropriate activities and incentives
  - There were four providers believed that the goals were set too low.
  - One of the three providers believed the goals were low in comparison to what is asked of providers per the Bright Futures specifications
  - Three providers like the incentives but believe parents should not be incentivized for completing preventative visits

- Suggested interventions to meet established goals for CY 2018 included:
  - Consider “punitive action” for members that see providers who are not their assigned primary care provider
  - Consider providing an easier method to change member’s PCP
  - Discontinue Medicaid services when members do not complete their preventative care visit
  - Continue to educate members on the importance of preventative visits
  - Continue Peach State Days
  - Consider working with the State to make well visits (for children) mandatory
  - Impose penalties on the parents of non-compliant members to emphasize accountability
  - Make sure parents are aware of the transportation services offered

Members and providers are encouraged to share their feedback about the QAPI Program, its goals, objectives, strategies and outcomes by contacting the Plan. This information is shared in the member handbook, on the PSHP.com website and in at least one newsletter a year.

2018 Goals, Objectives and Strategies

The goals, objectives, and strategies for 2018 are shown in the following tables. Peach State monitors administrative performance measure rates at least monthly. In 2018, metrics used to assess objectives and goals will be administrative (rates). The Plan believes improvements in monthly administrative rates will positively affect hybrid (final year) rates.

<table>
<tr><td colspan="3">Goal 1. Improve Member Health</td></tr>
<tr><td colspan="3">Objective 1.1 - Improve access/appropriate utilization of physical health services for members so that select performance metrics for 2018 will reflect a relative two percent increase over 2017 rates.
Metrics:
• Prenatal and Postpartum Care (PPC)
• Breast Cancer Screening
• Cervical Cancer Screening
• Colorectal Cancer Screening
• Adolescent Well-Care (AWC)
• Annual Dental Visits: total (ADV- total)
• Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
• Well-Child Visits in the First 15 Months of Life: 6+ visits (W15)</td></tr>
<tr><td>STRATEGY</td><td>POTENTIAL INTERVENTIONS</td><td>METRICS</td></tr>
<tr><td rowspan="4">Improve access/appropriate utilization of physical health services</td><td>Identify ‘walk in’ clinics in high member non-compliant areas. This will alleviate the need for members to take off work to first see their PCP then miss another day of work to have the mammogram.</td><td>• Number of walk-in clinics identified
• Number of members who received services at each identified walk in clinic</td></tr>
<tr><td>Identify practitioner offices who have the highest number of noncompliant members:
o Mail letters to those members under the provider’s name encouraging the member to schedule an appointment</td><td>• Number of practitioner offices identified
o Number of members who received mailed letter under the provider (office name)
o Number of members who (schedule and) keep an appointment within 90 days of the mailing</td></tr>
<tr><td>Implement a pilot program in East and Southeast regions in which a Plan EPSDT Coordinator will contact members from their provider’s office and assist with scheduling appointments.</td><td>• Number of offices in the East that participated in the pilot
o Number of members who were contacted from the provider’s office
o Number of members who scheduled an appointment
o Number of members who kept the scheduled appointment</td></tr>
<tr><td>Identify members who deliver at ≥37 gestational weeks and conduct telephonic outreach to encourage the importance of post-partum follow-up and to assist with scheduling appointment, if applicable.</td><td>• Number of members identified as delivering at ≥37 gestational weeks
o Number of members who received telephone contact (unique members) to encourage a post-partum visit
o Number of members who received scheduling assistance
o Number of members who kept appointment that did not receive scheduling assistance
o Number of members who kept appointment that did not receive scheduling assistance</td></tr>
<tr><td></td><td>Use USMM In-Home Mailings- FOBT testing kits</td><td>• Number of members who are mailed an FOBT test kit
o Number of members who return the FOBT kit to USMM</td></tr>
</table>

	Partner with a FQHC that performs dental services to hold a "Dental Day" in which non-compliant members are called by the Plan or FQHC and invited to have the service completed	• Number of FQHC dental days conducted ○ Number of members who receive outreach/invitation to attend dental day ○ Number of members who schedule appointment/agree to attend dental day ○ Number of members who attend dental day
Reward members for healthy behaviors	Implement the Peach Pays Program (through pilots) which includes incentives for certain members to obtain screenings.	• Number of members who receive outreach ○ Number of members who schedule appointment ○ Number of members who receive an incentive
	Revise (receive approval) and implement new incentives to increase member compliance	• Number of members who receive outreach ○ Number of members who schedule appointment ○ Number of members who receive an incentive

Goal 1. Improve Member Health		
Objective 1.2 - Improve access/appropriate utilization of behavioral health services for members so that select performance metrics for 2018 will reflect a relative two percent increase over 2017 rates. Metrics: Follow-Up Care for Children Prescribed ADHD Medication: Initiation (ADD-Initiation) Antidepressant Medication Management: Continuation (AMM-Continuation) Follow-Up After Hospitalization for Mental Illness: 7 day (FUH- 7)		
STRATEGY	POTENTIAL INTERVENTIONS	METRICS
Increase access/appropriate utilization of behavioral health services	Implement 14 day initial fill on ADHD medication to encourage members to schedule and keep a follow up visit within 30 days.	• Number of members who receive 14 day supply of medication ○ Number of members who receive a follow up visit within 30 days
	Design a performance improvement project (PIP) with a focus on improving 7 day follow up after mental health hospitalization	• Submit modules 1-3 and receive approval from DCH/EQRO Vendor
	Determine and implement appropriate metrics of effectiveness for the Depression Disease Management Program	• Determine metrics to assess the effectiveness of the Depression Disease Management Program ○ Implement the metrics

Goal 1. Improve Member Health

Objective 1.3 - Improve access/appropriate utilization for chronic disease services for members so that select performance metrics for 2018 will reflect a relative two percent increase over 2017 rates.

Metrics:

Controlling High Blood Pressure: total (CBP- total)
Comprehensive Diabetes Care: BP Control (CDC- BP)
Comprehensive Diabetes Care: HbA1c control <8% (CDC- <8%)
Comprehensive Diabetes Care: Eye Exams (CDC- eye)
Medication Management for People With Asthma: 75% Total (MMA-75% Total)

STRATEGY	POTENTIAL INTERVENTIONS	METRICS

Increase access/appropriate utilization of health services for chronic conditions	Use USMM In-Home Mailings- HbA1c test and nephropathy monitoring kits	• Number of members who are mailed an HbA1c test kit
		  ○ Number of members who return the HbA1c test kit to USMM
		• Number of members who are mailed a nephropathy test kit
		  ○ Number of members who return the nephropathy test kit to USMM

	Identify members with hypertension (HTN) who have multiple co-morbidities and target them for outreach.	• Number of members identified with HTN and comorbidities
		  ○ Number of members who received outreach and enrolled in HTN DM
		  ○ Number of members enrolled in HTN DM who were admitted into the hospital for hypertension crisis
		  ○ Number of members not enrolled in HTN DM who were admitted into the hospital for hypertension crisis

	Conduct a "Diabetes day" with either a large volume low compliant practitioner or in a high non-compliant member area	• Number of members who receive outreach/invitation to attend the Diabetes Day
		  ○ Number of members who schedule appointment/agree to attend the Diabetes Day
		  ○ Number of members who attend the Diabetes Day

	Collaborate with the CHOA **Ronald McDonald Care Mobile®** to provide asthma care at select schools in Atlanta.	• Number of members who PS staff 'scheduled' a visit with the **Ronald McDonald Care Mobile.** ○ Number of members who received a visit on the **Ronald McDonald Care Mobile.**

Reward members for healthy behaviors	Pilot the Peach Pays Program for Diabetic members implemented in the Q3, 2018.	• Number of members who receive outreach
		  ○ Number of members who schedule appointment
		  ○ Number of members who receive an incentive

Goal 2. Improve Member & Provider Experience with Care		
Objective 1.1. Improve member experience with the Plan by decreasing the number of disenrollment requests from the Plan by 10% points when compared to the number of disenrollment requests for CY 2017 Metric: Number of members who request disenrollment from the Plan		
STRATEGY	POTENTIAL INTERVENTIONS	METRICS
Improve member experience with the Plan	Implement use of a personal advocate for care (PAC) through the member services department	• Number of members who request disenrollment from the Plan ○ Number of members who request to disenroll who are successfully touched by the PAC ○ Number of members who request to disenroll after PAC contact

Goal 2. Improve Member & Provider Experience with Care		
Objective 1.2. Improve provider experience with the Plan over the 2017 rate of 80.6% Metric: Overall Rating of the Health Plan (Provider Satisfaction Survey)		
STRATEGY	POTENTIAL INTERVENTIONS	METRICS
Improve provider experience with the Plan	Conduct on-demand webinars being created for New Provider Orientations	• Number of webinars conducted ○ Anecdotal feedback from provider (office) participants on the webinars
	Implement Provider After-Call Survey in Q4 2017. As part of the survey process, call backs are made to any Provider that expresses dissatisfaction to resolve the concern. In addition feedback is tracked to provide any needed coaching or training to staff members.	• Number of providers who express dissatisfaction ○ Number of providers who receive a call back to resolve concerns ○ Anecdotal feedback from provider (office) participants on the call back/resolution

GOAL 3. Lower per Capita Cost		
Objective: Have smarter utilization of each dollar by improving select rates associated with appropriate utilization of services/visits by a relative two percent when comparing 2017 rates to 2018 rates Metrics: • C-section rate • Low Birth Weight (LBW) • Plan All-Cause Readmissions (PCR) • Ambulatory Care: ER use (AMB-ER use)		
STRATEGY	POTENTIAL INTERVENTIONS	METRICS
Improve optimal birth outcomes	Conduct Mutual Approach to Parenting & Partnership (M.A.P.P) Event – These events will target pregnant members and will include topics on bathing, feeding, injury prevention, sleeping and illness while allowing members to participate in interactive activities (i.e. Infant assimilator). Members will also learn the importance of Primary Care Physician (PCP) home, the appropriate use of the ER, and will also encourage preventive care.	• Number of MAPP events o Number of attendees o Number/percent of members who attended a MAPP event and had a LBW/VLBW baby
	Conduct targeted outreach to identified providers to educate staff on the benefits of 17-P usage and to encourage providers to refer members earlier to the HROB program for case management and/or care coordination interventions/services.	• Number of successful outreach calls to providers to educate about the benefits of 17-P. o Number/percent of provider's deliveries who had 17-P and delivered a LBW/VLBW baby o Number/percent of provider's deliveries who did not have 17-P and delivered a LBW/VLBW baby
Decreasing avoidable ED use and readmissions	Enhance its ER Case Management Program to target outreach to member's newly diagnosed with chronic conditions in the ER. Peach State understands that early implementation of interventions with members who are newly diagnosed with medical conditions can prevent inappropriate ER utilization.	• Number of members who are newly diagnosed with a chronic condition in the ER and receive outreach o Number of members who are newly diagnosed with a chronic condition in the ER, receive outreach and enroll in ER CM Program o Number/percent who return to the ER for their newly diagnosed chronic condition within 90 days who enrolled in ER CM o Number/percent who return to the ER for their newly diagnosed chronic condition within 90 days who were not enrolled in ER CM
	Continue to the discharge planning efforts with the facilities listed to ensure the safe transitions of members and appropriate follow-up. o DeKalb Medical Center o DeKalb Medical Center (Hillandale) o Grady Health System	• 30 day readmission rate (for the Plan) • 30 day readmission rate for each of the three facilities

Review and Approval

All Plan functional areas utilize standards/guidelines from these sources and those promulgated by national and state medical societies or associations, the CDC and the federal government. Peach State complies with all Federal, State and Georgia Families requirements. Plan departments perform required quality of service, clinical performance, and utilization studies throughout the year based on contractual requirements, requirements of other state and regulatory agencies and those of applicable accrediting bodies such as NCQA.

Regulatory Compliance and Reporting

The QI department maintains a schedule of relevant QI and QAPI reporting requirements for all applicable state and federal regulations and submits reports in accordance with all requirements. Additionally, the QAPI Program and Plan departments fully support every aspect of the federal privacy and security standards, Plan's Business Ethics and Integrity Program, Plan's Compliance Plan, and Plan's Waste, Fraud and Abuse Plan.

Signatures

The annual QAPI Program Evaluation was reviewed and approved by the Quality Oversight Committee on June 27, 2018 and will be presented to the Peach State Health Plan Board of Directors.

06/28/2018

Dean Greeson, MD, MBA — Date Signed
Senior Vice President, Medical Affairs/Chief Medical Officer
Peach State Health Plan

06/28/2018

Michael D. Strobel MPA, MA, LMHC — Date Signed
Vice President, Quality Improvement
Peach State Health Plan