



May 18, 2015

Ms. Carrie Lindgren
 Hoover Building, 1st Floor
 1305 East Walnut Street
 Des Moines, Iowa 50319-0114

RE: Response to MED-16-009 Iowa High Quality Healthcare Initiative

Dear Ms. Lindgren:

Amerigroup Iowa, Inc. (Amerigroup) is pleased to submit this proposal in response to MED-16-009, the Iowa High Quality Healthcare Initiative (Iowa Initiative). Amerigroup is a wholly owned subsidiary of Anthem, Inc. (Anthem). All references throughout this proposal to “Anthem” refer to this parent entity. Please note that our parent organization underwent a legal name change on December 3, 2014. As such, attachments for requested documents related to our parent organization may also reference the prior legal name of this entity, WellPoint, Inc. (WellPoint).

As requested, we have provided one original and six identical copies of the original, along with a USB Drive containing an electronic copy of the Bid Proposal and a separate USB Drive containing the financial reports. We have also provided a redacted copy of the Bid Proposal labeled as a “public copy.”

In submitting this proposal, we provide the following assurances:

1. Amerigroup will furnish the services required by enrollees as promptly as is appropriate, and the services will meet the Agency’s quality standards.
2. Amerigroup acknowledges that the capitation rates will cover all services required by enrollees and meet the Medical Loss Ratio requirements as listed in Attachment 1: Scope of Work, Section 2.7.
3. Amerigroup acknowledges that liquidated damages, as described in Exhibit E to Attachment 1: Scope of Work, may be imposed for failure to perform as set forth in this RFP.
4. Amerigroup acknowledges that the contract will be performance based, and both incentives and disincentives may apply to the Contractor’s performance as set forth in this RFP.

In addition, Amerigroup has enclosed the required certifications, executed by the undersigned. In executing these certifications, Amerigroup has relied upon the completeness and accuracy of information provided by the Agency through the RFP and subsequent amendments received as of May 18, 2015.

Executive Summary

Amerigroup is part of an organization that is the nation’s leading provider of healthcare solutions for state-sponsored programs. Together with our affiliate health plans, we serve more than 5.2 million people in state-sponsored health plans across 19 states. We bring deep organizational expertise and passion for serving individuals with complex needs through a variety of state-sponsored programs. The following are some of our additional qualifications for providing high-quality healthcare in Iowa:

- **Experience launching new programs with minimal disruption to participants and stakeholders.** During the last 24 years, Amerigroup’s affiliate health plans have implemented more than 100 publicly funded healthcare programs, service area expansions, and program enhancements. In this time, we have never missed an operational start date. Indeed, in our last four implementations, we went live an average of less than six months after kickoff, with two of the implementations within four months. ***For this reason, based upon these and other successful implementation experiences, we are confident that we can meet a January 1, 2016, go-live timeframe in Iowa.*** We analyze each



implementation and apply those learnings in our next opportunity, continually improving our processes. Moreover, we have been particularly successful in transitioning complex programs and populations from fee-for-service to a managed care environment and look forward to bringing this expertise to the Iowa Initiative, as we have recently done in Kansas, Indiana, Tennessee, and Kentucky.

- **Expertise in implementation of large initiatives that support multiple and diverse membership populations.** As an organization, Amerigroup is one of the few managed care organizations with the experience, capacity, infrastructure, and proven processes to tackle an initiative the size and complexity of the Iowa Initiative. In one 15-month period, our affiliates managed the start-up of three Medicaid health plans—Kansas, Louisiana, and Washington—representing more than 256,000 new members, and these three implementations were completed without any disruption in service within our existing health plans. In fact, our call center abandonment rate during those 15 months of intense activity was just 1.04 percent.
- **Fully integrated care coordination with a holistic and member-centric focus.** Our integrated care and service models and systems deliver superior quality through superior coordination. Outside of potential ACO partnerships, *Amerigroup* will directly provide all case management and care coordination for Iowa Initiative members, allowing us to fully integrate case management to address each individual’s holistic needs through one care plan and a carefully synchronized team of case management experts by leveraging technology tools that link all team members and organize activities and interventions. As such, the physical health, behavioral health, and long term services and supports (LTSS) needs of our members are managed by an interdisciplinary team of people. Our person-centered approach addresses member preferences and goals regarding their quality of life and life stressors including employment, housing, community inclusion and family supports. Our provider network includes specialized clinicians and non-clinicians utilize best practices with field based practices to meet the unique physical health, behavioral health, and social support needs of each of our members. This holistic approach is designed to increase integration and decrease fragmentation across systems of care improving member outcomes and quality of life.
- **Expertise across all Medicaid populations, including those traditionally considered complex.** Amerigroup operates best-in-class programs for each population from many years’ experience. Our affiliates successfully manage all populations and services referenced in this RFP in multiple states in a capitated environment. Our affiliates’ national experience with populations requiring specialized services includes, but is not limited to:
 - 17 years of experience as *LTSS experts*, coordinating the services and supports for more than 200,000 members in eight states.
 - Currently serving more than 160,000 *dual-eligible members* across 11 states.
 - Recently implementing *home and community-based services*, training, and supported employment services in Kansas for individuals with intellectual and/or developmental disabilities.
 - Managing Indiana’s HIP 2.0, an *ACA Medicaid expansion alternative* that includes 19 different benefit packages.
 - Managing *all behavioral health services in-house* as an integrated function. The programs in 16 of our 19 affiliate health plans include behavioral health services, and we will add two more that include behavioral health by the beginning of 2016. These services range from crisis services and outpatient therapy for families and children, to intensive psychiatric rehabilitation, to peer support services.
 - Understanding that health outcomes improve more dramatically when care and services are fully integrated, we have been a *proponent of integration* since we began serving state customers 24 years ago.



- **Member-centered care and support are a foundational value.** Amerigroup and our affiliate health plans embrace and promote a system that emphasizes member informed choice, independence, and engagement in all aspects of care and services. Our care coordination emphasizes member responsibility comprehensively from our member communications and outreach through our person-centered planning process to our selection of value-added services and member incentive programs. Member access to care and services is guided through development and maintenance of robust Provider Networks and self-direction of personal care and services that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of member satisfaction, well-being and quality of life measures. In addition, we promote independent and community living in the least restrictive and most integrated manner. In 2007, we created the National Advisory Board (NAB) to provide continued guidance and innovations to promoting services and supports that foster living independently, choice, recovery, and quality of life for older adults and people with disabilities.
- **Strong local presence and connections promote local accountability, service delivery, and relationships.** Amerigroup understands the value of and need for strong community connections. Amerigroup has more than 150 local letters of intent or support and has met with in excess of 500 local provider organizations, associations, community organizations, and other local stakeholders. We have already met with the leadership of most of the physicians, physician groups, hospitals and other institutional providers, safety net providers (Federally Qualified Health Centers [FQHC], Rural Health Clinics, and critical access hospitals), Community Mental Health Centers (CMHC), Community Developmental and Disability Organizations, Centers for Independent Living, Area Agencies on Aging, ancillary service providers and networks, and providers of waiver services to begin the contracting process. Some of the marquee providers that we have already engaged include Iowa Clinic, Catholic Health Initiatives, Mercy Health Networks, Unity Point, and University of Iowa Health Alliance. Additionally, we have reached out to all, have letters of intent with many and intend to contract with every FQHC and CMHC in Iowa. Hallmarks of our model of care are understanding the community needs and assets and tailoring our care and services to address these needs and leverage local and state assets.
- **Robust network development by on-the-ground Provider Services Staff.** Amerigroup and our affiliate health plans are an industry leader in building robust network solutions for our state partners: Solutions that recognize and support the needs of some of the most vulnerable citizens of the state while offering geographic accessibility. We have 10 associates on our national Network Development Team who are committed to building networks in Iowa. They have built 12 unique state Medicaid networks (including networks for many specialized populations) in the last 36 months. In our last three builds (Kentucky, Tennessee, and Virginia), we contracted more than 72,000 providers. Additionally, we have partnered with Wellmark Blue Cross and Blue Shield, the leader in ACO initiatives in Iowa, to assist Amerigroup in developing collaborative relationships with Wellmark's existing providers, which include more than 2,000

"...Amerigroup shares the State and Wellmark's commitment to work in innovative ways to transform health care and improve the health of Iowans. Evidence of this commitment is the high level of support and interest Amerigroup has shown in continuing the ACO and State Innovation Model Grant initiatives pioneered by Wellmark in Iowa. We believe Amerigroup will be an accountable, innovative partner with the Iowa Medicaid Enterprise as the Initiative is implemented and as it matures."

Laura Jackson,
Executive Vice President,
Health Care Innovation and
Business Development,
Wellmark Blue Cross
and Blue Shield

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Iowa primary care providers and cover 525,000 Wellmark members. Laura Jackson, Wellmark's EVP of Health Care Innovation and Business Development, attests to Amerigroup's support of the ACO and SIM Grant initiatives.

- **Superior value combining quality health care with financial predictability.** Amerigroup and our affiliate health plans generate significant savings for our state customers by providing high-quality care in the most appropriate setting and at the right time. We do this through a variety of approaches, including strong care coordination, developing programs and utilizing advanced technologies to reduce re-hospitalizations and preventable emergency room use, and by offering pay-for-performance incentives to providers and facilities for efficient, evidence-based quality care delivery. Currently, across all of our affiliate health plans, approximately 54 percent of members in our state-sponsored programs receive their healthcare from providers participating in a value-based reimbursement program. The result is improved access to higher quality care and services resulting in cost efficiencies and better health outcomes.
- **Strong stewardship with nationally recognized program integrity results and savings.** As an organization, we pride ourselves on being a good steward of public funds. We are focused on program integrity and have systems in place to detect and address unnecessary or wasteful practices and/or fraudulent activities. In calendar year 2014 alone, these programs produced more than \$210 million in savings across our state-sponsored programs in 19 states.
 - Our affiliate health plans opened 1,200 fraud, waste, and abuse cases and identified \$28.9 million in net savings. This equates to a return on investment of approximately 9-1, as compared to the national average of 8-1.
 - Provider code editing solutions strengthen our program integrity by utilizing sophisticated claim payment logic (post-service, pre-payment) to identify unbundled services, overpayments (for example, duplicates or components of a global service) and implement National Correct Coding Initiative (CCI) logic. These code editing solutions produced \$184.6 million in savings.
- **Developing real solutions for publicly funded healthcare programs.** When a solution does not exist, we invent one. Our proposal to Iowa includes a wide array of innovative programs that will drive improvements in member and provider engagement, improve quality, and reduce the cost of healthcare in Iowa. One such program, LiveHealth Online, allows our members to communicate with physicians through web-based consultations. We are also excited to introduce CareMore, an Anthem affiliate, to Iowa, starting with Des Moines. CareMore offers a breakthrough model of care delivery that combines wellness, medical supervision, and a revolutionary approach to coordinating care for at-risk members who require higher levels of clinical intervention due to complex and/or chronic conditions. Our real solutions in healthcare have been noted by Letters of Support from some of Iowa's most prominent leaders, including Julianne Beckett, mother of Katie Beckett, an Iowan and the first Medicaid home and community-based waiver person in the country; from Jessica Reiter-Flax,

"I am impressed with Amerigroup Iowa's early investment in better understanding the new populations you seek to serve in Iowa. I believe that [Amerigroup's] innovations (child obesity, prenatal care, asthma, etc.) will make a significant contribution to improving the lives of Iowans who participate in the State's Medicaid program. I view this as an opportunity to advance coordinated and meaningful access to long-term services and supports and promote community-based, self-directed and person-centered services and supports for Iowans with disabilities and their families."

Julianne Beckett,
Advocate for Children
with Disabilities and Mother
of Katie Beckett

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Executive Director of the Communities Health Charities of Iowa, and Carol Sipfle, Executive Director of the Alzheimer Association (Greater Iowa Chapter). These letters, and others, can be found in Attachment 1.1-1.

- **Commitment to quality and improved health outcomes for Iowans.** Our comprehensive quality programs drive improvements in many areas, including but not limited to chronic disease management and prevention, behavioral health, patient safety, and community health for all members. In Iowa, our quality management program will serve as a central source of quality data, coordination, and performance improvement. As evidence of our commitment to quality, the National Committee for Quality Assurance (NCQA) ranks seven Amerigroup affiliate health plans in the Top 100 of its ranking of 1,000 Medicaid health plans in the country. Additionally, our members will benefit from our eight accredited NCQA Disease Management Programs developed through our National Medicaid Division.
- **Experienced leadership coupled with managed care expertise.** A Transition Team will get the Iowa Initiative off to a strong start. As President of the Amerigroup North Region–Medicaid Government Business Division, I will lead the Iowa Transition Team. I will oversee all Iowa health plan operations until a local leader is hired as the Contract Administrator/CEO. A pediatrician by training with extensive senior leadership experience in managed care, I have been a strong advocate of ensuring access to healthcare for vulnerable populations for my entire career. Mr. John Crowley will serve as COO for the Transition Team. He currently serves as Staff Vice President of Medicaid Provider Networks and has a solid track record in successful network development, management, and operations execution within government programs for more than 20 years. In those 20 years, he has developed an extensive expertise in transitioning states from fee-for-service programs to managed care and in developing as well as implementing suites of provider collaboration programs with proven results in improving member access to higher quality and more efficient healthcare.

Throughout this letter, we highlight some of our solutions. You will find more in-depth answers in the attached proposal where we provide detailed responses to the questions in Attachment 5, describe our approach, and outline tasks in meeting the Scope of Work. These solutions are the product of our affiliates' 24 years of experience in 19 states in establishing state-sponsored healthcare programs. We have performed this work very successfully, learned many lessons along the way, and believe that we have communicated this knowledge and experience in the details of this proposal. There are several keys to a successful implementation:

1. **Development and adherence to a detailed implementation plan.** Our plan will include our task list, staff responsibilities, timelines, and processes that we will use to ensure services begin on the contract effective date. If awarded, we fully intend to faithfully carry out this work in the timeframes described. Amerigroup's affiliate health plans have never failed a readiness review or missed an operational start date.
2. **Identification of Iowa-based staffing and leadership.** Amerigroup will be using a highly experienced and capable Transition Team to initiate services in Iowa. These individuals are already identified and ready to serve upon notification of contract award. The Transition Team will hire highly qualified Iowa-based individuals to carry out proposal activities.
3. **Creation of a robust Provider Network.** Amerigroup and its affiliate health plans have a strong track record in developing broad-based Provider Networks that are tailored to the needs of the communities we serve. We are already in the process of building this network.
4. **Development of policies and procedures.** Amerigroup, in accordance with Agency rules and requirements and using our affiliates' 24 years' experience in 19 other markets, will develop and



maintain Iowa-specific policies and procedures for each functional area, including physical health, behavioral health, LTSS, and quality management policies.

Through participation in the Iowa High Quality Healthcare Initiative, Amerigroup looks forward to joining DHS in continuing Iowa's transformation of its publicly funded healthcare system into a model of efficiency, effectiveness, and quality. We have broad and extensive experience from other localities in coordinating services that meet these goals, and we intend to apply this knowledge in Iowa. Moreover, we will bring to bear our experience serving specialized populations, including adults and children with physical disabilities, traumatic brain injuries, intellectual and/or developmental disabilities, serious mental illness, severe emotional disturbances, and substance use disorders. That said, through the extensive experience of our affiliates, we know that one size does not fit all when it comes to the delivery of high-quality care and services across systems of care. For this reason, we will work closely with DHS, members, providers, and other partners to make sure our programs, systems, and services are tailored to reflect Iowa's needs, concerns, and aspirations.

We embrace the four goals of the Iowa Initiative. For each one, we provide information on our approach to meet and exceed these goals and some of the experience, expertise, and achievement we bring to our work.

Goal 1. Improve the quality of care and health outcomes

We drive improvements in quality and health outcomes in many ways. Here, we provide three examples of our approaches to enhancing quality of care and services aimed to improve health status and well-being.

A Focus on Prevention - We applaud Iowa's participation and progress in the Healthiest State Initiative and drive to incorporate wellness and prevention principles into its programs. In our response, we detail our plans to work collaboratively with DHS and other partners to address tobacco use, healthy eating and active living, and diabetes. In Iowa, as one of our many value-added services, we will implement our "Healthy Families" program to address childhood obesity.

Assuring Quality - Our comprehensive quality programs drive improvements in many areas, including but not limited to chronic disease management and prevention, behavioral health, patient safety, and community health for all members. In Iowa, our quality management program will serve as a central source of quality data, coordination, and performance improvement.

Pay-for-Performance - We will be implementing our proven pay-for-performance provider incentive model in Iowa. This program offers shared savings to ACOs, providers, hospitals, nursing homes, and behavioral health providers, providing financial incentives to providers for high-quality performance in areas including, but not limited to, children's health, adult preventive and chronic condition management, birth outcomes, and avoidable hospitalizations. Our Pay-for-Performance models have demonstrated success: in our most mature primary care incentive program, participating provider groups have shown a 3 percent favorable difference in quality and an 8.6 percent favorable difference in total medical cost.

Goal 2: Emphasize member choice, access, safety, independence, a recovery focus, and responsibility and services delivered in the least restrictive manner appropriate to a member's health and functional status

Amerigroup's strong focus on quality improvement and experience supporting diverse populations comparable to Iowans has led refinement of our processes to better serve our members maximizing informed choice and self-determination. Our person-centered approach and practices facilitate member driven and family services and supports that are responsive and meaningful to evolving preferences, health and functional support needs and personal goals. Our community-based case management and care coordination models involve a continuous process of communicating, coordinating, delivering,



monitoring and assessing services and supports and progress toward achieving member goals to optimize person-centered service delivery.

Outstanding Care Coordination and Community-Based Case Management – Our approach utilizes regional care management teams with multifunctional expertise to assist community-based case managers, members, families, representatives, and members’ interdisciplinary teams in the development of person-centered service plans and serve as an ongoing resource to meet the varying needs of members.. *No matter what we do, we emphasize the member, not the process.* We engage members as active participants in their healthcare decisions and address their biopsychosocial strengths and needs through quality services and supports, care coordination and management, and health promotion. Our Care Coordinators meet with members to develop individualized service plans that span the service delivery systems of physical health, behavioral health, and LTSS and, as indicated, maximize member independence and facilitate care in the least restrictive setting possible while promoting member responsibility for their health and wellbeing.

Telehealth Services – Amerigroup will deploy innovative solutions to enhance the already existing telehealth platforms to increase access and reduce barriers to care for Iowa Initiative members. We will work with the substantial telehealth services currently in place in Iowa, such as those provided by the University of Iowa, and partner with providers to expand existing services as needed to meet the needs of our members.

Breakthrough Technologies – We will partner with Breakthrough, a telehealth platform for behavioral health, and we will explore other methods to deliver one-on-one consultations with board-certified clinicians either through personal computers or other strategically located community locations.

LiveHealth Online – Amerigroup will provide a variety of options for Iowa members to access physical and behavioral health consultations. Our LiveHealth Online program supports members to connect with physicians virtually. Iowa members will also have access to our Behavioral Health Services Hotline through a single toll-free Member Services call center. Callers who do not speak English or Spanish will be provided free, immediate interpretation services in more than 200 languages through a language line. Interpreters will be available to join a call 24 hours a day, 7 days a week, and can also support members calling from a provider’s office.

Goal 3: Provide physical health, behavioral health, and long-term services and supports in a highly coordinated manner

We believe in holistic, whole-person care. In full recognition of the inseparability of physical health and behavioral health, we directly manage physical and behavioral healthcare networks ourselves rather than outsourcing these services to a subcontractor. This allows us to better integrate these services into our members’ care and assure that our approach is recovery focused and strengths based. We leverage specialized clinicians, clinical practices, and guidelines that address the unique physical, behavioral health, and social support needs of each of our members, aiming for reduced fragmentation of care and improved member outcomes.

Our affiliate health plan in New York has been selected by the state to participate in the launch of a comprehensive and innovative program to support members with severe mental illness (SMI). Our care management model for this program, significant elements of which will be replicated in Iowa, has been commended by New York for its “appreciation of the unique needs of individuals with serious behavioral health conditions.”

Goal 4: Decrease healthcare costs through the reduction of unnecessary, inappropriate, and duplicative services

Amerigroup uses a variety of methods to efficiently provide high-quality care, including developing programs to reduce re-hospitalizations and preventable emergency room use and by detecting and



ameliorating unnecessary or wasteful practices and/or fraudulent activities. The result is higher quality care and better health outcomes for less per-member cost and better value for Iowa's taxpayers.

HomeConnect Program – Avoidable hospital readmissions are primarily driven by a lack of appropriate follow-up care. The greatest risk occurs within the first 48 hours post-hospitalization. To reduce this, our HomeConnect Program engages members before discharge to create a transition plan with appropriate follow-up care. To complement this, we reconnect members with their primary care providers to improve access to follow-up care and increase member contact through face-to-face interactions during the inpatient stay.

Program Integrity – Amerigroup and our affiliates have one of the most proactive regulatory compliance programs in the industry. We maintain a robust system of processes and controls to prevent, identify, and mitigate inappropriate, duplicative, and unnecessary payments. As shared earlier, these programs produced in excess of \$210 million in 2014 savings in our state-sponsored programs across 19 states. Our commitment to compliance and to establishing a culture that encourages our employees to embrace this commitment and demands that providers as well as other vendors embrace it is reflected in one of our company's core values: being trustworthy.

We believe the Iowa Initiative is a closely aligned to the way Amerigroup and our affiliate health plans are successfully delivering high quality, strong value managed care across the country today. In short, we believe we are very well suited to partner with the State of Iowa and the Iowa Department of Human Services to transform Iowa Medicaid to higher quality of care for its membership and stronger value for Iowa's dollar.

I am authorized to legally bind Amerigroup Iowa and able to respond to the Department about the confidential nature of the information. Please do not hesitate to contact me using the information below:

Tunde Sotunde, MD
Amerigroup Iowa, Inc.
5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266
(678) 587-4840
Tunde.Sotunde@amerigroup.com

We greatly appreciate the opportunity to provide an overview of our qualifications and approaches toward meeting the RFP specifications and the goals of the Iowa High Quality Healthcare Initiative. We look forward to partnering with DHS and others in carrying out the admirable goals and objectives of this initiative.

Sincerely,

Tunde Sotunde, MD
Contract Administrator, Amerigroup Iowa
President, North Region–Medicaid Government Business Division



Document A310™ – 2010

Conforms with The American Institute of Architects AIA Document 310

Bid Bond

CONTRACTOR:

(Name, legal status and address)

Amerigroup Iowa, Inc.
5550 Wild Rose Lane
West Des Moines, IA 50266

SURETY:

(Name, legal status and principal place of business)

Liberty Mutual Insurance Company
71 Stevenson Street

San Francisco, CA 94105
Mailing Address for Notices

Liberty Mutual Insurance Company
Attention: Surety Claims Department
1001 4th Avenue, Suite 1700
Seattle, WA 98154

This document has important legal consequences. Consultation with an attorney is encouraged with respect to its completion or modification.

Any singular reference to Contractor, Surety, Owner or other party shall be considered plural where applicable.

OWNER:

(Name, legal status and address)

Iowa Department of Human Services
Hoover Building, 1305 East Walnut Street, 1st Floor
Des Moines, IA 50319-0114

BOND AMOUNT: \$ 100,000 One Hundred Thousand Dollars and 00/100

PROJECT:

(Name, location or address, and Project number, if any)

Iowa High Quality Healthcare Initiative RFP #MED-16-009

The Contractor and Surety are bound to the Owner in the amount set forth above, for the payment of which the Contractor and Surety bind themselves, their heirs, executors, administrators, successors and assigns, jointly and severally, as provided herein. The conditions of this Bond are such that if the Owner accepts the bid of the Contractor within the time specified in the bid documents, or within such time period as may be agreed to by the Owner and Contractor, and the Contractor either (1) enters into a contract with the Owner in accordance with the terms of such bid, and gives such bond or bonds as may be specified in the bidding or Contract Documents, with a surety admitted in the jurisdiction of the Project and otherwise acceptable to the Owner, for the faithful performance of such Contract and for the prompt payment of labor and material furnished in the prosecution thereof; or (2) pays to the Owner the difference, not to exceed the amount of this Bond, between the amount specified in said bid and such larger amount for which the Owner may in good faith contract with another party to perform the work covered by said bid, then this obligation shall be null and void, otherwise to remain in full force and effect. The Surety hereby waives any notice of an agreement between the Owner and Contractor to extend the time in which the Owner may accept the bid. Waiver of notice by the Surety shall not apply to any extension exceeding sixty (60) days in the aggregate beyond the time for acceptance of bids specified in the bid documents, and the Owner and Contractor shall obtain the Surety's consent for an extension beyond sixty (60) days.

If this Bond is issued in connection with a subcontractor's bid to a Contractor, the term Contractor in this Bond shall be deemed to be Subcontractor and the term Owner shall be deemed to be Contractor.

When this Bond has been furnished to comply with a statutory or other legal requirement in the location of the Project, any provision in this Bond conflicting with said statutory or legal requirement shall be deemed deleted herefrom and provisions conforming to such statutory or other legal requirement shall be deemed incorporated herein. When so furnished, the intent is that this Bond shall be construed as a statutory bond and not as a common law bond.

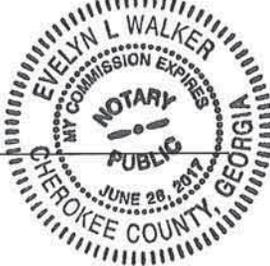
Signed and sealed this 5th day of May, 2015

Evelyn L. Walker
(Witness)

Amerigroup Iowa, Inc.
(Principal) _____ *(Seal)*

[Signature]
(Title) TRUDE SORUDE REGIONAL PRESIDENT

(Witness)



Liberty Mutual Insurance Company
(Surety) _____ *(Seal)*

[Signature]
(Title) Betty L Tolentino Attorney-in-Fact

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

CIVIL CODE § 1189

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

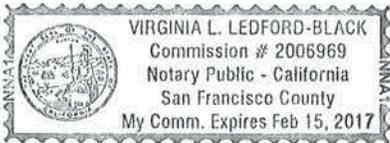
State of California)
County of San Francisco)
On May 5, 2015 before me, Virginia L. Ledford-Black, Notary Public
Date Here Insert Name and Title of the Officer
personally appeared Betty L. Tolentino
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature Virginia L. Ledford-Black
Signature of Notary Public



Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____ Document Date: _____
Number of Pages: _____ Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____
 Corporate Officer -- Title(s): _____
 Partner -- Limited General
 Individual Attorney in Fact
 Trustee Guardian or Conservator
 Other: _____
Signer Is Representing: _____

Signer's Name: _____
 Corporate Officer -- Title(s): _____
 Partner -- Limited General
 Individual Attorney in Fact
 Trustee Guardian or Conservator
 Other: _____
Signer Is Representing: _____

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS PRINTED ON RED BACKGROUND.

This Power of Attorney limits the acts of those named herein, and they have no authority to bind the Company except in the manner and to the extent herein stated.

Certificate No. 6881732

American Fire and Casualty Company
The Ohio Casualty Insurance Company

Liberty Mutual Insurance Company
West American Insurance Company

POWER OF ATTORNEY

KNOWN ALL PERSONS BY THESE PRESENTS: That American Fire & Casualty Company and The Ohio Casualty Insurance Company are corporations duly organized under the laws of the State of New Hampshire, that Liberty Mutual Insurance Company is a corporation duly organized under the laws of the State of Massachusetts, and West American Insurance Company is a corporation duly organized under the laws of the State of Indiana (herein collectively called the "Companies"), pursuant to and by authority herein set forth, does hereby name, constitute and appoint, Betty L. Tolentino; Brian F. Cooper; Janet C. Rojo; K. Zerounian; Kevin Re; M. Moody; Maureen O'Connell; Robert Wrixon; Susan Hecker; Virginia L. Black

all of the city of San Francisco, state of CA each individually if there be more than one named, its true and lawful attorney-in-fact to make, execute, seal, acknowledge and deliver, for and on its behalf as surety and as its act and deed, any and all undertakings, bonds, recognizances and other surety obligations, in pursuance of these presents and shall be as binding upon the Companies as if they have been duly signed by the president and attested by the secretary of the Companies in their own proper persons.

IN WITNESS WHEREOF, this Power of Attorney has been subscribed by an authorized officer or official of the Companies and the corporate seals of the Companies have been affixed thereto this 23rd day of February, 2015.



American Fire and Casualty Company
The Ohio Casualty Insurance Company
Liberty Mutual Insurance Company
West American Insurance Company

By: David M. Carey
David M. Carey, Assistant Secretary

STATE OF PENNSYLVANIA ss
COUNTY OF MONTGOMERY

On this 23rd day of February, 2015, before me personally appeared David M. Carey, who acknowledged himself to be the Assistant Secretary of American Fire and Casualty Company, Liberty Mutual Insurance Company, The Ohio Casualty Insurance Company, and West American Insurance Company, and that he, as such, being authorized so to do, execute the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal at Plymouth Meeting, Pennsylvania, on the day and year first above written.



COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Teresa Pastella, Notary Public
Plymouth Twp., Montgomery County
My Commission Expires March 28, 2017
Member, Pennsylvania Association of Notaries

By: Teresa Pastella
Teresa Pastella, Notary Public

This Power of Attorney is made and executed pursuant to and by authority of the following By-laws and Authorizations of American Fire and Casualty Company, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company which resolutions are now in full force and effect reading as follows:

ARTICLE IV – OFFICERS – Section 12. Power of Attorney. Any officer or other official of the Corporation authorized for that purpose in writing by the Chairman or the President, and subject to such limitation as the Chairman or the President may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Corporation to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact, subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Corporation by their signature and execution of any such instruments and to attach thereto the seal of the Corporation. When so executed, such instruments shall be as binding as if signed by the President and attested to by the Secretary. Any power or authority granted to any representative or attorney-in-fact under the provisions of this article may be revoked at any time by the Board, the Chairman, the President or by the officer or officers granting such power or authority.

ARTICLE XIII – Execution of Contracts – SECTION 5. Surety Bonds and Undertakings. Any officer of the Company authorized for that purpose in writing by the chairman or the president, and subject to such limitations as the chairman or the president may prescribe, shall appoint such attorneys-in-fact, as may be necessary to act in behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations. Such attorneys-in-fact subject to the limitations set forth in their respective powers of attorney, shall have full power to bind the Company by their signature and execution of any such instruments and to attach thereto the seal of the Company. When so executed such instruments shall be as binding as if signed by the president and attested by the secretary.

Certificate of Designation – The President of the Company, acting pursuant to the Bylaws of the Company, authorizes David M. Carey, Assistant Secretary to appoint such attorneys-in-fact as may be necessary to act on behalf of the Company to make, execute, seal, acknowledge and deliver as surety any and all undertakings, bonds, recognizances and other surety obligations.

Authorization – By unanimous consent of the Company's Board of Directors, the Company consents that facsimile or mechanically reproduced signature of any assistant secretary of the Company, wherever appearing upon a certified copy of any power of attorney issued by the Company in connection with surety bonds, shall be valid and binding upon the Company with the same force and effect as though manually affixed.

I, Gregory W. Davenport, the undersigned, Assistant Secretary, of American Fire and Casualty Company, The Ohio Casualty Insurance Company, Liberty Mutual Insurance Company, and West American Insurance Company do hereby certify that the original power of attorney of which the foregoing is a full, true and correct copy of the Power of Attorney executed by said Companies, is in full force and effect and has not been revoked.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 5th day of May, 2015.



By: Gregory W. Davenport
Gregory W. Davenport, Assistant Secretary

Not valid for mortgage, note, loan, letter of credit, currency rate, interest rate or residual value guarantees.

To confirm the validity of this Power of Attorney call 1-610-832-8240 between 9:00 am and 4:30 pm EST on any business day.

Bid Proposal Security

The original Bid Proposal Security Bond can be found in the binder marked "Original".

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Purpose (1.1)

Amerigroup Iowa, Inc.'s (Amerigroup) experience, expertise, and resources perfectly align with the mission and goals of the Iowa High Quality Healthcare Initiative, and we are extremely excited to respond to this Request for Proposal. With our organization's extensive experience in implementing and managing administratively complex managed care programs comprised of individuals who have diverse and specialized healthcare needs, we look forward to working with the Department of Human Services (DHS), plan members, providers, stakeholders, and other partners to deliver high-quality healthcare to Iowans.

Of the more than 5.2 million individuals our affiliate health plans serve in state-sponsored programs throughout the nation, *nearly 1 million have specialized needs, such as foster care youth, individuals with intellectual and/or developmental disabilities (ID/DD), persons with dual eligibility, individuals with physical/functional disabilities, and those requiring Long Term Services and Supports (LTSS)*. We are proud of our leadership position among managed care organizations in effectively serving these individuals through our locally led and managed affiliate health plans in 19 states as shown in Table 1.1-1.

Table 1.1-1. Amerigroup's Affiliates Provide Integrated Care in Many States, for Many Populations¹

Amerigroup Health Plans and Programs they Serve, by State											
	Medicaid	CHIP	Foster	Dual Demos	ABD	SMI	ID/DD	AIDS/HIV	TBI	ACA Expansion	LTSS
CA	✓	✓		✓	✓		✓	✓		✓	✓
FL	✓	✓	✓		✓		✓	✓	✓		✓
GA	✓	✓	✓								
IN	✓	✓	✓		✓						
KS	✓	✓	✓		✓	✓	✓		✓		✓
KY	✓	✓	✓		✓					✓	
LA	✓	✓	✓		✓						
MA		✓									
MD	✓	✓	✓		✓					✓	
NV	✓	✓				✓				✓	
NJ	✓	✓	✓		✓		✓	✓	✓	✓	✓
NY	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
SC	✓				✓			✓			
TN	✓				✓		✓	✓			✓
TX	✓	✓		✓	✓		✓				✓
VA	✓	✓	✓	✓	✓	✓	✓				
WA	✓	✓	✓		✓					✓	
WV	✓				✓		✓				
WI	✓				✓						
Total	4.1 million	334,000	41,000	15,000	470,000	250	2,300	10,000	2,100	461,000	202,000

¹ Membership numbers presented above are inclusive of membership as of December 31, 2014, for our parent company Anthem, Inc. and its state sponsored health plans. Members may be counted in more than one category and numbers may not be exact. In addition, in February 2015, our parent company completed the acquisition of two Florida managed care organizations, Simply Healthcare Plans, Inc. (Simply) and Better Health, Inc. (Better).

This proposal will describe in detail how Amerigroup will deliver high quality healthcare and improve health outcomes while decreasing cost. We will present our disciplined and systematic approach to implementing best practices, testing new strategies, and leveraging the experience of our affiliate health plans. Most of all, we will demonstrate how we build care systems with local communities, local providers, and local organizations to achieve member choice, access, safety, independence, and responsibility; reduce gaps in care and services; integrate services across the delivery system; address chronic health conditions; support care and treatment in the least restrictive setting appropriate; link resources enhancing independent living; eliminate duplicative services; and promote wellness. In short, we will provide evidence of our commitment to supporting Iowa in becoming the nation’s healthiest state, starting with the Iowa High Quality Healthcare Initiative.

Expertise in Launching New Programs

One of our core competencies is the ability to successfully implement new programs in a manner that seamlessly transitions members, providers, and stakeholders and avoids disruption to care. Across Amerigroup and our affiliate health plans operating state-sponsored programs, we have successfully executed more than 100 program implementations, encompassing new program start-ups, service area expansions, and new products. ***Our organization has never missed an operational start date nor had a contract involuntarily terminated by a state partner.*** Indeed, in our last four implementations, we went live an average of six months from kick off, with two of the implementations occurring within four months. ***Based upon these and other successful implementation experiences, we are confident that we can meet a January 1, 2016, go-live timeframe in Iowa.***

In particular, we have been extremely successful in transitioning specialized services from the fee-for-service to managed care environment with wholesale changes for members, providers, and stakeholders. For example, our Kansas affiliate collaborated with the state to launch a redesign of the state’s Medicaid program. The program, which went live in 2013, includes the full range of populations and services, including LTSS, waiver programs, individuals with ID/DD, and members of all ages with disabilities.

Figure 1.1-1. Demonstrated Success with Aggressive Timelines



Short implementation periods can prove challenging, but when our state partners make strategic decisions that require them, we have stepped up to the task each and every time as shown in Figure 1.1-1. We have learned from the challenges that short implementations invariably experience and apply those lessons in our implementation efforts going forward. We make sure we offer our informed insights to our state partners to help each transition take place as seamlessly as possible. In fact, our affiliate plan president from Kansas has been involved in the Iowa plan development to help Iowa mitigate risk and implement best practices.

Seamless transitions require multiple complementary strategies: an extensive Provider Network that supports existing provider-member relationships and minimizes disruption; rapid identification of and outreach to members who have acute or chronic care needs; careful analysis of members’ ongoing health service needs and preferences; and a framework of comprehensive care planning, coordination, and

execution to help providers meet those needs. Additionally, when we implement a new program, we focus on ensuring continuity of care and the seamless transitions to ensure needed services for our new members are received without disruption. This attention to detail and commitment to member health and

wellbeing minimizes overall implementation risk and demonstrates good stewardship for our members, state partners, providers, and all stakeholders.

Amerigroup will collaborate with DHS both before and after the program effective date. Our implementation team will meet regularly with DHS staff to review progress, respond to and escalate as necessary any concerns, and resolve operational issues. *New program success is more than just Amerigroup's success—it is Iowa's success.*

Focus on Members, Quality, Outcomes and Cost

Our proposal includes a wide array of programs that will help improve member health outcomes and access to higher quality, less costly health care. These programs will also help enhance member experiences and choice while promoting member responsibility, and provider engagement, all while helping reduce the cost of healthcare in Iowa. Our programs have been designed to:

- **Engage Iowa's provider community to deliver higher quality, lower cost healthcare.** Amerigroup's affiliates have experience in value-based reimbursement as a tool to help improve outcomes while decreasing cost. Currently, across all of our affiliates, 54 percent of state-sponsored program members are served by providers participating in a value-based reimbursement program. Amerigroup applies a data-driven model to help providers manage their patients' health at the population level and employs best practices to increase the quality and reduce the cost of health care.
- **Provide integrated care.** Our interdisciplinary teams, provider partners, and other extended members of the team use technology tools to support integration. This includes our multifaceted, bi-directional care coordination and a single member information system platform that enables us to drive improved communication, care efficiency, and outcomes, as well as a seamless member experience across the delivery system. Amerigroup does not subcontract any essential part of our care coordination model beyond its family of companies. Instead, our model facilitates a seamless member experience across the delivery system, including physical health, behavioral health, and LTSS. When we do utilize vendor partners, they are thoroughly vetted and proactively managed by Amerigroup through our proprietary integrated platform.
- **Facilitate access to services.** Members need access to care delivered at the right time and in the right place. We have developed innovative programs such as Live Health Online, which is a convenient alternative for members needing non-emergent care. When members call the Nurse Helpline, via a direct toll-free telephone number, licensed nurses determine if a virtual physician consultation would be beneficial in helping resolve the member's inquiry, based on the member's condition and video streaming capabilities. In addition, we will enhance existing telemedicine and telehealth capabilities, with a particular emphasis on behavioral health services as a means to expand member access to services, particularly in rural areas.
- **Ensure rural access to services.** We have substantial experience delivering care in rural areas: across our affiliate health plans, approximately 65 percent of the areas served are comprised of counties designated as "rural" by the U.S. Census Bureau. Using GeoAccess to identify Network adequacy gaps, we will partner with local providers and create incentives to open offices in rural areas. We will assist members in accessing transportation to appointments as a covered benefit where applicable and as a Value-Added Service for eligible members as well. Additionally, just as we have done in other markets, we plan to promote in-home clinical service delivery by board-certified physicians and nurse practitioners. Finally, we will also expand utilization of telehealth services for both primary and specialty care, to improve access to care in rural areas or for homebound individuals.
- **Deliver best-in-class programs to individuals with specialized needs.** Through our extensive experience, we have become experts in serving members with specialized needs, including but not limited to individuals with disabilities, out-of-home youth, and pregnant women. Additionally, we are

excited to introduce our CareMore program—an innovative solution focused on members with complex and/or chronic conditions—starting with a central location in Des Moines to be accessible to the highest density of appropriate members in the Iowa Initiative.

- **Encourage member responsibility.** Our “Healthy Rewards” program offers incentives for members to seek preventive services and screenings and manage their chronic conditions. Additionally, we have designed rewards for members to achieve their service plan goals, take their medications and learn about potential risks to maintaining their independence. The incentives provide a tool to enhance personal responsibility and self-management as a critical component of improving member health outcomes and satisfaction.

A Culture of Compliance and Ethics

Amerigroup takes the role of protecting public funds and complying with program requirements and obligations very seriously. While we adhere to our own time-tested compliance procedures, we will review and enhance them based on the needs of Iowa. Furthermore, we also incorporate new best practices from our affiliate health plans as the need for changes becomes apparent—nationally or locally.

We will have a local Iowa Compliance Officer who will report directly to the National Compliance Officer for our Medicaid line of business, while maintaining a day-to-day matrix reporting relationship with our local plan Contract Administrator and a close relationship with DHS. Our national Medicaid Compliance Program Services Department oversees a variety of programs that comply with federal and state laws and regulations. It administers all aspects of the compliance program, including training required of each Amerigroup employee in the areas of contract requirements, ethics, member rights, privacy and HIPPA, cultural diversity, disability awareness, and fraud, waste, and abuse.

A Commitment to Innovation & Customization

Amerigroup continuously improves our care model by seeking out innovative approaches to providing high quality health care that offers strong economic value to our state partners. From our use of technology to guard against fraud and abuse, to our utilization of data to aid providers in their delivery of care, to developing community based services for long term services and supports, to employing ancillary care centers through our CareMore clinics, Amerigroup is committed to seeking out new and better ways to improve member health outcomes and access to high quality, cost efficient health care.

Each Amerigroup affiliate health plan is unique and develops customized approaches for the state it serves. *The ability to draw from the experience of all our affiliate plans and leverage a centralized infrastructure that offers broad knowledge, cost-efficiency and scale, creates a perfectly balanced local health plan positioned to meet the needs of the many specialized member populations being served.* It's a model that delivers customized service, but with the benefit of deep and varied experience, and the strength and resources only a national leader in managed care can offer.

Our Purpose in Iowa

We look forward to partnering with DHS, the Iowa provider community and the many other community stakeholders in Iowa in effecting Medicaid Modernization. To this work, Amerigroup brings our track record in establishing large, multi-population implementations and its associated experience in assisting states with transitions from fee-for-service to managed care delivery systems. We also bring our proven model for care coordination and service integration and the resultant improvements in

healthcare quality, value, cost and outcomes. We look forward to fashioning delivery and support systems that emphasize member choice, independence, responsibility, safety, and engagement in all aspects of care through a member-centered care model that is at the core of all we do.



Nearly 1 million of our more than 5.2 million members have specialized needs, such as foster care youth, ID/DD, dual eligibles and LTSS.

IA_1_COB_1

Goals (1.2)

Health care across the United States is moving toward fully integrated delivery systems that emphasize quality, efficiency and improved health outcomes. Through participation in the Iowa High Quality Healthcare Initiative, Amerigroup Iowa (“Amerigroup”) looks forward to joining DHS in continuing Iowa’s transformation of its publicly funded health care system into a managed care model that embraces wellness, efficiency, and innovation.

With health plan affiliates operating state-sponsored programs in 19 states, we have extensive experience in delivering high quality health care, based on three principal objectives we believe are the building blocks for exemplary health care with superior value. ***These three objectives are: driving improvement of outcomes and quality of care; decreasing the overall cost of care; and improving the member experience.*** We feel these core tenets of our business approach align perfectly with the goals of the Iowa Initiative as demonstrated in Table 1.2-1.

Table 1.2-1. Amerigroup’s Objectives Match Iowa’s Health Care Goals

Principle Objectives of Amerigroup	Iowa Initiative Goals
Improve care quality and health outcomes	<ul style="list-style-type: none"> Improve the quality of care and health outcomes Provide physical health, behavioral health, and long-term services and supports in a highly coordinated manner
Decrease the cost of healthcare	<ul style="list-style-type: none"> Decrease health care costs through the reduction of unnecessary, inappropriate, and duplicative services
Enhance the member care experience	<ul style="list-style-type: none"> Emphasize member choice, access, safety, independence, and responsibility Provide services in the least restrictive manner appropriate to a member’s health and functional status Provide physical health, behavioral health, and long-term services and supports in a highly coordinated manner

Amerigroup will bring our vast affiliate experience in serving a wide range of individuals with specialized needs, including adults and children with physical disabilities, brain injuries, intellectual and developmental disabilities, serious mental illness, and substance use disorders. We also realize that one size does not fit all when it comes to the delivery of high quality health care. For this reason, we intend to work closely with DHS, providers, members and other partners to make sure our programs, systems, and services are tailored to reflect Iowa’s needs, concerns, and aspirations. Amerigroup’s locally focused, custom approach is central to how these principles have been accomplished in our affiliate plans and how Iowa’s goals will be met under the Iowa Initiative.

We drive improvements in care quality and health outcomes through care coordination, a focus on prevention, and strong quality management. We control costs through programs focused on preventing readmissions and emergency room visits among high risk individuals, through shared savings with providers and facilities, and through processes to reduce unnecessary, inappropriate, and/or duplicative procedures and tests. Finally, we pride ourselves on putting the needs and concerns of members first. This includes engaging members and their families where they are, empowering them to take responsibility and self-directing their care where at all possible. We emphasize independence and care in the least restrictive setting, and provide technology solutions and superior coordination of all events across the delivery system. The detail below demonstrates a few of our accomplishments and programs that support these three foundational objectives:

Objective 1: Improve Care Quality and Health Outcomes

Amerigroup takes great pride in driving measurable improvements in care quality and health outcomes. We adhere to the belief that “that which gets measured gets done.” A few of our affiliate health plans’ accomplishments:

These are but a few examples of our effectiveness in quality and outcomes, and we fully expect to create new standards in Iowa. We attribute these improvements to the following actions:

- Listening to and understanding our stakeholders, members, and providers
- Providing full care coordination across services
- Tracking quality of care and population health indicators
- Creating cross-sector partnerships to address health problems
- Implementing innovative solutions that address the holistic needs of our populations
- Identifying and developing quality program improvement opportunities

Following are a few programs and approaches that exemplify our passion for and excellence in improving health care quality and outcomes.

Outstanding Care and Service Coordination

Our successful cross-disciplinary care and service coordination model, honed over many years serving diverse and complex Medicaid and other populations across the U.S., emphasizes a member-centric focus: ***No matter what we do, we emphasize the member, not the process.*** We engage members as active participants in their health care decisions and address their biopsychosocial strengths and needs through quality services and supports, care coordination and management, a recovery focus, and health promotion. Our case managers meet with members to develop individualized service plans that span the service delivery systems of physical health, behavioral health, and LTSS and, as indicated, maximize member independence and offer care in the least restrictive setting possible.

In addition, we support the development of health homes, patient-centered medical homes (PCMHs), and other models that facilitate strong care coordination and improved care access on a systems level. Our efforts have resulted in improvements in provider compliance with evidence-based clinical practice guidelines and a reduction in avoidable, unnecessary inpatient admissions and emergency room (ER) visits, including measured improvements in the quality of health care delivery. Through these models, our affiliate health plans have successfully served:

- Expectant mothers
- Young children
- HCBS waiver populations
- Members who are hospitalized and those transitioning place of service
- Nursing home patients
- Persons with behavioral health needs
- Children and youth with special health care needs
- Other persons with chronic care or complex care needs

A Focus on Prevention: Healthy Families

We applaud Iowa's participation and progress in the Healthiest State Initiative and the emphasis DHS has placed on wellness and prevention in the Iowa Health and Wellness Plan. In Section 10.2.3, Healthiest State Initiative, we detail our plans to work collaboratively with DHS and other partners to address tobacco use, healthy eating and active living, and diabetes. We understand that what happens in the community can be as important to a person's health as what happens in the doctor's office or hospital. For this reason, we place a focus on community-based health promotion programs. In response to high rates of obesity in Iowa, particularly among low-income residents (CDC, 2013), Amerigroup will be rolling out our "Healthy Families" program. This Value-Added Service is a free, six-month telephonic coaching program for children and adolescents who are overweight, obese, or at risk for being overweight or obese. The program promotes making lifestyle changes such as healthier eating and increased physical activity.

Quality Improvement

Our comprehensive quality programs drive improvements in many areas, including but not limited to chronic disease management and prevention, behavioral health, patient safety, and community health for all members. In Iowa, our quality management program will serve as a central source of quality data, coordination, and performance improvement.

In 2014, our quality management program at our affiliate health plan in New Jersey generated the following improvements for our members:

- Increased their customer service ranking from the 25th to the 90th percentile
- Increased their "Getting Care Quickly" ranking from the 25th to the 75th percentile
- Increased their "Health Plan Overall" ranking from the 25th to the 50th percentile

Innovation through the CareMore Model



Amerigroup will bring to Iowa the unique capabilities of CareMore, an Anthem company and Amerigroup affiliate. If Amerigroup is awarded a Contract, CareMore will open at least one care center, starting with a centrally located to be accessible to the low-income residents in Des Moines, to serve the members of the Iowa Initiative who require higher levels of clinical intervention due to complex and/or chronic conditions. CareMore offers a ground-breaking model of care delivery that combines wellness, medical supervision, and a revolutionary approach to member engagement and participation. Our PCPs, acting as primary care team leaders, and our Extensivists guide members through every step of an integrated health care journey, regardless of the setting – facility-based, within the home, or outpatient – thereby managing acute and chronic events from beginning to end to ensure continuity of care. We utilize the expertise of physicians, nurse practitioners, behavioral health and other specialty clinicians, and social support experts adept in managing the experience of our members in body, mind, and spirit. ***CareMore outcomes include a 78 percent lower rate of amputation among individuals with diabetes compared to the national average and a 30-day readmission rate of 13.6 percent, compared to 20 percent nationally.***

Objective 2: Decrease the Cost of Care

Amerigroup generates savings for our state customers by providing high quality care in the most appropriate setting and at the right time. We do this through a variety of approaches, including developing programs and utilizing advanced technologies to reduce re-hospitalizations and preventable ER use, by offering training and pay-for-performance incentives to providers and facilities for efficient, evidence-based care delivery and by detecting and ameliorating unnecessary or wasteful practices and/or fraudulent activities. The result is higher quality care and better health outcomes for less per-member cost.

Home Connect Program

Avoidable hospital readmissions are primarily driven by a lack of appropriate follow-up care. The greatest risk occurs within the first 48 hours post-hospitalization. To reduce this, our HomeConnect Program engages members before discharge to create a transition plan with appropriate follow-up care. To complement this, we reconnect members with their PCP to improve access to follow-up care and increase member contact through face-to-face interactions during the inpatient stay.

We will implement the Home Connect Program in Iowa. The program will consist of the following activities to enhance a seamless transition for the member into the community:

- Discharge planning
- Daily census reports
- Educational letters to members
- Care manager engagement with members during hospital stay
- Member visits, including transitional facility visits and bridge on discharge visits
- Provider outreach during admission and for verification of follow up after hospitalization
- Member outreach calls within one business day of discharge
- Stabilization care management
- Readmission rounds
- Facility feedback presentations to share performance data with high volume providers

Pay for Performance: Rewarding Quality and Efficiency

We will implement our proven pay-for-performance provider incentive model in Iowa. ***This model offers a suite of incentives programs that can be applied to PCPs, OB /GYNs, other specialists, hospitals, nursing homes, behavioral health providers, and ACOs.*** This suite of incentive programs helps to drive improvement on measures relating to children's health, adult preventive and chronic condition management, birth outcomes, nursing facility and ICF/ID days of care, and avoidable hospitalizations. In fact, in our most mature primary care incentive program, participating provider groups have shown a 3 percent favorable difference in quality and an 8.6 percent favorable difference in total medical cost.

Amerigroup is in a unique position to be able to capitalize on a strong relationship with Wellmark in designing and implementing this model in Iowa. Wellmark has begun and will continue to assist Amerigroup in developing deep relationships with Wellmark's existing ACO provider partners, which includes over 2,000 Iowa primary care providers and covers 525,000 Wellmark members. We also intend to incorporate the 3M Treo Solution composite scoring methodology into the ACO Shared Savings/Shared Risk program in a manner consistent with the Wellmark ACO VIS approach, modified as required to be most applicable to our members.

One incentive program that we want to highlight is our PCP Quality and Population Health Management Program. Nationally, our organization has deployed this incentive model across 11 affiliate health plans, encompassing PCPs who care for 414,000 members. For full-year 2013 results (the most recent available), providers who were in this model showed a year-over-year quality and cost improvement rate that was better than providers who were not.

Tele-Connect Program: Keeping Members Safe

Many of our affiliate plans have significant experience and success in leveraging remote tele-monitoring tools to help reduce avoidable hospitalizations and emergency room visits. This program, particularly effective for members with targeted chronic illnesses and disabilities, will also be implemented in Iowa. Our Tele-Connect program links members at home to their PCP and care manager with easy-to-use

equipment. Members with targeted conditions, such as chronic obstructive pulmonary disease, diabetes, and congestive heart failure, are monitored remotely through blood pressure cuffs, weight scales, glucometers, pulse oximeters, and pedometers. This advance warning system enables the case manager and provider to act swiftly if a member's vital signs fall outside the predetermined range.

Amerigroup will offer an innovative telehealth system tailored to monitor members with chronic conditions. In partnership with an experienced vendor, we will watch for falls, exceptions to client's vital signs, and medication adherence 24 hours a day, 7 days a week, 365 days a year for members referred into this program. We have found telehealth to be an effective tool in improving health outcomes and promoting member safety, while preventing avoidable, expensive hospital admissions.

Reducing Fraud, Waste and Abuse

The increasingly complex Medicaid marketplace and interconnected programs require diligent monitoring and oversight to safeguard against fraud, waste, and abuse. Amerigroup maintains sophisticated detection tools and systems that we apply prior to claim payment; during post-payment claim review, systematic data mining, and referral follow-up. Systems such as iHealth Technologies and McKesson's ClaimCheck® are employed as a "final filter" before professional and outpatient facility claims are paid - all while maintaining prompt payment to providers. Proactive post-payment review resources include EDIWatch, a retrospective, rules-based system that detects anomalies in data using thousands of statistics, rules, and patterns. Amerigroup's experience managing and integrating these tools has been very effective in preventing fraud, waste and abuse in addition to recovering inappropriate payments.

Across our national organization, we are focused on program integrity and have systems in place to detect and address unnecessary or wasteful practices and/or fraudulent activities. In calendar year 2014, these programs produced in excess of \$210 million in savings in our 19 state-sponsored programs.

- Our affiliate health plans opened 1,200 fraud, waste, and abuse cases and identified \$28.9 million in net savings. This equates to a return on investment of approximately 9-1; the national average is 8-1.
- Provider code editing solutions strengthen our program integrity by utilizing sophisticated claim payment logic (post-service, pre-payment) to identify unbundled services, overpayments (for example, duplicates or components of a global service) and implement National Correct Coding Initiative (CCI) logic. These code editing solutions produced \$184.6 million in savings.

Objective 3: Improve the Member Care Experience

Amerigroup continuously identifies opportunities to improve member choice, protections, and access to services. Related to member choice, our affiliates have a solid history of rapidly establishing a geographically broad provider network and, just as importantly, have high provider satisfaction ratings. To ensure optimal choice in providers, we will require providers to retain open member panels.

Cultural accessibility is emphasized through requisite staff cultural competency training. Our staff is specifically trained to work with diverse individuals, respecting their cultural differences and providing comprehensive supports, including interpretation and translation services and solutions focused on persons with speaking, hearing, or visual impairments. Our affiliates' voluntary abandonment rates are extremely low, and our member satisfaction ratings are very high. Provided below are some of the approaches and programs we intend to utilize in Iowa to optimize our members' care experience.

Effective Care Integration.

We believe in holistic, whole-person care. In full recognition of the inseparability of physical and behavioral health, we directly manage physical and behavioral health care networks ourselves, rather than outsourcing these services to a subcontractor. This allows us to better integrate them in our members' care. We leverage specialized clinicians, clinical practices, and guidelines that address the unique physical, behavioral health, and social support needs of each of our members.

For example, our affiliate health plan in New York is implementing a comprehensive and innovative program called Health and Recovery Plans (HARPs) to support members with severe mental illness (SMI). The State of New York has commended our efforts in this regard, noting our “...appreciation of the unique needs of individuals with serious behavioral health conditions.” Our program in Iowa will replicate significant elements of this program, and facilitate cross-communication between outpatient and inpatient systems of care; promote evidence-based practices across settings; and provide a more seamless, holistic, and recovery-focused experience for the member.

Electronic Access – Any Time, Any Language

Amerigroup will be providing a variety of options for Iowa members to access physical and behavioral health resources 24 hours a day, 7 days a week. Members will always have access to our Nurse HelpLine, a part of our Amerigroup On Call program for nonemergent medical questions, and may be referred for a web-based physician consultation through our LiveHealth Online program. Iowa members will also have access to our Behavioral Health Services Hotline through a single toll-free member Services call center. Recognizing that more than 80 languages are spoken in Des Moines alone, callers who do not speak English or Spanish will be provided free, immediate interpretations services in more than 200 languages through a language line. Interpreters will be available to join a call 24/7 and can also support members calling from a provider’s office.

Telemedicine/Telepsychiatry Services



Amerigroup is very interested in working with DHS to expand Iowa’s telemedicine and telehealth capabilities as a means to expand member access and choice – particularly in rural and remote areas. Indeed, in conversations with Iowa providers and stakeholders, we have consistently heard a need expressed for telehealth solutions related to member access, especially as it relates to specialty care. As such, Amerigroup will deploy telehealth platforms to further increase access and reduce barriers to care for Iowa members. We will work with the substantial telehealth services currently in place in Iowa, such as those provided by the University of Iowa, and partner with providers to expand existing services as needed to meet the needs of our members. We will also provide LiveHealth Online, our telehealth platform for primary care, and partner with Breakthrough, a telehealth platform for behavioral health, as additional avenues to deliver one-on-one consultations with board-certified clinicians either through personal computers or at kiosks

installed at strategic community locations. Breakthrough’s overall member satisfaction is 87 percent, while 50 percent of members report they would not have had access to a Behavioral Health provider without Breakthrough’s technology. Amerigroup will continuously work to identify appropriate locations for both of these platforms, so this technology will be easily accessible to our members in a private setting. Further, since our LTSS staff currently uses iPad technology in the field today to support care coordination, they will also be able to facilitate telehealth sessions throughout Iowa when necessary for members who do not have access to a computer or smartphone. We believe this multipronged telehealth strategy will help us eliminate gaps in care for members in both rural and urban areas by disaggregating healthcare from its traditional locale, empowering homebound or otherwise inconvenienced members to access required care and consultation.

Member Responsibility: Healthy Rewards

Our Healthy Rewards program provides incentives for members to seek preventive services and screenings and to manage their chronic conditions. This free program serves to enhance personal responsibility and self-management. We have an established and proven platform in place supporting

program administration (card issuance and financial management of incentive accounts) in our Kansas, Louisiana, and Texas affiliates. This platform enables us to tailor Healthy Rewards to reflect the unique needs of our State customers and members. Early data from Kansas suggest that Healthy Rewards has had a powerful positive impact in areas such as adolescent well-care visits, well-child visits, cervical cancer screening, diabetes care, and postpartum appointment rates. As the Iowa program develops and matures, we will continually re-evaluate its impact and make modifications as necessary to reflect evolving State priorities and member behaviors.

Achieving the Goals of the Iowa High Quality Healthcare Initiative

In summary, Amerigroup is extremely excited to work with DHS in further transforming the publicly funded health care system in Iowa into a model for delivering high quality health care in a manner that improves health outcomes and addresses the needs of a wide variety of populations. We believe we bring a depth of experience and expertise unparalleled in the industry, well-documented effectiveness and value, and a passion for innovation that will serve Iowa well in its new initiative. ***Our goals are aligned, and Amerigroup's experience and capabilities position us to help achieve each of these goals –from a seamless transition to a successful, comprehensive implementation.***

Reserved (1.3)

The State has marked this requirement as “Reserved” in the RFP.

General Contractor Responsibilities (1.4)

Federal and State Laws and Regulations (1.4.1)

Question 1.4, #1

1. Indicate your ability to comply with all Federal and State Laws and Regulations that may affect this Contract.

Our affiliates' extensive experience operating health plans that are built to comply with the unique state and federal requirements that accompany state sponsored health programs gives us confidence in our ability to comply with all laws and regulations. Amerigroup agrees to meet all Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act; and Section 1903(m) and 1932 of the Social Security Act, as well as the implementing regulations set forth in 42 CFR 438, as may be amended. Furthermore, we will observe and comply at all times with all, then current, Federal and State Laws related to or affecting this RFP or Contract, including any Law that may be enacted during the term of this RFP or Contract. We affirm that we will be compliant with all applicable Federal and State Laws pertinent to member rights and assure that our staff, network providers, and subcontractors take those rights into account when furnishing services to members. We understand that it is our responsibility to remain aware of changes in Federal and State Laws and Regulations as they affect our duties and responsibilities under this RFP or the Contract.

Qualifications (1.4.2)

Question 1.4, #2

2. Summarize how you are qualified to provide the services listed in Section 1.4.2

Diversity, Track Record, and Partnership (1.4.2.1)

Amerigroup can draw from the experience, diversity, and track record of our affiliate health plans. We understand that providing a comprehensive array of services requires a diverse and substantial network of providers, partners, and stakeholders. In new markets, our affiliates have a track record of quickly building broad and robust provider networks to assure a wide range of service availability to our members and their families.

In addition, we understand and value of the resources available through Iowa State government. We will work closely with State agencies such as DHS (for example, TANF and child protection), the Iowa Department of Public Health (for example, WIC and Iowans Fit for Life programs) and the Iowa Department of Corrections. We are already reaching out to local agencies such as federally qualified health centers, rural health clinics, hospitals (including Critical Access Hospitals), community mental health centers, substance use disorder agencies, county health departments, nursing facilities, home and community-based service agencies, rehabilitation providers, centers for independent living, and emergency medical services. We will take a leadership role in creating and coordinating a robust network that combines the integrated delivery of a broad base of health and social services with geographic, cultural, and linguistic accessibility.

Moreover, we know the importance of strong connections with community-based organizations, and we look forward to building relationships with agencies such as school districts, area education agencies, decategorization boards, job placement and vocational service agencies, and judicial districts. In fact, Amerigroup has already begun efforts to engage with these and other agencies. An example is that our behavioral health experts have been in discussions with the 15 regional mental health agencies to understand commonalities and nuances of their operations and how we can work with them effectively to:

- Promote integration of behavioral and physical health
- Improve access to behavioral health services in the program
- Another example is that on March 25, 2015, Amerigroup representatives participated in a general meeting with county administrators of the Iowa Counties Public Health Association (ICPHA). We are in discussions with ICPHA to explore use of an **enhanced telehealth network** that will expand access to specialty care and behavioral health services. We have also met with additional Iowa community-based organizations including National Alliance on Mental Illness Iowa, Iowa Association of Area Agencies on Aging, Statewide Independent Living Council, Iowa Behavioral Health Association, Orchard Place, Iowa Health Care Association, and LeadingAge Iowa, among others.

"Throughout the readiness process, launch, early implementation and operation, Amerigroup has been a strong and responsive partner with us on the KanCare program. They proactively learned the Kansas system, providers, members, advocates and other stakeholders... They are always solution-focused and responsive, extremely organized with strong administrative staff and processes, and consistently good communicators and collaborators."

**Elizabeth Phelps,
Program Finance and
Informatics – Public Service
Executive III,
Kansas Department of
Health and Environment**

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Kansas: A Complex, Multi-faceted Program

One of our core competencies is successfully implementing new programs, including those involving broad scale changes across a delivery system, in a manner that smoothly transitions members, providers, and stakeholders and avoids disruption to care.

Our affiliates' recent expansions include transitioning specialized services from a fee-for-service system to managed care environment with wholesale changes for members, providers, and stakeholders. As illustrated in one of our many letters of support found in Attachment 1.1-1, our organization and affiliate health plan was a "strong and responsive" partner that "proactively learned the Kansas system, providers, members, and other stakeholders..." Amerigroup will bring that same level of commitment to Iowa.

Our Kansas affiliate recently collaborated with the State to launch a significant redesign of its Medicaid program. Launched in 2013, the new program includes the full range of populations and services, including Long Term Services and Supports (LTSS), waiver programs, individuals with intellectual or developmental disabilities, and members of all ages with disabilities.

Our affiliate has developed an innovative array of expanded services to meet the needs of this unique program: healthy living coaching for families with kids 7–14 years, up to \$100 in special bedding for members with allergies, pest control, dental care for adults, and member and caregiver transportation. The Kansas implementation was compressed, similar to the timeline required by the Iowa Initiative, and offers many lessons for navigating a complex and fast-paced implementation.

Managing All Statewide (1.4.2.2)

Amerigroup affirms that we will manage all statewide physical health, behavioral health, and LTSS, for Iowa residents who meet Iowa Initiative eligibility requirements and are enrolled in our health plan. As illustrated in Table 1.4-1, Amerigroup's affiliates have considerable experience coordinating statewide care that offers integrated physical health, behavioral health, and LTSS. Our overall philosophy is that integration of these services offers the most efficient and effective care model.

In each of our affiliate, Amerigroup's integrated team **directly administers** physical health, behavioral health, and LTSS benefits in-house. Direct management aligns all teams and allows us to remain nimble in responding to changing needs and market conditions. We will bring integrated care model to Iowa.

Our **Quality Management Work Plan spans all benefits and functional areas**—medical health, behavioral health, and LTSS—and includes initiatives that strengthen integration. For example, our Tennessee affiliate developed a program to improve screening rates for members receiving LTSS who have cardiovascular disease. In its first year, this program boosted low-density lipoprotein screening rates by more than 120 percent.

We train for success in integrated care. Case managers and clinical employees receive both classroom- and field-based education in care integration. At the center of our curriculum is full integration of physical, behavioral, functional, and social health. All case managers must demonstrate the requisite skills to assist individuals with co-occurring disorders. Once they demonstrate competency, they are tested annually.

Table 1.4-1. Amerigroup Affiliates Integrate Care Across Systems

State	Membership	Medical	Behavioral Health	LTSS	Pharmacy	Substance Use Disorder
CA	1,081,270	•	•	•	•	
FL	361,277	•	•	•	•	•
GA	352,860	•	•		•	•
IN	244,753	•	•		•	•
KS	130,158	•	•	•	•	•
KY	60,148	•	•		•	•
LA	133,131	•			•	
MA	261,152	•	•		•	•
MD	18,961	•			•	
NV	180,656	•	•		•	•
NJ	214,992	•	•	•	•	•
NY	464,530	•	•	•	•	•
SC	83,393	•	•		•	•
TN	222,134	•	•	•		•
TX	811,511	•	•	•	•	•
WA	129,180	•	•		•	•
WV	88,546	•			•	
WI	79,378	•	•			•
VA	272,004	•	•		•	•

This systematic and intentional approach has borne fruit. *Our New York affiliate, which coordinates physical, behavioral, and LTSS services, is ranked by the National Committee for Quality Assurance (NCQA) in the top 10 nationally among all Medicaid health plans, based on consumer satisfaction, prevention, and treatment.*

New York: Fully Integrated Program Success

Amerigroup and its affiliate plans promote fully integrated healthcare systems that incorporate the behavioral health benefit into mainstream managed care. As part of this construct, our New York affiliate is supporting the State of New York in fully integrating the behavioral health benefit into managed care and creating specialized Health and Recovery Plans (HARP) to meet the needs of individuals with severe mental illness (SMI). HARPs will offer eligible members additional intensive supports and recovery-focused benefits through a separate product line. *Our affiliate designed a program that the State of New York commended during the design and qualification process for its “appreciation of the unique needs of individuals with serious behavioral health conditions.”*

Through the HARP, our New York health plan will facilitate cross-communication between outpatient and inpatient systems of care; promote evidence-based practices across settings; and provide a more seamless, holistic, and recovery-focused experience for the member. It requires dedicated, comprehensive, recovery-focused processes and systems; highly trained and skilled staff; and ongoing collaboration with health homes, physical and behavioral health service providers, and other community stakeholders. In collaboration with community partners, our New York health plan is working to expand awareness of and access to services and will be part of determining the capacity and overall system needed for growth of these services.

Reducing Problems, Maximizing Member Functioning and Improving Quality of Life (1.4.2.3)

Amerigroup agrees to operate in a manner that results in timely, culturally relevant, and effective statewide services. Our goal is to reduce problems and symptoms stemming from physical or behavioral health issues, maximize functioning, and improve quality of life. We will partner with the State and the community to assure delivery of effective services that sustains individual functional gains.

With 24 years of experience coordinating care for low-income populations and currently serving more than 5.2 million members in Medicaid and other state-sponsored programs across 19 states, Amerigroup and our affiliate plans have vast experience providing integrated, member-centric care coordination to all populations included in the Iowa Initiative. We serve our members through a “whole person” approach that supports their physical, behavioral, cognitive, functional, and social strengths and needs across the full spectrum of healthcare settings. Our member-centered model helps members optimize their benefits and available services to get the high quality care and support they need. Our care model incorporates health promotion and preventive care services, coordinating care among treating providers and including social supports that reinforce positive health and quality of life outcomes.

We will bring to Iowa our years of experience and hard-earned lessons, national expertise, specialized programs, and innovative technology to give our Iowa members voice and choice in receiving the support they need to access the services that enable their health, wellness, and quality of life.

In compliance with 42 CFR §438.208 and all the requirements outlined in the Scope of Work, our integrated care coordination program drives the processes, policies, procedures, and tools that support the following activities:

- Identification of members with potential or actual care coordination needs through early screening, comprehensive assessments, and periodic reassessments
- Stratification of risk level for each member based on a multi-faceted consideration of available information for each individual
- Placement of members into care coordination programs based on needs assessment
- Development of an integrated care plan that addresses physical health, behavioral health, and LTSS needs for members as they transition across all settings
- Reciprocal referrals and information sharing
- Formation of an interdisciplinary team to support the member, providing consistency and continuity of contact with a familiar support system, as well as the expertise of a broader team of specialists as members' needs evolve over time
- Care coordination support for the member in accessing needed services, including scheduling appointments; arranging transportation; conducting appointment reminders; following up to verify service initiation, member progress, and need for service and care plan adjustment
- Ongoing evaluation of our care coordination program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and performance improvement
- Emphasis on disease prevention and member wellness, chronic condition management, and increasing member compliance with recommended treatment protocols
- Member education to enhance understanding of healthcare conditions and prescribed treatment
- Member empowerment through comprehensive communications, equipping members with information about their care, providing multiple communications channels, and encouraging member communication with providers.

In addition, we support the development of health homes, patient-centered medical homes, and other tested models that facilitate strong care coordination and improved care access on a systems level. Our affiliates’ efforts in these areas have resulted in improvements in provider compliance with evidence-based clinical practice guidelines and a reduction in avoidable, unnecessary inpatient admissions and emergency room visits, including measured improvements in the quality of health care delivery.

We strive to achieve the combined high rates of member satisfaction with improved functioning and quality of life, and we are confident that we will be successful in Iowa.

Establishing a Comprehensive, Accessible Provider Network in All Areas of the State (1.4.2.4)

Amerigroup and our affiliate plans are industry leaders in building robust network solutions for state partners: solutions that recognize and support the needs of some of the most vulnerable citizens while offering geographic accessibility. Our provider network development and management is based on the experience we gain by being on-the-ground; collaborating with providers, community leaders and advocacy groups; and listening to our potential members’ and their families’ describe the challenges they face as they maneuver the health care system. Building our network strategies around this feedback creates a strong foundation for the repeatable and sustainable success of our networks. Table 1.4-2 demonstrates that we contracted more than 72,000 providers in our last three significant affiliate builds.

Table 1.4-2. Amerigroup and Our Affiliate Health Plans Build Solid Provider Networks

Network Builds			
Provider Type	Kentucky*	Tennessee*	Virginia*
Primary Care	5,672	2,167	7,765
Behavioral Health	2,452	1,348	5,783
Specialists	23,176	5,068	14,202
Federally Qualified Health Centers/Rural Health Centers	207	101	87
Urgent Care	482	246	51
Hospitals (including Critical Access Hospitals)	113	52	74
Nursing Facilities	10	166	159
LTSS/Ancillary	985	763	1,352
TOTALS	33,097	9,911	29,473

**Products in Kentucky were TANF/CHIP/BH; in Tennessee for east and west territory expansion products were TANF/CHIP/LTSS/BH/DSNP; in Virginia product was MMP.*

In Iowa, we will deliver a statewide provider network that meets or exceeds all State adequacy standards. But just as importantly focus on addressing underlying member access to care issues that may not be addressed fully within the States adequacy standards. Our network will include providers who traditionally serve the population covered by the Iowa Initiative, including community mental health centers, community developmental disabilities organizations, centers for independent living, local area agencies on aging, substance use disorder providers, federally qualified health centers, nursing facilities, and other safety net providers. It will also include providers who offer specialized services for those with disabilities, chronic conditions, and unique or specialized healthcare and service needs such as the populations with home- and community-based service waivers. We do not restrict access to specialty services and do not require referrals to network specialists.

Amerigroup promotes access to quality care by maintaining a network capacity that exceeds the level required for our expected enrollment. We have a proactive outreach and contracting plan to fill out our target provider network in advance of the readiness review. ***Amerigroup and our affiliates take pride in never having failed a readiness review.*** Additionally, we understand the extra attention it takes to build

and maintain a successful LTSS network in the rural areas of the State where providers are unaccustomed to managed care and need extra attention or face-to-face interactions. This knowledge will allow us to fully leverage our experience and collaborate with providers to improve the delivery of services in Iowa.

Offering a Coordinated Array of Services (1.4.2.5)

Amerigroup is committed to providing members with services addressing a wide range of physical, social, functional, behavioral, and LTSS needs. This breadth of services, particularly for individuals with complex care needs, demands strong care coordination practices and systems.

We know the importance of precise care coordination across the entire delivery system. Using the knowledge we have gained through the overwhelmingly positive experiences we have had with such programs in the past, we have a solid foundation for implementing comprehensive care coordination across the care continuum for the Iowa Initiative. We have found that many members who received multiple diagnoses and various treatment regimens have been unable to attain their recovery goals because, prior to Amerigroup administering the coordination of care, there was no open line of communication between physical and behavioral health providers, facilities, and community resources.

Once we establish coordination and communication across providers, hospitals, and other community supports and stakeholders in the delivery system, we are able to decrease re-admissions and recurring, unnecessary emergency room visits, while increasing the quality and completeness of care. Using this approach, we were able to impact care for high risk mothers and children that were part of our Indiana Plan membership, driving a 17.4 percent decrease in inpatient admissions, a 15.0 percent reduction in emergency room visits, and a 10.9 percent decrease in re-admission rates from 2012 to 2013.

We are committed to driving improved health outcomes one member at a time, by doing the right thing for every member every time. We engage members where they are to help them achieve their health goals. Our model is member-centric and provider-focused – our strong relationships with PCPs enable us to utilize our member's health home as the hub of the care delivery system.

Tennessee Recognizes Successful LTSS Implementation

In 2010, our Tennessee affiliate health plan successfully implemented CHOICES, Tennessee's program serving members requiring LTSS. Through that implementation, our affiliate successfully assumed coordination and coverage responsibilities for LTSS services for 3,902 seniors and people with physical disabilities living in the community or in nursing facilities and contracted with 217 LTSS providers.

In 2011, our Tennessee health plan received the overall CHOICES implementation award from the Tennessee, citing the high quality of our processes, policies, and procedures; knowledgeable approach; and implementation readiness. Following program implementation, our affiliate provided services to LTSS members who are aging, blind or disabled members that resulted in a decrease in members residing in a nursing facility from 81 to 65 percent, and transitioned more than 200 members from a nursing facility to a community-based alternative, potentially saving the state of Tennessee \$3.6 million annually.

Additionally, our Tennessee affiliate collaborated closely with the state in the design and launch of the Population Health Program, a comprehensive disease management initiative. From its initial planning in 2011 through implementation in July 2013, our leadership team worked closely with the state and other managed care entities to lend our expertise and understanding of members and providers in Tennessee, as well as the opportunities and challenges of a new model. The health plans' Population Health Program also won a "Case in Point Platinum Award" in 2014 in the category of Integrated Disease Management Programs from Dorland Health. This unique awards program recognizes the most successful and innovative case management programs working to improve healthcare across the care continuum.

Improving Quality of Care (1.4.2.6)

At Amerigroup, quality is embedded in everything we do. Our multilevel strategy to improve quality indicators sets goals at the organization level, the department level, and even at the individual employee level. We individualize health plan and regional goals according to each area we serve.

Our comprehensive quality programs improve quality of care with initiatives that target chronic disease and prevention, behavioral health, patient safety, care coordination, community health, service quality, and care management for all members. Amerigroup will deliver quality health care services and drive health outcome improvements for Iowa Initiative members.

We will meet or exceed the standards for Quality Assessment and Improvement (QAPI) programs required by CMS, NCQA, and the State of Iowa. Our commitment to these standards is evident in our affiliates' widespread NCQA accreditations, strong HEDIS and CAHPS performance measures, innovative quality programs that are responsive to the identified needs of our members, and effective continuous improvement processes. As evidence of our commitment to quality, NCQA includes seven Amerigroup affiliate health plans in its list of the Top 100 Medicaid health plans in the country. Other key achievements include:

- NCQA accreditation in 13 states
- Exceeding the NCQA 90th percentile on critical performance measures such as timeliness of postpartum care, use of appropriate medications for members with asthma, follow-up after discharge for members hospitalized for mental illness, breast cancer screening, HbA1c screening, and adult body-mass index assessment
- Widespread improvement across our affiliates in Follow-Up After Hospitalization, Well Care, and Annual Dental Visit HEDIS rates
- Innovative and effective quality strategies that capitalize on technology and community partnerships
- Rigorous and methodical performance improvement projects

To achieve quality goals, we embrace QAPI as a workplace culture and philosophy, not simply a separate function within the health plan. All of our employees participate in improving processes, services, and the culture in which we work. We implement cross-functional approaches that include representation from local health plan operational areas to work with national leaders in their functional areas. Representatives from Quality Management, Utilization Management, Case Management, Disease Management, Behavioral Health, Credentialing, Network, Communication, Technology, Compliance, and our specialty organizations come together to solve problems and identify quality best practices. Our College of Quality provides a Quality 101 orientation for our employees, as well as ongoing training on continuous clinical quality improvement structure. Our quality management philosophy extends to every level of management in the organization, and we embed quality goals into every employee's performance plans for success. Amerigroup's Culture of Quality is embedded in every aspect of our organization. Every employee is a quality advocate, and quality is the number one priority in every functional area.

In Iowa, we will implement creative, proven member and provider incentive strategies to drive performance improvement and favorable outcomes, as detailed in our response to 10.3 below. ***This includes partnering with Wellmark to implement the 3M Treo Solution as a consistent measure of value across ACO providers.*** We will use ongoing assessment, tracking, and work plans based on measurable goals to promote member outcomes, drive provider quality and efficiency, and decrease negative outcomes and incidents. We will also design special programs and partnerships in support of Iowa's specific goals, such as the Healthiest State Initiative (see Section 10.2).

Our Quality Management leadership evaluates our performance measures periodically to assess their continued significance. For example, Table 1.4-3 illustrates a sample set of reduction in ER visits, as well

as inpatient admissions, across our health plan affiliates that offer disease management programs. The sample set shows improved outcomes for members in our disease management program. *Claims analysis showed that between 2012 and 2013, our affiliates experienced an overall reduction in their disease management programs of 19.6 percent in ER visits and 25.3 percent for inpatient admissions.*

Table.1.4-3. Effectiveness of Amerigroup Disease Management Programs

Affiliate Medicaid Health Plans’ Disease Management Results for Emergency Room Visits and Inpatient Admissions: 2012 – 2013 Year-Over-Year Comparison		
Disease Management Program	ER Visits per 1,000 Members	Inpatient Admissions per 1,000 Members
Asthma	-27.2%	-39.5%
Congestive Heart Failure	-12.5%	-10.6%
Diabetes	-14.7%	-8.2%
Major Depressive Disorder	-16.5%	-9.9%
All Disease Management Programs	-19.6%	-25.3%

At Amerigroup we believe “that which gets measured gets done.” Our Quality Management Program is at the core of our success in optimizing health outcomes, decreasing the cost of care, and increasing quality of care and services. We look forward to working with DHS to advance quality outcomes for the Iowa Initiative and using our tools to help achieve improvement in its priority measures.

Improving Outcomes (1.4.2.7)

We are intensely proud of our achievements related to improved health outcomes, and we look forward to working shoulder to shoulder with DHS and other partners to help achieve optimal outcomes for our members and other groups affected by health disparities. Indeed, we are excited to work with Iowa in its bid to become the nation’s healthiest state. To make this happen, we will appoint a local Amerigroup team led by a senior plan executive to work directly with key constituents (e.g., DHS, Iowa Department of Public Health, Healthiest State Initiative workgroups, local businesses, community organizations, providers, other MCOs, other State agencies, and, of course, our members) to tailor our market-leading programs to address key state performance gaps and lead by example. We are committed not only to help drive superior health and wellness performance, but to improving quality and cost-effectiveness across the entire healthcare delivery system.

We believe our willingness to collaborate is at the heart of our success. For instance, our Tennessee affiliate worked closely with the state of Tennessee in designing and launching the Population Health Program, a comprehensive disease management initiative. From its initial planning in 2011 through implementation in July 2013, our leadership team worked closely with the state and other health plans to lend our expertise and understanding of members and providers in Tennessee as well as the opportunities and challenges of a new model.

The Population Health Program uses an integrated care management model that has delivered results. In one quality improvement initiative, we measured the impact of integrated case management for TennCare members diagnosed with both severe mental illness (SMI) and diabetes. Between 2008 and 2012, behavioral health visits increased by 116 percent in the participating population, emergency room visits decreased by 59 percent, and inpatient admissions decreased by 15 percent. Additionally, clinical improvements in the diabetes standard of care for retinal eye exams increased by 17 percent.

Other data validate our integrated model. In 2012, 69 percent of members enrolled in case management reported an improvement in their quality of life, and 99 percent of members were satisfied with their case management. Additionally, 73 percent reported that they are either much more or more confident in their ability to handle their healthcare needs after receiving case management services. Table 1.4-4 provides additional data regarding our effectiveness in outcomes in our New York and Tennessee affiliates.

Table 1.4-4. Amerigroup’s Effectiveness in Well Child Visits and ADHD Care

Well Child Visit, 3 – 6 Years of Age			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90 th percentile	83.04	82.08	82.69
New York	82.27	84.58	86.23
ADHD Initiation Phase			
NCQA 90 th percentile	52.48	51.86	53.03
Tennessee	61.33	60.54	60.59

This year, the NCQA ranked more than 1,000 commercial, Medicaid, and Medicare health plans based on clinical performance, member satisfaction, and NCQA accreditation. The annual NCQA rankings are based on a weighted score for each plan, combining scores from: NCQA Accreditation Standards (15 percent); HEDIS measures (60 percent); and CAHPS (patient-satisfaction measures) (25 percent)

Our New York affiliate ranked eighth nationally and did so in its first year of reporting. In addition, our affiliate health plans managing Medicaid programs in *Georgia, New Jersey, Tennessee, and Nevada* were ranked in the Top 50. Tennessee ranked 23rd and has been in the Top 50 for three consecutive years.

Accessible Services (1.4.2.8)

As outlined in Section 1.4.2.3, our case managers, as part of an interdisciplinary team, work directly with members to develop an integrated care plan that addresses physical health, behavioral health, LTSS and other member needs across all service settings. Case managers support the member in accessing the services, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation, member progress, and need for service adjustment and incorporation into the care plan. Within this service provision, Amerigroup respects and appreciates the Independent Living movement and philosophy. Our organization created a National Advisory Board, a volunteer panel of family members and persons with disabilities which advises, promotes services and supports models that foster independent living and quality of life for people who are aging or have disabilities. We are working continuously to assure that services are readily accessible for *all* members.

Access to Providers & Member Choice

Recognizing our responsibility to provide members with accessible services and a choice of providers, we strive to be proactive in network development and management – carefully identifying and planning for potential network gaps before they become an issue. Most network gaps are the result of providers ceasing to do business, leaving the service area, closing their panel to additional members, or losing their credentials. *Across our affiliate plans, voluntary turnover rate for providers disenrolling from the network is less than one percent.* When we identify network gaps, we use a variety of integrated and comprehensive intervention strategies to quickly fill these gaps. When disruptions in care do occur, we have systems in place to ensure affected members are communicated with as soon as possible and made aware of their options, in addition to regular review of those members’ utilization of care to make sure they receive all necessary care.

Based on an analysis of current and future needs, we develop and maintain work plans that identify specific network development activities. The work plans will be developed and managed in accordance with DHS network requirements, company policies, specific staff positions and/or department responsibilities, and the anticipated timeframes for completion. Our senior network development leadership will review the work plans with applicable staff and other departments, will monitor progress, and will update and/or revise activities as necessary. Specific assignments will be made to the appropriate staff to oversee the filling of the identified network gaps.

Easy, extended access to care positively impacts member satisfaction. We believe when members are able to choose providers with convenient appointments, the likelihood of positive health outcomes and

adherence to treatment plans and follow-up is increased. Our provider agreement in Iowa will require providers to abide by all appointment standards specified in the RFP. We will educate all providers on access standards through provider orientation, ongoing training, our provider manual (incorporated by reference as part of the provider agreement), and frequent reminders in newsletters and fax blasts.

To further expand the accessibility of our provider network, we will use the latest proven technology to offer telemedicine applications, web-based physician access, and remote monitoring to improve access for members in rural areas and for individuals with challenges in accessing traditional care and services.

Linguistic and Cultural Accessibility

We maintain our level of dedication to culturally appropriate care by regularly reviewing and analyzing our network and staff structure so that there is a diverse representation of providers and staff to members. We understand the Native American and Alaskan Native populations tend to choose providers based off of word of mouth. This is important to recognize when maintaining continuity of care within these populations. To that end, Amerigroup works to recruit additional culturally diverse providers, employees, and community advocates and/or liaisons to maintain a robust network of care.

We have established processes, policies, and procedures for capturing a member's preferred language in our integrated care management system, which is readily accessible by health plan employees who have direct contact with our members. We will connect members to providers who speak their language of choice and make health plan employees and/or resources available in the member's language twenty-four hours a day, seven days a week (24/7), providing members with the ability to change providers based on their cultural preferences and need. This includes the availability of bilingual employees and our 24/7 language interpreter services as described in detail in Section 8, Member Services.

We have learned from our affiliate plans to pay close attention to our members' distinct needs and to make immediate adjustments as needed. As we continue to connect with local members, providers, and community organizations like Iowa's Native American and Alaskan Native populations, we know it may be necessary to find ways to specifically address the needs we may discover.

24/7 Electronic Access

We offer programs that complement the urgent care services network, offering an additional opportunity to avoid an inappropriate ER visit. When a member calls our Nurse HelpLine, the nurse can advise the member on appropriate care options. Based on the member's condition, the nurse can refer the member for a web-based physician consultation through our LiveHealth Online program. This intervention often resolves the member's issue and avoids an unnecessary ER visit.

- **Nurse HelpLine.** Nurses, guided by sophisticated decision tree software, assess each caller's needs and recommend next steps, based on symptoms and severity. Nurses can route behavioral health emergencies to a tele-behavioral health provider, and alert case managers who coordinate follow-up care.
- **Amerigroup On Call.** Nurse HelpLine callers can speak to nurses with physician oversight through Amerigroup On Call. Amerigroup On Call offers translation services for over 200 languages and guides members on appropriate next steps for non-emergent medical conditions.
- **Web-based Consultations.** Amerigroup is bringing additional capabilities and innovations to Iowa. With LiveHealth Online, we will offer members another alternative to visiting the ER. We will offer online physician visits, when appropriate, given members' conditions and ability to secure online services. LiveHealth Online completes the continuum of options for members, enhancing their access to emergency room-alternative services.

Providing Covered Benefits and Administration, and Promoting Efficiency & Highest Quality (1.4.2.9 - 1.4.2.10)

Amerigroup and its affiliate health plans have a history of strong service delivery with proper administrative oversight and financial stewardship. ***Our organization has never had a state-sponsored contract terminated for performance.*** We affirm that we will provide all covered benefits and administrative functions as required in the RFP.

Amerigroup generates superior value for our State customers by providing high quality care in the right setting and at the right time. We do this through a variety of approaches, including implementing programs to reduce re-hospitalizations and preventable emergency room use; by offering pay-for-performance incentives to providers and facilities for efficient, evidence-based care delivery; and by detecting and ameliorating unnecessary or wasteful practices and/or fraudulent activities. The result is higher quality care and better health outcomes for less per member cost.

Decreasing Avoidable ER Use

To address the causes for unnecessary and frequent emergency room utilization, Amerigroup's affiliates have developed programs that connect members with the services and supports they need. One such program, Georgia's ER Case Management Program, has proven very effective. The goal is to assist members and their families/caregivers in managing the member's symptoms in alternative settings, avoiding unnecessary ER visits. Through this program, care coordinators outreach and inform members on proper utilization of services, enhance access to care, and improve care coordination. They also provide members with appropriate alternatives to emergency room use so that members receive services in the community.

Coordination, Integration, and Accountability (1.4.2.11)

Amerigroup acknowledges the requirement to coordinate, integrate, and be accountable for all services proposed. We embrace accountability and transparency. ***Amerigroup, our parent organization, Anthem, and its affiliate health plan organizations have never had a state-sponsored health program contract involuntarily terminated for performance.***

This proposal outlines in specific detail all of our methods to ensure accountability to the State in the delivery of Contract services, including maintaining financial and medical records (Sections 2.4.1 and 2.4.2), responsiveness to records requests (Section 2.4.3), disclosures (Sections 2.5.1 – 2.5.4), responsiveness to State inquiries and requests for information (Section 2.16), processing grievance and appeals (Section 8.15), program integrity activities (Section 12), State review (Section 10.2), and reporting (Sections 14.1 – 14.11).



IA_1.2_COE_1.3

Effects of the Federal Waiver (1.5)

Amerigroup Iowa (Amerigroup) agrees to comply with any modifications to this RFP and subsequent Contract resulting from the waiver approval process. In the event that CMS denies the waiver request(s), the State shall be under no obligation to award a Contract(s). We understand that if CMS denies the waiver request(s) following Contract award, DHS may terminate the Contract immediately without penalty. We acknowledge that in the event of a termination under this section, DHS shall not be liable or required to compensate Amerigroup for any work performed or expenses incurred. At the behest of the State, Amerigroup offers broad expertise in the waiver application and approval process.

Licensure/Accreditation (2.1)

Licensure/Qualified Health Plan (2.1.1)

Question 2.1, #1 - #2

1. Indicate if you are currently licensed as an HMO in the State of Iowa. If you are not currently licensed, describe your plan to achieve licensure.
2. Indicate whether you are currently a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange.

Amerigroup Iowa (Amerigroup) is a new entrant to the Iowa market and is currently in the process of obtaining an HMO license from the Iowa Insurance Division. Amerigroup submitted our application on April 6, 2015, and fully expects to be licensed as an HMO within five business days of the State's notice of intent to award.

Amerigroup is currently not a qualified health plan (QHP) issuer certified by the Iowa Healthcare Exchange. Upon award and after the implementation and transition period for the Iowa Initiative, Amerigroup will consider pursuing certification by the Iowa Healthcare Exchange.

Accreditation (2.1.2)

Question 2.1, #3

3. Indicate whether you are currently accredited by the NCQA. If you are not currently accredited, describe your plan to achieve accreditation.

As a new entrant to the Iowa market, Amerigroup is not currently accredited by the NCQA; however, we agree to attain accreditation at the earliest date allowed by NCQA. Our affiliate health plans are NCQA-accredited in 13 states across the nation, are experienced in operating according to the standards for accreditation, and can adeptly navigate the process of achieving accreditation without delay. ***Our affiliates have never failed to achieve accreditation in any state in which they have applied.***

Recognition for our commitment and results in the Quality realm are evidenced by these facts:

- NCQA includes seven Amerigroup affiliate health plans in its list of the Top 100 Medicaid health plans in the country
- Five Amerigroup affiliate health plans are in the top 50 of this ranking, and one has been included at this level for three consecutive years
- Relative to our competitors in various markets, three of our affiliate health plans maintain the number one position in their market

Amerigroup and our affiliates will leverage our organization's **eight NCQA-accredited disease management programs**, for asthma, diabetes mellitus, major depressive disorder, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, HIV/AIDS, and schizophrenia. ***In 2012, these programs earned a three-year NCQA renewal accreditation at the highest level possible.*** Our Iowa members will benefit from our intense focus on the full spectrum of disease management, from health education for a single condition to comprehensive management of all member conditions.

Our partnerships with local community programs, investment in emerging technologies, and strategies to drive member engagement, take our quality strategies beyond traditional health plan case management into a full delivery system approach to health care management.

In order to keep the State apprised of our accreditation progress, we will provide the following information at the following times:

1. Status update to include, at a minimum, the proof of application and all supporting documents as of the effective date of the Contract; and
2. Status update to include, at a minimum, the projected date for the on-site reviews 12 months after the first day of the effective date of the Contract. We understand that if we fail to meet the applicable requirements stated above, we will be considered to be in breach of the Contract terms and may be subject to remedies for violation, breach, or noncompliance of contract requirements.

Subcontracts (2.2)

Subcontractor Qualifications (2.2.1)

Question 2.2, #1

1. Summarize your proposed subcontracts, including any with parent companies, and key work to be delegated under the subcontracted relationship.

Amerigroup Iowa (Amerigroup) will leverage the experience of our affiliate health plans and our parent company, Anthem, Inc. (Anthem), who has established operations, practices, and processes to engage the services of subcontractors when we determine that they will improve the quality, efficiency, and/or value of services we deliver to our members, providers, and the State. Outside of potential Accountable Care Organization partnerships, ***Amerigroup does not subcontract any essential part of our care model beyond its family of companies.***

Before we contract with any subcontractor, we will thoroughly assess all aspects of the organization, including financial stability, history of compliance, and demonstrated ability to perform the functions or services proposed in accordance with State and Amerigroup standards, requirements, and expectations. We will also review subcontractor staff for applicable licensure and conduct a comprehensive readiness assessment to validate the subcontractor's ability to perform the required tasks.

As specified by 42 CFR 438.230, Amerigroup will maintain oversight and be fully accountable to DHS for all activities and processes of our healthcare service subcontractors. We will hold them to all Contract requirements, and certify and warrant all of their work. Our written subcontractor agreements will also explicitly state our expectations that each vendor will comply with all Contract requirements, including any amendments, requirement changes, and/or State initiatives that take effect at any time, and will include provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

Amerigroup will submit any material subcontract changes in writing to DHS 60 days before the effective date of the amendment. We will also provide any subcontracts DHS requests within 24 hours. In addition, Amerigroup understands that DHS may waive its right to review subcontracts and that such does not constitute waiver of any subcontract requirements. We also agree that DHS holds the right to request removal of a subcontractor for good cause.

Amerigroup intends to use the following subcontractors to provide services to meet the requirements of the Iowa High Quality Healthcare Initiative. Table 2.2-1 and 2.2-2 lists proposed subcontractors and services they will provide under the Contract.

Table 2.2-1. Subcontractors Providing Limited, specific functional area support as noted

Name	Description of service
Anthem Inc. and it’s subsidiaries	Administrative and support services including finance, claims administration, call center activities, information technology, legal, regulatory, treasury and compliance
American Imaging Management, Inc. (AIM Specialty Health)	Utilization management support activities specific to cardiology, radiology, and sleep-testing services
Express Scripts, Inc. (ESI)	Pharmacy Benefits Management
Logisticare Solutions, LLC	Non-emergent transportation services
Audiology Distribution, LLC (HearUSA)	Hearing care programs and access to professionals, latest technology
McKesson Technologies, Inc.	24-hour Nurse helpline for physical and behavioral health consultation
Superior Vision Benefit Management, Inc.	Vision Benefits Management

Table 2.2-2. Subcontractors Providing Added quality and/or value to our members

Name	Description of service
Careticker, Inc.	Web-based platform for in-home caregiver documentation and real-time sharing of information, and incentives for caregivers
Breakthrough Behavioral, Inc.	Video-based tele-behavioral health consulting for enhanced remote access
My Support, Inc.	Web-based platform that helps older adults, and those with chronic health conditions and disabilities connect with direct support workers with the skills that match their individual needs, preferences, and values
National Disability Institute	Financial education and training
Remind Technologies, Inc.	Web-based platform to support medication reminders and adherence
PCG Public Partnerships, LLC (PPL)	Participant-directed financial service model enabling members to choose which services they receive, how they are delivered, and by whom, within their budgets.
Telligen, Inc.	Services may include Minimum Data Set transmission support, onsite MDS validation, automation and education, quality review and oversight, core standardized assessments, level of care determinations for nursing facility, waiver programs.

As stated in Section 2.2.1, Question 1, Amerigroup will comply with all DHS requirements governing subcontractor qualifications and use.

Question 2.2, #2

2. Indicate if any of the subcontracts are expected to be worth at least five percent (5%) of capitation payments under this contract.

Amerigroup subcontractors projected to receive payments equal or greater than five percent of capitation rates are Express Scripts, Inc., the pharmacy benefit manager, and Anthem, Inc., our ultimate parent company, which, in conjunction with its subsidiaries, will provide administration and support services. We will submit those subcontractor agreements for DHS review and approval.

Subcontractor Oversight (2.2.2)

Question 2.2, #3

3. Describe the metrics used to evaluate prospective subcontractors’ abilities to perform delegated activities prior to delegation.

As stated in Section 2.2.1, Question 2, Amerigroup understands that it will have full legal responsibility for all activities under the Contract, including those performed by subcontractors, as required by 42 CFR 438.230. We will hold our subcontractors to those same requirements.

We will use subcontractors only after a thorough evaluation process to determine that they have the demonstrated capabilities and overall responsiveness to improve the quality, efficiency, and/or value of services we deliver to our members, providers, and the State. We use a thorough audit process to evaluate prospective subcontractors, incorporating among other things a review of the entity for compliance with all State Contract requirements, State and Federal requirements, NCQA standards, financial solvency measures, and any additional regulatory and accreditation standards for each market. Once we determine the preferred vendor, we request a pre-delegation audit – a comprehensive onsite review to evaluate the vendor’s readiness, applicable licensure, and compliance, including Office of the Inspector General screenings.

Question 2.2, #4

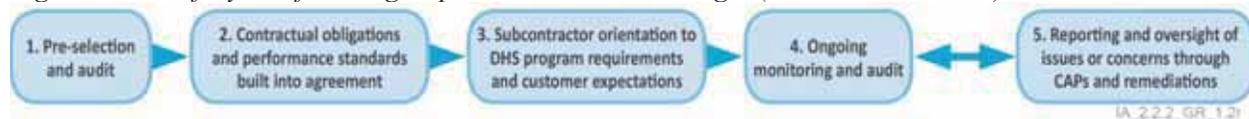
4. Describe the policies and procedures used for auditing and monitoring subcontractors’ performance.

Monitoring and Evaluating Subcontractors’ Performance

Amerigroup will continuously monitor its subcontractors to verify compliance with our standards and all Contract requirements. We will retain full legal responsibility for all activities under the Contract, including those performed by subcontractors. Our national Medicaid Delegation and Oversight policy, described more fully below, outlines processes for monitoring subcontractors, including procedures for the required annual audit.

Figure 2.2-1 depicts the lifecycle of the subcontractor oversight process we will put in place. Please note that monitoring and audit, followed by corrective action, will continue for the duration of the subcontractor’s relationship with Amerigroup.

Figure 2.2-1. Lifecycle of Amerigroup Subcontractor Oversight (Local and National)



Our subcontractor oversight will begin approximately four months before go-live. We will assemble a team from different areas of the company and subcontractor representatives who will meet weekly. During these implementation meetings, we will address various components of the program, including specifics for each subcontractor, such as membership, benefit coverage, and local infrastructure, as well as reporting, eligibility file, encounter data, claims processing, network adequacy, call center, complaint/grievance, and UM and compliance requirements. After go-live, we will continue to hold quarterly Joint Operations Committee meetings with subcontractors and representatives of the local health plan. During these meetings, we will discuss operational issues, HEDIS[®], and other program improvements, and provide updates and education on any changes in the program.

Amerigroup's Iowa-based local leaders will oversee and review subcontractor services to verify compliance. We will monitor performance through reports specific to the types of services our subcontractors provide, such as access and service quality indicators. These performance reports will enable us to quickly identify and address issues as soon as they arise. We will provide performance monitoring reports and reviews upon request, and will notify DHS when a subcontractor is placed on corrective action.

We will also leverage centralized national resources and processes to oversee and manage certain subcontractors' services. While we will subcontract for certain services, Amerigroup will be solely responsible for meeting the State's requirements, and we will hold our subcontractors to those same requirements. Our subcontractor agreements will clearly state our expectations, as applicable, for licensure and accreditation; eligibility verification; covered services and benefits; care coordination; record reviews; compliance with credentialing, utilization management, quality assurance, coordination of benefits, third-party liability, and other rules, regulations, policies, and procedures; insurance coverage; HIPAA compliance; and claims submission. We will also require subcontractors to comply with all contractual requirements, including any amendments, changes, and/or State initiatives enacted at any time during the Contract. We specifically include compliance with all regulatory requirements related to the agreement.

Local Oversight

At the local level, Amerigroup's Vendor Compliance Workgroup (VCW) and Quality Management and Improvement Committee (QM/QI) will work together to see that subcontractors comply with all applicable requirements and expectations. Their goal will be promptly identifying and mitigating potential risks. This workgroup will be a collaboration between our Compliance and Quality Management teams, and will include Department Leads and Account Managers for subcontractors that also serve our affiliate health plans. This is the cornerstone of our local subcontractor oversight program that includes:

- **Monthly Workgroup Meetings** with health plan leadership to formally review subcontractor performance metrics and data obtained through our attendance at quarterly national Vendor Selection and Oversight Committee (VSOC) and Delegated Workgroup (DWG) meetings. Examples of reviews will include vendor rosters to identify adequacy of service coverage and access; call center reports to monitor call volume and resolution; customer complaint reports to identify quality and compliance issues; and claims payment reports to monitor payment accuracy, timeliness, and service utilization.
- **Quarterly Meetings with Subcontractors** to discuss performance benchmarked against Contract provisions and customer expectations.
- **Monthly Reporting** including review of subcontractor information, such as performance metrics and grievance and appeals data.

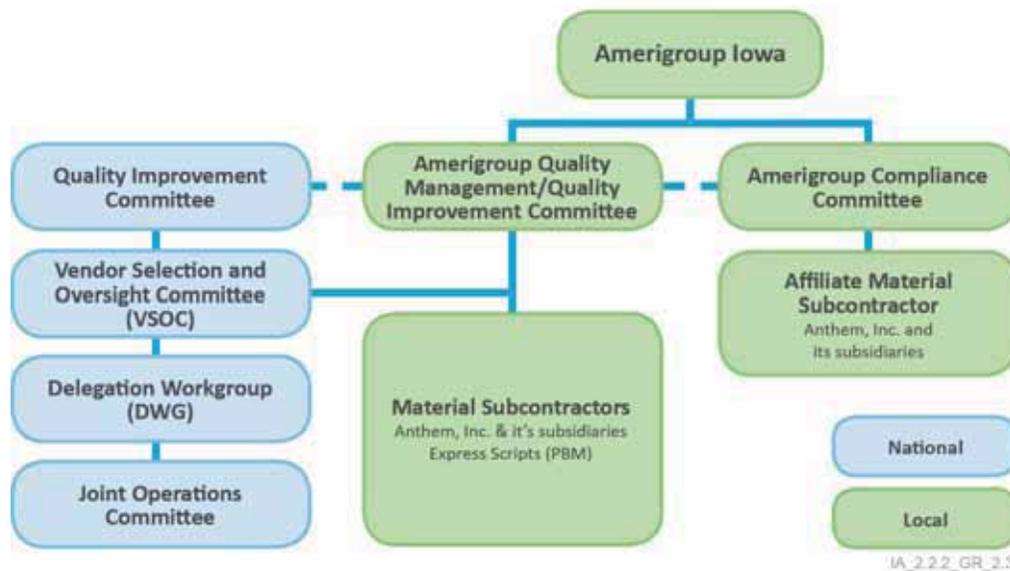
We will also routinely monitor the performance of our primary Administration and Support Services subcontractor, Anthem, and our National Medicaid Division through our VCW and other local committees, including the QM/QI, Compliance, and Medical Advisory Committees. Each quarter, we will review service-level standards and management reports such as claims processing timeliness and accuracy; Member Call Center and Provider Helpline statistics; and Fraud, Waste, and Abuse program activity and results.

At the national level, for vendors that also serve affiliate health plans, Amerigroup will leverage the following **oversight** functions and governance structures to select, monitor, and regulate subcontractor activities and performance (See Figure 2.2-2):

- The **Quality Improvement and Compliance Committees** meet quarterly and are responsible for reporting any quality or compliance-related issues to Amerigroup's local committees.

- **Vendor Selection and Oversight Committee (VSOC)** has primary responsibility for overseeing subcontractors who serve multiple health plans. It is responsible for subcontractor compliance with State, federal, NCQA, CMS, and individual program requirements, standards and expectations, as well as any other applicable regulatory or accreditation standards. VSOC reports to the national Quality Improvement Committee. Iowa’s compliance team will attend these quarterly meetings.
- **Joint Operations Committee (JOC) meetings** blend local and national oversight functions. Amerigroup’s quality management staff and key affiliate health plan personnel and staff attend quarterly JOC meetings to discuss subcontractors’ performance across markets and present issues and concerns to the DWG. Iowa’s local Medical Advisory and QM/QI Committees will receive a summary of each JOC meeting.
- **DWG reports to VSOC monthly.** Each Amerigroup affiliate health plan has voting members in the DWG. It is responsible for seeing that we follow established policies and procedures in accordance with State, federal, NCQA, and any other applicable regulatory and accreditation standards. The DWG has collaborative relationships with, and representation from, internal departments. As a governing body comprising local health plan representatives, DWG will also review results of the annual audits required by DHS, and will support corrective actions, as needed.

Figure 2.2-2. Amerigroup’s National and Local Governance Structure for Material Subcontractors



Compliance Audits for Subcontractors

Once contracted, Amerigroup will closely monitor subcontractor performance to verify continued compliance with all applicable standards and requirements, including Contract requirements. Our local VCW and QM/QI Committee monitoring and auditing activities will include:

- Conducting formal reviews specific to the types of services provided at least quarterly
- Reviewing performance management reports
- Conducting audits of subcontractor performance against the requirements in the subcontractor agreement
- Identifying and communicating deficiencies or areas for improvement
- Enforcing correction of any identified performance deficiencies, or termination if deficiencies cannot be corrected

Reporting Requirements

Monthly, Amerigroup's VCW will review reports that include subcontractor information, such as performance metrics and grievance and appeals data. If we identify any performance issues, we will address them through formal written Corrective Action Plans (CAPs), and we will work closely with subcontractors to investigate and take appropriate steps to promptly resolve them.

We will track and document progress on corrective action every 30 days until all items are addressed and the CAP is closed. Anthem's Quality Improvement and Compliance Committees also track and monitor all active CAPs – on both the local and national level. We will notify DHS whenever a subcontractor is placed on a CAP.

Question 2.2, #5

5. Describe the enforcement policies used for non-performance, including examples.

Amerigroup will routinely monitor the performance of our subcontractors through our local committees, including the VCW, QM/QI and Medical Advisory Committees. Each quarter, we will formally review service level standards and management reports, including, but not limited to:

- Overview of fraud, waste, and abuse activity
- Quality initiatives and HEDIS[®] scores
- Outreach initiatives conducted or planned for the following quarter

Every month, our VCW will review reports that include subcontractor information, such as performance metrics and grievance/appeals data. Reports are specific to the types of services subcontractors provide.

If any subcontractor is not meeting established performance metrics or goals, we will work closely with the vendor to investigate and take appropriate steps to resolve issues, including, but not limited to:

- Reviewing report results with the subcontractor and implementing a formal, written Corrective Action Plan (CAP) that includes oversight and monitoring
- Arranging site visits and/or accessibility calls to corroborate results, which will determine whether additional corrective action is necessary
- Terminating the subcontractor agreement if the vendor fails to implement or follow an acceptable CAP

Our local and national quality teams track and document corrective actions every 30 days until all items are addressed and the CAP is closed.

For example, in the first quarter of 2014, our Texas affiliate health plan's dental vendor was placed on a CAP for not meeting call timeliness standards. We discovered that the root cause was extended periods of inclement weather that created staff shortages. Its employees now have the ability to work from home during inclement weather, which has resolved the staffing issues and minimized problems with call timeliness standards.

Another example – our Louisiana affiliate health plan placed a transportation subcontractor on a CAP in October 2012, when it observed an increase in the number of complaints related to transportation. The affiliate health plan worked with the subcontractor to improve member service through increased training for customer service representatives, a revised call script that included warm transfers to the health plan, unannounced rides to promote compliance with vehicle and driver standards, and warnings and terminations to drivers who did not adhere to these standards. As a result, the subcontractor demonstrated marked improvement in customer service.

Subcontractor Financial Stability (2.2.3)

Amerigroup will closely monitor the financial stability of any subcontractors, including prepaid hospital plans, physician-hospital organizations, or other entities that accept financial risk for services we do not directly provide, and whose payments equal or exceed five percent of premium/revenue. We will evaluate their ability to fulfill their Contract financial obligations through contractually mandated reports demonstrating their solvency. We will require that subcontractors to our Iowa program submit the following documents quarterly to the VSOC, which has primary responsibility for overseeing vendors that serve multiple health plans, as well as the local VCW and QM/QI Committee, for review:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Incurred But Not Received (IBNR) estimates

We will also require subcontractors to submit the following documents at least annually:

- Audited financial statements, including statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance
- Actuarial opinion of the IBNR estimates

The Vendor Selection and Oversight Committee may also review other documents, such as tax returns or financial review questionnaires, to verify the subcontractor's ability to continue meeting its contractual obligations.

Amerigroup understands that DHS reserves the right to require additional financial reporting on subcontractors and will make those documents available upon request.

Excluded Subcontractors (2.2.4)

Amerigroup will comply with all Scope of Work Section 2.2.4 requirements that prohibit subcontracting with providers that have been excluded from participation by the Department of Health and Human Services, the Office of the Inspector General (OIG) under section 1128 of the Social Security Act, or by DHS from participating in the Iowa Medicaid program for fraud and abuse.

In addition to all contractually required databases, Amerigroup will also initially screen all potential providers through the General Services Administration Excluded Parties List. We will not contract or employ parties appearing in any of those databases.

Amerigroup will also exclude providers or individuals from our network if they are identified as having OIG sanctions, have failed to renew license or certification registration, have revoked professional licenses or certifications, or have been terminated by DHS.

We will maintain monthly protocols to process exclusions and disbarments that occur after the initial screening or credentialing process and before mandatory periodic screenings or re-credentialing. We will also use the databases identified above for monthly monitoring of providers that we contract, employ, or include in our network.

We will not contract for, or otherwise pay for, any items or services furnished, directed, or prescribed by any provider excluded from participation in federal health care programs by the OIG under Sections 1128 or 1128A of the Social Security Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.2.32.6.c.

Amerigroup will terminate its relationship with any provider identified by DHS as being in continued violation of law within 30 calendar days.

Integrated Subcontracting (2.2.5)

Question 2.2, #6

6. Describe how subcontracting relationships will provide a seamless experience for members and providers.

Amerigroup is committed to promoting a quality, seamless provider and member experience across all programs and services. We use subcontractors only after determining that they will improve the quality, efficiency, and/or value of services we deliver to our members, providers, and the State. In those instances, we integrate them into our infrastructure so that neither providers nor members notice a difference between contacting our employees or designated vendors’ staffs regarding high quality services. For example, across all of our affiliate health plans, all of our subcontractors, such as those who provide vision or pharmacy benefits, completely manage their delegated services. But their data warehouses interface with Amerigroup’s management information system. That means providers seeking pre-authorizations or checks on claims for vision services still call the same provider service hotline. It also means that members with questions about their prescriptions receive the same answer at the pharmacy or on their customer service hotline.

Nationally, our affiliate health plans that serve state-sponsored programs have an outstanding history of establishing and maintaining high-quality standards of service that result in improved health outcomes, as well as member and provider satisfaction. They use best practice methodologies to continuously evaluate data and processes; implement interventions; and re-examine our clinical, management, and operational processes to identify improvement opportunities and set quality improvement activities for our subcontractors. We will specifically incorporate these methodologies into our subcontractor agreements to support an integrated, seamless experience for our members and providers.

To accomplish that, we will work directly with each subcontractor to create a suite of reports that capture its performance on State and regulatory requirements, as well as against Amerigroup’s internal standards. We will use some of these reports to monitor performance of delegated functions, including verification that our subcontractors’ day-to-day business operations meet our expectations and provide quality service to our providers and members. We will hold quarterly Joint Operations Committee meetings to review these reports and discuss operational and performance issues. We will also monitor subcontractors’ performance monthly through our DWG and VSOC – two committees comprising both health plan and national staff who oversee the performance of all delegated functions. If we determine that a subcontractor’s performance has fallen below the required standards, we will issue a recommendation for a correction to the vendor.

We will collaborate with DHS to identify, design, and conduct annual programmatic reviews to assess the experience of providers and members in Iowa’s program, as well as the quality of services they receive. We will routinely analyze clinical and non-clinical data to identify proposed areas for review, including:

- Member and provider complaints
- Risk management adverse-incident results
- Member and provider satisfaction surveys
- Performance measure data
- HEDIS® data

We will review these data in our QM/QI Committee, which will be responsible for identifying issues and proposing improvements. We will identify those areas based on factors, including:

- Results of objective performance measures, such as HEDIS data
- Prevalence of the issue across the program
- Member, caregiver, stakeholder, and provider input
- Impact on member care and/or provider services

The cornerstone of fostering a seamless provider and member experience will be Amerigroup's comprehensive training and education program, which is grounded in our affiliate health plans' experience in state-sponsored health programs across 19 states. That experience has taught us what types and methods of training work best and how to offer multiple sources and touch-points to accommodate different needs.

All of our subcontractors will have initial/ongoing training and access to extensive educational materials. We will also make sure that all subcontractors are fully aware of their individual responsibilities and the responsibilities of others. Some of the ways we accomplish this is through:

- Contractual subcontractor agreements
- Standards of ethical business conduct
- Initial and ongoing training
- Orientations and in-service training
- Specific training for subcontractors with direct member contact
- Collaboration with our subcontractors to align training goals
- Educational materials, such as our member handbook, provider manual, newsletters, and website
- Training on fraud, waste, and abuse

Amerigroup will implement established education and training protocols in Iowa, and employ a customized approach and strategies to address local trends and issues within Iowa's communities.

Throughout the Contract, our Iowa Vendor Compliance Workgroup and QM/QI Committee will oversee subcontractors' performance, regularly review their performance reports, and monitor member and provider feedback to promptly identify and address issues when they arise.

We will continually monitor and act on information obtained through our Provider Relations, Medical Management, Quality Management, and Member Services departments. In addition, our Quality Management employees will review grievance trends over time to identify ongoing patterns of noncompliance and address them with quality improvement plans or Corrective Action Plans (CAPs).

Amerigroup will also enhance the seamless provider and member experience through annual satisfaction surveys administered by an independent third-party vendor. Initially, we will request our subcontractors to perform a satisfaction survey after the first six months of operation. We will require subcontractors to score equal or higher than an 80 percent overall positive response.

Those surveys will provide data on member and provider satisfaction with access, availability, and quality of services. We will assess year-over-year improvements in survey results and compare our performance to that of the industry overall. The results will provide us with valuable benchmark information and enable us to focus on areas needing improvement.

Financial Stability (2.3)

Question 2.3. #1

1. Provide verification of the financial requirements described in the subsections of Section 2.3.

Amerigroup Iowa (Amerigroup) is a new entrant to the Iowa market and is currently in the process of obtaining an HMO license from the Iowa Insurance Division. Amerigroup submitted its application on April 6, 2015, and fully expects to be licensed as an HMO within five business days of the State's notice of intent to award.

Additionally, we will comply with all requirements of Section 2.3 and Subsections 2.3.1 – 2.3.7 of the Scope of Work (SOW), including deposit requirements at Iowa Admin. Code 191 Chapter 40.12(514B) and reporting requirements established by DHS and at 191 Chapter 40.14(514B). We agree to copy DHS on all required filings with the Iowa Insurance Division. Amerigroup understands and agrees that DHS will continually monitor its financial stability and provide financial reporting requirements through the Reporting Manual.

As a newly formed company, we provide verification of the financial requirements described in subsections of Section 2.3 from our ultimate parent company, Anthem, Inc. (Anthem), in Attachments 3.2.7.2-1 that demonstrate our ability to maintain a fiscally solvent operation and protect against insolvency in accordance with federal and Iowa Insurance Division requirements for minimum net worth.

Solvency (2.3.1)

Amerigroup will comply with all requirements of SOW Section 2.3.1 to maintain a fiscally solvent operation and protect against insolvency in accordance with federal and Iowa Insurance Division requirements for minimum net worth.

Amerigroup is a wholly owned subsidiary of our ultimate parent company, Anthem, Inc. (Anthem). Anthem subsidiaries currently operate state-sponsored health programs that serve more than 5.2 million members in 19 states across the country. All references throughout this proposal to "Anthem" refer to this entity. Please note that our parent organization underwent a legal name change on December 3, 2014. As such, attachments for requested documents related to our parent organization may also reference the prior legal name of this entity, WellPoint, Inc. (WellPoint). Amerigroup, Anthem, and its affiliate health plans have never filed, or had filed against it, any bankruptcy or insolvency proceeding, voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

Anthem, is ranked 38th on the 2014 Fortune 500 list, and its insurance and HMO subsidiaries are well funded at levels above the minimum threshold of 200 percent of Authorized Control Level Risk-Based Capital (ACL RBC) set by the Code of Federal Regulations. In 2014, Anthem's combined ACL RBC across its insurance and HMO operating subsidiaries was 563 percent, almost three times the federal and state requirements. Similarly, Anthem has guaranteed it will provide financial resources to Amerigroup Iowa sufficient to maintain a 200 percent or higher RBC ratio as defined by NAIC. The guarantee is in writing, effective for the term of the Contract, and a copy will be delivered to DCH prior to Contract signature date. If additional capital is needed, Anthem maintains cash and/or investments that can be contributed. As of December 31, 2014, Anthem held \$2.7 billion of cash and investments.

Anthem will fund Amerigroup's required minimum capital upon incorporation and licensure, according to standards of the Iowa Department of Insurance.

Reinsurance (2.3.2)

Question 2.3. #2

2. Describe how you will comply with the requirements for reinsurance. Will you obtain reinsurance contracts or submit a plan of self-insurance?

Amerigroup will comply with all reinsurance requirements at Iowa Admin. Code r. 191-40.17(514B), as stipulated in SOW Section 2.3.2. Amerigroup will self-fund catastrophic losses associated with the Iowa High Quality Healthcare Initiative members rather than purchase commercial reinsurance. This is consistent with our ultimate parent company, Anthem's, practice of self-funding, where allowable, catastrophic HMO Medicaid losses for its subsidiary health plans. This decision is largely based on the financial and operational strength of Anthem, which has a long record of strong quarterly profits going back to the company's inception.

As of December 31, 2014, Anthem held approximately \$2.7 billion of cash and investments and equity of almost \$25 billion. Anthem has consistently been profitable for more than a decade.

Risk Adjustment (2.3.3)

Amerigroup understands and agrees to all specifications of SOW Section 2.3.3, including the State's risk adjustment methodology and right to change its risk adjustment models and tools. We also agree that total payments by the State will be risk score neutral and that adjustment will be calculated separately for the Long-Term Services and Supports (LTSS) and non-LTSS populations.

LTSS and Non-LTSS Populations (2.3.3.1-2.3.3.2)

Amerigroup understands that the State plans to blend the institutional and Home and Community-Based Services into one rate cell as a financial incentive to delivering LTSS in the least restrictive environment, and that the blending percentage will be updated at least annually, as stipulated in SOW Section 2.3.3.1.

Amerigroup also understands and agrees to all guidelines and stipulations in SOW Section 2.3.3.2 regarding assigning risk to non-LTSS individuals through claims data, provided services, and possibly pharmacy data. We understand that we will also be assigned a risk score, based on the total risks of the entire population, and how that will be applied to adjust capitation payments based on the availability of enrollment information. Amerigroup also understands and agrees that, after the first six months, rates will be adjusted every 12 months, based on member data. We understand that the State reserves the right to adjust rates prospectively or retrospectively.

Reserved (2.3.4)

The State has reserved this section in the RFP.

Annual Independent Audit (2.3.5)

Amerigroup understands and will comply with all requirements for financial reporting as stipulated in SOW Section 2.3.5. We agree to submit an annual audited financial report comprising our financial activities under the Contract within six months of the end of each calendar year. We agree that the report will be prepared according to Statutory Accounting Principles designated by NAIC by an independent Certified Public Accountant who is on the list of Iowa Insurance Division's approved auditors. We understand that Amerigroup is responsible for the cost of the audit.

Amerigroup agrees to negotiate the format and contents of that audit with DHS, and it will include at a minimum: (i) third party liability payments made by other third-party payers; (ii) receipts received from

other insurers; (iii) a breakdown of the costs of service provision, administrative support functions, plan management, and profit; (iv) assessment of Amerigroup's compliance with Contract requirements for insolvency protection, surplus funds, working capital, and any additional requirements established in Administrative Rules for organizations licensed as HMOs; and (v) a separate letter from the independent Certified Public Accountant addressing non-material findings, if any.

Quarterly Financial Reporting (2.3.6)

Amerigroup will comply with requirements for quarterly NAIC financial reports, as specified in SOW Section 2.3.6. We agree that the independent auditing firm that conducts the annual audit will complete a final reconciliation within required timeframes.

Insurance Requirements (2.3.7)

Amerigroup will comply with all requirements of SOW Section 2.3.7 throughout the term of the contract, including applicable insurance laws of the State and Federal government, and will maintain in force a fidelity bond on employers and officers in accordance with Iowa Admin. Code 191 Chapter 40.13.

Amerigroup will also maintain, with insurance companies licensed by the State of Iowa, specified types and levels of insurance. We have provided proof of the Auto Insurance Umbrella as Attachment 2.3.4-1, the Insurance Requirements Fidelity Bond as Attachment 2.3.7-1, the Certificate of Liability Insurance as Attachment 2.3.7-2, and the Commercial Property Insurance as Attachment 2.3.7-3. Additionally, we will provide evidence of our continued compliance with the insurance requirements in this section upon execution of the Contract.

Maintenance of Records (2.4)

Amerigroup Iowa (Amerigroup) will maintain financial and medical records pertaining to the Contract, including all claims records, for seven years following the later of the end of the federal fiscal year during which the Contract is terminated, or when all State and federal audits of the Contract have been completed.

Financial Records (2.4.1)

Question 2.4, #1

1. Describe your system for maintaining financial and medical records that fully disclose the extent of provided to members

We will respond to Question 2.4 #1 in two parts, under subheadings 2.4.1 and 2.4.2.

Amerigroup will retain accounting records pertaining to the Contract until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the Contract if the litigation has not terminated within the seven-year period. We understand that the financial records in question address matters of ownership, organization, and operation of our financial, medical, and other record keeping systems.

Amerigroup's Comprehensive Records Systems

Amerigroup's system for maintaining records that fully disclose the extent of services provided to our members consists of our comprehensive Medicaid Management Information System (MMIS) that stores electronic data and a set of detailed policies and procedures



Our MMIS maintains the history of member claims processed for all services - medical, behavioral health, pharmacy, vision, dental, and transportation.

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that govern the maintenance of records across our entire operations. Amerigroup complies with 42 CFR part 455 and 45 CFR 164.530(j)(2) and maintains records that disclose the extent of services provided to our members for six years or for the duration of contested case proceedings, whichever is longer.

Amerigroup's MMIS stores a significant amount of information about the services provided to our members through the claims submitted by their providers. ***Our MMIS maintains the history of member claims processed for all services—medical, behavioral health, pharmacy, vision, dental, and transportation.*** Amerigroup maintains backup and recovery plans and disaster recovery plans that protect our MMIS in case of day-to-day occurrences that could temporarily interrupt operations or catastrophic events. Please see our response to Section 13.2 for more information.

Our national Records Management Program provides a consistent and effective approach to managing company records from their creation to destruction. The program provides each business unit with direction and support for managing the life cycle of its records, including appropriate retention, storage, retrieval, and disposal. The Records Management Policy applies to all employees, as well as subcontractors and consultants.

A *record* is a document created, received, or maintained in the course of business operations, regardless of media. Record media include electronic records, written and printed documents, letters, reports, worksheets, and email.

The Records Management Program works toward meeting the following objectives:

- Records stored in an appropriate, safe, and accessible manner
- Records efficiently retrieved for legal, audit, or other business purposes
- Records maintained in compliance with applicable laws and regulations
- Provision for the identification and preservation of records relevant to pending or reasonably foreseeable legal or administrative proceedings or audits
- Appropriate disposal of records when retention periods are satisfied

The Records Management Program is managed by a national Records Management team that oversees the entire program, including compliance, security, and access. The team initiates and manages the quarterly destruction review process and the periodic review of on-site records. They monitor compliance and applicable laws and regulations and modify the program as needed. The national Records Management Committee provides oversight and helps confirm consistent, company-wide compliance with and implementation and enforcement of the Records Management Program. The Records Management Committee meets regularly and includes representatives from a number of areas, including Regulatory Services, Ethics and Compliance, Information Security, Information Technology, Operations, and Legal.

All employees receive annual training on Amerigroup's Records Management Program. Training includes modules about:

- Their need to comply with policies, requirements, and laws related to the retention, destruction, storage, and maintenance of information
- Local desktop procedures, including following the Record Retention Schedule for their department
- Where to go and who to contact for additional information

As an additional resource, our company-wide intranet houses a number of documents related to the Records Management Program; they are available to all employees for easy access and review. These documents include information related to overall policies and procedures, storage and access, confidentiality, retention schedules and approved methods for destruction of information when appropriate.

Medical Records (2.4.2)

Amerigroup's policies and procedures relating to medical records are intended to facilitate effective patient care and quality review while maintaining confidentiality. Amerigroup has electronic record-keeping system procedures in place to help verify patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of our computer systems. Security systems are in place to provide backup storage and file recovery, to provide a mechanism to copy documents, and to make sure that recorded input is unalterable. To that end, Amerigroup ensures that our retention practices align with the requirements outlined in the Scope of Work (SOW) Section 6.1.9.1 Medical Records Retention, including:

- Identifying each medical record by State identification number
- Identifying the location of every medical record
- Placing medical records in a given order and location
- Maintaining the confidentiality of medical records information and releasing the information only in accordance with SOW Section 6.1.9.4 Confidentiality of Medical Records
- Maintaining inactive medical records in a specific place
- Permitting effective professional review in medical audit processes
- Facilitating an adequate system for follow-up treatment, including monitoring and follow-up of offsite referrals and inpatient stays

In addition, in compliance with DHS rules, Amerigroup will maintain records:

- During the time the member is receiving services from the provider
- For a minimum of seven years from the date when a claim for the service was submitted to the medical assistance program for payment, or in the case of contested court proceedings, for the duration of the court proceedings or seven years, whichever is longer
- As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications

Response to Records Requests (2.4.3)

Amerigroup will cooperate fully in the provisions of records upon request as outlined in this RFP. We agree to furnish duly authorized and identified agents or representatives of the State and federal governments, including but not limited to the DHS, the Secretary of DHHS, the DHHS Office of the Inspector General (OIG) or the Iowa Medicaid Fraud Control Unit (MFCU), with such information as they may request regarding payments claimed for Medicaid services. We will provide copies of the requested records to DHS, DHHS, OIG, or MFCU within 10 business days from the date of the request. If such original documentation is not made available as requested, we agree to provide transportation, lodging, and subsistence at no cost for all State and/or federal representatives to carry out their audit functions at the principal offices of the Contractor or other locations of such records.

Additionally, we agree to grant the DHS, DHHS, OIG, and/or MFCU access during our regular business hours to examine health service and financial records related to a health service billed to the program.

Disclosures (2.5)

Information on Persons Convicted of Crimes (2.5.1)

Question 2.5, #1

1. Provide disclosures as described in the subsections of Section 2.5

Amerigroup Iowa (Amerigroup) conducts an in-depth background screening for all employees and those who perform work for it on a contract basis. Specifically, we conduct a robust criminal background check at the federal, State and local county levels, and also abide by all OFCCP requirements to verify that individuals we hire meet stringent criteria relating to providing services to our government-contracted business. Our screening process also includes adherence to Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994, which prohibits any individual with certain felony convictions from working in the business of insurance without a waiver from the respective State regulatory body.

Individuals who are excluded, suspended, debarred, sanctioned, or otherwise ineligible from participating in a Federal or State healthcare program (such as Medicare or Medicaid); or from contracting with the Federal government or a State government; or who have been convicted of a felony involving fraud, embezzlement, theft, dishonesty, or breach of trust are not eligible for employment with Amerigroup.

To the best of our knowledge, no persons with an ownership or control interest in, or who is an agent or managing employee of Amerigroup, have been convicted of a criminal offense related to their involvement in any program under Medicare or Medicaid.

Information Related to Business Transactions (2.5.2)

Amerigroup will comply with all requirements of SOW Section 2.5.2 regarding business transactions. Amerigroup has not operated previously in commercial or Medicaid/Medicare markets, so there are no significant business transactions to report at this time.

Upon contract award, Amerigroup agrees to provide, within 35 days of a request from DHS, full disclosure of significant business transactions, as set forth in 42 CFR 455.105, including full and complete information about the ownership of any subcontractor with business transactions totaling more than \$25,000 over a DHS-specified 12-month period and significant transactions between Amerigroup, any wholly owned supplier, and subcontractors over the DHS-specified five-year period. Amerigroup understands that there are financial penalties for failure to respond to requests for information by the Secretary or DHS.

Ownership Disclosures (2.5.3)

Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. Amerigroup Corporation is a wholly owned subsidiary of ATH Holding Company, LLC (ATH). ATH is a wholly owned subsidiary of Anthem, Inc. (Anthem). Shares of Anthem's common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary course of business through open market purchases. Based upon the most recent SEC filings, Anthem is aware of the following entity, listed below, that owns beneficially five percent or more of the outstanding shares of Anthem's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

Table 2.5-1. Vanguard Group Identified its Holdings as an Institutional Investment Manager

Company Name	Address	FEIN	Percent Owned	Shares Owned	Company Description	Shares Owned as of Date
Vanguard Group (Vanguard)	PO Box 2600 Valley Forge, PA 19842	231945930	5.4%	14,399,568	Vanguard is one of the world’s largest investment management companies offering services to individual and institutional investors.	12/31/14

The entity listed in Table 2.5-1 has filed a Form 13F and/or Schedule 13G with the SEC to identify its holdings as an institutional investment manager. If any entity had acquired five percent or more of Anthem’s common stock other than for investment purposes, such entity would be required to file a Form 13D with the SEC within 10 days of such acquisition. Therefore, to our knowledge, the entity listed above has acquired Anthem’s common stock for investment purposes only.

Officers and Directors identified in Table 2.5-2 will be responsible for the conduct of the affairs of Amerigroup Iowa, Inc.

The most recent consolidated holding company financial statement for Anthem, Inc., the ultimate parent company of Amerigroup Iowa, is included as Attachment 3.2.7.2-1.

Reporting Transactions with Parties in Interest (2.5.4)

Amerigroup shall report to DHS all transactions with a party in interest, as defined in 42 USC sec 300e-17(b).

Amerigroup is not a federally qualified HMO; therefore, we will disclose information on certain types of business transactions with parties of interest. The Iowa High Quality Healthcare Initiative will be our initial Contract with DHS. Amerigroup has not operated previously in commercial or Medicaid/Medicare markets, so there are no transactions to be disclosed between Amerigroup Iowa and parties of interest.

Amerigroup intends to become party to a master administrative services agreement where under Anthem and its subsidiaries will provide certain administrative, consulting, and other support services to one another from time to time. These services are intended to enhance organizational and administrative capacity and augment the abilities of one another. Examples of the services provided include, but are not limited to payroll, banking, legal support, compliance support, technology support, call center services, and claims processing. Amerigroup will disclose information regarding this transaction once executed.

Definition of a Party in Interest (2.5.4.1)

Amerigroup understands and accepts the definition of a party in interest, as defined in 42 USC sec 300e-17(b).

Appropriate Disclosures (2.5.4.2 – 2.5.4.4)

Amerigroup agrees to disclose (i) any property sale, exchange, or lease of any property, (ii) any loan of money or credit extension, and (iii) any furnishing for consideration of goods, services, or facilities between Amerigroup and a party of interest, as required by SOW Section 2.5.4.2.

Amerigroup agrees to disclose all financial terms and arrangements for remuneration, once executed, between Amerigroup and our PBM subcontractor, Express Scripts (ESI), and specified vendors, as specified in RFP Section 2.5.4.3. We understand that DHS or State auditors may audit that information at any time and that DHS will maintain confidentiality of that information under Iowa or federal law.

The Iowa High Quality Healthcare Initiative will be Amerigroup's initial Contract with DHS. Amerigroup Iowa has not operated previously in commercial or Medicaid/Medicare markets, so there are no transactions to be disclosed between Amerigroup Iowa and parties of interest.

Amerigroup intends to become party to a master administrative services agreement where under Anthem and its subsidiaries may provide certain administrative, consulting, and other support services to one another from time to time. These services are intended to enhance organizational and administrative capacity and augment the abilities of one another. Examples of the services provided include, but are not limited to payroll, banking, legal support, compliance support, technology support, call center services, and claims processing. Amerigroup will disclose information regarding this transaction once executed.

Debarred Individuals (2.6)

Question 2.6, #1

1. Describe mechanisms to ensure compliance with requirements surrounding debarred individuals.

In accordance with 42 CFR 438.610, Amerigroup Iowa (Amerigroup) certifies to the State that we do not knowingly have a relationship with (i) an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or (ii) an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above. The relationships include directors, officers, or partners of Amerigroup; persons with beneficial ownership of five percent or more of Amerigroup's equity; or persons with an employment, consulting, or other arrangement with Amerigroup for the provision of items and services that are significant and material to Amerigroup's obligations under the Contract. Amerigroup will make sure that relationships are checked against exclusion databases monthly (see below). We understand that, in accordance with 42 CFR 438.610, if DHS finds that Amerigroup is in violation of this regulation, DHS will notify the Secretary of noncompliance and recommend appropriate action, including termination of the agreement.

Screening for Debarred Individuals

Amerigroup will initially screen all potential contractors, employees, or network providers through the following entities:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- Iowa Department of Public Health — Bureau of Professional Licensure
- Other applicable sites as may be determined by DHS

In addition to the OIG list and State-initiated termination databases, Amerigroup also conducts searches using the General Services Administration (GSA) Excluded Parties List (EPL). Amerigroup will not contract or employ parties appearing on any of the databases we use. Amerigroup also maintains monthly protocols to process exclusions and disbarments that occur after the initial screening or credentialing process and before mandatory periodic screenings or credentialing. We also use the databases identified above to monitor entities that we currently contract, employ, or include in our network on a monthly basis.

Medical Loss Ratio (2.7)

In accordance with SOW requirement 2.7, Amerigroup Iowa agrees to maintain, at a minimum, an annual Medical Loss Ratio (MLR) of 85 percent. We understand that DHS shall define how the MLR will be calculated and, in the event the MLR falls below this target, that DHS reserves the right to recoup excess capitation.

Organizational Structure (2.8)

Question 2.8, #1

1. Describe your proposed organizational structure and indicate which operational functions will be conducted in Iowa and which functions will be conducted out-of-state.

Amerigroup Iowa's (Amerigroup) organizational and operational structure reflects our belief that our healthcare solutions are most effective when developed and delivered locally while leveraging our vast network of national resources and expertise provided by our parent company, Anthem, and our affiliate health plans in 19 other states. Through our local and field-based staffing program, as well as our proven service operations delivery systems, our organizational structure allows us to be directly accountable to our State partner and our members and providers. Our people, combined with our organizational and operational structure, are the foundation to effectively deliver highly integrated physical health, behavioral health, and long-term services and supports to serve all Iowa High Quality Healthcare Initiative members while improving quality of care and health outcomes and decreasing healthcare costs through the reduction of unnecessary, inappropriate, and duplicative services.

Local Presence, National Expertise

We will rely on our proven *Local Health Plan Staffing Model*, currently operating successfully in our 19 state sponsored health program markets. This model consists of a comprehensively staffed *Iowa-based team* responsible for, and accountable to, meeting and exceeding major job objectives for all key member- and provider facing functions, as well as vital operations that support the overall program, the community, and the State. Our Iowa-based team will work and communicate with DHS on a daily, ongoing basis, to foster the development of a strong collaborative relationship between our staff and State staff. With senior Amerigroup personnel living and working in Iowa, we will work closely with DHS and make sure that we implement and manage all program components effectively, that members have access to all medically necessary services in a timely manner, and—in collaboration with network and community-based providers—that our services meet the highest standards of quality. Our affiliates have helped state agencies in other markets build solutions to various healthcare and service challenges, and we will work with DHS to do so in Iowa as well. Our team will also be responsible for continuously reviewing program performance and enhancing the program as needed.

Table 2.8-1 below shows which operational areas will be based in Iowa and those which will be handled by our national team (out-of-state):

Table 2.8-1. Location of Operational Areas

Operational Area	Iowa-Based	National
Administrative and Fiscal Management	x	
Member Services		x
Provider Services*	x	x
Care Coordination*	x	x
Marketing	x	
Provider Enrollment*	x	x
Network Development and Management	x	
Quality Management and Improvement	x	x
Case Management	x	
Utilization Management	x	x
Behavioral and Physical Health, including Disease Management	x	x
Information Systems		x
Performance Data Reporting and Encounter Claims Submission		x
Claims Payments		x
Grievance and Appeals*	x	x

* In addition to the primary responsibility and full accountability for this function residing with the local health plan staff, this area is supported by additional Iowa-dedicated national support services staff to supplement Iowa staff resources and leverage economies of scale to meet programmatic requirements.

This list is based on the Scope of Work requirements. Later in this section, we list additional operational and administrative Iowa-dedicated resources provided by our National Support Services team.

We will employ staff who fully understand the DHS program and needs of Iowans across the State, especially diverse highly complex populations we will serve through the Iowa Initiative. We also fully appreciate the importance of continuity and tenure within our staffing to ensure that the State, members, and providers have access to employees who have Iowa-specific expertise and are consistently available to address their specific support needs. Our employees will be highly qualified and experienced to perform the duties for which they have been hired and will have sufficient training to provide exemplary, culturally competent, and timely services. Amerigroup uses a well-structured and methodical staffing and training process that we have successfully implemented with repeatable results in past and recent public sector contracts, and we will do the same for the DHS program.

The local, Iowa-based team will have full ownership of the program and help assure that decisions regarding service delivery and administration are made at the local level. The team will also work closely with providers, community programs, State and local agencies, and other stakeholders to help assure Iowa’s program objectives are achieved. Additionally, we drive accountability through shared goals that are built into each employee’s annual performance evaluation, which drives a highly collaborative and team approach in meeting the goals and objectives of the Iowa program.

The local team is anticipated to be approximately 346 full-time equivalents (FTEs), supplemented by Iowa-dedicated support, expertise, and resources provided by our National Support Services teams. More than 206 additional individuals will be hired by our National Support Services areas to serve as Iowa specialists. In total, 552 FTEs will support our program in Iowa. Section 2.9 contains the Iowa Health Plan Organizational Chart.

National Support Services

Our National Support Services group provides specialized, centrally delivered services that *complement local employees* in the functional areas that we strategically determined create both better value and results for our state partners and members. The group is composed of national experts designated to Amerigroup and the Iowa Initiative. In addition to bringing the State increased efficiency and economies of scale, the national team will actively support Iowa-based health plan employees, and they, too, will be accountable to the Iowa Initiative through shared goals that drive continued and effective cross-functional collaboration.

This team leverages lessons learned from our Amerigroup affiliate health plans and will facilitate the sharing and use of best practices in state-sponsored program administration with the local team. They will also create a *peer-mentoring program* that allows our health plan employees to access national support resources to collaboratively develop and implement best practices across the Iowa program in a seamless manner. Together, they will continuously evaluate and enhance the program with up-to-date insights and experiences from their national exposure. This program has been successfully implemented most recently in Indiana.

Some of the key National Support Services functions that will be provided include:

- State Customer Implementation
- National Care Management, Disease Management, and Quality Programs
- Pharmacy Program
- Member Services
- Information Technology
- Healthcare Economics
- Member and Provider Communications
- Actuarial services
- Legal advisory and oversight
- National compliance advisory and oversight
- Regulatory advisory and oversight
- Government affairs advisory
- Human Resources

The combined strengths of this model will allow Iowa to benefit not only from a fully accountable local team, but also from the years of cumulative institutional and customer knowledge and experience our national teams possess. All designated employees will be knowledgeable about and follow all Iowa program requirements, and ***their functions will be fully accountable to the local leadership team.*** As we have proven consistently across the 19 states in which we operate state-sponsored programs, the local health plan employees and their national support services counterparts will collaborate closely to make sure that we provide all services in a seamlessly integrated, effective, and transparent manner and meet or exceed the State's expectations.

This model will deliver to Iowa the best of what Amerigroup has to offer: exceptional and high-quality services, built on local accountability and control, and an Iowa employee base, coupled with an array of supplementary national support services. The combination of local expertise and national best practices will promote operational continuity and seamless experience and enable Iowa to cultivate the kind of Medicaid program performance to which it aspires. We are extremely excited to work with the State of Iowa in this area. Amerigroup's health plan organizational table is discussed in greater detail and shown in Section 2.9.

Question 2.8, #2

2. Describe how your administrative structure and practices will support the integration of the delivery of physical health, behavioral health and LTSS.

Through our affiliate health plans in 19 other markets, we have 24 years of experience serving members with chronic illnesses who receive their healthcare from government-sponsored programs across the nation. In addition, these plans have 17 years of experience supporting more than 200,000 members living in their communities and those residing in facilities. ***Amerigroup has a depth and breadth of LTSS expertise that few other health plans can bring to Iowa.*** That experience has allowed us to develop an organizational and operational structure that supports the collection and integration of data across our service delivery system. We have performance metrics in place across all key functional areas that are monitored and evaluated by the local health plan leadership on a regular basis to assess the performance and effectiveness of our delivery system of physical health, behavioral health and LTSS.

Amerigroup's organizational and operational structure represents our belief that healthcare is best delivered locally and in an integrated and highly coordinated manner through an interdisciplinary team approach. Therefore, our role in the delivery system for the Iowa Initiative's members includes a highly integrated physical health, behavioral health, and long-term services and supports structure. This allows us to effectively serve all members while improving quality of care and health outcomes, as well as decreasing healthcare costs through the reduction of unnecessary, inappropriate, and duplicative services.

A key feature of Amerigroup's care coordination program is our member-centered focus and approach. We realize our members often must make significant changes to their lifestyles and daily living behaviors to achieve sustainable progress in health outcomes related to chronic conditions. ***Amerigroup achieves positive outcomes by providing individualized services via screening, assessing, and developing tailored member interventions while working collaboratively with the member, family, caregivers, providers, and others involved in the member's care.***

To do so, Amerigroup's locally based LTSS, behavioral and medical leadership provides oversight of the staff that perform the day to day execution of the contractual requirements to coordinate the delivery of medical and behavioral health care, long term services and supports to our members. The organizational structure of these teams allows Amerigroup to operate in a cross functional and seamless manner to ensure that the delivery, coordination and oversight to actively collaborate across interdisciplinary care coordination teams to engage with providers, community organizations and resources (as applicable), members, and their families and others to ensure integrated delivery and reduce the duplication of services.

Our organizational model allows us to incorporate both LTSS and clinical case rounds with an interdisciplinary team of professionals. Weekly chronic condition rounds include our medical and Behavioral Health Medical Directors; Community-Based Case Managers; Utilization Management Nurse-s; subject matter experts on issues with children, the field of behavioral health, individuals who are aged, or with disabilities; a pharmacist; and Case Managers. Case Manager for physical and behavioral health prepare and present cases at rounds for validation of the care plan and to obtain suggestions on how to better manage the member. In addition, community based case managers prepare and present cases at the rounds for validation of LTSS care and service plans, review of the member's physical health and behavioral health conditions and obtain suggestions on how better to provide support to the member The teams discusses available community resources and receives input from the medical directors regarding medical management, medications, and suggested modifications to the treatment plan.



Our organizational model allows us to incorporate both LTSS and clinical case rounds with an interdisciplinary team of professionals.

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In addition to our care coordination program, Amerigroup’s team of Nurse HelpLine, Community-Based Case Manager teams, and Amerigroup clinical staff partners seamlessly together in addressing members’ health needs telephonically. The Nurse HelpLine nurses will have access to Care Compass, our care coordination and management information system, so they can review the member’s Individual Service Plan (ISP), provider, and clinical history to inform their assessment of the member’s support needs and provide individualized assistance to the caller. While Nurse HelpLine nurses will be trained to handle crisis calls, a licensed behavioral health clinician will be available 24/7 to assist via a warm transfer to the Behavioral Health Hotline. If additional clinical assistance is needed, the Nurse HelpLine nurse can connect members to board-certified, Iowa-licensed physicians through our innovative LiveHealth Online feature. In addition, the nurse will be able to engage our Amerigroup clinical staff, such as a pharmacist, or refer the member to our State-level interdisciplinary experts. If the caller requests or requires assistance from a Community-Based Case Manager, the Nurse HelpLine nurse will warm transfer the caller to the Community-Based Case Manger or to the on-call Community-Based Case Manager after-hours.

Another crucial component of our operational model is addressing the needs of our Network Providers, both traditional and non traditional providers, to ensure that the integrations of delivery of care and services operate in an optimal manner. Our organizational structure also includes local claims resolutions specialists and provider relations staff working together in cross functional teams to make sure that the spectrum of all provider needs is met—from assisting a provider looking to join our Network, to updating a provider’s information, to helping a provider with their claims payment questions. Our team of provider services staffing will also include subject matter experts trained to address the needs of providers serving our specialized populations. These employees will be colocated with our LTSS, behavioral and medical clinical teams—allowing for highly effective and tightly coordinated issues resolution management for the provider and, ultimately, the member.

Our organization’s long history of delivering both LTSS and high-quality healthcare solutions for members in a cost-effective manner for State partners is premised upon our ability to deliver care locally and in an integrated manner. This success is due to our ability of effectively managing the functional linkages between major operational areas through our organizational and operational structure.

Staffing (2.9)

Staffing Requirements (2.9.1)

Question 2.9, #1

1. Describe in detail your staffing plan and expected staffing levels.

Amerigroup will leverage our affiliate health plans’ 24 years of experience building and operating precisely the type of local, community-based health plan that Iowa requires. Our staffing model reflects our belief that the most effective healthcare delivery system is locally based. Through our field-based staffing program, we will hire qualified individuals who live and work in the Iowa communities they serve, allowing us to adequately serve members located throughout the entire State, regardless of bricks-and-mortar office locations. We understand that regional variations affect our members’ and our providers’ behaviors. Rural conditions, cultural differences, demographics, and many other regional characteristics have a profound effect on the availability of services and access to those services and how they are utilized. Nationwide, approximately 65 percent of our affiliates’ covered counties are located in areas defined as “rural” by the Census Bureau. Our organization has a proven track record of hiring qualified employees who serve on interdisciplinary teams that seamlessly blend physical, behavioral, and

long-term services and supports to achieve optimal health outcomes. Staffing the health plan based on Iowa’s specific requirements, cultural and geographic nuances, and member population health and social needs are our priority.

Staffing Levels

Amerigroup will hire talented, qualified employees to fill positions to meet the requirements of the contract in addition to designated national support services positions to further support Iowa operations. We continually evaluate and adjust our staffing to maintain and exceed quality service for our members. Table 2.9-1 outlines our anticipated staffing levels based on current membership assumptions and projections for the Iowa Initiative. We anticipate hiring 552 employees – 346 employees who will be locally based and additional 206 who will be located elsewhere in Amerigroup’s national support facilities. We will continually adjust based on membership volume and/or type.

Table 2.9-1. Number and Location of Staff to be Hired for this Contract

Position	Location	Staffing Level
Executive and Executive Support		7.0
Contract Administrator CEO	Iowa	1.0
Chief Operating Officer	Iowa	1.0
Government Relations Officer	Iowa	1.0
Ombudsman	Iowa	1.0
Program Director	Iowa	1.0
Support Staff	Iowa	2.0
Accounting and Finance		11.0
Chief Financial Officer	Iowa	1.0
Manager Finance	Iowa	1.0
Finance Analysts	Iowa	4.0
Actuarial & Accounting Services	Out of State	5.0
Medical Directors		3.0
Medical Director	Iowa	1.0
Associate Medical Director	Iowa	2.0
Clinical Leadership		4.0
Care Management Manager	Iowa	1.0
Utilization Management Manager	Iowa	1.0
Behavioral Health Manager	Iowa	1.0
Clinical Administrative Support	Iowa	1.0
Care Management		57.0
Care Management Team Leader / Supervisor	Iowa	9.0
Physical Health Support Staff, including Disease Management	Iowa	8.0
Community-Based Physical Healthcare Managers	Iowa	40.0
Disease Management Staff	Out of State	4.0
Behavioral Health		56.0
Behavioral Health Team Leader / Supervisor	Iowa	2.0
Community-Based Behavioral Healthcare Managers	Iowa	18.0
Behavioral Health Peer Support & Recovery Staff	Iowa	4.0
Employment Outreach Specialist	Iowa	2.0
Substance Abuse Utilization Management Staff	Iowa	4.0
Behavioral Health Support Staff	Iowa	14.0
	Out of State	12.0
Prior Authorization & Concurrent Review		36.0
Prior Authorization & Concurrent Review Team Leader/Supervisor	Iowa	1.0
Prior Authorization & Concurrent Review Nurses	Iowa	16.0
	Out of State	4.0



Tab 3: Bidder's Approach to Meeting the Scope of Work

2 General and Administrative Requirements

Position	Location	Staffing Level
Prior Authorization & Concurrent Review Support Staff	Iowa	15.0
Long-Term Care		131.0
Long Term Care Manager	Iowa	1.0
Long-Term Care Team Leader/Supervisor	Iowa	11.0
Community-Based Long-Term Care Managers	Iowa	114.0
Long-Term Care Support Staff	Iowa	5.0
Quality Management		27.0
Grievance & Appeals Manager	Iowa	1.0
Quality Management Manager	Iowa	1.0
Quality Management Team Leader/Supervisor	Iowa	1.0
Quality Improvement Nurses	Iowa	11.0
Quality Management Support Staff	Iowa	5.0
Grievance & Appeals Staff	Iowa	3.0
Member Complaints Staff	Iowa	2.0
Quality Management Program Analysis Staff	Out of State	3.0
Compliance		7.0
Compliance Officer	Iowa	1.0
Compliance Support Staff	Iowa	2.0
Regulatory Services Staff	Iowa Out of State	1.0 3.0
Provider Services		41.0
Provider Services Manager	Iowa	1.0
Provider Services Team Leader/Supervisor	Iowa	2.0
Provider Services Staff	Iowa Out of State	11.0 8.0
Member-Centered Care Coordination Staff	Iowa	1.0
Provider Services Hotline Staff	Out of State	18.0
Claims Processing		68.0
Claims Administrator	Out of State	1.0
Claims Administration Team Leader/Supervisor	Out of State	2.0
Claims Staff	Out of State	65.0
Community Health Outreach		6.0
Community Health Outreach Staff	Iowa	6.0
Marketing and Outreach		9.0
Community Relations/Engagement Manager	Iowa	1.0
Tribal Liaison	Iowa	1.0
Community Relations Staff	Iowa	5.0
Marketing Communications Support Staff	Out of State	2.0
Member Services		24.0
Member Services Manager	Out of State	1.0
Member Services Staff	Out of State	23.0
Operations		18.0
Operations Manager	Iowa	1.0
Operations Team Leader/Supervisor	Iowa	1.0
Claims Resolution Staff	Iowa	6.0
Operations Support Staff	Out of State	9.0
Program Director	Iowa	1.0
Human Resources		4.0
Human Resources Manager	Iowa	1.0
Human Resources Support Staff	Out of State	3.0

Position	Location	Staffing Level
Program Integrity		3.0
Program Integrity Manager	Iowa	1.0
Program Integrity Support Staff	Iowa	2.0
Pharmacy		11.0
Pharmacy Director/Coordinator	Out of State	1.0
Pharmacy Services Staff	Out of State	10.0
Information Systems		26.0
Information Systems Manager	Out of State	1.0
Information Systems Support Staff	Out of State	24.0
Information Systems Technician	Iowa	1.0
TOTAL		552.0
Iowa-Based Employees		346.0
Out of State Employees		206.0

Staffing Plan

To meet our staffing levels, we engage in a robust staffing plan/recruitment strategy. Through our experience and in preparation for implementation of the Iowa Initiative, we have gained a comprehensive understanding of successful strategies to recruit and acquire qualified employees to serve Iowa Medicaid programs. We use a multipronged approach to attract and retain quality staff as well as address staffing changes. More information about how Amerigroup effectively manages staffing changes to continually meet service level requirements is provided in Section 2.9.4.

Our recruitment cycle begins with determining the skills and qualifications required by each position and how the position factors into our overall staffing plan. Amerigroup and our affiliate health plans use a centralized recruiting system to post job openings internally and externally. We employ succession planning strategies to recruit from within and conduct behavioral interviewing techniques as a means of screening internal and external candidates. Our carefully honed and tested recruitment cycle, described in Figure 2.9-1, results in matching highly qualified candidates with the requisite skills and experience needed to meet the needs and preferences of our members in an operationally efficient manner.

Figure 2.9-1. Recruitment Cycle



Recruitment methods include an associate referral program, using job postings on job search engines and networks, social media campaigns, newspaper ad campaigns when appropriate, and job fairs as shown in Table 2.9-2. We often collaborate with professional organizations and community stakeholders to promote job openings.

Table 2.9-2. Job Posting on Job Search Engines and Networks

Media	Overview	Reach
Local Newspapers	When appropriate to bolster regional recruitment and target rural areas, we may advertise in local newspapers. Examples of such newspapers include the Des Moines Register (Polk), Cedar Rapids Gazette (Linn), Quad-City Times (Scott), Waterloo-Cedar Falls Courier (Black Hawk), Sioux City Journal (Woodbury), Council Bluffs Daily Nonpareil (Pottawattamie), Iowa City Daily Iowan (Johnson), Iowa City Press-Citizen (Johnson), Mason City Globe Gazette (Cerro Gordo) and Dubuque Telegraph Herald (Dubuque).	Readership and reach vary by county
Local Job Fairs	When appropriate to bolster regional recruitment and target rural areas, we engage in job fairs in local communities.	Attendance and reach vary by location
Indeed	Indeed is a job search aggregator, a search engine that collects job postings from all over the Internet and allows users to search for them in one location. Indeed is the largest job aggregator and uses a sponsored search model similar to Google’s.	20,565,000 unique visitors per month (comScore)
Health Callings	HealthCallings is a healthcare job bank encompassing medical jobs in nursing, allied health, pharmacy, physician employment, executive, rehabilitation, and laboratory. It is the top healthcare media recommendation.	224,000 unique visitors per month (comScore)
HealthECareers	The HealthECareers Network includes more than 100 associations and hundreds of local chapters with a total reach of four million healthcare professionals and a quality controlled database of more than 130,000 job seeker résumés.	300,000 unique visitors per month (comScore)
SocialService.com	SocialService.Com is a job site for social work, counseling, psychology, mental health, care management, EAP, volunteer management, substance abuse treatment, domestic violence, community development, youth development, child welfare, developmental disabilities, and all other areas of social services.	69,000 unique visitors per month (comScore)
Beyond.com	Beyond.com offers a broad network of niche online job sites, including several healthcare sites. Their Talent Communities consist of more than 500 channels and 25 million members and attract and connect job seekers and employers based upon their needs and interests. Communities include various local sites and sites targeted specifically by industry. The Healthcare community features healthcare Jobsite, which receives 840,000 unique visitors per month.	3,177,000 unique visitors per month (comScore)
CareerBuilder	CareerBuilder provides labor market intelligence, talent management software, and other recruitment solutions such as online career search services for more than 1,900 partners, including 140 newspapers and portals such as AOL and MSN. CareerBuilder also owns and operates several niche job search sites, including Sologig.com, Headhunter.com, CareerRookie.com, MiracleWorkers.com, WorkinRetail.com, and JobsInMotion.com.	More than 24 million unique visitors each month[3] and a 34% market share of help-wanted web sites in the United States
LinkedIn	LinkedIn allows users to research companies with which they may be interested in working. When typing the name of a given company in the search box, statistics about the company are provided. These may include the ratio of female to male employees, the percentage of the most common titles/positions held within the company, the location of the company’s headquarters and offices, or a list of present and former employees.	33.9 million unique visitors per year

Our Iowa-designated Talent Acquisition Team includes in-house recruiters, sourcing specialists, administrators, and managers who are well equipped to support the hiring of local talent. This staff is supplemented with a sophisticated outsourcing component (ADP), which will allow our recruiters to flex quickly to meet our staffing plan goals. ADP has been an able partner and has never missed a Service Level Metric throughout our business partnership. We have a manager dedicated to this relationship who runs a seamless organization, combining the in-house and external recruiters. *In 2014, our Recruitment Team filled approximately 15,000 positions in support of the business across our affiliate health plans.* There are 16 recruiters specifically designated to our state-sponsored business programs.

We employ a Talent Acquisition Lead or Manager with a team of recruiters to work with the local health plan leadership and Human Resources partners to achieve the goal of appropriate staffing levels to support the need. Some examples of staffing projects for our state-sponsored business organization from 2014 include:

- Texas Medicaid Expansion: over 300 FTEs hired
- Tennessee Medicaid Service Area Expansion: over 550 FTEs hired
- Texas Medicare-Medicaid Duals Demonstration Program: 170 hired (ongoing)

Amerigroup is expert at successfully addressing the unique staffing requirements necessary to effectively support Iowa's members. We understand the distinct local labor market of experts and experienced individuals needed to make the program successful and work with the local communities that we serve to find the best talent in support of our business goals.

Staffing Plan (2.9.2)

Question 2.9, #2

2. For staffing positions proposed in your staffing plan, provide job descriptions that include the responsibilities and qualifications of the position, including the number of years of experience.

An integral part of our staffing plan is to hire the staff necessary to provide the highest level of quality services to Iowa members and carry out our member-centric philosophy in managing their care. This mirrors the approach our organization has taken in other markets. For example, our affiliate health plan in Indiana is in the process of completing a successful implementation for a statewide contract in the State of Indiana where more than 200 local employees are being hired who bring a wealth of knowledge of the populations served (which include individuals who are aged, blind or disabled (ABD), children enrolled in CHIP, and people receiving home and community based waiver services.). Their knowledge is being effectively applied through our organizational and operational model that supports our proven interdisciplinary approach to care coordination. In Iowa, Amerigroup will also be hiring highly qualified local staff for the following position classifications per Table 2.9-1, as suggested by DHS, to provide comprehensive Iowa Initiative services. Nearly 70 percent of the employees hired will be Iowa-based. Table 2.9-3 provides *job descriptions* for our proposed staff.

Table 2.9-3. Job Descriptions of Proposed Staffing Positions, Nearly 70% of Which Will Be Based in Iowa

Position	Responsibilities	Qualifications
Prior Authorization and Concurrent Review Staff	Responsible for making sure that the delivery of healthcare services is available, accessible, timely, and medically necessary. Assesses clinical information to promote appropriate use of resources and quality care. Responsible for activities such as consulting with providers, reviewing clinical guidelines annually, monitoring of clinical issues and trends (for example, over/underutilization of services), identifying and implementing initiatives to improve member health outcomes, and conducting policy evaluations and programmatic studies.	Requires current active unrestricted RN license to practice as a health professional in applicable state(s) or territory of the United States and 3-5 years acute care clinical experience or case management, utilization management, or managed care experience, which would provide an equivalent background. Must have knowledge of medical management process and ability to interpret and apply member contracts, member benefits, and managed care products. Prior managed care experience strongly preferred. Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Member Services Staff	Responds to inquiries from members, providers, and/or others for information and assistance. Performs research to respond to inquiries and complaints and interprets policy provisions to determine most effective response, including assisting members to locate providers. Also responsible for providing non-clinical support, which includes handling more complex file reviews and inquiries from members and providers. Responds to requests, calls, or correspondence within scope. Provides general program information to members and providers as requested. Acts as liaison between the member and other internal departments to support ease of administration of medical benefits. Has access to real-time data on members, including eligibility and service and utilization data.	Requires a HS diploma or GED: 1 to 3 years of the company's experience in an automated customer service environment; or any combination of education and experience, which would provide an equivalent background.
Provider Services Staff	Responsible for building lasting and trusting relationships with providers to offer our members the right size, the right composition, best quality, and most efficient network. Collaborates with providers to systematically improve health outcomes through strategic partnerships with our providers. Responsible for responding to provider inquiries and complaints through the Provider Helpline. Researches, analyzes, and suggests solutions to issues related to disputes and participates in network development. Provides technical assistance to providers about operations and innovations. Refers difficult or complex issues to higher levels. Reports issues that may impact Provider Relations. Develops reports to aid in the identification of network access and deficiencies. Assists in developing and implementing the recruitment and contracting plan. Drafts training materials and assists in training. Conducts provider outreach and refresher training using a variety of modalities, including on-site at provider locations, via WebEx, in central locations, or by telephone.	Requires a high school diploma; 1-3 years of customer service experience; for staffing dedicated to behavioral health or LTSS providers then 1-3 years experience in the applicable field is highly preferable; or any combination of education and experience that would provide an equivalent background.
Claims	Responsible for processing HIPAA-compliant electronic and	Requires a high school diploma or GED;

Position	Responsibilities	Qualifications
Processing Staff	paper claims in a timely and accurate manner, processing claims correction letters, processing claims resubmissions, and addressing overall disposition of all claims per State and federal guidelines.	1 to 3 years of claims processing experience; previous experience using PC, database system, and related software (word processing, spreadsheets, etc.); or any combination of education and experience that would provide an equivalent background.
Reporting and Analytics Staff	Responsible for the maintenance of information technologies and ensures the timely and efficient production of reports and processing of data requests. Maintains thorough knowledge of the data dictionary, data structures, and data warehouses in the MMIS. Proficient in the use of reporting and data access tools. Understands Medicaid and healthcare terminology. Analyzes requests for reports and information, designs solutions, and meets deadlines.	Requires a BS/BA degree, 3-5 years related business analysis experience, or any combination of education and experience that would provide an equivalent background.
Quality Management Staff	Responsible for developing, coordinating, implementing, and evaluating the continuous quality improvement activities throughout the health plan according to the established Quality Management program and annual work plan. In collaboration with other departments, conducts barrier analyses; designs targeted interventions for provider, member, health plan, and system barriers; implements interventions across the health plan system; and monitors for effectiveness.	Requires an AS/BS in nursing; 5 years of managed care experience; 2 years of clinical experience; 2 years of professional presentations to small and large audiences; or any combination of education and experience that would provide an equivalent background. Current, unrestricted clinical license appropriate to field of specialty (LVN/LPN, RN, NP, PA, LCSW, LSW, etc.) as required. BSN or MSN preferred.
Marketing and Outreach Staff	Responsible for community-level marketing and outreach in assigned regions. Talks with people in the community to provide information about important health messages, and how Amerigroup will help them address their healthcare needs. Seeks additional avenues and partners to reach new member populations. Works daily with community organizations, senior centers, statewide aging and disability organizations, faith-based organizations, and public health departments to conduct joint outreach. May assist in developing member materials and providing member outreach and education.	Requires an AS; 4 years of experience in managed care/healthcare or sales/marketing environment; or any combination of education and experience that would provide an equivalent background. BA/BS preferred. Valid driver’s license and access to a motor vehicle with valid motor vehicle insurance required. State health insurance licensure preferred.
Compliance Staff	Responsible for ensuring that health plan functions are in compliance with State and federal laws and regulations, the State’s policies and procedures, and contractual requirements.	Requires a BA/BS in a related field, 3-5 years of compliance, regulatory, and/or customer service experience; or any combination of education and experience that would provide an equivalent background. Previous healthcare and policy interpretation experience preferred.
Community-Based Case Managers –	Ensures member support needs are met, manages resources effectively, and ensures member’s health, safety, and welfare are met. Assists the members in gaining access to appropriate	<i>Physical Health:</i> Requires a BA/BS in a health-related field; 3 years of clinical experience; or any combination of

Position	Responsibilities	Qualifications
Physical Health, Behavioral Health and Long-Term Care	resources.	<p>education and experience that would provide an equivalent background. Current, unrestricted RN license in applicable state(s) required. Certification as a Case Manager is preferred.</p> <p><u>Behavioral Health:</u> Requires a BS in a related field; 2 years of direct psychiatric and/or substance abuse experience; or any combination of education and experience that would provide an equivalent background. Current unrestricted license as an RN, LBSW (as allowed by applicable state laws), LPC (as allowed by applicable state laws), LCSW, LMSW, or LMHC, in applicable state(s) required.</p> <p><u>Long-Term Care:</u> Requires an RN, LPN/LVN, LSW, LCSW, or LMSW; 2-4 years of experience in working with individuals with chronic illnesses, co-morbidities, and/or disabilities in a Service Coordinator/Community-Based Case Manager, Case Management, or similar role; or any combination of education and experience that would provide an equivalent background. Current, unrestricted RN, LPN/LVN, LSW, LCSW, or LMSW license in applicable state(s) required. Masters in health/nursing preferred. May require state-specified certification based on state law and/or contract. Travel required. <i>For Non-Clinical Service Coordinators / Community-Based Case Manager (where clinical licensure is not required):</i> BA/BS in a health-related field preferred; 2 years of experience working with a social work agency; or any combination of education and experience that would provide an equivalent background. Travel required.</p>

In addition to the State’s suggested staff above, in Table 2.9-4, we list the additional staff positions that will support Iowa Initiative services not listed above. These employees are key to the delivery of fully integrated and highly coordinated care and services to our members, and we will employ sufficient staff in each area to meet the needs of the Iowa Initiative’s beneficiaries.

Table 2.9-4. Additional Staff Positions

Position	Responsibilities	Years & Type of Experience
Operations Manager	Responsible for health plan dashboards, operations policies, best practices, and regulatory compliance. Identifies and prioritizes health plan opportunities for improvement in the areas of efficiency and effectiveness. Partners and supports leadership across the health plan on assigned projects. Participates in operational process improvement initiatives and facilitates collaborative effort between health plan and National Anthem functional support areas for implementation. Serves as primary contact to health plan leaders to ensure appropriate key operational indicators are in place for monitoring and analysis. Resolves operational issues to include enrollment, benefit configuration, call metrics, authorizations, high dollar claims, pended claims, appeals, adjustments, customer service, and policy issues. Assists health plan Provider Relations with contracting process and resolution.	7 years of related experience, including 3 years of management experience and 2 years of experience in data assimilation; BA degree, or any combination of education and experience that would provide an equivalent background.
Health Promotions Coordination Staff	Responsible for designing and implementing health promotion initiatives, including identifying and communicating services, and implementing health promotion-related recruitment and enrollment activities. Develops and maintains strong relationships with local health departments, schools, and community-based organizations to promote access to appropriate health promotion programs and services.	2 years of related experience; BA degree, or any combination of education and experience that would provide an equivalent background.
Member-Centered Care Coordination Staff	Responsible for providing support to providers to improve the effectiveness and efficiencies of provider practices. Obtains and analyzes quality metrics and reports for care opportunities; supports practice implementation of care coordination and care management; identifies action plans for providers to implement to improve cost, quality, and the patient experience; and participates in design, development, and implementation of community learning forums. Collaborates with other health plan provider and operations staff to meet provider and practice service needs. Supports the efforts of providers and practice teams on office-based care delivery interventions resulting in cost of care savings and improved health outcomes for patients. Promotes practice transformation to team-based member-centered care delivery. Provides education for practices to develop expertise with metrics and data review for quality improvement. Maintains up-to-date knowledge on Patient Centered Medical Home, Care Delivery System Redesign, and Accountable Care Organizations.	3 years healthcare experience; or any combination of education and experience that would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, and electronic health records preferred.
Behavioral Health Peer Support &	Responsible for assisting in the development, implementation, evaluation, and expansion of Amerigroup’s Recovery and	4 years of experience in health services, a managed care

Position	Responsibilities	Years & Type of Experience
Recovery Staff	Resiliency program and service delivery system for members with Serious Mental Illness (SMI) or Substance Use Disorder (SUD). Identifies opportunities for developing and expanding a Wellness and Recovery network to support member needs. Acts as a resource for staff and functional departments to ensure decision-making and problem-solving is in accordance with established principles. Determines and recommends changes for increased efficiencies and improved outcomes; determines training needs and assists in development of training materials. Collaborates with the community and key stakeholders to expand and promote the development and value of wellness and recovery. Establishes working relationships with provider networks and community stakeholders.	organization, or the behavioral health field, including a peer support services role, knowledge of care coordination and case management concepts. Peer Specialist Certification required.
Substance Abuse Specialist - UM Staff	Responsible for collaborating with healthcare providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of behavioral health resources. Ensures appropriate, high- quality, cost-effective behavioral healthcare through assessing the necessity of inpatient admissions, outpatient services, out-of-network services, and appropriateness of treatment setting by utilizing the applicable medical policy, clinical criteria, and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs or community resources. Ensures members access medically necessary, quality behavioral healthcare in a cost-effective setting according to contract. Consults with clinical reviewers and/or medical directors to ensure medically appropriate, high-quality, cost-effective care throughout the medical management process. Collaborates with providers to assess member support needs for early identification of and proactive planning for discharge planning. Facilitates member care transition through the healthcare continuum and refers treatment plans/plan of care to clinical reviewers as required and does not issue non-certifications.	Requires a BS in a related field; 2 years of direct psychiatric and/or substance abuse experience; or any combination of education and experience that would provide an equivalent background. Current active unrestricted license as an RN, LBSW (as allowed by applicable state laws), LPC (as allowed by applicable state laws), LCSW, LMSW, or LMHC, to practice as a health professional within the scope of licensure in applicable state(s) or territory of the United States required.
Health Homes Staff	Responsible for managing members who are experiencing complex or catastrophic illness, ensuring that these members receive cost-effective and efficient utilization of health services by providing education, guidance, and support concerning our Health Home model of care. Acts as a member advocate, seeking and coordinating creative solutions to member healthcare needs without compromising the quality of outcomes.	Requires a BS in a related field; 2 years of direct psychiatric and/or substance abuse experience; or any combination of education and experience that would provide an equivalent background. Current unrestricted license as an RN, LBSW (as allowed by applicable state laws), LPC (as allowed by applicable state laws), LCSW, LMSW, or LMHC, in applicable state(s) required.
Practice Consultant Staff – Quality Management	Responsible for creating a partnership relationship with providers and other initiatives and implementing the concept of a Medical Home for our members to achieve this fully integrated and accountable system of care. Assesses current	5 years of managed care experience; 2 years of clinical experience; 2 years of professional presentations to small and large

Position	Responsibilities	Years & Type of Experience
	<p>practice patterns, assets, and challenges utilizing Medical Home Index, NCQA Standards, HEDIS audits, site reviews, and medical records reviews. In partnership with the PCP, evaluates results of the initial assessment. Establishes a project plan with the practice that establishes goals and objectives for improvement. Provides ongoing practice support and sustains the partnership. Establishes regular meetings to track progress. Identifies and facilitates at least one practice in each MPC region to become SSB Physician Champions by obtaining NCQA certification as a Member-Centered Medical Home. Improves the understanding and sensitivity to the unique support needs of this population and the caregivers.</p>	<p>audiences; AS/BS in nursing, or any combination of education and experience that would provide an equivalent background. Current, unrestricted clinical license appropriate to field of specialty (LVN/LPN, RN, NP, PA, LCSW, LSW, etc.) as required. BSN or MSN preferred.</p>
<p>Medical Director Associates – Family Practice, Geriatrics and Psychiatry</p>	<p>Responsible for providing day-to-day guidance, support, and leadership for the clinical and quality activities and supporting the Medical Director in ensuring the clinical integrity of broad and significant clinical programs (behavioral health, long-term care, etc.), and identifies and develops opportunities for innovation to increase effectiveness and quality. Provides support to clinicians in daily tasks and ensuring timely and consistent responses to members and providers, conducts peer-to-peer clinical reviews with attending physicians or other ordering providers to discuss review determinations, office visits with providers and external physicians as necessary. Assists in the practitioner appeal reviews, appropriateness criteria reviews, medical policy and technology assessments, setting and implementing QM initiatives, and practitioner/provider credentialing.</p>	<p>5 years of clinical experience; M.D.; Board certification approved by the American Board of Medical Specialties required where applicable to duties being performed. Must possess an active unrestricted medical license to practice medicine or a health profession; or any combination of education and experience that would provide an equivalent background.</p>

In addition to these staff, we will engage and leverage our in-house support services experts across a broad range of functional areas to achieve high-quality healthcare solutions for Iowa members in a cost-effective and carefully integrated manner.

Key Personnel (2.9.3)

Question 2.9, #3

3. Confirm that a final staffing plan, including a resume for each Key Personnel member, will be delivered within ten (10) calendar days after notice of award.

Amerigroup confirms that it will deliver its final staffing plan, including a resume for each Key Staff member to the DHS within ten calendar days after notice of Award. Amerigroup will staff the Iowa health plan in a manner that complies with all DHS requirements and positions us to deliver high-quality services to Iowans from Day One. Because Amerigroup is new to the Iowa Initiative, we do not currently have individuals fulfilling the Key Personnel roles. However, in preparing to implement operations in Iowa, Amerigroup has identified a seasoned Transition Team comprised of our national functional leaders with extensive Medicaid and state-sponsored program experience and a deep understanding of the care and service needs of these members. The Transition Team will be responsible for overseeing initial operations of the contract, which includes hiring highly qualified, Iowa-based staff to fill these key roles, and will have ultimate accountability and responsibility for the success of Iowa health plan on a go forward basis, as well as being able to easily step in on an interim basis (having knowledge of the Iowa operating landscape without any disruption to members, providers, and other stakeholders) in the event of a Key Personnel vacancy at any point during the life of the contract. More information regarding our well-documented history of successful large-scale Medicaid plan implementations can be found in Section 1.1.

Our Transition Team will be led by Dr. Tunde Sotunde, who is the President of the North Region–Anthem’s Medicaid Business Division. He will oversee all Iowa health plan operations until a local leader is hired as the Contract Administrator/CEO, and he will maintain ongoing oversight of the market. Dr. Sotunde will have responsibility for every aspect of the program during implementation. Our Transition Team is listed below in Table 2.9-5. We provide résumés for these individuals in Tab 6.

Table 2.9-5. Key Personnel List

Title	Required/Additional Key Staff Position	Name
Contract Administrator	Required – 2.9.3.1	Tunde Sotunde, MD
Chief Operating Officer (COO)	Required – 2.9.3.17*	John Crowley
Medical Director	Required – 2.9.3.2	John Chang, MD
Chief Financial Officer (CFO)	Required – 2.9.3.3	Aimee Dailey
Compliance Officer	Required – 2.9.3.4	Georgia Dodds-Foley
Government Relations Officer	Additional	Pamela Perry
Pharmacy Director	Required – 2.9.3.5	Patrick Convey
Human Resources Manager	Additional	Bradley D. Soto
Grievance & Appeals Manager	Required – 2.9.3.6	Tamera Lathan
Quality Management Manager	Required – 2.9.3.7	Barbara Kupferman
Utilization Management Manager	Required – 2.9.3.8	Lisa McCormick

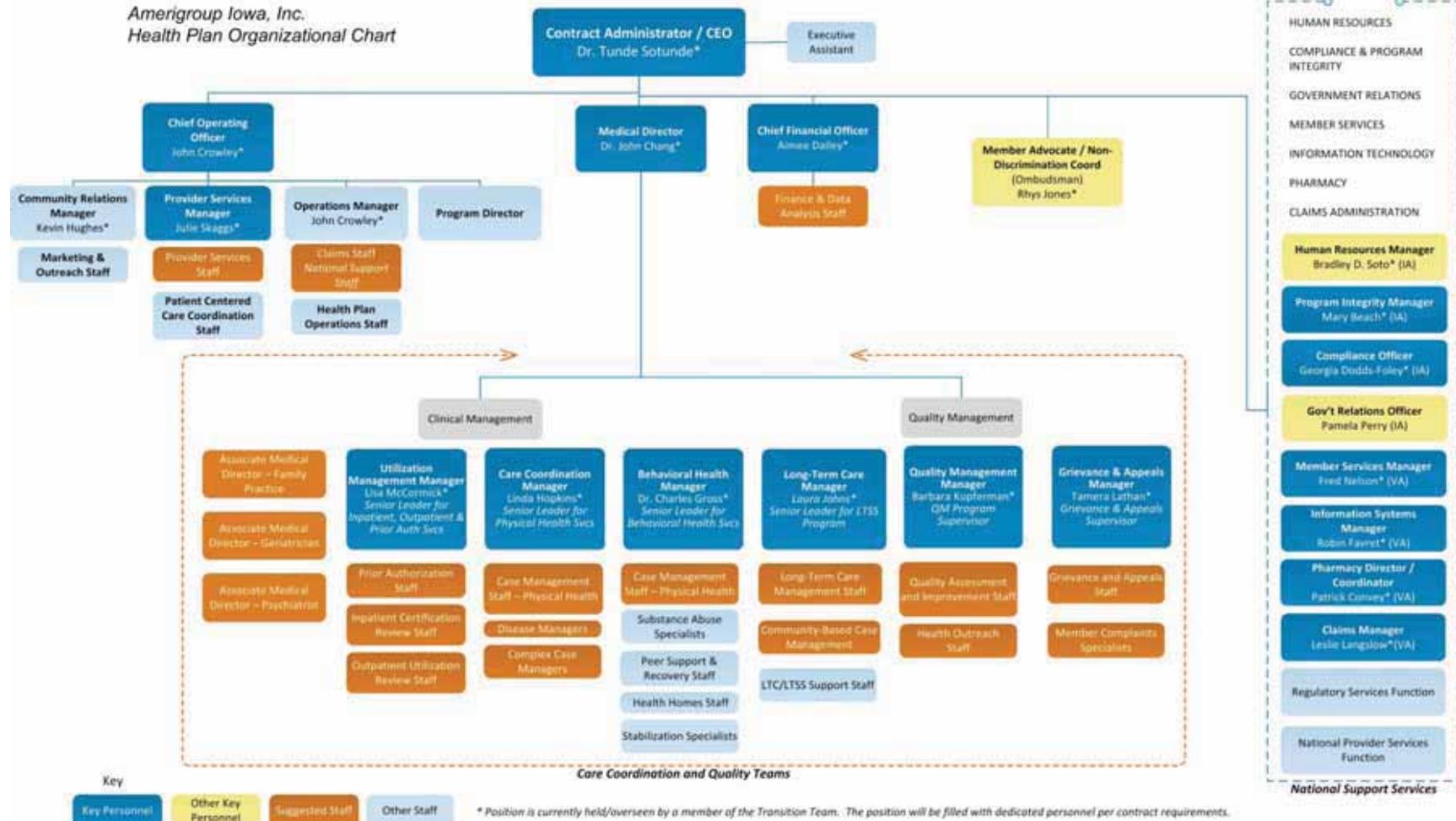
Title	Required/Additional Key Staff Position	Name
Behavioral Health Manager	Required – 2.9.3.9	Charles Gross, PhD
Member Services Manager	Required – 2.9.3.10	Fred Nelson
Provider Services Manager	Required – 2.9.3.11	Julie Skaggs
Information Systems Manager	Required – 2.9.3.12	Robin Favret
Claims Administrator	Required – 2.9.3.13	Leslie Langslow
Care Coordination Manager	Required – 2.9.3.14	Linda Hopkins
Program Integrity Manager	Required – 2.9.3.15	Mary Beach
Long-Term Care Manager	Required – 2.9.3.16	Laura Johns
Community Relations Manager	Additional	Kevin Hughes
Member Advocate/Non-Discrimination Manager (Ombudsman)	Additional	Rhys Jones

** The COO will serve as the primary point of contact for delivery system reform activities and will be supported in execution of those activities by a dedicated Program Director fully accountable to the COO for managing all project management activities and represent the COO as a liaison between Amerigroup and the various stakeholders as identified in SOW 2.9.3.17.*

Organizational Chart

Amerigroup health plans offer a Care Coordination Team (CCT) approach to member clinical care delivery, where we leverage the different skill sets provided by our community-based nurses, social workers, in-house physicians, and specially trained staff in the areas of LTSS, behavioral health, and physical health. These teams also regularly engage in interdisciplinary collaboration efforts with other areas such as Quality and Provider Services to offer an integrated member-centric approach to care. The below table illustrates the Amerigroup health plan structure for Iowa. Our local staff has ready access to collaborate and share best-practices, not only with one another but with our national support services teams without compromising local authority and control on health plan operations. Figure 2.9-2 illustrates the local health plan organizational model.

Figure 2.9-2. Iowa Health Plan Organizational Chart



Staffing Changes (2.9.4)

Question 2.9, #4

4. Describe your back up personnel plan, including a discussion of the staffing contingency plan for:
- The process for replacement of personnel in the event of a loss of Key Personnel or others.
 - Allocation of additional resources in the event of an inability to meet a performance standard.
 - Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.
 - The time frame necessary for obtaining replacements.
 - The method of bringing replacement or additions up to date regarding the Contract

The success of Amerigroup Iowa's operations depends on qualified and stable staffing at all levels of the organization and flexible policies and procedures that allow us to scale up or scale down resources as the circumstances dictate. It also allows us to replace Key Personnel and other management staff quickly and efficiently. Amerigroup plans for change.

Replacement of Key Personnel

When a Key Personnel or management staff member departs, we are prepared. Amerigroup policy is to maintain an ongoing list of qualified candidates for various key positions. This is in addition to the Transition Team's functional leadership who can easily step in on an interim basis without any disruption to health plan operations. These qualified replacements are identified through a number of modalities, including:

- Short-listed candidates for each position
- Amerigroup and affiliate employees in similar positions who are interested in making a change
- Qualified individuals referred to Amerigroup by providers, community leaders, the State, and other stakeholders
- Known subject matter experts who may be interested in working within the managed care field

In addition, we rely on national resources to assist in the search process. Amerigroup has a robust Talent Management and Succession Management process, and we are working to identify successors to all key positions with individuals who are either internal to Amerigroup, its affiliate health plans, our parent company, or external in the community. Succession planning allows us to identify and develop future leaders. Having a strong pipeline of talent in place helps us fill critical leadership positions with individuals who have the necessary skills to take our company into the future.

With Succession Management, we are creating a pipeline of leadership talent to allow us to:

- Execute our business strategies
- Minimize the disruption to the business, as well as our customers
- Invest proactively in our leadership talent so that we have readily available talent at the right time and in the right role

To facilitate this, we use an online tool with which directors, executives, and key leadership in our organization describe their job preferences that best align with their experience and aspirations. In addition, leaders complete a career summary where they may outline their experience, education, achievements, and competencies. This information is utilized to complete a succession plan for a variety of leadership positions within the organization.

Our Talent Acquisition Department uses the completed succession plans to develop a pool of internal talent. Upon review of position-appropriate succession plans with the hiring manager and Human Resources business partner, a successor can be identified. This then allows us to have a robust talent pool of qualified employees across both the enterprise and health plan who are available to us for potential leadership opportunities.

As part of the overall staffing plan, we identify potential replacements for all key positions and positions with direct member contact. As needed, we provide these individuals with any additional training. We also offer shadowing, stretch assignments, and collaborative and interdepartmental project work to increase employee competencies. In addition to this plan, we use a comprehensive approach to recruitment that includes assignment of professional recruiters, advertising, job fairs, word of mouth, employee referrals, and community referrals. Similar to the way we recruit employees for implementation, we deploy our resources to fill any Key Personnel vacancies within 60 days.

Many of Amerigroup's management personnel have strong and active ties within the healthcare community, and we are able to attract highly qualified individuals who are often eager to join an organization with a stellar reputation for quality care. In addition, we maintain a list of eligible and highly qualified internal and external individuals who can be expeditiously recruited and interviewed for any of the key staff positions. As soon as any key employee submits his or her resignation, we mobilize and review this list and begin reaching out to, recruiting, and interviewing those who are most qualified. We have used this process successfully; most recently, in our affiliate health plans in the States of Indiana, New York, Maryland, New Jersey, and Wisconsin.

When a person in a Key Personnel position resigns, we will notify the State and provide information on the process for replacing Key Personnel. We will immediately begin the process of contacting possible qualified candidates, posting the position, and identifying qualified Amerigroup and affiliate employees as well as qualified individuals working for the prior contract holder. We will begin an aggressive recruitment and interviewing process to fill the position with a qualified replacement as expeditiously as possible. In doing so, we will consider the following:

- Replacement employee must demonstrate the same or higher qualifications and experience as the departing employee.
- The search for a replacement must begin immediately and must continue until such time a replacement is found.
- The State must be updated on the need for a replacement and Amerigroup's efforts in finding a qualified replacement.

As we conduct the search process, we ask departing key employees to document detailed information on their ongoing activities and projects. This facilitates a transfer of knowledge between the departing employee and the new employee. We will also ask the key employee to attempt to complete any deadline-specific activities before their departure.

We work to identify and hire replacement employees before the departing employee leaves so as to allow for as much shadowing and knowledge sharing as possible. If this is not possible, we will ensure that detailed information and documents about each of the activities and services provided by the departing key employee are shared with the individual's supervisor or the interim replacement employee to minimize any transition issues.

Allocating Additional Resources When Necessary

We continually review our staffing numbers and quality and service standards to determine whether we need additional employees to adequately support members and providers. Each manager and department routinely reviews their specific responsibilities and determines whether sufficient numbers of employees are committed to the department to meet staffing needs. *Changes in volume, service delivery, and*

products are reviewed, and staffing is adjusted based on these changes. In addition, we use lessons learned from our other programs to determine whether best practices within a specific service will require additional staff. Based on the information we identify, managers refine existing staffing plans, identify additional resources that can be rapidly mobilized, continue to provide required training, and work with other departments to streamline any cumbersome processes.

Supervisors and other key management members also work closely with their counterparts in other programs to share best practices, review new processes and programs, and determine whether global or systemic changes may be required to enhance service delivery.

In the unlikely event that Amerigroup Iowa is unable to meet performance standards or our staffing model does not accurately predict our staffing needs, we will immediately deploy additional resources to correct the deficiency. Our plan for back-up staffing will include temporarily re-allocating resources within the State as necessary, taking care to not negatively impact our other programs. Our Iowa employees are our first line of defense because they know Iowa and understand the local population.

Our bench strength allows us to quickly deploy resources and provide any necessary training to these individuals while we work to acquire additional qualified employees. By using cross-trained local staff, we are able to seamlessly transition functions, minimizing the impact on member care and daily operations. We are also able to temporarily fill vacant positions with employees from our national offices or affiliate health plans in nearby states, if necessary.

Our well tested and proven approach to adequately staff for our programs includes:

- Identifying at least one backup for each key position and for positions with direct member contact
- Quickly mobilizing backups to provide needed services
- Training managers to provide the same services as the functional employees and provide services in cases of crisis or unexpected changes such as changes in volume
- Requiring employees to have detailed documentation of service and activities that can be easily followed by other employees as needed
- Identifying employees in our national offices and other health plans who are able to provide backup
- Working with contract agencies that can quickly augment the regular full-time employees as needed; our parent company, Amerigroup, has a large-scale temporary services organization available to our management to fill short-term needs

Assuring Continuity during Replacement of Key Staff

When Key Personnel are hired, Amerigroup facilitates a knowledge transfer between the departing employee and the new employee. This is an important step in ensuring continuity of services and minimizing any disruptions in member care. Key Personnel participate in a variety of meetings, including “meet and greets,” Leadership Committee, Town Halls, and other activities that allow them to spend time with other Key Personnel one-on-one and in group settings to review burning issues and learn about other functional areas. Each new Key Personnel employee is presented with a copy of the applicable State contract, and they are expected to familiarize themselves with contractual requirements as part of their on-boarding. In addition, we have policies and procedures that require the departing employee to document all relevant and essential detailed information to help assure a smooth transition. Supervisors and managers also play an important role in the transition by facilitating communication between the two employees, especially if there is no other opportunity for knowledge transfer between them due to other job demands.

Newly hired Key Personnel will receive extensive training and education as described in our Training section. To quickly get new staff in key positions acclimated, we pair each new employee with a mentor

possessing the same requisite skills and credentials to provide the guidance and assistance necessary to assist the staff in being successful.

It is also important to point out that Amerigroup is committed to retaining its employees and our organization has created an engaging and supporting working environment across all of our 19 state-sponsored program health plans. We live this commitment daily through our internal processes and programs. Maintaining a positive and productive work environment is a priority, and we have robust menu of programs available to our employees and managers that drives employee commitment and retention. Through our selection, development, wellness, recognition, promotion, and transfer policies and day-to-day processes, we strive to be the best employer possible to our employees and retain a highly qualified workforce that reflects the availability of the talent in the communities we serve.

In 2014, Amerigroup's affiliates retained nearly 90 percent of their employees across our state-sponsored program health plans, and we continue to see a high level of employee commitment in 2015 with an employee retention rate of nearly 90 percent year-to-date. Most recently, Forbes and Statista.com polled more than 20,000 workers at companies employing more than 2,500 associates across several industries, including ours. The result was Forbes naming our parent company, Anthem, as one of America's Best Employers for 2015. Our employees are at the heart of what we do for our members every day in the communities that we are proud to serve.

Notifications and Assurances

Amerigroup understands the need to notify the State of Key Personnel transitions. We assure the State that we will:

- Report Key Personnel departures to the State staff within five (5) business days of receiving notification of intent to terminate employment or within five business days before the employee's last day of employment, whichever occurs first. Our Compliance Officer will be responsible for communicating this information to the appropriate individual at DHS.
- Notify the State in advance of any plans to change, hire, or re-assign designated Key Personnel. The Contract Administrator or designee will notify the State immediately by phone, email, or in writing of any plans to change, hire, or re-assign designated key personnel. We will do so at least 30 calendar days in advance of any such plans, wherever possible. Notification will include our interim plan to cover the responsibilities created by the vacancy.
- Provide DHS with the name and résumé of the candidate filling a Key Personnel vacancy within ten business days after a candidate's acceptance to fill a Key Personnel position or ten business days prior to the candidate's start date, whichever occurs first.
- Fill all Key Personnel positions within 60 calendar days of departure, unless a different timeframe is approved by the State.

Business Locations (2.9.5)

Question 2.9, #5

5. Describe which staff will be located in Iowa, and where other staff will be located:
- Describe how out-of-state staff will be supervised to ensure compliance with Contract requirements and how Iowa-based staff shall maintain a full understanding of the operations conducted out-of-state.
 - Indicate the location of the Iowa office from which key staff members will perform their duties and responsibilities

Our organizational structure, as discussed in Section 2.8, will deliver to Iowa the best of what Amerigroup has to offer: exceptional and high-quality services, built on local accountability, control, and robust community-focused staffing, coupled with an array of supplementary national support services. The combined strengths of this model will ensure that Iowa benefits not only from a fully accountable local team, but also from the years of cumulative institutional and customer knowledge and experience our national teams possess.

All designated out-of-state employees will be knowledgeable about (and follow) all Iowa Initiative program requirements, and *their functions will be fully accountable to the local, Iowa-based leadership team. To be specific, either the CEO or a direct report to the CEO will have oversight responsibility for any function performed by any out-of-state personnel. As explained further below, this person or their designee will regularly receive information regarding the performance of these duties and will also meet regularly with the leadership of these teams to oversee performance and ensure they are meeting the needs of our Iowa based team and the members they serve.* The teams will collaborate closely to make sure that we provide all services in a seamlessly integrated, effective, and transparent manner and meet or exceed the State's expectations.

In Exhibit 2.9.1 we outline, by position, which employees will be locally Iowa-based or will be located out-of-state. As shared earlier, nearly 70 percent of the anticipated hiring associated with the Iowa Initiative will be Iowa-based and we have secured a location for our Iowa health plan headquarters in Des Moines. However, based on the geographic location of our members, we likely will open additional office locations (as we have in most of our other states) to serve those members. Furthermore, we will highlight that we anticipate that several members of our clinical and provider services teams will work from their home offices in rural parts of the State in order to serve that population. They will regularly travel to one of our office locations for team building, member / provider coordination and training activities.

Additionally in Exhibit 2.9.6 we indicate if Key Personnel will be Iowa-based. At this time we anticipate that all Iowa-based Key Personnel (17 out of the 20 people listed in the exhibit) will be located in our Des Moines State health plan headquarters.

Oversight of Out-of-State Employees

Amerigroup has an established communication strategy and oversight structure that promotes coordination, collaboration, and accountability between in-state and out-of-state employees. We employ the use of technology, reporting capabilities, workgroups, committees, sub-committees, and other routine meetings to assure that every functional area of the health plan has a regularly scheduled time to communicate with other related areas. As discussed in Section 2.8, regardless of position, all employees hired to support the Iowa Initiative are aligned to specific goals and metrics on an annual basis to further drive our culture of accountability and operational excellence.

Additionally, our health plan senior leaders meet on a routine basis with the national support services leadership to discuss operational issues, process changes and/or enhancements, and priority issues. For example, our Member Services call center staff located in Virginia Beach, Virginia, will have access to Iowa-specific policies and procedures at their fingertips with the use of our internal database systems, as well as direct access to local Iowa staff to coordinate information exchange and remain current on DHS requirements and member benefits. This national support function is accountable to the Iowa health plan leadership—with frequent service level updates provided to, and reviewed with, the health plan's leadership team. Our Claims Administration team, also located in Virginia Beach, Virginia, operates in a similar manner, whereby local member and provider data are housed in a central database that facilitates information-sharing across teams and is coupled with access to a dedicated Claims Resolution team that is locally based in Iowa and fully accountable to the health plan leadership.

Our organizational structure, information-sharing and coordination processes, along with our strong local accountability model support a seamless Iowa member and provider experience with Amerigroup.

A Solid Iowa Presence

Amerigroup is excited to confirm its company headquarters will be located at:

5550 Wild Rose Lane
West Des Moines, IA 50266

Upon contract award, we will be prepared to quickly identify additional office location(s), as needed, based on the membership, provider, and community-based stakeholder dispersion within Iowa to best serve their needs. Notwithstanding, our office location(s) will house key staff within case management, provider relations, quality management, local business, information technology, finance, strategy, compliance, medical management, provider contracting, community relations, government relations, and human resources.

For positions within Amerigroup that support community-based interactions and face-to-face contact with members, providers, and stakeholders, we will use regionally based staff who will be fully accountable to the local health plan leadership, allowing us to adequately serve all counties, regardless of our office location(s). Our regionally based staff will be supported by statewide resources (further discussed in Sections 2.9.7 and 2.9.8) and employees in our Iowa office(s), supplemented by our national support services team.

Assurances

Amerigroup further acknowledges that it will be responsible for all costs related to securing and maintaining the facility for interim start-up support and the subsequent operational facility, including, but not limited to, hardware and software acquisition and maintenance, leasehold improvements, utilities, telephone service, office equipment, supplies, janitorial services, security, storage, transportation, document shredders, and insurance. Amerigroup will also provide toll-free communications with DHS staff to conduct business operations if activities are performed off-site and to provide meeting space to DHS as requested when on-site at Amerigroup Iowa headquarters. Additionally, Amerigroup is strongly committed to providing the best possible office working environment for our employees and will, therefore, apply to become a Blue Zone certified workplace as we already meet the program's criteria. Details about our commitment to becoming Blue Zone certified are provided in Section 10.2.

Out-of-State Operations (2.9.6)

Amerigroup understands that all staff functions conducted outside the State of Iowa are readily reportable to DHS at all times to make sure such location does not hinder the State's ability to monitor the contractor's performance and compliance with contract requirements. Section 2.9.1 Staffing Requirements describes which contract functions are to be conducted outside of Iowa, and Section 2.9.5 Business Location describes how out-of-state staff will be supervised to ensure contract compliance.

Staff Training and Qualifications (2.9.7)

Question 2.9, #6

6. Describe your process for ensuring all staff have the appropriate credentials, education, experience and orientation to fulfill the requirements of their position (including subcontractors' staff).

Amerigroup's employees and those of our subcontractors are essential to providing quality services to our members. It is necessary to consider both the quality and suitability of potential employees to further the mission and goals of the Iowa Initiative. The decision to hire an employee begins with an informed assessment. Amerigroup's hiring practices and policies establish the expected level of employment verification and background investigation and provide tools and resources to assist us in appropriately selecting qualified candidates. Our hiring practices include employment verification through reference checks, confirmation of academic credentials and licenses, and investigation of criminal histories to include reviewing information from the Office of the Inspector General's exclusion database.

Our recruitment, interviewing, and hiring decisions focus on vetting candidates to be sure that they have the skills, credentials, education, and experience necessary to be successful. Our Human Resources team confirms the academic, certifications, and experience credentials of all candidates selected for a position. For any position that requires or prefers a license or certification, Amerigroup shall confirm that such license or certification is current and in good standing. For employees whose driving is a requirement for their position, we will confirm with the Iowa Department of Motor Vehicles their safety and driving records.

Amerigroup applies the same diligence to maintain oversight and accountability for all subcontractor activities and their hired staff. In turn, we leverage our national support team to aid us in obtaining and managing the services of high-quality subcontractors. The selection and management process assigns responsibilities in a way that drives authority to the appropriate organizational level, particularly at the local level, and creates a system of checks and balances. When we determine that a service will be best delivered by subcontracting to a vendor, we engage the support of our experienced national support team that has extensive experience and relationships with a wide variety of vendors.

Question 2.9, #7

7. Describe how you will ensure that all staff is knowledgeable in Iowa-specific policies and operations.

We understand the important role that community- and faith-based organizations play in the lives of our members and how these organizations offer a wealth of information that is specific to the state in which they fulfill their missions. In every state that our affiliates operate in, we have a rich history of actively engaging community agencies and stakeholders to educate both ourselves and our members about available services, such as with our 211/The United Way of Southeast Louisiana/Amerigroup Partnership. This is an information and referral system that was developed through a significant knowledge transfer between United Way and our Louisiana affiliate staff to better understand and support the member populations served in Southeast Louisiana. This referral system provides a cost-effective, efficient communications system linking citizens, service providers, and government for daily use and in times of disaster or crisis; and the information learned during the knowledge transfer process was incorporated into the Louisiana-specific training on cultural competency for employees. Through this knowledge transfer process, health plan leadership and local community and faith-based organizations meet to review and discuss programs and services and develop plans to integrate these available services into the care management process and, subsequently, our staff training programs.

In Iowa, Amerigroup has actively engaged with key agencies and stakeholders to identify gaps in services and cultural issues that may influence our members with various conditions, disabilities, or life situations. Examples include: The Iowa Family Child Care Association, The National Alliance on Mental Illness (NAMI) of Iowa, The Iowa Behavioral Health Association, The Brain Injury Alliance of Iowa, The Iowa Developmental Disabilities Council, ARC of Eastern Iowa, The University Centers for Excellence in Developmental Disabilities, The University of Iowa Center for Child Health Improvement, the Area Agencies on Aging, The Centers for Independent Living, Alzheimer's Association of Iowa, and the Iowa Foster and Adoptive Parents Association. In our experience, maintaining a visible community presence through local partnerships with community-based agencies promotes a clear understanding of the needs of our members but also fosters information-sharing, extending the reach of the health plan. This will be of particular importance when we are arranging for continuity of care during program implementation. We also engage national partners who support local Iowa organizations, such as the Autistic Self Advocacy Network, the Association of University Centers on Disabilities, Family Voices, and Parent to Parent USA. We will use input from these community-based organizations and incorporate it into employee training for our associates working for or supporting our Iowa plan.

Key collaborators in these efforts include the agencies administering the Home and Community-Based Services (HCBS) Waiver and providers of long-term services and supports (LTSS). Amerigroup affiliates have worked closely and successfully with these organizations and providers in other states such as Kansas, Tennessee, and Texas. We are in the process of developing a long-term partnership with Telligen, a current contractor with DHS that will allow Amerigroup to combine Telligen's robust and extensive expertise and experience with the State's waiver programs and populations with Amerigroup's innovative care model. Through this partnership, we intend to learn from and leverage the most impactful elements of Telligen's Iowa experience, enhancing our ability to fully understand the programs and processes that have served these Members historically. Telligen's experience in contributing to the development of the state assessment tool criteria for waiver and LTSS benefits will complement and inform Amerigroup's existing care model, and allow us to more effectively provide seamless continuity of care for our most vulnerable members on day one. Additionally, we are exploring opportunities to utilize Telligen resources to support Amerigroup's care coordinators and their activities under our proposed care model and programs. Additional information regarding this collaboration with Telligen can be found in Section 3.3.

Question 2.9, #8

8. Describe in detail your staff training plans (including subcontractors' staff) and ongoing policies and procedures for training all staff.

Our organization is experienced in the development and implementation of employee training plans when entering new markets as well as when responding to programmatic changes. We collaborate with clinical training experts in the industry and at leading academic institutions, such as Georgetown University. In fact, local clinical and training team leaders in our affiliate health plan in Georgia are now collaborating with the Georgetown University Center for Child and Human Development to develop Georgia-specific trainings for our employees and providers.

We provide employees with job-related training for safe, efficient, and effective program operations from initial orientation through their entire tenure with us. We will offer initial and ongoing training to our employees on the major components of the contract, as well as policies, procedures, and the tools necessary to make sure all employees in all departments are aware of programmatic changes, when they occur, and how those changes impact their daily activities.

New Employee Training

Our new hire training consists of two major components: orientation and job-specific training. We have designed our new hire orientation to help employees fully understand Amerigroup and the importance of our role as the Iowa Initiative program administrator. The orientation includes an in-depth introduction to our mission and vision, so that each new employee gains an immediate sense of our company culture. We emphasize understanding the importance of diversity and inclusion and acquaint new employees with our philosophy, specific strategies, and programs. We make sure that new employees are equipped with all the information they need to be successful. Even for our most experienced new employees, this initial training includes, at a minimum, the modules listed in Table 2.9-6, which meet and exceed the Scope of Work requirements outlined in the Contract.

Table 2.9-6. Initial Training Modules

Training Module	Scope of Work Requirement Met and/or Exceeded	Trainee Audience
Concepts of managed care	X	All employees
System of Care Model	X	All employees
Introduction to Amerigroup and Iowa health plan operations	X	All employees
Introduction to Iowa Medicaid	X	All employees
The Iowa Initiative	X	All employees
Covered populations	X	All employees
General contract provisions	X	All employees
Covered services and benefits	X	All employees
Compliance orientation	X	All employees
Ethics, Privacy, Information Security, and Compliance (including HIPAA)	X	All employees
Records and Information Security	X	All employees
Introduction to Fraud and Abuse (including False Claims Act)	X	All employees
Cultural Competency	X	All employees
2013 National CLAS Standards	X	All employees
Iowa health plan Cultural Competency Strategic Plan	X	All employees
Emergency Response Procedures	X	Member-Facing employees
Customer Service	X	Member- and Provider-Facing employees
Basic position-specific training	X	All employees
Basic system tools for communications and data search	X	All employees
Utilization Management principles, processes, and tools (including systems)	X	Clinical Staff
Care Coordination and Case Management theory and practice under a System of Care model (including predictive modeling tools for case stratification)	X	Clinical Staff
Care Coordination and Case Management processes and tools (including core processing systems and mobile technology to support field work, case documentation, and information sharing)	X	Clinical Staff
Quality Management Program	X	Clinical Staff

Training Module	Scope of Work Requirement Met and/or Exceeded	Trainee Audience
Legal and Ethical Issues in Care Coordination and Case Management (abuse, neglect, exploitation, and prevention including the detection, reporting, investigation, and remediation procedures and requirements)	X	Clinical Staff

During the first 60 days of employment, all employees receive in-services and department-specific training and education. It is the responsibility of each department head, as the subject matter expert, to work with national Learning and Development resources, and local experts, to develop and implement the training programs their employees need to be successful

The Iowa Clinical Team

Our clinical team is at the core of what we do. For new or existing employees who join the Iowa clinical team, we offer a variety of intensive training opportunities. All of our clinical employees undergo a 90-day orientation and training period during which they learn the basic functions of their job and the policies and procedures that govern the Iowa Initiative’s program operations. Employees receive both classroom and field-based education to make our policies and procedures “come alive” and to foster opportunities for discussion and questions.

At the center of this comprehensive curriculum is our interdisciplinary team approach—the full integration of physical, behavioral, functional, and social health; and all clinical employees must master the requisite skills to manage cases with co-occurring disorders. For example, the 11-day *initial* training for new employees who will join our Care Coordination Teams (CCTs) as case managers follows the extensive new hire orientation and covers the topics listed in the Table 2.9-6 above.

This initial training includes skills practice sessions throughout to embed the didactic transfer of knowledge and information. Following the classroom instruction and skills practice, trainees receive ongoing, on-the-job training for at least the remainder of the 90-day training period, from the clinical management team, and from senior team members. This includes a systematic phase-in approach to assigning live cases during the 90-day period where the case manager is partnered with a “buddy” (a seasoned case manager or team leader) to support them through the transition to live case management while providing superior quality care to our members. *It is important to note that we are not training novices. We recruit and hire clinical employees who already have multiple years of working with populations similar to those we serve, in programs similar to the ones we administer. They also have established relationships with many of the providers, state agencies, and community organizations with whom we collaborate under our System of Care approach to care coordination.*

Ongoing Training

Ongoing training and professional development is part of the Amerigroup culture. This is especially important to the experienced and seasoned employees who staff our clinical teams. Our employees receive training throughout their career, beginning with orientation on their first day at work through intensive job-specific training to prepare them to assume their new responsibilities, and including refresher and enhancement training to maintain and further develop their skills. This includes training to support programmatic changes. As they do for new hire training, each of our department leaders partners with our corporate Learning and Development Department *and local vendors in Iowa* such as The Public Consulting Group and Andres Gallegos of Robbins, Salomon & Patt, Ltd. to assist with designing and developing training programs to meet both DHS and our own internal standards and requirements. These programs make sure we continue to meet or exceed the specific requirements of the Iowa Initiative and Medicaid.

We will collaborate with clinical training experts in the industry and at leading academic institutions, such as the University of Iowa. In fact, *local Amerigroup leaders are now collaborating with a number of local Iowa organizations—as specified in Section 2.9.7—to develop Iowa-specific training for our employees and providers.*

All employees have access to an online catalog of resources on the company intranet, maintained by our national Learning and Development team, which helps employees further hone hard skills, soft skills, and professional development in a wide variety of knowledge areas. As part of this ongoing development program, our managers work with employees to identify, plan, and meet individual employee training needs.

Amerigroup also strongly supports educational opportunities outside the company. We offer employees tuition assistance and paid time off to attend training that will enhance professional development and provide for the continuing education needs of licensed employees.

Training Methods and Formats

We offer and deliver our new hire and existing employee training programs using a range of different delivery methods and formats, including:

- Instructor-led training. This is the method we use for most of our clinical team training, such as for care coordination and case management training.
- Self-directed or web-based training. For example, our on-line Compliance Training program is required by all new employees to complete and pass within their first 30 days of employment.
- 1:1 focused training. This approach works well when a manager or one of our more senior employees is paired with either a new hire, or an employee ready for career advancement, in a mentor relationship. It also is a valuable tool to provide short-term support to an employee who needs more intense support.
- Training bulletins published and distributed by our national Learning and Development Department. These include training offerings and listings on a dedicated intranet learning site. We also include feature highlights of new training offerings on the enterprise-wide intranet and in the weekly briefing communications sent through our parent company.

Additionally, our employees have access to trainers who are certified in specific professional development courses that require trainer certification, such as Meyers & Briggs, Unconscious Bias, and Discovery Insights.

Finally, there is no formal training program that can substitute for the experience and skills our staff gain from each encounter with members and their families or caregivers, providers, community organizations, and other stakeholders they work with every day. What we can do is maximize opportunities for such encounters in ways that go beyond their usual daily activities. As an example, in many of our health plans, such as Indiana, we include as a Major Job Objective for all staff eight hours of community service and eight hours of participating in marketing activities, annually. This serves to develop and maintain a broader perspective and understanding of state program goals and objectives, and how we, as an organization of individuals, can make a difference in the lives of those we are committed to serving.

Program Updates

The Iowa Initiative will continue to evolve. Amerigroup has established a communication strategy and reporting structure that make sure all employees are aware of, and know what to do about, programmatic changes, regardless of how or through whom Amerigroup receives the new information. This strategy and reporting structure promotes coordination and collaboration among all employees, regardless of location. We use informal workgroups, committees, subcommittees, and other routine meetings to make sure that every functional area of the health plan has a regularly scheduled time to communicate with other related

areas. Our Leadership Committee, which meets on a monthly basis, provides operational oversight for all health plan functions. The Committee establishes the direction for operational effectiveness and oversees supportive committees and workgroups. As we described briefly earlier in this response, it is through these organizational mechanisms that we will identify impacted functions and departments and plan the necessary implementation activities and accountabilities for any programmatic change.

We will alert employees to changes through our regular Amerigroup town hall meetings, formal and informal department meetings, on each department's dedicated page on our website, in the health plan newsletter, in email blasts, and during one-on-one meetings that each Amerigroup manager has with direct reports. We will notify our employees as soon as possible after we receive new information, with each manager advising employees of the effective date of the changes that will impact their activities.

Monitoring for Completion and Comprehension

As we described above, we have the processes and resources to make sure every employee in every department receives the training needed to implement a programmatic change. And we will make sure that every employee receives this training, and that this training is effective. Trainees demonstrate their competency throughout the training process, and after they have joined their work teams, through regular audits that are specific to their position and level of responsibility. The same applies to the training needed to implement programmatic changes. All training programs and training plans include timeframes for completion and tests for individual and organizational comprehension (learning). Depending on the particular training and mode of delivery, monitoring mechanisms for completion may include one or more of the following:

- Completed training schedules from managers who maintain records of associate adherence to required training
- System records of web-based trainings that are kept in our training database
- Reports/status updates from Classroom Trainers to managers on the progress of trainees in the class
- We also have various methods and tools for monitoring and assessing comprehension after a particular training or course of training. These may include one or more of the following, depending on the topic and the characteristics of the training process:
- Pre- and Post-test scores. For example, we use these for some of our web-based Compliance and Cultural Competency trainings.
- In-process audits during and after training. For example, we conduct ongoing audits of a newly trained Nurse Case Manager to measure the frequency of any given errors made during the opening of a member's case management record with the goal of correcting the issue early on.
- Process audits. For example, we conduct monthly audits of our Nurse Case Managers' activities through a review of their case notes in our case management system applying NCQA criteria.
- System edits such as claims and authorizations
- Member and Provider complaints, appeals, and grievances
- Referrals to Ombudsman
- Member and Provider satisfaction surveys

Amerigroup is committed to providing employees with ongoing opportunities to enhance their skills, knowledge, and abilities in service to Iowa members. Preparing our employees for success in the duties that they perform is part of what we do every day to make sure each member receives the right care, in the right place, at the right time. It is what we do, what we have always done, and what we will do under the contract. We will be ready.

The Agency Meeting Requirements (2.10)

Amerigroup Iowa (Amerigroup) looks forward to partnering with DHS on the launch, implementation, and on-going operation of the Iowa High Quality Healthcare Initiative. We will comply with all meeting requirements established by DHS, including but not limited to preparation, attendance, participation, and documentation, and we will provide in-person presence at meetings as appropriate.

We understand that DHS reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule as it deems necessary. DHS may also require the participation of subcontracted entities when determined necessary.

We acknowledge that all expenses for attendance at all meetings are considered to be included in the total bid price.

Coordination with Other State Agencies and Program Contractors (2.11)

Question 2.11, #1-2

1. Describe how you propose to work with other program contractors, subcontractors, state agencies and third-party representatives.
2. Describe how you propose to work with IDPH related to IDPH-funded substance abuse services.

Program Contractors (2.11.1)

Collaborative relationships with all system stakeholders are crucial to developing, implementing, and sustaining a successful health care delivery system, one that improves outcomes for members, streamlines processes and eases administrative burdens for providers, all while providing cost efficiency for the State. Through our parent company and affiliate health plans, we have demonstrated experience working with state and local agencies, managed care organizations, subcontractors, and other stakeholders across the publicly-funded programs we manage and coordinate in 19 states. We are adept at collaborating with stakeholders to develop policies, processes, and initiatives that will achieve the best possible outcomes for members. We bring to Iowa established protocols and an approach that supports integration of care and services for members, even if that care is delivered by another program contractor, subcontractor, or other external entity or State agency.

Amerigroup Iowa (Amerigroup) agrees to cooperate with and work with the other program, contractors, subcontractors, state agencies and third-party representatives and to support community-based efforts as requested by the agency.

Amerigroup will support and advance the collaboration among various State agencies and stakeholders who are working with our members. We will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can help support our Iowa members in directing a meaningful plan with their desired health and quality-of-life outcomes.

We partner with organizations and work with stakeholders in the local communities we serve. Our regionally based Iowa staff will work to build relationships with all stakeholders and system partners involved in The Initiative. They will be supported by our statewide resources and Iowa leadership in the Des Moines office, as well as by our national resources. We have designated an Iowa Regulatory Market Manager who will serve as the primary liaison with DHS and with other State agencies for day-to-day contract management and oversight.

Working with Program Contractors

We acknowledge Iowa Department of Human Services' (DHS) right to mandate cross-contractor requirements to facilitate the development of streamlined provider and member processes. We consider State agencies, program contractors, subcontractors, health plans, and any other stakeholders involved in members' care to be partners in serving these members.

We will build relationships across the local communities we serve in Iowa to identify opportunities for improving the health and well-being of members and enhancing the overall delivery system. In Iowa, we will continuously look for opportunities to partner with stakeholders, including other program contractors, to streamline processes such as standardizing service codes, data field requirements for authorizations, and credentialing applications. This includes continuing our collaborative development with the University of Iowa in order to bring the full array of the University's services and programs to our membership. We will also work with program contractors through collaborative forums and meetings.

The following are examples of our affiliates' collaborations in other states that have helped streamline processes and improve outcomes:

- In Kansas, we worked collaboratively with other MCOs and the State to develop uniform credentialing applications for long-term care services and support and behavioral health providers to be used by all plans. By streamlining credentialing, we improved processes in a way that benefits both member and provider experience. We will encourage this same process for Iowa to help ease the transition for our provider partners to managed care.
- In Tennessee, we worked collaboratively with the State and other MCOs to launch TennCare's Population Health Program, a model that touches members across the care continuum, promoting healthy behaviors and disease management as well as providing a care coordination and management system supported by evidence-based and best practices. We will use this same collaborative approach in Iowa, including but not limited to working with the State and fellow health plans in developing a uniform initial health screening.
- In Louisiana, providers work with multiple MCOs and may be asked to comply with various practice guidelines across the different MCOs. To mitigate this, our CEO and a designated representative from our Provider Relations Department are members of the State's Administrative Simplification Committee. The goal of this committee is to reduce the administrative burden on providers and streamline processes by providing a vehicle for working with other MCOs to promote common practice guidelines.

Transitioning Members Seamlessly Via Coordination and Collaboration with Program Contractors and State Agencies

One of Amerigroup's core competencies is our ability to seamlessly support continuity of care during member and provider transitions. Our processes provide efficient member transition while assuring that continuity of care and services comply with all applicable State and federal requirements. We recognize that any type of transition can potentially be stressful for members, so we work with them every step of the way to make sure they have the information and supports in place to prevent disruption in care.

We work closely with the member's new or previous MCO, program administrator, and providers (in- or out-of-network) to facilitate a smooth transfer of medical records, prior authorization information, care plans, treatment plans, and other pertinent information.

When a member transfers from another MCO to Amerigroup, we will:

- Obtain State notification of the member's transfer from the MCO
- Evaluate the member's immediate health care needs through outreach and screening, then implement a care coordination and management system, as needed
- Coordinate with the MCO to obtain clinical information
- Contact the member's primary care provider (PCP) or specialty provider to coordinate care
- Document the member's information in our clinical management system

Coordinating care is a critical part of a member's treatment. When a member transitions from Amerigroup to another MCO, we work with the plan to provide a clinical summary of information that includes:

- The member's care plan, if he or she is enrolled in case or disease management
- A listing of prior authorized services
- The member's medication summary
- The member's PCP or any other specialty providers' contact information and treatment plan summary

Our clinical team coordinates benefits and services across managed care plans to verify that all gaps in care and services are identified and resolved, regardless of which plan pays. This includes coordination of shared case planning and regular care conferences to sync services for each member as needed. If we become aware that a member is transferring to another MCO, we will contact the other MCO within five business days of becoming aware of the member's transfer. We will share important member information and respond to questions regarding the member's care needs and services. When we are contacted by a new member's health plan requesting member information, we will provide that information within five business days of receiving the request.

Iowa Department of Public Health (2.11.2)

Public health departments are key partners for Amerigroup affiliate health plans managing state-sponsored health programs in a number of ways. We partner with WIC programs to provide education classes on how to access health care. These plans also participate on committees on overall health and provide personal and financial support to events. We offer written education modules on topics like how to access transportation to immunization services. In all the states we serve, we hold periodic meetings with behavioral health services and substance abuse services providers. We look forward to building on our collaboration with the leadership and staff who drive initiatives that serve individuals dealing with substance abuse. In addition, we will work with IDPH on other programs mentioned in the RFP for which IDPH holds authority including local public health services, family planning services, the Iowa Health Information Network (IHIN), Maternal and Child Health services (Iowa's Title V), and tobacco cessation services.

Amerigroup understands the Iowa Department of Public Health (IDPH) is a critical partner of DHS. Our local behavioral health and healthcare management leads will meet regularly with IDPH as the State authority over substance abuse services.

We will sign a standardized Memorandum of Agreement (MOA) with IDPH to establish a positive, cooperative effort with members, including representatives of behavioral health and substance use disorder service providers, representatives from the child welfare system, peer supports, families, and

Health Home leads. To address emergent and urgent behavioral health challenges, the MOA will support data sharing; service system planning; facilitation of linkages with social services and criminal justice or courts; coordination of provider and community training; and support to PCPs, emergency rooms, and local fire and police organizations. Amerigroup is committed to working closely with IDPH throughout the term of the contract and building our relationship with them for a successful partnership understanding that they hold the decision authority for IDPH-funded services in the contract.

Iowa Department of Education (2.11.3)

Amerigroup will work closely with the Iowa Department of Education to develop initiatives that will help assure children and adolescents under the Iowa Initiative receive the care needed to thrive. For example, we will partner with the Department of Education to assist schools that have a large population of subsidized lunch programs to assure members are informed of the coverage they can receive. In partnership with the Department of Education, as well as with advocacy groups such as the Iowa Library Association, we will explore opportunities to support work done by schools and the community assisting our members.

The Amerigroup Iowa Medical Director will work closely with schools to facilitate appropriate information-sharing and coordination for child and adolescent members who receive Individual Education Program (IEP) services. Our on-the ground, local Care Coordinators will work with school staff and the Department of Education to assure children and adolescents under the Iowa Initiative receive the physical and behavioral health services they need.

Through our person-centered care coordination model, members of local school systems involved with a member's IEP will be invited to participate on our multidisciplinary care planning team. We will develop a common care plan to coordinate covered services, IEP, and other available services to help assure the child's physical and behavioral health care needs are met and to avoid duplication of services.

We know there are many considerations in the coordination of our member's IEP and the services provided through that plan. We will work directly with the child's caregivers to identify areas for improved coordination to augment and enhance services to assist in meeting their goals.

Amerigroup affiliates work extensively with schools, and we will do so in Iowa. Amerigroup will use free and reduced-price lunch program data to determine which schools have the highest underserved populations. Once we determine this information, we will establish relationships with school boards and specific schools to support our activities. Examples of effective partnerships include:

- PTA/PTO Events—We will partner with community advocates or health care experts and bring them in to speak to the parents. The topics can range anywhere from how to access care to the importance of preventive care or topics of the month.
- School Nurses—School nurses have a tremendous amount of interaction with children in their schools and often know which kids don't have adequate access to care. We will train school nurses on how to help get members onto publicly-funded programs.
- Wellness Days—We will bring fitness and health days to schools to teach children and their parents about living healthy.
- Registration Roundup—We will partner with schools to have resources available to talk with parents during school registration about accessing care, immunizations, and other EPSDT measures.
- Back to School Drives—Many school children cannot afford school supplies. We will partner with public and community organizations to help hold and fund school supply events.

Iowa Division of Mental Health and Disability Services (2.11.4)

Amerigroup will work closely with the DHS Division of Mental Health and Disability Services (MHDS) to support its policies. We support MHDS through working closely and in collaboration with the broad array of stakeholders in the Iowa mental health and disability services system. We initiated engagement with Iowa behavioral health and disability services providers, consumers, advocates, and stakeholders to gain an understanding of the State's reformed behavioral health and disability system. We are applying the knowledge we are gaining to build a model and service delivery system that enhances the existing providers and mental health and disability system that has been built. To date, we have met with stakeholders such as NAMI Iowa, the Developmental Disabilities Council, the Child and Health Innovation Center, Disability Rights Iowa, and the MHDS Regional CEO Collaborative, as well as representation from the 15 regional mental health agencies; the Iowa Behavioral Health Association (IBHA), Iowa Association of Community Providers, and Orchard Place.

Our continued work with mental health and disability service providers and stakeholders is a primary component of our strategy to serve Iowans in a meaningful and informed approach through the Iowa Initiative. We will work collaboratively with MHDS to share best practices developed in Iowa through our affiliates and strong relationship with national consumer advocacy groups, trade associations, and other partners.

The Agency Child Welfare and Juvenile Justice Services (2.11.5)

Amerigroup brings significant experience to serving individuals receiving child welfare/juvenile justice services and individuals in states' foster care and subsidized adoption programs through our affiliate health plans. Our Georgia health plan currently serves as the single statewide foster care MCO for the State. Additionally, we serve similar populations across our affiliates in 10 states. As a result, we can leverage the keen understanding and experience across our organization in providing the range of physical and behavioral health services needed to assure the well-being of children in foster care and adoption programs. We recognize close coordination with a range of human service agencies assisting these children and adolescents is critical.

We will coordinate and collaborate with the Division of Adult, Family, and Children Services and with the DHS's field workers and juvenile court officers. We will coordinate with ACFS to meet goals for safety, permanency, and well-being of the child and will be responsible for authorizing appropriate healthcare services to complement CW/JJ services upon request from the Agency field workers or juvenile court officers. We have already engaged key stakeholders and providers within Iowa's Foster Care system. We have held discussions with a number of key providers, including Orchard Place, Lutheran Services in Iowa, Christian Home Association, Youth Homes of Mid-America, and Cornerstone Recovery. Additionally, we have engaged the Iowa Foster and Adoptive Parents Association to learn about their services and their role in supporting children in supporting foster and adoptive families. We will collaborate with the Association to develop services and supports to meet the specialized needs of children who have been adopted from Iowa's foster care system.

Ombudsman's Office (2.11.6)

Amerigroup Iowa agrees to work closely and cooperatively with any State Ombudsman's Office to help assure the satisfaction and safety of members and resolution of conflicts, complaints and grievances. We recognize the importance of the State's ombudsman programs as an important source of external input for our ongoing quality improvement efforts. We will also work closely with ombudsman offices in

coordinating responses to unusual events, such as arranging for transition of members during facility or provider closures.

Community Based Agencies (2.11.7)

We believe the best way to reach members and empower them to lead healthy lives is by partnering with local organizations in the communities that already serve them and have earned their trust. *All of our affiliates serving state-sponsored health programs have established partnerships with faith- and community-based organizations and service agencies that educate, advocate, and serve Amerigroup members. By educating our service partners about the health plan and resources available to our members, we promote true integration throughout the community.* We will work with DHS to prioritize our community-based efforts and will leverage the 24 years of affiliate experience to develop programs and initiatives for Iowa in conjunction with community-based agencies. We have engaged more than 50 community-based organizations (CBOs) in Iowa as shown in Table 2.11-1.

Table 2.11-1. More than 50 Community-based Organizations in Iowa Engaged

Engaged Community-Based Organizations	
1. AARP Iowa State Chapter	2. Iowa Chronic Care Consortium
3. Access 2 Independence	4. Iowa Counties Public Health Association (ICPHA)
5. Iowa Developmental Disabilities Council	6. ARC of Eastern Iowa
7. Iowa Disabilities and Aging Advocates Network (IDAAN)	8. Iowa Foster and Adoptive Parents Association
9. Alzheimer’s Association	10. Iowa Health Care Association / Iowa Center for Assisted Living
11. Iowa Hospital Association	12. Brain Injury Alliance
13. Iowa Medical Society	14. Caregivers Association
15. Iowa Primary Care Association	16. Center for Child Health Improvement and Innovation
17. Iowa Public Health Association	18. Central Iowa Center for Independent Living
19. Johnson County Case Management	20. LeadingAge Iowa and member organizations
21. Children’s Center for Therapy	22. League of Human Dignity
23. Coalition for Family and Children’s Services	24. Leukemia and Lymphoma Society
25. Community Action Association	26. March of Dimes Iowa
27. Community Health Charities of Iowa	28. NAMI Iowa
29. Orchard Place	30. Disabilities Resource Center of Siouxland
31. Disability Rights Iowa	32. South Central Iowa Center for Independent Living
33. Drake University Law School, Office of Clinical Programs	34. Statewide Independent Living Council
35. Easter Seals	36. Susan G. Komen Iowa
37. Evangelical Lutheran Good Samaritan Society	38. University Center for Excellence on Developmental Disabilities (UCEDD)
39. Homestead Center for Autism Service	40. Elderbridge Aging on Aging
41. Illinois/Iowa Center for Independent Living	42. Northeast Iowa Area Agency on Aging
43. Iowa Association of People Supporting Employment First	44. Aging Resources of Central Iowa
45. Iowa Alliance in Home Care	46. Connections Area Agency on Aging
47. Iowa Association of Area Agencies on Aging (I4A)	48. Heritage Area Agency on Aging
49. Iowa Association of Community Providers	50. Milestones Area Agency on Aging
51. Iowa Behavioral Health Association and member organizations	52. Youth Homes of Mid-America
53. Iowa Center for Independent Living	54. Iowa Library Association

Our outreach to CBOs includes designating locally based staff to regularly meet with these organizations and with system partners. We also invite CBOs to participate in our quality improvement initiatives, we sponsor community outreach activities (health fairs, back-to-school events), and we assist local community agencies with funding and grant opportunities. Our Iowa employees will work side-by-side

with CBOs at food banks and shelters, and we will partner with agencies to provide health education materials to our members with specialized needs, such as cooking classes for members with diabetes.

To promote integration of behavioral and physical health (and improved access to behavioral health services), our behavioral health experts have been in contact with the 15 regional mental health agencies. These relationships have increased our understanding of commonalities and nuances of their operations and how we can work with them effectively. We have also met with the member organizations of the IBHA, a number of which operate Integrated Health Homes.

To explore the use of an enhanced telehealth network to help expand access to specialty and behavioral health services, Amerigroup representatives participated in a general meeting in March 2015 with county administrators of the Iowa Counties Public Health Association (ICPHA).

We have also met with additional Iowa CBOs, including the National Alliance on Mental Illness (NAMI) Iowa, Iowa Association of Area Agencies on Aging (AAAs), Statewide Independent Living Council, IBHA, Orchard Place, Iowa Health Care Association (IHCA), and LeadingAge Iowa and the Iowa AARP state chapter. We continue dialogue and engagement with many of these organizations. Examples are listed below.

- We have had several meetings with the I4A and the regional AAAs to discuss potential contracting relationship and services the AAAs can provide, especially in the State's rural counties. The I4A signed a Letter of Intent to collaborate with Amerigroup on behalf of the six AAAs.
- At the March 18 Statewide Independent Living Council meeting, we met with directors of the Iowa centers for independent living to understand respective approaches and programs to support independence for people with disabilities. As a follow-up to that meeting, Amerigroup participated in the Iowa Disability and Aging Advocacy Network's managed care discussion on April 1, 2015.
- After meeting with IBHA leadership, we met with a group of IBHA member directors on April 14, 2015, to introduce them to Amerigroup, our approach to behavioral health, and integration with physical health services.
- Amerigroup met with the IHCA to discuss the Iowa Initiative, our respective approaches to balancing nursing home and home- and community-based services, and diversification of continuing care services. Subsequently, we sponsored the IHCA's Spring Education Conference on April 1.

Amerigroup will use this platform to help teach employers, particularly in low-wage industries, about the availability of public health insurance programs for their employees. We do this by participation on boards as well as through business expos. If invited, our employees will speak at individual businesses to provide education on access to care. Additionally, we will also work with ethnic chambers to help with the unique needs in their communities.

Iowa Department of Inspections and Appeals (2.11.8)

Amerigroup is committed to working closely with the Iowa Department of Inspections and Appeals (DIA) throughout the term of the contract. Amerigroup will collaborate with the DIA on initiatives related to credentialing and program integrity. In addition, Amerigroup will coordinate with DIA regarding:

- Administration of the appeals and grievance processes with the State fair hearing process processes
- Our program fraud, waste and abuse efforts

Media Contacts (2.12)

Amerigroup Iowa (Amerigroup) will comply with all requirements governing Media Contacts in SOW Section 2.12. We will not have contact with the media without the express consent of DHS and will refer all contacts by the media, other entities, or individuals not directly related to the program to DHS.

Written Policies and Procedures (2.13)

Question 2.13, #1

1. Describe your process for developing and maintaining written policies and procedures for each functional area.

Amerigroup Iowa (Amerigroup) will develop and maintain an extensive library of policies and procedures, subject to DHS review and approval, for each functional area. The appropriate Department Lead will sign, date, and approve all policies and procedures and the local Iowa Medical Director will sign, date and approve all medical and quality policies and procedures. We will maintain written guidelines for developing, reviewing, and approving all policies and procedures at least annually to verify that they reflect current practice and update them as necessary. We will submit all draft policies and procedures to DHS within 30 days of contract execution, and final versions, incorporating feedback from the Agency, will be submitted within 30 days of receiving comments on draft policies and procedures. Additionally, we acknowledge that if DHS determines that it lacks a policy or procedure or requests evidence that a policy or procedure has been fully implemented, Amerigroup shall comply with this request within the timeframes specified by DHS.

Through our affiliate health plans, we will be able to leverage an extensive set of existing policies and procedures for each functional area that represent best practices in state-sponsored managed care operations. These policies will help guide our activities and operations. Our Regulatory Oversight Manager and locally based, dedicated Iowa Compliance Officer will take the lead in collaborating across all functional areas to review, adapt, and develop policies and procedures that meet all DHS Contract requirements.

Our national Medicaid Compliance Operations Unit will oversee our policy and procedure management process. We will also maintain a central repository of our state-sponsored program policies and procedures on an internal website for ease of employee access.

Development of New Policies and Procedures

Amerigroup will develop and maintain an extensive library of policies and procedures that address our regulatory, contractual, and other requirements. Functional managers throughout the organization, in consultation with our Iowa Compliance Officer and Regulatory Oversight Manager, will develop policies and procedures as follows:

- We will create new policies as needed to comply with all State and federal regulations and legislation, new State Contract amendments, accreditation standards, or to satisfy any other business need.
- Business owners will submit the new policy, along with a Policies and Procedures Submission Form, to Medicaid Compliance Operations via the policy and procedure mailbox on our internal email system.

Medicaid Compliance Operations will create a database record, then obtain appropriate review, inclusive of a compliance review against contractual requirements, and signatures before posting the new policy or procedure on the internal website, which is accessible to all employees.

Review and Approval of Policies and Procedures

Amerigroup will adhere to an established written process for reviewing and approving policies and procedures. Unless a more stringent review timeframe is required, this process typically spans eight weeks. We understand that DHS will have the right to review all policies and procedures and request additional ones, if needed. Our process for review and approval follows:

- The Medicaid Compliance Operations Unit will notify the Business Owner in advance when a policy or procedure is due for a scheduled review.
- If a policy or procedure requires revisions outside of a scheduled review, the Medicaid Compliance Operations Unit is alerted to schedule an appropriate review.
- The Business Owner will be responsible for:
 - Reviewing the policy and procedure for accuracy
 - Making any necessary changes using the track changes feature in Microsoft Word®
 - Returning the revised electronic copy to the Medicaid Compliance Operations Unit
- Upon receiving the Business Owner's review, the Medicaid Compliance Operations Unit will prepare the policy or procedure for presentation to the appropriate committee(s) for review.
- The Medicaid Compliance Operations Unit will distribute the revised policy or procedure to the Compliance Officer, the Regulatory Oversight Manager, and any appropriate secondary departments for review and compliance with program requirements.
- Upon closing compliance and secondary reviews, the Medicaid Compliance Operations Unit will compile requested changes/comments and redirect the policy or procedure back to the Business Owner for final review.
- At any time during the review process, there may be occasion(s) to return to a prior step arising from concerns with accuracy.
- Upon completing these steps, the Medicaid Compliance Operations Unit will incorporate any changes and obtain Department Lead approval via signature. Amerigroup's Medical Director will approve, sign, and date all medical and quality management policies. All others are approved, signed, and dated by the senior executive of the functional area responsible for the policy or procedure.
- Upon approval, the new policy or procedure is posted in the internal website for employee access. The Business Owner will be alerted via email when it is posted.

An electronic copy is also distributed to the Business Owner of the policy and procedure when it is finalized. All updated policies and procedures will be provided to the Iowa Quality Management Manager via the Monthly Update Report. Upon request, additional employees are added to the distribution of the monthly update. Amerigroup will conduct formal reviews of medical and quality policies and procedures at least annually. Where necessary, we will promptly update them to align with new or revised standards. If DHS determines that a policy requires revision, Amerigroup will revise it within the specified timeframe. If DHS determines that Amerigroup lacks a policy or procedure necessary to fulfill the terms of the Contract, we will adopt that policy or procedure as directed.

Submitting Policies and Procedures to the State

Upon request, Amerigroup will provide evidence to DHS that all policies and procedures have been fully implemented. We will submit policies, procedures, and any associated documents to DHS as requested. We will deliver them and make any requested changes in the format and timeframes specified by DHS.

Participation in Readiness Review (2.14)

Question 2.14, #1

1. Submit a detailed implementation plan which identifies the elements for implementing the proposed services, including but not limited to:
 - a. Tasks;
 - b. Staff responsibilities;
 - c. Timelines; and
 - d. Processes that will be used to ensure contracted services begin upon the Contract effective date.

Amerigroup believes that a successful relationship is built on a strong implementation strategy. We recognize that transition from a fee-for-services (FFS) system to a risk-based managed care system requires careful, comprehensive, and competent implementation based on previous successes and lessons learned. We will leverage best practices built on over 100 successful managed care implementations, including more than 50 in the last 10 years, encompassing new health plan implementations, new program implementations, service area expansions, and new contract implementations. *None of our affiliate health plans has ever failed a readiness review.*

Implementation Plan

Amerigroup's Implementation Plan (presented in Attachment 3.2.7.5-2) identifies the elements for implementing the proposed services, including tasks to be completed prior to the January 1, 2016, Contract effective date:

- Tasks are included in the column entitled "Task Name"
- Staff responsible for the tasks are identified in the "Resources" column by business area
- Timelines are specified in the Start and Finish columns and include the duration of each task in the duration column
- Processes used to make sure contracted services begin upon the Contract effective date are described in rows 52 through 72; these tasks will be executed for each major task in the project plan and are included once to illustrate the quality control process

Our draft Implementation Plan has been developed to complete all significant tasks on or before the January 1, 2016, Contract effective date. All tasks that remain to be completed focus on operational monitoring and support, transitioning operations to local health plan staff, and typical project closeout activities, including conducting a lessons-learned survey. We expect to complete the following tasks after the January 1, 2016, Contract effective date:

- **Monitor/Support Go-live Operations.** The Transition and Implementation Teams will monitor and support the health plan after the Contract effective date to confirm that new processes and systems are functioning as planned, with a core national support team on-site in Iowa to assist health plan staff.
- **Project Transition to Operational Health Plan Owners.** The Transition and Implementation teams will transfer knowledge and operations to health plan staff for each functional area when operations are stable and outstanding issues are closed.
- **Lessons Learned.** We will conduct a formal survey and interview process to gather feedback (both positive and negative) from Implementation Team members and health plan staff and will then create an action plan of specific tasks that will strengthen future implementation efforts.

Experience

Our experience includes multiple implementations with aggressive timelines as displayed in Figure 2.14-1, **including our success in Kentucky with an implementation that moved from contract execution to member enrollment in just 131 days.** Each implementation is unique, and we take the time to understand and adapt our approach to meet the needs of members, providers, and State customers. Amerigroup affiliate experience includes successful implementation of comprehensive managed care programs that include long term services and supports (LTSS) in seven states based on:

- A thorough understanding of LTSS program goals and member needs
- Early and effective LTSS stakeholder engagement
- Engaging LTSS providers and providing specialized provider support

Figure 2.14-1. Demonstrated Success with Aggressive Timelines



A sample of more recent implementations is provided in Table 2.14-1.

Table 2.14-1. Other Recent Experience Implementing New Programs and Service Areas

State	Type of Implementation		
Tennessee	Service area expansion: managed LTSS for existing health plan	Y	4/1/2015
Texas	Service area expansion: managed LTSS for existing health plan	Y	9/1/2014
New Jersey	Existing health plan implemented managed LTSS	Y	7/1/2014
California	Duals demonstration, addition of managed LTSS to existing health plan	Y	7/1/2014
Kentucky	Added populations to existing health plan	N	7/1/2014
Florida	Added new managed long-term care program to existing health plan	Y	6/1/2014
Virginia	Duals demonstration for existing health plan and D-SNP	Y	4/1/2014
Georgia	Sole managed care plan selected for children in foster care, adoption assistance, and Department of Juvenile Justice youth	N	3/3/2014
Kansas	New managed HCBS for persons with I/DD for existing health plan	Y	2/1/2014
Wisconsin	Service area expansion for existing health plan	N	1/1/2014
California	Service area expansion into rural areas for existing health plan	N	11/1/2013
Florida	New managed long-term care program for existing health plan	Y	11/1/2013
New York	Implementation of health homes	N	10/1/2013
Virginia	Expansion of program to foster care children and adopted children for existing health plan	N	9/1/2013–12/1/2013
Louisiana	Pharmacy carve-in for existing health plan	N	11/1/2012
Florida	Service area expansion for existing health plan for Florida Healthy Kids	N	10/1/2012
Texas	Service area expansion, pharmacy carve-in, including managed LTSS	Y	3/1/2012
Kansas	All populations covered under Medicaid	Y	1/1/2013
Kentucky	One of 5 MCOs chosen to serve new ACA expansion populations	N	1/1/2014

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In addition, our implementation approach supports rapid response to a State’s changing needs. For example, our Texas affiliate stepped forward to help the State meet the needs of STAR+PLUS (managed LTSS) members when another health plan failed readiness review. *In 60 days, the Texas health plan hired and trained 19 professionals and staffed a special hotline exclusively assisting enrollees who were switching to Amerigroup, some of whom had complex medical needs.*

Staffing to Support Successful Implementation

We have assembled an executive leadership team to oversee and guide our Iowa implementation. Our Iowa Transition Team includes leadership with extensive Medicaid managed care experience and a deep understanding of the State’s objectives in launching the Iowa Initiative. As we launch the program, we will blend our highly skilled Transition Team with an Iowa-based staff. We will hire professionals who have established relationships and who understands the unique, local healthcare challenges. The Transition Team will oversee and monitor the new local staff and transition them to successful, ongoing administration and operation of the Contract.

Our Transition Team and local health plan staff will be supported by our national, award-winning Implementation Management Office (IMO) as indicated in Figure 2.14-2. The IMO is led by a certified Project Management Professional (PMP) with more than 20 years of health insurance industry experience. Our team of Project Management Professionals brings a disciplined approach to the implementation of new contracts, in accordance with the Project Management Institute’s (PMI) global standards for project management methodology. One of the IMO’s core competencies is its ability to successfully implement new Medicaid health plan business while seamlessly transitioning new members and providers into Amerigroup’s operations. We have a proven track record of successfully and effectively implementing programs within short timelines. We will use our proven model for implementing new business with our State partners. This includes the key components needed for a successful readiness review and seamless implementation, including:

- Thorough understanding of the State’s goals, Iowa provider landscape, and member needs
- Stable, predictable, and proven operating model
- Solid project management practices
- Skilled, dedicated, and experienced implementation team
- Experience successfully implementing new Medicaid programs that adhere to the implementation plan and requisite timelines

Transition Team Members

Since Amerigroup is new to the Iowa Initiative, we do not currently have individuals fulfilling the roles of Health Plan Administrator, Medical Director, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Case Management Supervisor, Behavioral Health Coordinator, and Chief Financial Officer. We have included resumes for our experienced Transition Team behind tab 3.2.7.3: Résumés.

Figure 2.14-2. Our National IMO Was Awarded Project Management Office of the Year



In preparing to implement operations in Iowa, Amerigroup has identified a seasoned Transition Team with extensive Medicaid experience and a deep understanding of the needs of Medicaid members. The Transition Team will be responsible for overseeing initial operation of the Iowa Initiative Contract, which will include hiring highly qualified staff to fill the roles of the Contract Administrator, Medical Director, Chief Financial Officer, Compliance Officer, Pharmacy Director, Grievance and Appeals Manager, Quality Management Manager, Utilization Management Manager, Behavioral Health Manager, Member Services Manager, Provider Services Manager, Information Systems Manager, Claims Administrator, Care Coordination Manager, Program Integrity Manager, and Long Term Care Manager.

Our Transition Team will be led by Dr. Tunde Sotunde, who is the President of the North Region– Medicaid Government Business Division. He will oversee all Iowa health plan operations until a local leader is hired as the Contract Administrator/CEO and will maintain ongoing oversight of the market. He will have responsibility for every aspect of the program during implementation. Our Transition Team, led by Dr. Sotunde, is listed in Table 2.14-2.

Table 2.14-2. A Transition Team of Experienced and Highly Qualified Professionals Will Work with Local Health Plan Staff Throughout Implementation

Name of Key Personnel	Title	Experience and Qualifications
Dr. Tunde Sotunde, MD	Contract Administrator / CEO	Dr. Sotunde currently serves as President of the north region Medicaid business. Prior to this role, he was President/CEO of Amerigroup Georgia. Dr. Sotunde is a Pediatrician by training with extensive senior leadership experience in managed care spanning over a decade. He is a strong advocate of helping assure access to healthcare for vulnerable populations. Dr. Sotunde kept an active medical practice throughout most of his career, including providing pro bono pediatric services to the underserved, most recently with the Mercy Children’s Clinic in Franklin, Tennessee. Dr. Sotunde holds an MBA from the University of Memphis, received his Doctor of Medicine from the University of Ibadan in Nigeria, and completed his residency at the Howard University Pediatric Residency program.
John Crowley	Chief Operating Officer (COO)	John currently serves as Staff Vice President of Medicaid Provider Networks since 2014 with a solid track record in successful network development, management, and operations execution within government programs for more than 20 years. John holds a master’s degree in Economics from the University of South Carolina.
Dr. John Chang, MD	Medical Director	Dr. Chang is currently Staff Vice President and Chief Medical Officer for the Medicaid business since 2014. He is a seasoned professional with over 11 years’ experience in integrated healthcare delivery and strategic health plan management. Dr. Chang received his MBA from the University of Michigan and received his Doctor of Medicine from Hahnemann University School of Medicine.
Aimee Dailey	Chief Financial Officer	Aimee is Vice President of Medicaid Finance for the organization’s Government Business Division since 2013. She is a Certified Public Accountant with over 20 years of experience in progressively complex environments and has diverse experience in corporate finance, accounting, public company financial reporting, audit, management, and administration. Aimee holds a bachelor’s degree in Commerce from the University of Virginia.
Georgia Dodds-Foley	Compliance Officer	Georgia serves as Vice President and Medicaid Compliance Officer for the organization’s Government Business Division since 2011. A seasoned healthcare professional with 25 years experience in the legal and compliance arena, Georgia brings extensive executive leadership experience in Medicaid and Medicare managed care. She received her Juris Doctor from the University of Pittsburgh School of Law.

Name of Key Personnel	Title	Experience and Qualifications
Pamela Perry	Government Relations Officer	Pamela serves as Regional Vice President of Government Affairs Officer for the organization's Government Business Division since 2003. A Seasoned professional with over 20 years of government relations experience, Pamela brings extensive leadership experience in managed care. She received her Master of Public Administration and Public Finance degree from the University of Georgia.
Patrick Convey	Pharmacy Director	Patrick is Staff Vice President of Pharmacy Sales and Account Management for Medicaid business since 2013. A seasoned professional with over 20 years of healthcare experience in Customer Service, Account Management, Business Planning and Strategic Initiatives, Patrick brings significant senior pharmacy leadership experience in Medicaid managed care. He received his Doctorate of Pharmacy from the University of Southern California School of Pharmacy.
Bradley D. Soto	Human Resources Manager	Brad is Director of Human Resources for the organization's North Region Medicaid business. Prior to his current position, he served as Director of Human Resources for the HealthPlus Amerigroup New York health plan. Brad brings more than 10 years of human resources experience within managed care and operations. He received his master's degree in University Personnel Administration from New York University.
Tamera Lathan	Grievance & Appeals Manager	Tamera is Director of Grievances and Appeals within Clinical Quality Management for the organization's Government Business Division since 2012. She is a seasoned healthcare professional with over 17 years of experience in the commercial, government, and specialty managed care industry. Tamera brings extensive grievance and appeals leadership experience of Medicaid managed care. She holds an MBA from the University of Phoenix.
Barbara Kupferman	Quality Management Manager	Barbara currently serves as Staff Vice President of Medicaid Quality Management. Prior, she served as Director of Quality Management for HealthPlus Amerigroup New York. A seasoned RN professional with over 15 years of healthcare experience in Quality Management, Program Development and Implementation, Barbara brings significant quality programs senior leadership experience in managed care. She holds a master's degree in Healthcare Administration from St. Joseph's College of Maine.
Lisa McCormick	Utilization Management Manager	Lisa is Director of Healthcare Programs within the Clinical Operations group since 2004. A seasoned RN professional with over 25 years of healthcare experience in clinical and network operations, Lisa brings extensive senior leadership experience in managed care. She received her AASN from Thomas Nelson Community College in Virginia.
Dr. Charles Gross, PhD	Behavioral Health Manager	Dr. Gross currently serves as Vice President of Behavioral Health since 2014. A seasoned psychologist and healthcare leader with over 25 years of experience in Commercial, Medicaid, Medicare managed care, including all EAP and MBHO models, staff models, integrated, carve-out and carve-in models, and sub-capitated arrangements with an emphasis on behavioral health in various roles, Dr. Gross brings extensive behavioral health clinical leadership experience in managed care. Dr. Gross holds a Ph.D. in Clinical Psychology from Yeshiva University.
Fred Nelson	Member Services Manager	Fred is Director of National Customer Care within the organization's Government Business Division since 2011. A seasoned professional with over 35 years of business experience in Customer Service and Quality Measurement and Analysis, Fred brings extensive senior leadership experience in the member services and call center environments. He holds an associate's degree from Suffolk County Community College of New York.

Tab 3: Bidder’s Approach to Meeting the Scope of Work
2 General and Administrative Requirements

Name of Key Personnel	Title	Experience and Qualifications
Julie Skaggs	Provider Services Manager	Julie serves as Director of Health Plan Support and National Provider Relations since 2002. A seasoned professional with over 20 years of healthcare experience in building and enhancing provider networks, managing network operations, exceeding financial targets, formulation of health plan policy and the development of health plan accreditation programs, Julie brings extensive leadership experience in managed care. Julie attended the University of Texas.
Robin Favret	Information Systems Manager	Robin is currently Director of Business Relationship Management for Amerigroup’s Government Business Division since 2012. A seasoned professional with 30 years of healthcare experience in Customer Service, Account Management, Service Operations, and various other roles, Robin brings significant leadership experience in managed care. She holds a Bachelor of Science degree in Business Administration from Old Dominion University.
Leslie Langslow	Claims Administrator	Leslie serves as Director of Claims for Amerigroup’s Government Business Division since 2007. A seasoned professional with over 25 years of Medicaid and Medicare claims and appeals experience, Leslie brings extensive leadership experience in managed care. She attended Old Dominion and the University of Virginia.
Linda Hopkins	Care Coordination Manager	Linda is currently Staff Vice President of Healthcare Management Services since 2014. A highly seasoned professional with over 25 years of healthcare experience in Medical Cost Management, Provider Network Management, Consumer Outreach, and Clinical Evaluation and Health Management Operations within Medicaid, Linda brings extensive senior leadership experience in managed care. She received her MBA from the College of William and Mary.
Mary Beach	Program Integrity Manager	Mary serves as Director of the Medicaid Special Investigations Unit since 2007. A highly seasoned professional with over 25 years of healthcare experience in Healthcare Fraud, Investigations, Customer Reimbursement, and Auditing within Medicaid, she brings extensive leadership experience in managed care. She received her Bachelor of Science degree from Indiana University.
Laura Johns	Long-term Care Manager	Laura is currently the organization’s Director of Health Services/Long-term Services and Supports for the Government Business Division since 2014. A seasoned professional with over 30 years’ experience in staff management, case management, long-term care, home- and community-based waivers, assessment/evaluation, regulatory compliance, staff training, program development, and performance/quality improvement, Laura brings extensive leadership experience in managed care. She holds a master’s degree in Psychology from Stephen F. Austin State University in Texas.
Kevin Hughes	Community Relations Manager	Kevin serves as Staff Vice President of Medicaid Marketing Operations and Retention for the Government Business Division since 2007. With over 25 years of strategic and tactical experience in member and community engagement and operations management, Kevin brings extensive senior leadership experience in managed care. He received his Bachelor of Science degree in Business Administration from Old Dominion University.
Rhys Jones	Member Advocate/Non-discrimination Manager (Ombudsman)	Rhys is currently Senior Director of Medicaid Business Development for the Government Business Division since 2014. A seasoned professional with over 20 years of healthcare industry experience in Medicare, Medicaid, and commercial health plans; Medicare/Medicaid integration and dual eligible programs; long-term care, services, and supports; Big Four healthcare consulting; and hospital and outpatient care settings, Rhys brings extensive member and local advocacy knowledge to the healthcare industry. He holds a master’s degree in Public Health, Health Policy, and Administration from the University of California.

In addition to the aforementioned individuals, we will engage local and national experts across a broad range of functional areas to lead a thorough, high-quality implementation of all Contract requirements.

The local Iowa health plan staff will coordinate with the Implementation Project Team and our national Implementation Team throughout the project and will ultimately hold full accountability for meeting all requirements.

Early and Effective Stakeholder Engagement

When Amerigroup and our affiliates choose to enter a new program, we identify potential providers and other stakeholders well in advance of implementation and meet with them early and often. Our experience teaches us that early engagement creates collaborative partnerships and establishes trust, resulting in better outcomes for our members while addressing the needs of our providers and State customers. We form an Advisory Board of provider associations, providers, advocacy groups, and health plan staff, including care coordination, provider relations, and quality management employees. The meetings provide a forum for the open exchange of ideas to promote a smooth transition. Advisory Board input in other states has enabled us to:

- Incorporate advocate feedback into program development and refinement
- Enhance partnerships with providers
- Extend our reach to underserved communities
- Increase access to services in rural areas

Amerigroup has been meeting with key advocacy and provider groups and will form an Advisory Board to provide input during implementation. The Board will transition to the Stakeholder Advisory Board upon program implementation.

Question 2.14, #2

2. Confirm that you will revise the implementation plan and keep it updated throughout the readiness review process.

Amerigroup will maintain and continually update an Iowa implementation plan that contains the required elements specified in the Scope of Work and as subsequently required by DHS. The IMO updates the project plan weekly, and it is considered a living document that the work groups use to lead their discussions. The list of the requirements and the Project Plan, are the two documents that guide all implementation meetings and actions. There are weekly meetings with the stakeholders, and frequent meetings between the Project Team Meeting and the Steering Committee to go over progress on each deliverable and address any issues that come up. Amerigroup is prepared to submit a revised implementation plan as part of readiness review and are fully equipped to do so.

Confidentiality of Member Medical Records and Other Information (2.15)

Question 2.15, #1

1. Describe your plans to ensure that health and enrollment information is used in accordance with the requirements set forth in the Health Insurance Portability and Accountability Act and other applicable federal and state privacy laws and regulations.

Policies and Procedures to Maintain Confidentiality of Member Records and other Information

Amerigroup understands the sensitive nature of medical records and any other health and enrollment information we collect and maintain to conduct our business. We also understand the importance of securing this information to protect the privacy of our members and providers. We have policies, procedures, and infrastructure to maintain continued compliance with the requirements set forth in the HIPAA Privacy Rule, State and federal privacy and confidentiality requirements, and as outlined in *Scope of Work (SOW) Section 2.15, SOW Section 1.4.1, and SOW Section 13.1.7.*

Using Information in Compliance with HIPAA

Amerigroup will comply the HIPAA Privacy Rule, including designation of national Privacy and Security Officers through our national Privacy and Security Offices. Our policies and procedures are compliant with the HIPAA Privacy Rule, including the granting of the following individual rights:

- An individual's right to access his or her designated record set containing his or her own protected health information (PHI)
- The right to request an amendment to PHI contained in a designated record set
- The right to place a restriction on the use and disclosure of PHI for treatment, payment, and healthcare operations
- The right to authorize the use of PHI before its use in certain marketing activities
- The right to receive confidential communications at an alternate address or location
- The right to request an accounting of disclosures
- The right to voice a complaint about Amerigroup Iowa's privacy policies and procedures

Amerigroup will also maintain compliance with the provisions of the HIPAA Security Rule through our national Information Security Program by:

- Maintaining an information assurance risk management program
- Protecting the confidentiality, integrity, and availability of electronic PHI
- Using administrative, physical, and technical safeguards to address reasonably anticipated threats and hazards to electronic PHI
- Continually evaluating program effectiveness and adequacy

We are committed to protecting member and patient privacy and safeguarding related health information. As such, we maintain security policies and procedures designed to protect the confidentiality, integrity, and availability of electronic PHI collected, maintained, used, or transmitted. We use secure email

systems and encrypted file transfer protocols to protect PHI that is exchanged both within and outside of the organization.

Amerigroup will employ an encryption system to securely transfer files containing PHI using protocols such as SFTP, SSL/TLS, and IPsec. This will include automatic encryption of all email containing PHI to anyone outside of the Amerigroup network. In addition, we encrypt portable devices such as laptop computers and mobile devices and controls what can be saved to removable devices such as CDs and USB drives. Those who are authorized may save PHI to a portable device for business purposes, but it will automatically encrypt the data, protecting member privacy.

We maintain a national Medicaid-specific Privacy Officer and designated employees in the Member Privacy Unit who focus on the fulfillment of member privacy rights requests, investigate and resolve privacy incidents, and maintain Medicaid privacy procedures. The Privacy Officer is responsible for the procedures related to PHI and Individually Identifiable Health Information (IIHI), as well as follow-up for any incidents identified with either.

In addition, our transaction code sets and National Provider Identifier (NPI) are HIPAA-compliant. Our affiliate health plans have data interfaces with state partners, as required, and can support the interfaces with the State and its agents, such as the fiscal agent and enrollment broker. Current data interfaces include incoming and outgoing consumer information regarding enrollment and eligibility, claims and encounters, third-party liability data, provider data, and specialized extracts as required. Interface formats vary from negotiated proprietary formats to preferred HIPAA-standard transactions.

HIPAA Privacy and Security Infrastructure

Our national Privacy and Security Offices oversee, guide, and direct privacy and security programs that support compliance with all applicable privacy and security laws and regulations. Our privacy and security programs:

- Facilitate and coordinate development and approval of organization-wide privacy and security compliance policies
- Facilitate compliance with State-specific privacy and security guidelines in conjunction with the local health plan Compliance team
- Facilitate and coordinate privacy and security training and awareness programs and, when required, maintain training activity records
- Monitor Amerigroup Iowa's compliance with these policies
- Work to address privacy and security compliance risks and remediate any deficiencies
- Compliance is an essential part of the Amerigroup Iowa culture, and we work hard to educate our employees and monitor their adherence to policies and federal and State regulations.

Employee HIPAA Training

All employees receive initial and ongoing training on the overall requirements of the HIPAA Privacy and Security rules, as well as how these rules apply to their specific job functions. All new employees receive their HIPAA Privacy and Security training online within 30 days of their hire date. Each year thereafter, every employee must complete HIPAA online training and certification.

Ongoing Monitoring for Compliance

Amerigroup's local compliance program will deliver continued visibility and awareness regarding the obligation of each employee to maintain the confidentiality of member information. Our



national Privacy Office published a new "Privacy Site Inspection Procedure," which guides the health plans in conducting their own site inspections. We propose that the plan adopts this inspection process. To help assure compliance with Amerigroup Iowa's member confidentiality and privacy policies, we will:

- Educate, train, and remind employees about policies:
 - Frequently Asked Questions and resources related to confidentiality and privacy are readily available on our company intranet site
 - In addition to annually required training, Amerigroup Iowa departments routinely cover privacy and security during team meetings
- Provide a workspace designed to support member privacy:
 - Employees have locking cabinets and drawers at their desk
 - Multi-function printers allow for secure printing, which allows an employee to send a print job to the printer and release the job for printing after they physically log into the printer
 - Locked shred bins are readily available to securely dispose of information in accordance with Amerigroup Iowa's Record Retention Program
- Display visual aids throughout the office as reminders:
 - Colorful posters placed throughout the office remind employees about their responsibility to protect member information and address topics like "HIPAA Do's and Don'ts"
 - Employee computers have automatic screensaver messages that reinforce privacy policies
- Provide options for employees to report compliance concerns:
 - Speak with a manager or Human Resources representative
 - Contact the local Iowa Compliance Officer
 - Call the Ethics and Compliance HelpLine or send an email
- Have our Iowa Compliance Officer and compliance staff conduct regular walkthroughs to inspect for compliance with HIPAA and our policies and procedures to maintain the confidentiality of information. During this walkthrough, the compliance staff will:
 - Inspect office space, including desks, printers, conference rooms, and break areas
 - Discuss compliance with employees to confirm their understanding
 - Immediately address any concerns and, if necessary, initiate follow-up attention and action

Protecting Mental Health Information

To protect and maintain the confidentiality of mental health information and the release of mental health information, in accordance with Iowa Code §228, Amerigroup will maintain appropriate policies and procedures for our employees and through our network provider agreements. Amerigroup requires that all network providers maintain compliance with all relevant State and federal laws regarding privacy and confidentiality. The Provider Manual specifies the limitations on sharing member PHI as defined by HIPAA. All providers must follow HIPAA-compliant protocols when coordinating care with other providers (in-network or out-of-network) for all Amerigroup members.

Protecting Substance Use Disorder Information

In addition to protecting mental health information, Amerigroup Iowa is committed to protecting and maintaining the confidentiality of substance use disorder information. We agree to allow the release of substance use disorder information *only* in compliance with policies set forth in 42 CFR Part 2 and other applicable State and federal laws and regulations.

Breach Notification

In the event of a HIPAA-related breach, Amerigroup will notify the DHS in accordance with the terms of Section 1.5 of the Contract's Special Terms. Upon discovery of a non-HIPAA-related breach, we will notify the DHS within one business day.

Material Change to Operations (2.16)

Question 2.16, #1-3

1. Describe how you will inform DHS in advance of any material changes, and how far in advance DHS will be informed.
2. Confirm that DHS may deny or require modification to proposed material changes if, in its sole discretion, it determines that such changes will adversely impact quality of care or access.
3. Describe your ability to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

Amerigroup Iowa (Amerigroup) believes it is important to communicate any material change in business operations (that is, systems, policies, or processes) to our members, providers, and other stakeholders. We take this responsibility seriously and will comply with the requirements in Scope of Work Section 2.16 to inform Iowa Department of Human Services (DHS) of any material change expected to affect more than five percent of Iowa membership or our Network Providers.

When we make a material operational change driven internally, by program, or by contract requirement, we analyze the impact of the change to systems, processes, and stakeholder groups. Examples of material changes include:

- Updates to the scope of covered services as directed by the State
- Availability of additional approved Value-Added Services
- Information that assists in correct claims payment

When evaluating a material change, we assess the impact to all stakeholders—members, providers, Amerigroup employees, and State agencies—and develop appropriate communication and training plans. Our procedures already align with the DHS requirement to communicate any change affecting more than five percent of our members or providers at least 30 days prior to implementation.

Our experienced Iowa management team recognizes the impact of material changes and will be actively involved in making sure that the changes are minimized, but when necessary, implemented effectively. To that end, our Iowa leadership will engage and work directly with the State to communicate these changes. Our process for making and communicating a material change is described below.

Identifying a Material Change

The Amerigroup Regulatory Oversight Manager monitors events, such as contract amendments and policy notices, and works with business owners to evaluate the impact of the event on operations. Using our Compliance 360 software, the Regulatory Oversight Manager will prepare a high-level summary of the upcoming change in requirements or guidance and distribute it to Iowa stakeholders and across our national support functional areas.

Compliance 360 requires business owners to acknowledge receipt and review of the regulatory alert by indicating whether or not the change will require any action on their part to bring current operations into

compliance with the proposed changes. If a business owner provides an affirmative response, they are required to enter an Action Plan to document the steps that will be taken to implement the change.

Notifying Iowa DHS of a Material Change

Amerigroup will notify DHS of any proposed material changes to operations and associated member and provider communications at least 30 calendar days before the effective date of the material change. This allows for timely notification of the material change to members and providers. We will partner with DHS to submit proposed material changes using the DHS preferred method, including email, telephone, fax, or letter. We will provide DHS with a description of the material change, including the rationale, proposed effective date, impact on stakeholders, and draft member and provider communication materials for review and approval as required. We are willing and available to discuss all proposed material changes with DHS.

Communicating a Material Change

Communication and training are key components of system changes. Amerigroup recognizes that every change is different in the manner and extent to which it affects our members and providers. Depending on the nature of the change and its impact to members and providers, we determine the effective ways to communicate externally and train our call services staff for smooth continued operations and effective handling of questions. For example, a change impacting how all providers must submit claims requires a more extensive communication campaign than a change eliminating the prior authorization requirement for a particular service.

It is part of Amerigroup's commitment to our stakeholders to communicate a material change of operations to our members and providers. We realize that effective communication requires us to employ a variety of methods and media to thoroughly reach our intended audiences.

Communicating Material Changes to Members

We will communicate material changes to our members in several ways, including:

- Email messages that notify members of the nature, impact, and timing of the change (members may sign up voluntarily to receive information from us by email.)
- A print notification mailed to the member (for print materials, members may use Amerigroup's Translation on Demand service to request materials in alternate formats such as Braille, large print, audio CD, or in the member's preferred language.)
- Information and alerts posted on the member website, including member newsletters and updates to the member handbook
- Member Services Helpline employees who answer questions and provide information on how the change will impact members
- Audio messages through our member helpline to provide information on the change when the call is answered by the automated voice response system or during brief periods when members are on hold
- Outbound calls using an automated outreach vendor, whose employees make member calls from a carefully prepared script outlining the change, its impact, and how to get more information
- Direct member outreach by employees on our care coordination and management team to initiate discussion of a change during regular member visits and calls

Communicating Material Changes to Providers

Depending on the nature and significance of the material change, we use a variety of methods to communicate with our providers, including:

- Print notifications in provider bulletins/newsletters, emails, faxes, and mailings to identify the change, impact, and timing of the change
- Information and alerts posted on the provider website and updates to the provider manual
- Provider helpline employees who offer information about the impact of the change and where the provider can obtain additional information
- In-person or online training sessions specific to the change
- Provider Services Staff who initiate discussion on change during regular provider visits and calls

Our Process in Action

Our affiliate health plans applied the processes described above during implementation of the National Drug Codes (NDC) unit of measure to comply with health care reform legislation. Because the change impacted claims submission, the provider communication campaign was lengthy, extensive, and aggressive. We used multiple methods to notify providers of the material change and its impact to their operations. This included direct fax blasts to providers, provider workshop updates, and outreach (with FAQs) by our Provider Services Staff. We also trained our provider helpline employees to address provider questions, issues, and concerns.

Our communication strategy included multiple communications for more than nine months prior to NDC implementation and additional communication after the material change. Prior to the implementation, our communication was designed to educate providers that NDC material changes were coming, how material changes would impact their operations, and what steps they needed to take to be ready. As the implementation date neared, we formed a special team to address claim issues with providers who had not yet implemented the new NDC processes. After implementation, we continued additional education for eight months to confirm provider compliance and address any outstanding claim issues.

Denial or Modification of Material Changes

Amerigroup confirms that DHS may deny or require modification to proposed material changes if it determines that such changes will adversely impact quality of care or access. We will work proactively with DHS to have open lines of communication ahead of time to avoid such situations.

Ability to Communicate in Advance

Amerigroup's material change processes require that changes be communicated to members or providers at least 30 days prior to the change effective date. We understand and will comply with all Scope of Work Section 2.16 requirements concerning member notification of material changes to operations, State approval requirements, and compliance with State-specified content. We will communicate material changes to members or providers using the above-identified methods.

Response to State Inquiries and Requests for Information (2.16)

Amerigroup Iowa understands that DHS may, at any time during the term of the Contract, request financial or other information, and we will fully disclose all financial or other information requested in the specified DHS response time frames.

We understand that DHS may receive inquiries and complaints from external entities, including but not limited to providers, enrollees, legislators, or other constituents, that require our research, response, and resolution. Amerigroup will respond to all such inquiries and complaints specified by DHS when the inquiry or complaint is forwarded to us for resolution.

Dissemination of Information (2.17)

In compliance with the Scope of Work Section 2.17, Amerigroup Iowa will distribute information prepared by DHS, its designee, or the federal government to our members and provider networks. In Sections 8.2 and 6.1, we describe in detail our overall strategy and manner in which we will communicate with our members and providers, respectively, and our ability to build upon the proven success of our affiliate health plans that operate state-sponsored programs in 19 other states.

DHS Ongoing Monitoring (2.18)

We understand that the DHS will conduct ongoing monitoring of our operations to help assure our compliance with Contract requirements and performance standards. Furthermore, Amerigroup Iowa (Amerigroup) understands that the method and frequency of monitoring is at the discretion of DHS and may include but is not limited to both scheduled and unannounced on-site visits, review of policies and procedures, and performance reporting. Please refer to Section 14 for a detailed description of our approach to comply with the State's performance targets and reporting requirements.

Furthermore, Amerigroup will fully cooperate with planned and unannounced on-site reviews, provide requested documents, and be available during review activities.

Future Program Guidance (2.19)

Amerigroup Iowa (Amerigroup) will comply with the Policies and Procedures Manual that the State will publish prior to the Contract start date. In addition, we will comply with future program manuals, guidance, and policies and procedures, as well as any amendments to such materials, at no additional cost to DHS. We further understand that any future modifications that have a significant impact on Amerigroup's responsibilities, as set forth in this RFP, will be made through the Contract amendment process.

Scope (3.1)

As part of the Anthem family of companies, Amerigroup and our affiliate health plans have 24 years of experience in state-sponsored programs coordinating and providing integrated physical and behavioral healthcare services, pharmacy, and Long Term Services and Supports (LTSS) to more than 5.2 million members in 19 states. Our affiliate health plans have never missed a go-live date in more than 100 public-sector healthcare program implementations, service area expansions, and program enhancements in 24 years. We understand how to successfully enroll, transition, and manage all populations and services included in the Iowa Scope of Work, and we currently do so in multiple other states. We have a strong track record transitioning Medicaid members from fee-for-service (FFS) to managed care, and we have the infrastructure, processes, and expertise to rapidly operationalize the Iowa High Quality Healthcare Initiative across the entire State of Iowa.

Eligible Members (3.1.1)

Amerigroup and our affiliate health plans currently serve all populations and manage all benefits included in the Iowa Initiative across more than 5.2 million members in the 19 states where we operate state sponsored health programs (see Tables 3.1-1 and 3.1-2, below). ***This includes experience serving nearly one million members with specialized medical, behavioral, and/or social needs.*** Our affiliate health plans across the country have extensive experience as evidenced by the following:

- 17 years of organizational experience as LTSS experts, coordinating the services and supports for over 200,000 members in seven states
- 19 years' of organizational experience providing fully integrated physical health, behavioral health, and LTSS benefits to Aged, Blind, or Disabled (ABD) Medicaid populations across 16 states
- Our affiliate health plans currently serve more than 20,000 members with intellectual and/or developmental disabilities across 9 states
- Our Indiana affiliate manages Indiana's HIP 2.0, an Affordable Care Act (ACA) Medicaid expansion alternative that includes 19 different benefit packages

We currently manage behavioral health services as an in-house, integrated function of 16 of our 19 affiliate health plans. Two additional affiliates will manage behavioral health benefits by the beginning of 2016. Our affiliates are responsible for crisis services and outpatient therapy for families and children in 16 states, intensive psychiatric rehabilitation in 11 states, and peer support services in seven states.



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Table 3.1-1. Amerigroup Affiliates Have Extensive Experience Managing Care for the Populations Included in the Iowa Initiative¹

Amerigroup Health Plans and the Programs they Serve, by State											
	Medicaid	CHIP	Foster	Dual Demos	ABD	SMI	ID/DD	AIDS/HIV	TBI	ACA Expansion	LTSS
CA	✓	✓		✓	✓		✓	✓		✓	✓
FL	✓	✓	✓		✓		✓	✓	✓		✓
GA	✓	✓	✓								
IN	✓	✓	✓		✓						
KS	✓	✓	✓		✓	✓	✓		✓		✓
KY	✓	✓	✓		✓					✓	
LA	✓	✓	✓		✓						
MA		✓									
MD	✓	✓	✓		✓					✓	
NV	✓	✓				✓				✓	
NJ	✓	✓	✓		✓		✓	✓	✓	✓	✓
NY	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
SC	✓				✓			✓			
TN	✓				✓		✓	✓			✓
TX	✓	✓		✓	✓		✓				✓
VA	✓	✓	✓	✓	✓	✓	✓				
WA	✓	✓	✓		✓					✓	
WV	✓				✓		✓				
WI	✓				✓						
Total	4.1 million	334,000	41,000	15,000	470,000	250	2,300	10,000	2,100	461,000	202,000

Membership numbers presented above are inclusive of membership as of December 31, 2014 for our parent company Anthem, Inc. and its state sponsored health plans. Members may be counted in more than one category and numbers may not be exact. In addition, in February 2015, our parent company completed the acquisition of two Florida managed care organizations, Simply Healthcare Plans, Inc. (Simply) and Better Health, Inc. (Better).

Table 3.1-2. Amerigroup Affiliates Have Extensive Experience Managing the Benefits Included in the Iowa Initiative

State	Membership	Medical	Behavioral Health	LTSS	Pharmacy	Substance Use Disorder
CA	1,081,270	•	•	•	•	
FL	361,277	•	•	•	•	•
GA	352,860	•	•		•	•
IN	244,753	•	•		•	•
KS	130,158	•	•	•	•	•
KY	60,148	•	•		•	•
LA	133,131	•			•	
MA	261,152	•	•		•	•
MD	18,961	•			•	
NV	180,656	•	•		•	•
NJ	214,992	•	•	•	•	•
NY	464,530	•	•	•	•	•
SC	83,393	•	•		•	•
TN	222,134	•	•	•		•
TX	811,511	•	•	•	•	•
WA	129,180	•	•		•	•
WV	88,546	•			•	
WI	79,378	•	•			•
VA	272,004	•	•		•	•

Our affiliates have extensive experience implementing multiple programs that transitioned directly to managed care from a FFS environment. For example, our Kansas affiliate collaborated with that State’s leadership to launch a significant redesign of their Medicaid program. It includes a full range of populations and services, including LTSS, home and community-based services(HCBS) waiver programs, individuals with ID/DD, and members of all ages with disabilities.

Our Louisiana affiliate participated in Louisiana’s 2012 move from FFS to managed care, successfully transitioning the care and services of more than 120,000 members, including Temporary Assistance for Needy Families (TANF), CHIP, and ABD populations.

Our Georgia affiliate worked with Georgia as the sole plan to serve children in foster care in their state-wide program launched in 2014.

Our Tennessee affiliate worked with Tennessee to roll out its TN CHOICES program, which transitioned full waiver services for HCBS waiver participants from FFS to managed care.

Our organization has an impeccable track record of meeting implementation milestones and deliverables while making sure transitions are smooth for enrollees and the state. In the 15 months that ended in January 2013, our organization managed the start-up of three Medicaid managed care health plans — Kansas, Louisiana, and Washington — representing more than 180,000 new members at go-live. ***These three implementations were completed without any disruption in service within our existing health plans. In fact, our call center abandonment rate during those 15 months of intense activity was just 1.04 percent.***

Iowa Department of Public Health Participants (3.1.1.1)

Amerigroup affiliates have extensive experience partnering with states to administer publicly funded substance use disorder (SUD) programs and services. In Iowa, we will coordinate with DHS and IDPH to identify eligible persons for these services, and deliver, coordinate, track, and monitor their care and services. These services will include, among others, outpatient treatment, day treatment, clinically managed low- to high-intensity residential treatment, medically monitored intensive inpatient treatment, intake, assessment, diagnosis services, evaluation, treatment planning, and service coordination.

We have extensive experience partnering with states to administer publicly funded substance use disorder programs and services. Currently, our affiliate health plans provide SUD benefits in 13 states. By first quarter 2016, we will provide substance use disorder benefits in 14 states.

To make sure high-quality services are provided to IDPH participants, we will:

- Establish relationships and work closely with designated, contracted IDPH SUD providers; we have already begun meeting with SUD providers, such as the Iowa Behavioral Health Association, to discuss our approach to behavioral health and SUD treatment and to explore how we can work together
- Work closely with the courts regarding court-ordered substance use disorder treatment for IDPH-covered beneficiaries
- Work closely with IDPH-funded Women and Children service providers to provide substance use disorder services to women who are pregnant
- Use the IDPH data system and data to understand IDPH service levels and complete required documentation

Our collaboration with designated IDPH substance use disorder providers will include outreach and engagement strategies for specific populations such as intravenous (IV) drug users and pregnant women. See Section 3.2.8 on Behavioral Health for more detail on these strategies.



By Q1 2016, we will provide substance use disorder benefits in 16 states; this includes outpatient treatment and court-ordered evaluation for SUD in 15 states, medically monitored intensive inpatient treatment in 13 states, and intake, assessment and diagnosis services in 14 states.

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Excluded Populations (3.1.1.2)

We understand that excluded populations will not be enrolled in the Iowa Initiative. Our organization is experienced using data elements from incoming 834 files to categorize members into distinct populations within our system. We will extend this capability to the excluded populations and configure our system specifically for Iowa. If the data elements driving population categorizations change so that a given member is categorized in an excluded population, our system will flag the member as not covered. We will coordinate with the State to address members whose categorization changes to an excluded population. This includes undocumented immigrants receiving time-limited coverage of certain emergency medical conditions, beneficiaries who have a Medicaid eligibility period that is retroactive, persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage, persons enrolled in the Health Insurance Premium Payment program (HIPP), and persons eligible only for the Medicare Savings Program.

We will coordinate with the State to enroll Alaskan Native and American Indian populations who elect to enroll in The Iowa Initiative voluntarily. We have experience partnering with Indian Health Service (IHS) and Tribal 638 health facilities in other states.

Effective Date of Contractor Enrollment (3.1.2)

Our affiliates have extensive experience managing enrollment processes in other states, and we will be prepared for the Iowa Initiative's intended go-live date of January, 2016. Our processes are proven. For example, in 2013, after implementing three new health plans, our member load automation accuracy rate was 99.4 percent overall across all markets covered by our organization. Eligibility reconciliation was completed within 48 hours (our internal service level agreement) 100 percent of the time.

We will coordinate with the State of Iowa to accept enrollment assignments and changes to aid type on a prospective basis. We will only cover retroactive Medicaid eligibility periods in the case of babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth. We will align with the State's definition of a retroactive Medicaid eligibility period as up to three months prior to the Medicaid application month.

Geographic Service Area (3.1.3)

We will provide statewide access to covered benefits for members in all Iowa counties on day one of the Contract period. Our affiliates have extensive experience establishing robust provider networks quickly in other markets around the country and currently count more than 118,000 providers in our government program networks. We have ten employees on our national Network Development team who are committed to building networks in Iowa. They have built 12 different state sponsored program networks (including networks for many specialized populations) in the last 36 months.

We have already begun a multifaceted provider outreach strategy in Iowa, aided by a close partnership with Wellmark, Inc., that includes a particular focus in the area of Accountable Care Organization (ACO) relationship development. We have met with numerous physicians, physician groups, hospitals and other institutional providers, safety net providers (Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and critical access hospitals), Community Mental Health Centers, Community Developmental and Disability Organizations, Centers for Independent Living, Area Agencies on Aging (AAAs), ancillary service providers and networks, and HCBS providers to begin the contracting process. Some of the marquee providers that we have already engaged include Catholic Health Initiatives, Mercy Health Network, Unity Point, and University of Iowa Health Alliance. See our response to 6.1.1 for more detail on the number of provider organizations with which we have met and executed letters of intent. We expect that these relationships exceed 80 percent of the FFS payment volume within the current Iowa Medicaid program.

CareMore. We are also excited to introduce CareMore to Iowa, starting with the Des Moines market. CareMore, an Anthem affiliate, is a ground-breaking model of care delivery that combines wellness, medical supervision, and a revolutionary approach to care coordination for at-risk members who require higher levels of clinical intervention due to complex and/or chronic conditions.



Additionally, we have developed a plan to provide care in Iowa's rural areas. Across our affiliate health plans operating state-sponsored health programs, 65 percent of the counties in our plans' service areas consist of rural counties, so we are experienced addressing gaps in access and will deploy the best practices we have developed in other states to help assure all Iowans can access the care and services they need as easily as possible. Using GeoAccess® to identify network adequacy gaps, we will partner with strong local providers and create incentives to open offices in rural areas. We will also assist eligible members in accessing transportation to appointments. We also provide enhanced transportation benefits for members eligible for the Children's Mental Health Waiver as a value added service. We plan to promote in-home clinical service delivery by board-certified physicians and nurse practitioners to

improve access in rural areas or for individuals who have a difficult time visiting traditional provider offices.

Another network innovation is our plan to deploy expanded telehealth platforms to further increase access and reduce barriers to care and services. We will work with the substantial telehealth services currently in place in Iowa, such as those provided by the University of Iowa, and partner with providers to expand existing services as needed to meet the needs of our members.

CONTAINS CONFIDENTIAL INFORMATION

Currently, *more than 50 percent of members enrolled in our affiliates' state-sponsored health programs across 19 states are impacted by some form of payment incentive*. Once the Iowa program is mature, we expect similar, if not superior, results.

Covered Benefits (3.2)

General (3.2.1)

We will provide all benefits and services deemed medically necessary that are covered under the Contract as outlined in Exhibit D of the RFP. We have experience providing all benefits and services included in the Scope of Work through our affiliate health plans in 19 states (see Figure 3.2-1). We will leverage our experience in these states to apply the appropriate Utilization Management (UM) processes and medical necessity or other applicable criteria to furnish benefits and services according to Iowa's policies. We will build robust Provider Networks, develop innovative Provider Network solutions, and support members in selecting their preferred providers. We will leverage primary care providers (PCPs) as a key partner in

delivering covered benefits and will utilize tools, information, and incentives to empower PCPs as well as other provider types to improve the access, quality, and cost of healthcare.

Figure 3.2-1. Our Health Plan Affiliates Have Extensive Experience Delivering All Benefits Covered Under the Iowa Contract to Medicaid Members in Other States



We will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. We will not deny reimbursement of covered services based on the presence of a pre-existing condition. ***UM decision-making is based only on appropriateness of care or service and existence of benefit coverage.*** We do not reward practitioners or other individuals for issuing denials of coverage. We do not base decisions about hiring, promoting, or terminating practitioners or other staff on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits. We do not structure compensation to individuals or entities that conduct UM activities to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with regulations.

We will use nationally accepted, evidence-based criteria to promote appropriate utilization of covered services. We will implement criteria and guidelines that are objective and provide a rules-based system for screening proposed care and services based on member-specific, best practice processes and consistently match services to member needs. We will coordinate with DHS and local stakeholders to align with Iowa-specific criteria and processes.

- For **medical State plan benefits**, UM nurses will review the members’ conditions and compare to the appropriate medical necessity criteria. We will use nationally accepted, evidence-based medical necessity criteria, unless superseded by State requirements or regulatory guidance

- For **behavioral health State plan benefits and substance use disorder services**, we will utilize Anthem Behavioral Health Medical Necessity Criteria and American Society of Addiction Medicine (ASAM) Criteria, unless superseded by State requirements or regulatory guidance. We will also develop psychosocial medical necessity criteria specific to the Iowa Initiative
- For **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services** for members under 21, we will comply with State requirements to provide any services that could correct or ameliorate physical or behavioral health
- For **emergency services**, we will not impose restrictions on coverage that are more restrictive than those permitted by the prudent layperson standard. We will not deny emergency services when a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part
- For **Long Term Services and Supports (LTSS)**, we will determine functional necessity based on the member's assessment/re-assessment and needs. We will determine and approve the provision of LTSS and related durable medical equipment (DME) through our person-centered care planning process in consultation between the member, their family/legal representative (if applicable) or caregiver, Community-Based Case Manager and the integrated health home care coordinator (as appropriate). Spending on covered services must fall within the budget cap.

Additionally, we are in the process of developing a long-term partnership with Telligen, a current contractor with DHS, which will allow Amerigroup to combine Telligen's robust and extensive expertise and experience with the State's HCBS waiver programs and populations with Amerigroup's innovative care model. Through this partnership we intend to learn from and leverage the most impactful elements of Telligen's Iowa experience, enhancing our ability to fully understand the programs and processes that have served State Medicaid members historically. Telligen's experience in the State's implementation of standardized needs based assessment tools and administering the InterRAI-HC and the Supports Intensity Scale to determine level of care for member enrolled in HCBS waiver programs will complement and inform Amerigroup's existing care coordination model, and allow us to more effectively provide seamless continuity of care for our most vulnerable members on day one. Additionally, we are exploring opportunities to utilize Telligen resources to support Amerigroup's care coordinators and their activities under our proposed care model and programs.

We will work collaboratively with Iowa providers and community resources to provide cost-effective, quality-driven care. We do not refer members to publicly supported healthcare resources in an effort to avoid costs. We will build a robust Provider Network to meet member needs and outreach with education and reporting to partner with providers to address gaps in care, incentivize high-quality and value-based care, and help assure members access covered services appropriately.

We support enrollees to choose their healthcare professional and LTSS providers and provide support in making informed decisions. We recognize that members and their families will look for providers who have specialized expertise to meet their needs. We will implement a credentialing application that would include a profile for PCPs and for specialty care, behavioral health, and LTSS providers, which will make it easier to identify who has experience working with members who have specific conditions or implementing specific evidence-based modalities or promising practices. This information will be available to members on the member website, in the member handbook, and through calls to the Member Services Department to provide members with choice and access in self-directing their care.

Benefit Packages Overview (3.2.2)

As outlined in Figures 3.2-1 and 3.2-2, we deliver all covered benefits to all populations in the Scope of Work through our affiliates across 19 states. Through our affiliates’ experience matching benefit packages to specialized member eligibility groups, such as HCBS waiver populations, foster care children, individual dually eligible for Medicaid/Medicare, the Medicaid Expansion population, and others, we have established trusted systems and processes to consistently configure and deliver benefits as specified by the contract. Nationally, our affiliate health plans configured our systems to administer varying Medicaid and other state-sponsored program benefit packages for more than 600 eligibility groups. Given the customization of benefits for different eligibility groups in different states, over 8,000 plan configurations are managed by our systems and staff every day. We will combine our best practices and infrastructure for benefit configuration with our local approach to the Iowa market to assure a seamless experience for members accessing covered benefits.



Question 3.2.2, #1

1. Describe your proposed approach to ensure benefit packages will be delivered in accordance with a member’s eligibility group.

Benefit Configuration

To make sure that the Iowa benefit packages are delivered in accordance with member eligibility group, we will leverage internal technology and follow a robust process that will seamlessly coordinate multiple benefits based on members’ eligibility group. Our process follows these primary steps:

1. The Iowa Business Plan Analyst will determine the benefit requirements, using the State Contract, provider manuals, Exhibit D, Iowa Admin Code r.441-78, State plan and publications, and all CMS-approved waivers as a point of reference. These requirements will include coverage, restrictions, limitations, exclusions, and other State- and program-specific parameters. This information will be documented in a requirements document in standard format.
2. An internal national Implementation Benefit Committee will review and approve the requirements documentation prior to system configuration. This group will include health plan representatives, clinical, medical coding, and contract/methodology and other subject matter experts and include final sign off by officials from the Iowa Health Plan.
3. Based on approved requirements, a Configuration Analyst will create the design and map the unique coverage properties, limits, exclusions, and restrictions for each specific benefit product and membership eligibility group category to help assure the proper product differentiation
4. After the approved design is configured in a development environment of our core operations systems, several levels of peer review, quality testing, and user acceptance testing will occur to confirm that benefits will pay correctly and according to all requirements. The Health Plan will make a final review prior to completion. The resulting benefit grid will delineate benefits based on member classification/group, as determined by the 834 file provided by the State.

5. The Benefit Principal Architect will review the benefit grid design against the Amerigroup MMIS standards and approved requirements to confirm full compliance.
6. The Iowa Benefit Configuration Analyst will systematically and manually configure, or build, the approved design in the development environment of our core operations system. Once this is completed, a second benefit analyst conducts a peer review for each benefit category and member eligibility group.
7. Our internal national Provider Data Quality team will conduct a full audit of the build against the approved requirements and design.
8. Amerigroup health plan operations, configuration, and quality teams will conduct user acceptance testing to make sure that the benefits will pay correctly, according to the requirements. Upon completion, Amerigroup Iowa's Health Plan leadership will sign off on the configuration prior to the benefit build being migrated to the production environment.
9. The Iowa Benefit Analyst validates migration by reviewing the core operations production system and sends a notification of completion to the health plan and business owners.

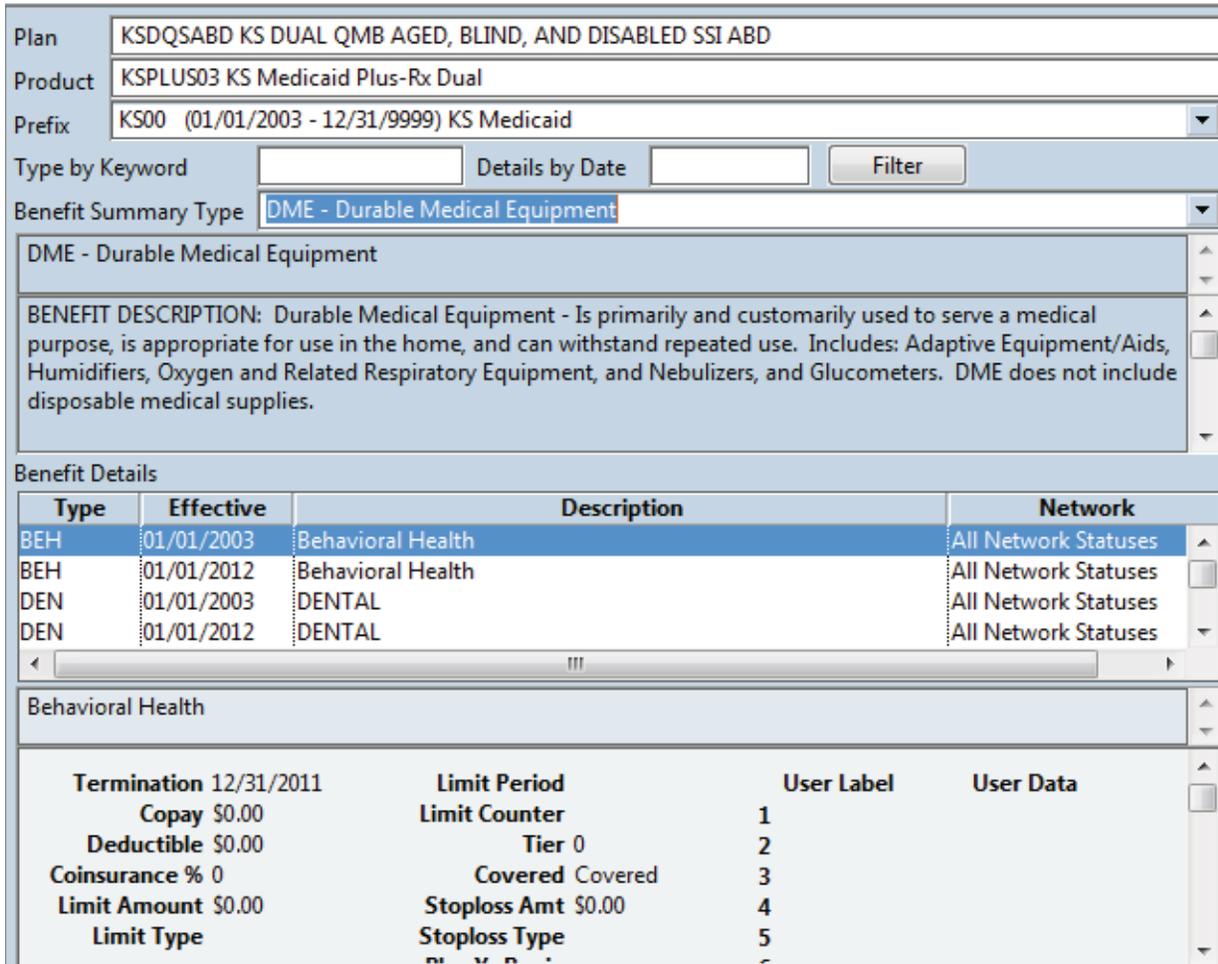
Figure 3.2-2. Amerigroup Systematically Implements the Attributes of Each Benefit Package



There will be a single member handbook and a single provider manual for Iowa, each delineating the different benefit packages available for each eligibility group, including waivers. Our health plan Utilization Management (UM) nurses and Member Services call center and Provider Helpline staff have constant, easy access to this information. We also configure and regularly update our member eligibility system to reflect the covered medical, behavioral health and LTSS services in the comprehensive benefit package for each member as of the effective date of coverage. Starting with a baseline benefit package, we will manage customizations for all eligibility groups, and our system will reflect the unique benefits, coverage properties, limits, exclusions, and restrictions applicable to each member.

Our technology will seamlessly coordinate multiple benefits based on members' eligibility group. The system denotes in the member profile what population the member is a part of, and the system configures to match the benefits for which the member is eligible as seen in Figure 3.2-3. For example, if a benefit is only allowed for members age 21 and younger, we would establish business rules that check the member's age on the date of services for the assigned member's eligibility group.

Figure 3.2-3. Relevant Amerigroup Staff Have Easy Access to Benefit Package Information for Each Member



Plan: KSDQSABD KS DUAL QMB AGED, BLIND, AND DISABLED SSI ABD
 Product: KSPLUS03 KS Medicaid Plus-Rx Dual
 Prefix: KS00 (01/01/2003 - 12/31/9999) KS Medicaid

Type by Keyword: [] Details by Date: [] Filter: [Filter]
 Benefit Summary Type: DME - Durable Medical Equipment

DME - Durable Medical Equipment

BENEFIT DESCRIPTION: Durable Medical Equipment - Is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use. Includes: Adaptive Equipment/Aids, Humidifiers, Oxygen and Related Respiratory Equipment, and Nebulizers, and Glucometers. DME does not include disposable medical supplies.

Benefit Details

Type	Effective	Description	Network
BEH	01/01/2003	Behavioral Health	All Network Statuses
BEH	01/01/2012	Behavioral Health	All Network Statuses
DEN	01/01/2003	DENTAL	All Network Statuses
DEN	01/01/2012	DENTAL	All Network Statuses

Behavioral Health

Termination	Limit Period	User Label	User Data
12/31/2011	Limit Counter	1	
Copay \$0.00	Tier 0	2	
Deductible \$0.00	Covered Covered	3	
Coinsurance % 0	Stoploss Amt \$0.00	4	
Limit Amount \$0.00	Stoploss Type	5	

We configure and regularly update our member eligibility system to reflect the covered medical and behavioral health services and LTSS in the comprehensive benefit package for each member as of the effective date of coverage. The scope of our physical health and behavioral health services is designed to support robust service availability and accessibility for eligible members and includes activities related to HCBS, facility-based, and ambulatory care. Our UM staff work closely with other departments in care coordination, discharge planning, and Case Management to meet the physical and behavioral healthcare needs of our members. Our UM Department, in collaboration with other departments such as our national Disease Management Centralized Care Unit and Case Management, facilitates delivery of the most appropriate medically necessary medical and behavioral healthcare and services to eligible members in the most appropriate setting.

Question 3.2.2, #2

2. Describe your ability to provide covered benefits and services.

Benefit Packages

Amerigroup's extensive experience in providing benefits and services in 19 states positions us to make sure members have access to the quality care and services they need while considering the full picture of their health situation. We will provide comprehensive benefit coverage, specific to each eligibility group, for all relevant Iowa Initiative populations. We are prepared to administer all benefit packages in Iowa, which will be a program of similar magnitude to our affiliate's recent implementation in Kansas. We will use best practices from other states and localized Iowa strategies to assure access to covered benefits through a robust Provider Network as well as transportation, extended provider visit options, and telehealth to reduce barriers to access.

We will manage customizations for all eligibility groups, and our system will reflect the unique benefits, coverage properties, limits, exclusions, and restrictions applicable to each member.

The benefit system will include, but is not limited to the following variations:

- **Iowa Health and Wellness Plan.** Members enrolled in the Iowa Health and Wellness Plan who have not been identified as Medically Exempt will be eligible for the Alternative Benefit Plan benefits outlined in the State Plan. Members enrolled in the Iowa Health and Wellness Plan who have been identified as Medically Exempt will be eligible for services in the State Plan and will have the option to change coverage to the Alternative Benefit Plan known as the Iowa Wellness Plan.
- **Iowa Family Planning Network.** Members enrolled in the Iowa Family Planning Network will be eligible for services that are either primary or secondary to family planning services as described in the Iowa Family Planning Network 1115 waiver.
- **Presumptive eligibility for pregnant women.** Members eligible under the presumptive eligibility for pregnant women Medicaid coverage group will qualify for ambulatory prenatal care services during the presumptive period. This will include all Medicaid-covered services except inpatient hospital or institutional care and charges associated with delivery of the baby, including miscarriage or termination of a baby.
- **CHIP and hawk-i.** Members of the CHIP and hawk-i programs will be eligible for the CHIP and hawk-i benefit packages as outlined in Exhibit D.
- **Waiver populations.** Members enrolled in any of the seven waivers will be eligible for specific incremental benefits according to the waiver stipulations.



We will use best practices from other states and localized Iowa strategies to assure access to covered benefits through a robust provider network as well as transportation, extended provider visit options, and telehealth to reduce barriers to access.

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Access to Covered Benefits

We will operate a comprehensive provider network that includes specialized medical, behavioral, and LTSS and other providers with experience serving all Iowa Initiative populations. Our local provider relations employees will assist in ongoing support and contracting providers as it may be necessary. Where there is insufficient local provider capacity, we will provide innovative solutions, including transportation, home visits, and telehealth, to resolve access issues.

In addition to our core provider contracting strategies, we will conduct an array of supplemental activities to assure the full range of covered services is readily available to members. For example, we will work to:

- Engage local child welfare stakeholders, advocates, and provider associations to identify potential providers for Network participation and collaborating on solutions to access to care and services
- Encourage PCPs to provide after-hours coverage, on a regular basis where possible, or minimally as non-recurring events where necessary to help fill care gaps. We encourage providers to have extended hours at least a few days a week to better accommodate the schedules of members assigned to their panel. We also work with specific providers on a targeted basis to have extended hours as a one-time event where we help the provider office schedule members to come in for services that will help fill care gaps, such as clinic days during school vacations for EPSDT, as detailed in Section 3.2.7
- Encourage strong providers to expand their office footprint into more rural areas by providing incentives to open offices in underserved communities and leverage telehealth capabilities
- Promote in-home clinical services and rotate specialty/mobile clinics by board-certified physicians and nurse practitioners to improve access in rural areas or for individuals who are homebound
- Leverage reporting from Member 360, which provides Case Managers with a member dashboard that displays HEDIS care alerts, prescriptions, lab results, and more, to conduct outreach to providers and members to promote access to preventive care, identify and address barriers to accessing care and services, and deploy education and incentives to close gaps in care
- Engage in member outreach and education to assist in scheduling appointments and obtaining preventive care services
- Assist with provision of transportation to appointments as a covered benefit

We will staff our local Iowa office with Community-Based Case Managers, Case Managers, member advocates in order to communicate effectively with our members and support optimal access and choice of providers. We go beyond minimum network access standards to seek our providers who bring high quality, comprehensive, and specialized service to our members, when and where they need it the most.

Changes in Covered Services (3.2.3)

We are fully prepared to update our benefit systems upon notification of changes in covered services from DHS within the prescribed 90 days. We have extensive experience processing benefit and rate changes across our affiliate health plans. **From March 2014 to March 2015, our organization processed 1,144 benefit change orders.** On average, we completed these changes within 34 days of receiving notice.

Following the proven process we have developed through our experience in other states, benefit changes in Iowa will be handled as follows:

- We will configure, regularly update, and test our member eligibility system to reflect the covered medical services, behavioral health services, and LTSS in the comprehensive benefit package for each member as of the effective date of coverage
- When we receive notification of changes to covered services from DHS, an Iowa health plan Operations lead will coordinate with various departments to implement and communicate the changes
- The Compliance Officer and Chief Operating Officer will work with all departments to put into place an implementation plan to make sure changes are implemented in a timely manner. This includes obtaining confirmation that changes have been made and compiling supporting documentation to prove that changes were made. The Compliance Officer and the Regulatory

Oversight Manager will share supporting documentation and the implementation plan with DHS as requested or required

- We will produce and distribute relevant information and documents necessary for health plan staff, providers, members, and families to recognize and understand changes (including member and provider materials, websites, provider contracts, staff training materials, etc.)
- We will disseminate related communication and documentation in accordance with the 90-day time frame via mail, electronic websites or bulletin boards, secure e-mail, fax, or any other communication method approved by DHS
- We will establish and utilize an internal SharePoint website to document, store, and circulate the Iowa-specific implementation plan and related documentation among our health plan staff

For example, in 2008, state legislative changes impacted covered services for our affiliate health plan in Georgia. Changes impacted multiple benefits, interest payments, eligibility requirements, provider reimbursement rates, claims processing, critical access hospitals, and hospital cost reporting. A designated Operations lead created and executed a cross-functional implementation plan to communicate and conduct all changes. Work plans included timelines and owners for work steps within the following categories:

- | | |
|---------------------------------------|-------------------------------------|
| • System changes | • Member communication and outreach |
| • P&P development or updates | • Staff training |
| • Testing and verification | • Reporting |
| • Provider communication and outreach | |

All changes were implemented within the timeframes designated, including readiness review with health plan staff and the State to demonstrate implementation of all changes.

Integrated Delivery of Care (3.2.4)

Question 3.2.4, #1

1. Describe proposed strategies to integrate the delivery of care across the healthcare delivery system.

In a policy brief on integrating physical and behavioral health care, The Kaiser Commission on Medicaid and the Uninsured described what they consider to be the most advanced and ambitious form of state transformation efforts:



“System-level integration of services and fiscal accountability underpins truly person-centered, holistic care and represents the most advanced model for the integration continuum.”

Amerigroup’s affiliates have a well-established history of this type of systems-level integration, administering both physical and behavioral health benefits in an integrated fashion that focuses on healthy behaviors. , as well as integrating disease and condition-specific expertise in addressing physical and behavioral health conditions with a focus on health behaviors. We have built the operational systems and infrastructure and developed programs and

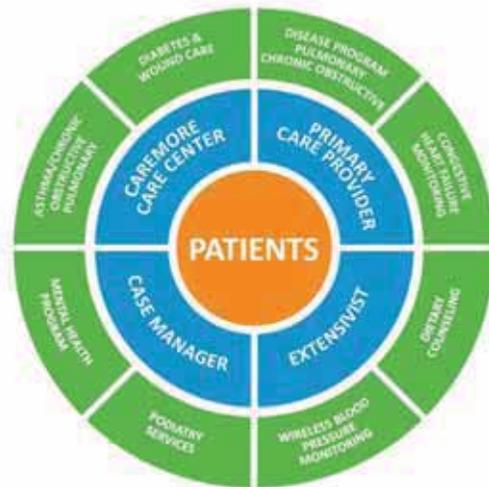
services that promote integration and a holistic approach in addressing member health service needs. Moreover, our approach to integration addresses psychosocial needs such as housing, education/employment, and meaningful participation in the community through linking and coordinating with community services and supports.

Amerigroup strongly believes in taking a fully integrated approach to members’ physical health, behavioral health, Long Term Services and Supports (LTSS), oral health, social needs, and waiver-related needs. We believe this integrated approach is crucial to improving the member’s quality of care and outcomes while proactively managing costs; emphasizing member choice, access, safety, independence, and responsibility. *We will bring our interdisciplinary team approach to Iowa to assure integrated care delivery in supporting the State’s health goals.* Our approach does not subcontract core components of our care coordination model; services are integrated internally and promoted with our provider network.

Our integrated care system incorporates a broad array of services and supports and is organized into a comprehensive service network to promote collaboration and coordination, identify and addresses health disparities, provide culturally competent care and services, and build on Iowa’s strengths.

In Iowa, we will use our proven interdisciplinary team infrastructure, processes, and technology tools to assure integration and coordination and thus promote high quality, cost-efficient, and well-coordinated care.

Figure 3.2-4. Member’s Interdisciplinary Team



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- The member’s interdisciplinary team (see Figure 3.2-4) includes the member, family members, our medical and behavioral professionals, Community-Based Case Managers, health care specialists, staff from Integrated Health or Chronic Condition Health Homes, and home and community-based providers; this multifaceted team works together on a day-to-day basis and during joint rounds to design and execute a single, person-centered care plan based on members’ holistic needs and goals.
- Providers are critical partners in integrating care and a core component of the interdisciplinary team. This includes medical, behavioral, and LTSS providers, as well as the Iowa dental vendor and community partners providing social supports. We provide a feed of comprehensive, actionable information to empower providers to take a coordinated approach to providing high-quality, cost-effective care. We link integration to provider incentive programs and encourage providers to flow information back to the health plan and the State to improve data integration. We have already had discussions with the Iowa Hospital Association, Iowa Health Care Association, Iowa Center for Assisted Living, Iowa Primary Care Association, Iowa Behavioral Health Association, CMHCs, and the MHDS Regional service systems for Mental Health and Disability Services, among others. We plan to work with these partners and others to collaborate on evolving integrated care clinics and supporting integrated data sharing.
- Our interdisciplinary team uses a flexible and person-centered process to meet members where they are, assess needs, risk stratify, and work with members and providers to deliver integrated care and services, emphasizing member choice, access, safety, independence, and responsibility.
- Innovative technology tools are available to the interdisciplinary team, our provider partners, and other extended members of the ‘treatment team’ to support integration. This includes our multifaceted, bi-directional care coordination and member information platform that enables all members of the interdisciplinary team to view and contribute to the member’s record.

Telehealth Visits Expand Access to Services

Our interdisciplinary team approach is flexible, such that the team assigned to a given member will include different specialists or shift emphasis based on the member's evolving situation. We will use specific strategies to serve specialized populations' unique needs and address key transitions of care.

- Amerigroup appreciates the relationship the State has built with the University of Iowa and the relationship that all of the entities within the University have with Iowans who need and access a full range of services that increase their overall health and quality of life. We fully recognize that the University of Iowa Health Alliance is a crucial provider of these health care services to all Iowans. Therefore, to enrich our commitment to integrated care in Iowa and to assisting in the growth of our interdisciplinary teams, Amerigroup has engaged with the University of Iowa to establish a partnership that will bring the full array of the University's services and programs to our membership. In addition to acute and behavioral health care services linkages, we look to collaborate on an array of programs that range from training of support specialists to Applied Behavioral Analysis (ABA) and Autism services to building a financial incentive model to recognize better access to care and support services, decreased medical costs, and improved quality scores. In working with the University of Iowa, we will create integrated and innovative solutions that improve the health and quality of life for Iowans. We are working with the University of Iowa to incorporate the following programs into our integrated care coordination model:
 - Child Health Specialty Clinics
 - Center for Disabilities & Development (CDD)
 - University Center for Excellence on Developmental Disabilities (UCEDD)
 - Department of Psychology

Our Track Record for Integrated Care

Our health plan affiliates in 19 states provide integrated health care services to over 5.2 million members in state-sponsored programs. Our care management model focuses on person-centered planning that helps members optimize their wellness and take personal responsibility for their health care across a continuum of care and settings. It emphasizes coordinating health care services, supports, and resources that address all members' needs.

Our organization has been managing integrated care for state Medicaid agencies for 24 years. We are proud of the outcomes our integrated model has delivered to align with each state's goals. For example, our Tennessee health plan established a program to provide proactive care transition services for members with complex needs, including members diagnosed with SMI and co-occurring medical conditions.

The members in the program transitioned to us from a non-integrated behavioral health MCO, where coordination efforts were focused primarily on the members' SMI, rather than their total health care and social service needs. We assigned these new members were assigned to one of our behavioral health Case Managers who were certified in integrated Case Management and skilled in addressing members' behavioral and medical needs. Case Managers collaborated with behavioral health and medical providers, and members, to ensure that care was closely coordinated and supported members in receiving health screenings, behavioral health services, and follow-up services.

We conducted a retrospective study of members in this program who were diagnosed with SMI and diabetes mellitus to determine if our Case Management efforts led to improvements for both physical



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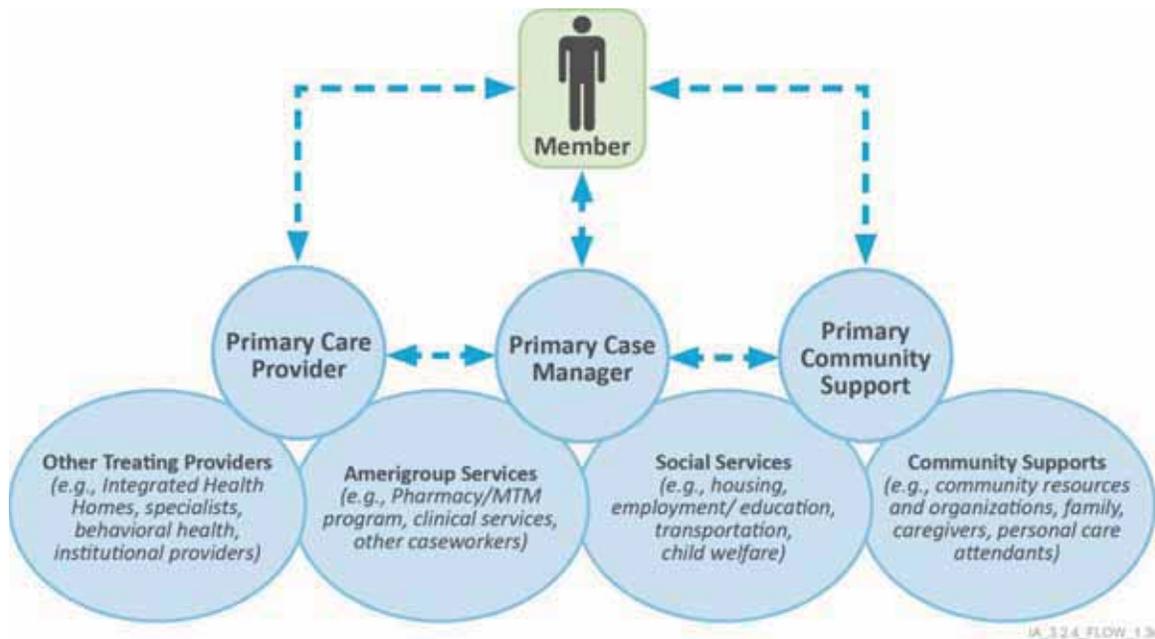
health and behavioral health quality metrics. We selected diabetes mellitus because it is one of the most common co-occurring conditions for members diagnosed with SMI and one that can benefit significantly from comprehensive care coordination. We were pleased to find that our holistic approach resulted in significant improvements between in both physical health and behavioral health utilization trends for members living with a diagnosis of SMI and co-occurring diabetes, which underscores the benefit of comprehensive integrated system.

- 116 percent increase in behavioral health visits
- 15 percent decrease in inpatient admissions
- 59 percent decrease in emergency room (ER) visits
- 17 percent increase in retinal eye exams.

Interdisciplinary Team Infrastructure

Our interdisciplinary team will work side-by-side, access the same data systems, and use a shared approach to the care/service planning process in order to integrate behavioral health, physical health, oral health, LTSS, and social services as shown in Figure 3.2-5. Just as our care planning process reflects the member as a “whole person,” we use a “whole team” approach to care coordination and Case Management. We establish Iowa-based teams of licensed professionals (behavioral health, physical health, and pharmacists) and support specialists (both family and peer) to engage members, their families, and network providers to address members’ holistic needs, establish person-centered goals, and deliver services that are responsive to cultural, racial, and ethnic differences.

Figure 3.2-5. Sample Interdisciplinary Team Infrastructure



The internal interdisciplinary team will come together to discuss members enrolled in Case Management during weekly integrated case rounds. This integrated Case Management activity is led and co-managed by both physical health and behavioral health medical directors. Rounds provide a venue for discussion of members with behavioral health concerns that may also be facing physical health crises, challenges to remaining in their preferred community, or awaiting approval to participate in a Waiver program.

Integrated team staff may also make joint member and/or facility visits to further coordinate with members, families or caregivers, and/or providers.

Interdisciplinary Team Components

- **Case Managers** offer members a single point of contact where all of their physical, psychosocial, and mental health needs can be addressed. Case Managers may have specialized expertise in medical, behavioral, social, LTSS, or HCBS waiver programs in order to provide specific insight and knowledge aligned with member preferences and support needs. Different specialists will stay involved with a given member so that no gaps in care and services occur.
 - Our Case Managers will be based in Iowa, with experience and strong ties in the communities in which they work
 - Our Integrated Case Management and Utilization Management (UM) Certification Programs increase clinical knowledge and expertise for physical health and behavioral health conditions, regardless of the Case Manager's specialty area
 - Case Managers will work together with PCPs, Behavioral Health providers, CMHCs, FQHCs, RHCs, health homes, peer support specialists, waiver staff, and family support specialists to facilitate close collaboration for members with high risk and specialized health care needs
- We will have a local Iowa Medical Director who is a psychiatrist, as well as other **behavioral health clinicians** who participate on the interdisciplinary team. Because we always manage behavioral health in-house and utilize the same information technology platform for physical and behavioral health, which is fully integrated and is a core component of our model of care.
- For LTSS, the following stakeholders are a part of the member's interdisciplinary team: the member, family members, their appointed legal representative, Community-Based Case Manager, PCP, physical and behavioral health providers as needed, others that the member wants on the team, and LTSS/waiver providers. If the member resides in a nursing facility, then nursing facility staff are a significant part of the team as well.
- In Iowa, our Case Managers will coordinate with the **Iowa Dental program** to coordinate necessary dental services. We will promote consistent teamwork, frequent training opportunities, and regular access to clinical consultation to enable information sharing and brainstorming among clinicians and use of social services to promote positive health outcomes for our members. We will also encourage primary care network providers to integrate oral health into their preventive care approach. If the State makes available claims data on dental, we will include dental data in our reporting, member record, and data mining to promote outreach from our health plan staff and network providers to close gaps in care and services.
- We will engage with **providers**, including PCPs, hospitals, and institutional providers, BH providers, CMHCs, FQHCs, RHCs, LTSS providers, and health homes to facilitate the holistic integration process. Incentives to integrate care will be offered to providers, including incentives both in primary care settings and in community mental health settings. We will share reporting with providers and encourage a continuous information feed to improve the quality of Medicaid data. We are willing to be the aggregation point/repository for data if providers are willing to provide requisite data. We are currently partnering with Wellmark to begin engaging with providers in Iowa and plan to work with Wellmark to launch similar ACO models to those Wellmark has successfully deployed in Iowa.
- Our model also incorporates community resources and **social systems of care**, like employment training, vocational rehab, housing resources, and other public programs to address the full spectrum of members' social needs.

In summary, integrated care builds on the knowledge of the “generalist” professionals, such as the PCP, with a focus on health behaviors, as well as the specialist’s detailed knowledge of a health condition. Thus, this approach stands in contrast to an “either-or” model of care. Addressing a member’s holistic needs is enhanced by a system of care in which professionals use core knowledge and skills that include motivational interviewing, member activation, and self-care.

Interdisciplinary Team Process

The interdisciplinary team uses the following approach to ensure an integrated, person-centered approach to care planning and service delivery.

- **Identifying** members who will most benefit from Case Management/Disease Management. Our predictive modeling and assessment tools blend medical, behavioral, oral, and social metrics
- **Stratifying** the intensity of Case Management /Disease Management services based on the member’s individual needs. Our risk stratification tools blend medical and behavioral conditions as well as social factors
- **Engaging** members and their caregivers and family in their health care decisions through ongoing outreach and communication
- **Establishing** an individualized care and service plans that incorporates personalized Disease/Case Management services and coordinates with all the providers necessary to deliver the physical health, behavioral health, long-term service and supports, oral health, and social needs necessary to meeting the member-specific care plan goals
- **Improving** care delivery for our members by ensuring coordination between providers, health plan Case Managers, and members. This includes assisting members and providers with scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation, sharing updates on member progress, etc. We also conduct ongoing evaluation, including reviewing, tracking, monitoring, adjusting, and analyzing the care plan for outcomes, quality matrices, and performance improvement
- **Developing** members’ personal responsibility and self-management skills through education and incentives

Our care management model also fully integrates Disease and Case Management while fostering continuity for our members. Rather than enrolling members in separate Care Management programs based on their specific conditions (for example, separate plans for managing diabetes and depression for a member diagnosed with both), Amerigroup’s integrated program fully coordinates the member’s care and services. Once the member is enrolled in a program (Disease or Case Management), an assigned disease or Case Manager assumes sole responsibility for coordinating all necessary care and services across the member’s system of care.



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However, when a member’s needs change (for example, complications increase his or her condition’s acuity level), the individual may be transferred from Disease Management to our Case Management program, where the Case Manager can provide more intensive assistance. Conversely, if during the course of Case Management a member’s condition improves and that level of support is no longer necessary, the Case Manager may transfer the individual to less intensive Disease Management. The team may also provide specialized Case Management for our members with complex needs, for example, pregnant women, members with elevated lead levels, members transitioning from hospitals, and members with Hepatitis C.

Our assessment process to identify candidates for these programs incorporates a multifaceted approach to holistic health. All members who enroll in active Disease Management, regardless of primary diagnosis, are screened for depression. The screening begins during the general assessment where the Personal Health Questionnaire, Version 2 (PHQ-2) is administered. If the PHQ-2 score is 3 or greater, the nurse then completes the PHQ-9 with the member. The nurse may then refer the member to a behavioral health specialist and/or his or her PCP to discuss the results of the screening, depending on the final score. Identifying depression is important, as it often exists in tandem with chronic conditions.

Interdisciplinary Team Technology Tools

Our interdisciplinary team will be equipped with innovative technology tools developed and refined over years of practical application to further support integration.

CareCompass, our internal care coordination system, provides information about member conditions and medications. Chronological progress notes promote comprehensive care coordination for member needs/issues, regardless of whether the driver is physical health, behavioral health, social issues, or LTSS.

CareCompass Mobile provides virtual office solutions to Community-Based Case Managers who are primarily working in the community and visiting members in their homes.

Member 360 provides Case Managers with a member dashboard that displays HEDIS care alerts; authorizations; prescriptions; lab results; and claims organized by type, such as inpatient, emergency room (ER), office visit, and behavioral health. ***This dashboard is also available to providers for members in their panels through our provider facing Member 360 program.*** The dashboard, demonstrated in Figure 3.2-6, also provides a timeline of clinical events for the member across a number of domains, including diagnosis, providers, transition periods, and medication history. Case Managers and providers can also access the treatment plan in Member 360. The integration of all domains of member data in one dashboard makes it easy for providers and health plan outreach staff to act on filling in gaps in care and making sure members are getting the services they need. With appropriate attestations and releases from providers and after consultation with the State, our system has the capacity to enable providers to see members' entire medical record. We are open to working with the State to serve as a repository for comprehensive information in order to improve the quality and integration of Medicaid data.

CONTAINS CONFIDENTIAL INFORMATION

Innovative Integration Strategies for Specialized Populations

Amerigroup has developed innovative Case Management strategies for our members who have specialized physical, behavioral, or social challenges. Our interdisciplinary team deploys these strategies to support specialized populations. Examples include:

1. **PC INSITE** integrates behavioral health capabilities into primary care clinics in order to carry out universal depression and substance use disorder screening for members, provide treatment, and monitor and follow-up with members
2. **CareMore Model** improves coordination of care for members with complex and/or chronic Disease Management needs

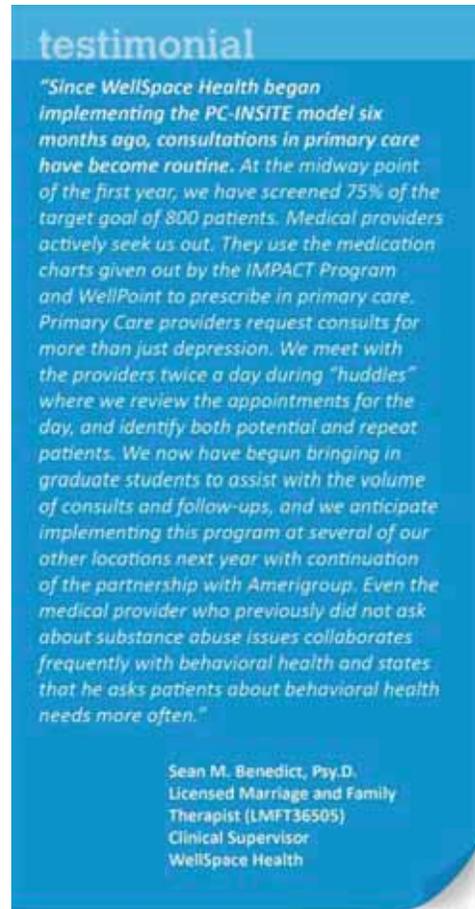
3. **Community Mental Health Center Primary Care** integrates behavioral health care services with medical primary care for SMI members through CMHC partnerships
4. **Autism Services and Supports** are delivered in an integrated manner through the Autism Specialist role
5. **Intellectual and Developmental Disability Services Program** coordinates health plan staff and relevant community partners to fully integrated IDD service plan execution
6. **Prescription Opiate Use Interventions** take a multipronged approach to reducing prescription opiate abuse
7. **Behavioral Telehealth** provides telehealth platform services to connect members to their providers for services needed when they are unable to travel, or in remote locations

PC-INSITE

The Primary Care Integrated Screening, Identification, Treatment, and Evaluation of depression and substance use disorders (PC-INSITE) is based on the evidence-based IMPACT model developed by psychiatrists at the University of Washington. The program was developed to facilitate and enhance primary care clinics’ capability to address behavioral health conditions. A behavioral health coach (licensed clinical social worker, psychologist, marriage and family therapist) is co-located in a primary care clinic to carry out universal screening on members using the BHQ-9 (depression) and a modified Audit C (alcohol and illegal drug use, as well as potential prescription drug abuse). Individuals screening positive are engaged in an assessment to rule out other behavioral health conditions, e.g., trauma, bipolar, unresolved grief, or other conditions that might include depressive symptoms. Based on the assessment, a coordinated intervention involving the member and the primary care physician is developed that may include health coaching based on EBP, solution-focused therapy, psychotropic prescription, referral to a behavioral health specialist, or watchful waiting. Systematic monitoring and follow-up include re-administering the BHQ-9 to evaluate changes and adjust the intervention plan based on that response (stepped-care). This integrated care program is currently being carried out in participating clinics in our affiliate health plans in Maryland, Tennessee, Texas, and California.

In Sacramento, our California affiliate has built on our collaboration with WellSpace, a large FQHC with clinics in the urban center as well as rural locations, to implement PC-INSITE. Funding supported their hiring a licensed behavioral health professional as a co-located behavioral health consultant in their medical clinics. The goal of the program is twofold: first, to address members’ needs in a holistic manner by screening for depression and SUD, with solution-focused interventions and follow-up, and second, to evolve the clinic practice model from a level three to a level six integrated care model as defined by the SAMHSA/HRSA paradigm for integrating physical and behavioral health.

This program builds on an EBP model, IMPACT, as well as the SAMHSA best practices for integrating physical and behavioral health in facilitating practice transformation by recognizing this is a “cultural



shift” in practice for medical providers as well as behavioral health professionals. Our organization’s long history in addressing physical and behavioral health through integration is thus being carried out through PC-INSITE, including a clinical model and financial support for clinics and community providers. The result: improved access for members, better care, and improved health outcomes – over 60 percent of members in this program have follow-up in which a PHQ-9 is completed. Of these members, over 60 percent have a decrease in PHQ-9 scores, which reflects improvement, and clinic staff report increased satisfaction because of the behavioral health expertise and support in responding to their patients' mental health conditions.

CareMore Model

One of the examples of Amerigroup’s innovation in delivering integrated care is our CareMore model. If awarded, Amerigroup will work with our affiliate, CareMore to open at least one care center, starting with a centrally located center in Des Moines to serve the members of the Iowa Initiative with complex or chronic conditions. CareMore uses a breakthrough model of care delivery that combines wellness, medical supervision, and a revolutionary approach to member engagement and participation.

CareMore’s PCPs, acting as primary care team leaders, and their Extensivists guide members through every step of an integrated health care journey, regardless of the setting – facility-based, within the home, or outpatient—thereby managing acute and chronic events from beginning to end to ensure continuity of care. CareMore utilizes the expertise of physicians, nurse practitioners, behavioral health and other specialty clinicians, and social support experts adept at managing the experience of our members in body, mind and spirit.

The CareMore experience includes physical locations that are a central part of the communities served. The locations are equipped to provide highly responsive care and provide an opportunity for members to connect with members of their health care team and participate in individualized support, preventive care, Disease Management and health education. CareMore currently maintains care centers for members of their Medicare Advantage Plans in California, Arizona, Nevada, Ohio, and Virginia; three care centers specifically designed to serve the needs of Medicaid members in Tennessee; and, because of the populations served by CareMore, they can demonstrate over ten years’ experience serving members who are dually eligible.

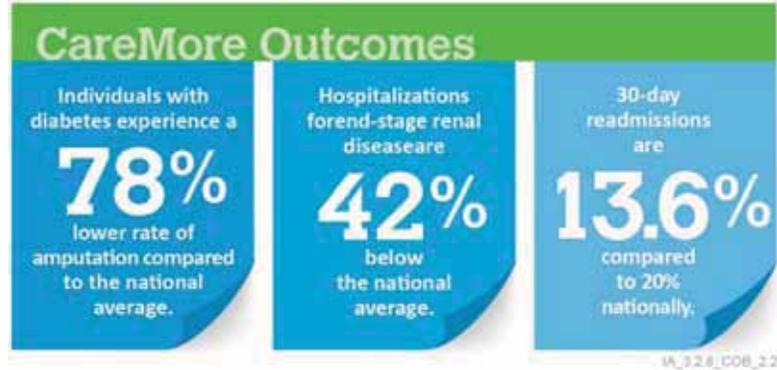
Amerigroup will assess the care and access needs of our Iowa members, as well as opportunities to engage with the existing provider community in order to introduce the CareMore delivery system model in Iowa. Specific services may include, for example:

- Primary Care Services
- Care coordination for high-risk members with chronic conditions
- On-site, holistic Behavioral Health support
- Asthma/Chronic Obstructive Pulmonary Disease (COPD) Program
- Congestive Heart Failure (CHF) Program
- Diabetes Care Program
- Fall Prevention Program
- Wound Care Program

Successful Outcomes

Founded by a group of physicians over 20 years ago, CareMore has received national recognition for its outcomes, particularly related to seniors, persons with disabilities, and individuals with chronic conditions. Members treated through the CareMore model of care incur 15 to 20 percent less (risk adjusted) total health care spending per year than members treated by regional peers, while still receiving quality care:

CareMore's array of member interventions and programs address the full continuum of a member's health care and behavioral status, and will serve to provide additional access and deep engagement where it is most needed. This includes culturally competent palliative program focused on member comfort and relief from the symptoms, pain, and stresses of a serious illness, with a goal of improving quality of life for members and their families.



Community Mental Health Center Primary Care

We are committed to integrating behavioral health components with primary care. In addition, we work to integrate primary care into Community Mental Health Centers (CMHCs). Because many of our SMI members receive services from large CMHCs and feel comfortable with these providers, CMHCs are a logical partner for integrating necessary primary medical care with behavioral health services. Our Tennessee affiliate launched a significant CMHC primary care partnership as a behavioral health medical home with Mental Health Cooperative in September 2013. The model's holistic orientation recognizes the importance of integrating primary and behavioral health services while coordinating linkages to community LTSS, including community housing options. Our approach emphasizes member-centered services and engages members in preventive health services while monitoring their response to interventions. We plan to launch similar models in collaboration with Iowa CMHCs like Eyerly Ball CMHC (who have signed an LOI with us), which will be adapted to the specific Iowa landscape and SMI population needs.

Autism Services and Supports

The behavioral health team in Iowa will include an Autism Specialist who will lend expertise to the team and will collaborate with Iowa's Regional Assistance Program, the University of Iowa, Center for Child Health Improvement and Innovation, the UCEDD, schools, providers, and community organizations to ensure that the behavioral health team facilitates service authorizations, required assessments are completed, and the members are getting the services of their preference to meet individual needs (including physical health services as well as services and supports such as education and employment). Further, the Autism Specialist will continue to provide expertise to the care coordination staff for members with Autism who may be participating in the health plan in a variety of cohorts.

Intellectual and Developmental Disability Services Program

In Iowa, we plan to partner with the Iowa Division of Mental Health and its Regional Coordinators of Disability Services, Iowa Medicaid Enterprise, Bureau on Long Term Care, and community



partners to facilitate service integration and transitions at the State, regional, and local level. Case Managers will also facilitate access to acute care benefits provided by Amerigroup.

In Kansas, where our affiliate health plan has full risk for all State plan and IDD waiver services, the IDD team and LTSS team work closely and collaboratively with the Autism Specialist and the BH team to support the breadth and depth of the member's and family's needs, including co-occurring behavioral health conditions or episodic challenging behaviors. In other states where our affiliate health plans have responsibility for limited services for members with ID/DD, such as New Jersey, an integrated team coordinates care and services for members with IDD. In all cases, the health team collaborates with any applicable internal resource to provide a seamless experience for the member and their family or caregiver. We plan to deploy similar approaches to best serve members in Iowa, customized to the specific community organizations with whom we partner.

Prescription Opiate Use Interventions

In response to what has become a national problem with prescription opiate misuse, our organization has instituted a multifaceted opiate intervention program in several of our state partners' plans. Streamlined relationships and communication with pharmacies, physicians, and other specialized resources (pain



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medicine providers) allow more real-time recognition of problems beyond the typical purview of the primary care providers. Our pharmacy lock-in program restricts an over-utilizing member to a single pharmacy to obtain his or her medications, protecting against duplicate prescriptions from multiple pharmacies or providers. In some instances, and with prior State approval, we may restrict providers who can write prescriptions for opiates. This allows us to work closely with the provider and member to develop an integrated care plan. Implementation of these programs has decreased hospital admissions, inpatient days, ER visits, and opiate prescriptions.

Behavioral Telehealth

We will deploy **telehealth platforms** to further increase access and reduce barriers to integrated care. We will work with the substantial telehealth services currently in place, such as those provided by the University of Iowa, and expand them to serve the needs of our members. Specifically, we intend to provide LiveHealth Online, our telehealth platform for urgent needs, and partner with Breakthrough, a telehealth platform for behavioral health, as additional avenues to deliver one-on-one consultations with board-certified clinicians either through personal computers or at kiosks installed at strategic community locations. Breakthrough's overall member satisfaction is 87 percent, while 50 percent of members report they would not have had access to a Behavioral Health provider without Breakthrough's technology. Amerigroup will continuously work to identify appropriate locations for both of these platforms, so this technology will be easily accessible to our members in a private setting. Further, since our Community-Based Case Managers currently uses iPad technology in the field today to support care coordination, they will also be able to facilitate telehealth sessions throughout Iowa when necessary for members who do not have access to a computer or smartphone. We believe this multipronged telehealth strategy will help us eliminate gaps in care for members in both rural and urban areas by disaggregating healthcare from its traditional locale, empowering homebound or otherwise inconvenienced members to access required care and consultation.

Examples of Integrated Care Delivery for Specialized Populations

We’ve provided a few examples of the work of our interdisciplinary teams in our affiliate health plans to demonstrate the improved outcomes that will support redesign goals of the Iowa Initiative in Table 3.2-1.

Table 3.2-1. Integrated Care Delivery for Specialized Populations

Situation	We met with the member and daughter/POA, and identified that member was receiving attendant care under a waiver. The member’s daughter was her primary caregiver, but she did not live with the member and came over to stay with her when there was no attendant present. The strain of being committed to provide care for so much time was pushing her to consider nursing home placement.
Team intervention	We completed an assessment with both the member and caregiver, discussing alternative options and resources. We completed the Task/Hour guide, which recommended 56 hours per week of attendant care, versus the previously authorized 49 hours per week.
Outcome	The member’s daughter said that she was so relieved to have the additional assistance/care for her mother that she felt she could continue caring for her mother at home after all. She stated that she appreciated knowing that she has some support now that her mother is under LTSS and has a Case Manager.
Situation	This member, afflicted with multiple co-morbidities, was living at home with her extended family. She has a Personal Care Attendant through a consumer-directed waiver. Through close work with the member, her Case Manager discovered several unmet needs: the member’s family had been paying for incontinence supplies out of pocket, there were concerns about her falling while ambulating to the bathroom at night, and she had difficulty getting up and down from furniture in the living room.
Team intervention	We obtained incontinence supplies, a bedside commode, and a lift chair for the member through a DME company.
Outcome	The member’s family members are no longer paying for DME supplies. They don’t worry as much about her getting up at night and trying to walk to the bathroom. She is able to spend more time with the whole family. She continues to have monthly skilled nurse visits.
Situation	This member resided at a SNF under custodial care with a very involved family. He had end stage renal failure with mild dementia. The member’s son/POA conferenced with the LTSS Service Coordinator prior to the initial face-to-face assessment. During the conversation, the member’s son voiced much concern and frustration; the family and member had agreed to hospice/palliative care months ago, and the following week, the member was restarted on all medications and not involved in hospice.
Team intervention	The Service Coordinator completed the initial assessment and presented the family with all options that the Service Coordinator was able to take on their behalf: <ol style="list-style-type: none"> 1) Contact the MD to, again, discuss their wishes and request an order for comfort care. 2) Explore options at an alternative facility that would allow hospice care 3) Provide POA with the number for the local ombudsman. After consultation with the family, alternative placement in hospice care was decided upon.
Outcome	Within 48 hours of the initial assessment and meeting with the family, our Service Coordinator secured a long-term care bed at another nearby facility that had contracts with two local hospice agencies. Hospice was contacted and informed of the planned transfer and intent to begin hospice care once the member was admitted into the new facility. The family was informed that once hospice care was initiated, the member would not be eligible for MMP. The POA stated: “I understand, but we don’t want to lose you. You have been instrumental in making this happen for us.” The Service Coordinator thanked the son and agreed to stay involved through the transfer and until hospice was initiated. POA and member were very grateful for follow through.

Situation	This Georgia member is a 35-year-old woman with depression, HIV/AIDS, and hypertension. She was identified for care coordination through our predictive modeling process, and an initial health-risk assessment showed a PHQ-9 score of 17. She had stopped seeing her psychiatrist and counselors due to severe distrust and largely stayed in her room.
Team intervention	This member's Case Manager crafted a care plan that included education on the importance of hypertension medication and referral and continued support in locating and utilizing psychiatric and crisis services.
Outcome	The member has begun seeing counselors, is now taking her blood pressure medication as prescribed, and has agreed to see a psychiatrist that her Case Manager had recommended. Her follow-up PHQ-9 score dropped to 12.

Situation	This member was identified by our daily census report when he was admitted to psychiatric residential treatment and enrolled in our Complex Case Management Program. He was diagnosed with Autism Spectrum Disorder and psychosis, was having paranoid thoughts about his family members and peers, and was non-adherent to his medications.
Team intervention	His Case Manager assisted his discharge planner in identifying and coordinating outpatient care. After discharge, the Case Manager arranged for in-home intensive family intervention services, counseling, and medication management services.
Outcome	With the help of his supports, the member returned to school, participated in follow-up services, is adhering to his medications, and is no longer experiencing symptoms of psychosis. He has shown significant improvement in school and has not had any readmissions.

Situation	This member was diagnosed with diabetes and referred to Case Management/Disease Management because his poorly controlled blood sugar resulted in frequent ER visits.
Team intervention	The member's Care Manager developed a personally-tailored care plan that included referral to a smoking cessation program, diabetes education, coordination of dental care, referral for endocrinology services, and an exercise plan.
Outcome	The member has quit smoking, is working to improve his nutrition and monitor his sugar intake, and has reduced his BMI.

Situation	This member is a morbidly obese (300 lb.) adult male with schizophrenia, uncontrolled Type II Diabetes (HbA1C greater than 12), and hyperlipidemia, who is non-compliant with lifestyle modifications, medication therapy, diabetes testing, and follow-up appointments.
Team intervention	The member's mother contacted Amerigroup for help and was connected to the Case Manager. The Case Manager reviewed the member's claims history in Member 360 and noted that there were no claims for behavioral health, primary care outpatient visits, or prescription refills for the last three months. She brought the member's case to integrated complex case rounds, and the team recommended level III-Complex Case Management. She engaged the member to determine the source of his issues, and it was found that his medication made him drowsy, and his mother's car was too small for him to sit comfortably, leading to him not attending physician appointments. The Case Manager educated him on alternative medications, the importance of diabetes care, and arranged for alternative transportation. This led to the member attending a PCP appointment, beginning to take insulin and antihypertensive medication, seeing a psychiatrist, and switching psychotropic medications. The Case Manager then coordinated between the member, his mother, PCP, and psychiatrist to develop a care plan providing integrated Case Management services, education for the member, referrals to a nutritionist, endocrinologist, and counseling, as well as continued transportation arrangements.
Outcome	After three months in Level III-Complex Case Management, the member is adherent to his medication, attending appointments with his PCP, psychiatrist, and health counselor, and keeping up with diabetes testing. He is exercising each week and making changes to his diet. The member now has normal blood pressure, is not experiencing disorganized thoughts/hearing voices, lost 18 pounds, and lowered his HbA1c to six.

Integration of physical, behavioral, oral, social health and long-term care services are core to our organization. We recognize that integration is critical to meeting State goals. Throughout experiences in other states, our organization has developed best practices and evolved our infrastructure, process, tools, and approach to specialized populations. We look forward to partnering with Iowa to deploy our best practices to improve integration for Medicaid and other state-sponsored program members and partner with providers and community organizations to innovate further ways to optimize member outcomes and promote cost-effective use of State resources.

Emergency Services (3.2.5)

Question 3.2.5, #1

1. Describe your strategies to reduce inappropriate use of the emergency room and to address members who frequently utilize emergency services.

Through 24 years of experience in our 19 affiliate health plans, Amerigroup has developed a proven set of strategies that reduce the inappropriate use of emergency room (ER) services and assist members in finding the appropriate site of care for their situation. From 2012 to 2013, our affiliate health plans experienced an overall reduction of 19.6 percent in ER visits within our ER diversion program. We will deploy and adapt these strategies for Iowa members and according to the local provider landscape to help assure members access the right care, at the right time, in the right place.



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We continually update our claims adjudication system, our Utilization Management system, our data analytic system, our member education system, and our care coordination system to identify specific instances of emergency services as well as track and trend inappropriate ER usage. Our systems issue alerts to our interdisciplinary team so that team members can educate, outreach, and assist members in understanding and accessing alternative sites of care as appropriate.

Within our suite of predictive models, our TRIAGE tool synthesizes member data (such as diagnoses, claims history, and authorizations) and assigns risk scores to indicate likelihood of ER visits for ambulatory care sensitive conditions. Called the TRIAGE Score, this risk measure enables us to stratify members into meaningful intervention groups. Interventions targeted to these groups are most likely to divert care for Preventable Emergency Department Diagnoses to settings better aligned and more appropriate to meet members’ needs. Refer to Section 9.1.4 for more information on the TRIAGE tool.

Amerigroup understands the goals of the Iowa Medicaid program stated in the RFP and how integral appropriate use of emergency services is to obtaining those goals. We will deploy the following programs in Iowa to reduce inappropriate utilization of ER services and to aid members who frequently use emergency services in finding the best site of care for their medical, behavioral, and social needs. We also, through our strategic relationships with hospitals in Iowa, will coordinate the sharing of ER data to further inform our strategies to reduce inappropriate utilization.

Programs to reduce inappropriate use of the ER

- Disease Management
- Emergency Room Alternatives
- Provider Incentives
- Management of Eligibility Changes

Programs to address members who frequently utilize emergency services

- Integrated Emergency Room Case Management
- Member Outreach, Education, and Marketing Materials
- Reconnecting Members to Health Homes
- Pharmacy Interventions

An example of our success in this area is a program developed in our Georgia affiliate health plan. They conducted targeted network expansion to add additional providers, notified key hospitals of frequent ER utilizers through the ER Case Management program, shared a weekly ER Utilization Management report, and incentivized providers to have after-hours appointments outside of normal business hours. For

As a result of our ER prevention program in our Georgia affiliate plan, the top 20 ER Provider Strategic Solutions groups experienced an 11.5% decrease in OP ER visits, a 3.8% increase in PCP visits, and an 800% increase in UCC visits.

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Georgia members, the health plan provided education on the correct places to seek care for non-emergent services, enrolled members in ER, complex, and stabilization Case Management programs, set up Healthy Rewards member incentive program, held clinic days, placed regular health promotion calls, and sent health promotion mailings to members.

We tracked the outcomes of this effort from 2012 to 2014. As a result of the health plan’s efforts, the top 20 ER HDCS groups experienced an 11.5 percent decrease in ER visits, a 3.8 percent increase in PCP visits, and an 800 percent increase in urgent care center visits. A similarly multifaceted program in our Louisiana health plan saw a significant decrease in ER utilization in its highest utilizing members; we recorded a decrease from **47 percent of total utilization to 42 percent of total utilization in the year following implementation of these efforts.**

Strategies to Reduce Inappropriate Use of the ER
Disease Management

Our comprehensive Disease Management programs help members learn how to self-manage their illness—encouraging them to become active participants in primary and preventive care. This improves outcomes for the member and reduces the need for ER visits.

Disease Management promotes treatment in accordance with evidence-based clinical practice guidelines and connects members with the full array of biopsychosocial supports and services they need to achieve their goals. The result is reduced symptoms that cause ER visits. Based on national best practices, Amerigroup’s comprehensive Disease Management programs support members in accessing the most appropriate services to meet their needs. For example, from 2012 to 2013, our affiliate health plans experienced an overall reduction of 19.6 percent in ER visits and 25.3 percent for inpatient admissions for members enrolled in all Disease management programs, as shown in Table 3.2-2 below .

Table 3.2-2. Amerigroup and Our Affiliate Health Plans’ Disease Management Programs Improved Member Outcomes for ER Visits and Inpatient Admissions from 2012 to 2013

Amerigroup and Our Affiliate Health Plans’ Disease Management Results for Emergency Room Visits and Inpatient Admissions; 2012 to 2013 Year-Over-Year Comparison		
Disease Management Program	ER Visits Per 1,000 Members	Inpatient Admissions Per 1,000 Members
Asthma	- 27.2%	- 39.5%
Congestive Heart Failure	- 12.5%	- 10.6%
Diabetes	- 14.7%	- 8.2%
Major Depressive Disorder	16.5%	- 9.9%
All Disease Management Programs	- 19.6%	- 25.3%

Example: Asthma Support

As a component of our Disease Management program, we provide customized support for members with asthma to facilitate access to preventive care services, reducing ER use. Amerigroup outreach employees contact the parent/guardian of all children who have had ER visits with asthma issues. Our employees work with the adults to gauge the parent/guardian’s comfort level in dealing with asthma, make sure the child has appropriate medication, provide information on the **24 hour Nurse Helpline**, and provide a referral to an Amerigroup Case Manager if necessary. We also provide members with “**My Asthma Action Plan**,” a guide to understanding the severity of different asthma symptoms and when to contact the doctor or ER. Additionally, we provide **AMERITIPS** handouts to educate members on asthma triggers and how to avoid them.

Emergency Room Alternatives

Across the organization, Amerigroup offers our members access to PCPs with extended hours, urgent care centers, and physician telephone consults—all of which broaden member access to ER alternatives.

- **Nurse HelpLine:** Members can access the Nurse HelpLine for nonemergency medical questions and concerns. Nurses, guided by sophisticated decision tree software, assess each caller’s needs and recommend next steps, based on the nature and severity of the symptoms. Nurses route behavioral health emergencies to a Behavioral Health Clinician and alert Case Managers who coordinate follow-up care.
- **Behavioral Health Services Hotline:** Amerigroup will also maintain a Behavioral Health Services Hotline that members can access through the single, toll-free Member call center number. Representatives are available 24 hours a day, seven days a week (24/7), and 365 days a year to address member inquiries about behavioral health services, and qualified behavioral health professionals are available for crisis interventions.
- **Physician Consultations:** As allowed by State laws, Amerigroup has the capability to connect Nurse HelpLine callers presenting with certain non-emergent conditions, such as upper respiratory or urinary tract infections, to a board-certified, Iowa-licensed doctor who conducts a brief assessment, provides a diagnosis, and recommends treatment.
- **Urgent Care Services Network:** Our contracted network will include comprehensive and diverse urgent care service options, including PCPs who have extended hours, urgent care centers, and retail clinics. These services broaden member access to care and provide ER alternatives, especially after regular business hours. We will build a robust local urgent care network in Iowa by working with hospitals, systems of care, retail clinics, and other urgent care providers. Our Nurse HelpLine will educate and connect members with these resources if appropriate to meet their needs.
- **Telehealth:** We will deploy innovative telehealth platforms for both physical and behavioral health services to further increase access and offer an alternative to ER use. These services will deliver one-on-one consultations with board-certified clinicians either through personal computers or at

kiosks installed at strategic community locations. We will work with the substantial telehealth services currently in place in Iowa, such as those provided by the University of Iowa, and expand them to serve the needs of our members. Telehealth completes the continuum of options for our members, enhancing their access to ER-alternative services. We will deploy telehealth to Iowa in a way that complies with all State regulations regarding virtual healthcare services.

Nurses or other providers who are part of the alternative service offerings above will direct members to nearby ER resources when those services provide the most appropriate treatment for emergent issues.

Provider Incentives

Amerigroup will implement a shared savings program that incentivizes PCPs to efficiently and effectively deliver care to their assigned members. With our support, the provider group manages the medical cost of the assigned members efficiently by reducing unnecessary expenses like non-emergent ER use, focusing on care coordination for the members most at risk for high utilization, effectively coordinating needed specialty care, and other techniques. Providers who effectively manage the quality and efficiency of care for assigned members will receive rewards in the form of a shared savings payment.

Management of Eligibility Changes

The experience of our affiliate health plans confirms that Medicaid beneficiaries experience frequent enrollments and disenrollments. As a result, any gains an intervention has on overall ER use may be temporary as new members who have not received education on ER use and assistance in connecting with a PCP continuously join the plan. Members may also move to a new, unfamiliar community and return to the ER because of PCP disconnect. As a result, we continually and creatively promote long-term understanding of appropriate ER use for this population through investment in education and expansion of urgent care and retail clinic networks.

Strategies to Address Members Who Frequently Utilize Emergency Services

Integrated ER Case Management

For members at risk of an ER visit after a hospitalization, Amerigroup has adopted a transitional model of care, delivering intensive short-term support to successfully shift individuals from inpatient to outpatient care. Case Managers work with the individual, using member-defined strengths, needs, and preferences to prevent escalation to a readmission through the ER.

Our analytic systems and Case Managers also identify members who are most at risk of hospital admission, extended length of stay, and frequent ER visits; have actionable gaps in care; or could benefit from additional supports.

The Case Manager contacts the member by phone or face-to-face to identify the issues causing frequent ER use, and the Case Manager works collaboratively with the individual and his or her PCP/interdisciplinary team to develop a plan to connect the member with ongoing care that reduces unnecessary ER usage.

Members with more than three non-emergent ER visits in a year and a TRIAGE score indicating a likelihood of continued emergency use for low-level visits receive focused Case Management interventions that identify reasons for these visits and methods to reduce future use. Case Managers work with the member and family to help ensure members can access timely appointments and necessary specialty care for hard-to-treat



Between November 2012 and December 2014, our short-term Case Management strategies have prevented more than 600 expected readmissions, resulting in \$2.9 million in estimated savings across Amerigroup affiliate health plans.

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conditions and educate members about Amerigroup's after-hours resources, including our 24/7 Nurse HelpLine, and contracted urgent care centers. When a member requires additional medical management for conditions like chronic pain or substance abuse that are contributing to ER use, the Case Manager works with the interdisciplinary team, including medical and behavioral health directors, to identify specialized providers and additional resources needed to address the member's needs in the most appropriate ambulatory care setting.

Members flagged due to high ER utilization may also receive an interactive voice response approach that features an automated call with such question prompts as "do you have a PCP with whom you work well?" Respondents receive additional follow-up via live outreach from a specialized unit that pursues interpersonal interaction to assist them. This team also promotes *LiveHealth Online* telehealth visits during the conversation. In addition, at the member's request during a call or when a member cannot be reached, we mail a brochure about alternatives to ER use.

Example: Care Coordination Partnership with EMS

Our Indiana affiliate developed a care coordination program, "Connecting Members with Primary Care," to partner with Indianapolis Emergency Medical Services (EMS) to launch an innovative pilot program to serve our members in the surrounding area with repeated ER visits. Members identified by providers or via data mining who have repeated ER visits are referred to the program. We then deploy a team consisting of a paramedic and a social worker to outreach to the member, in their living environment, to assess the member's medical and social needs.

The Indianapolis EMS team investigates the member's health status, connection with PCP, understanding of plan of care, compliance with plan of care, condition of living space, and availability of food, shelter, clothing, heat, or any other social needs. The team helps the member make follow-up appointments; provides education regarding care, benefits, and the availability of other resources; and connects the member with needed community and other social supports. The Indianapolis EMS team works closely with the member's care team and PCP to best meet the member's needs and avoid duplication of services.

These services are designed to prevent avoidable ER visits through coordinated, individualized, and member-centered planning through promotion of the members' connections to their PCP and Case Manager. *We plan to explore similar programs in Iowa.*

Using short-term Case Management strategies, our stabilization model has demonstrated a reduction of readmissions. The model exploits opportunities for coordination of discharge care and augments our existing Utilization Management and Case Management activities. Between November 2012 and December 2014, the program prevented more than 600 expected readmissions, resulting in \$2.9 million in estimated savings across Amerigroup affiliate health plans.

Member Outreach, Education, and Marketing Materials

Amerigroup uses a comprehensive, thoroughly vetted strategy for influencing appropriate member utilization of emergency services. Amerigroup promotes appropriate use of the ER by providing detailed information in our member handbook regarding when and how to seek emergency care. Members who have visited the ER receive a letter alerting them that we take these visits seriously. The letter includes the member's PCP's name, address, and phone number and asks that he or she makes an appointment to follow up and determine what care is needed and understand the appropriate settings for such care. It also provides members with information on urgent care options available in their area and reminds them that they have access to our 24/7 Nurse HelpLine and transportation to their doctor's office.

When members are identified as high ER utilizers, our outreach team will initiate contact with them to discuss their care needs and assist in making follow-up appointments as necessary. When members cannot be reached by phone, we follow up with a **Trying to Reach You** letter asking them to call us regarding their ER use.

Throughout our long history in state-sponsored health programs, our affiliate health plans have actively pursued various strategies to reduce reliance on ERs. Through our member education and outreach efforts, these plans have achieved an overall 39.5 percent decrease in ER visits among targeted members who were designated as frequent users.

Reconnecting Members to Health Homes

Another method of reducing inappropriate emergency service utilization is to reconnect the member with their health home. We do this through:

- Providing our PCPs and other Network Providers with information on their members and their use of ER services
- Deploying Nurses in specific high-volume practices to collaborate with staff, redirecting and aligning members to appropriate levels of care
- Conducting direct outreach to PCPs after Amerigroup is notified or detects an ER visit for one of their members
- Enabling convenient, real-time, on-line appointment scheduling for health home sites

Pharmacy Interventions

We plan to implement two pharmacy-related programs, a lock-in program and a Medication Therapy Management (MTM) program, that we expect to impact ER utilization. The **lock-in program** will restrict members who have inappropriately utilized pharmaceutical treatment to a single pharmacy to obtain their medications, preventing duplicative prescriptions. Our **MTM program** will identify members with inappropriate or otherwise unsafe drug therapies and have a clinical pharmacist perform a comprehensive medication assessment and coordinate between the individual, caregivers, and prescribers of the member's medication to promote optimal therapy. Both of these programs have reduced inappropriate ER utilization in our affiliate health plans by eliminating the ER as a duplicative source of medication. Pharmacy programs support members in accessing improved care and outcomes while avoiding unnecessary ER use.

Question 3.2.5, #2

2. Describe your plans to ensure a response within one (1) hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week.

We have a comprehensive process and back-end systems to help assure timely responses to ER providers within one hour, 24 hours a day and seven days a week (24/7). Utilization Management nurses are available 24/7, including holidays, to verify eligibility for members with urgent or emergent conditions and to process requests for prior authorizations by phone or fax. These important numbers are printed on the member's ID card and are publicized in our provider manual and on our member website.

In addition, we also operate a 24/7 behavioral health call center. Behavioral health call center representatives and Utilization Management nurses have access to the entire member record, including medical, behavioral, LTSS, pharmacy, and social information.

Question 3.2.5, #3

3. Describe your plans to track emergency services notification of a member's presentation for emergency services.

Given our affiliates' management of state-sponsored health programs across 19 different states, we are experienced in configuring our systems to track members' presentation for emergency services. One of our integrated Case Management tools, Member 360, displays a variety of alerts, authorizations, and notifications include alerts to members' presentation for emergency services. This information, combined with other medical, behavioral, LTSS, pharmacy, and social member data into a single record, provides a holistic picture of the member's utilization, care coordination services, and gaps in care. Through the provider facing Member 360 tool, providers who have members attributed to them will be able see this same member record via the Amerigroup provider portal.

We also use emergency service utilization tracking to inform Case Management outreach and enrollment. Most notifications of emergency services come to us from claims, given that providers are not required to notify us before providing treatment. Once claims data are loaded into our system, health plan staff and providers are able to view emergency service utilization as part of the holistic member record. Our CI3 tool also incorporates ER utilization in risk stratification. In other states, we have established daily information feeds and fax protocols with hospitals to provide alerts when members are admitted. We will implement similar data feeds and fax protocols in Iowa.

Our providers will notify us of ER visits, and this notification will be processed in our system. This allows us to track and report on ER visits. By combining this information with claims data and Member 360, we have the ability to identify and intervene upon overutilization of emergency services. In our Provider Manual, we will place responsibility on the provider and facility to notify us of ER visits. Additionally, we will not need providers to notify us directly if we receive ER data from the Iowa HIN (through admission, discharge, and transmission (ADT) data that is being piloted with ACOs in 2015).

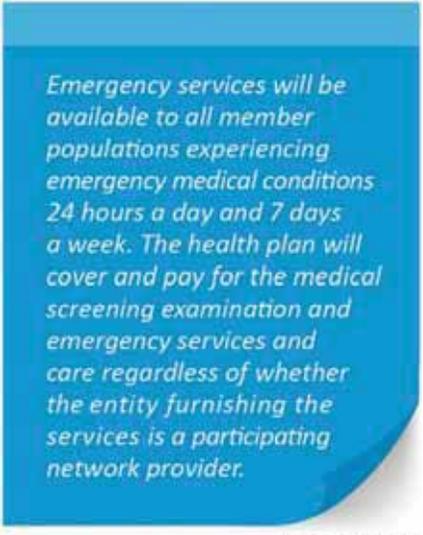
Question 3.2.5, #4

4. Describe your plans for reimbursement of emergency services, including what processes will be implemented to determine if an emergency condition exists.

Availability of Emergency Services

Emergency services will be available to all member populations experiencing emergency medical conditions, as defined in the Scope of Work, 24/7. The health plan will cover and pay for the medical screening examination and emergency services and care regardless of whether the entity furnishing the services is a participating Network Provider. We cover out-of-network services within the United States when emergency services are needed by a member who is in or outside the service area, regardless of whether the provider is part of our Network. No pre- or post-authorization is required for emergency medical, behavioral health, or substance use services, and it is not required for the member or provider to contact Amerigroup prior to treatment.

Because of the prevalence of interrelated medical, functional, and behavioral health issues, integration of physical, LTSS, and



Emergency services will be available to all member populations experiencing emergency medical conditions 24 hours a day and 7 days a week. The health plan will cover and pay for the medical screening examination and emergency services and care regardless of whether the entity furnishing the services is a participating network provider.

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behavioral healthcare remains a primary focus for appropriately managing members' care in an emergency. To provide members experiencing behavioral health issues with the access they may need, Amerigroup maintains a toll-free **emergency and crisis behavioral health services hotline** staffed by trained personnel 24/7. Refer to Section 8.3 for more detail.

While we will not deny claims based on failure to receive notification of ER services, we encourage our participating members and providers to contact us within 24 hours of treatment. This step enables us to begin care coordination, facilitating any necessary authorizations for ongoing service, transportation, or transfers to Network Providers. Follow-up activity is based on the severity of the issue and its impact on the member's well-being and ongoing ability to remain in the community.

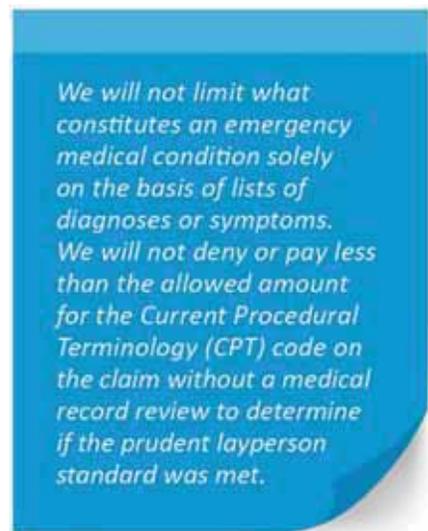
We know that members will also experience emergencies related to natural support availability and health status, environmental and weather disasters, and other situations. We have emergency back-up plans in place that can be brought to bear in these case-by-case examples. For example, with our affiliate health plan in Kansas, storm-related power outages recently put two ventilator-dependent TA waiver children at risk, an emergency we were prepared to respond to by engaging LTSS, providers, the State, and community agencies to resolve the issues safely and methodically.

If a member requires transfer from an out-of-network facility to a network facility, Amerigroup first requires the attending physician at the transferring facility to certify the member is medically stable for transfer. Upon receiving that determination, we identify available network facilities with required levels of services to meet the member's medical needs and facilitate an attending physician at the receiving institution to accept the case and transfer.

Emergency Services Reimbursement

When members present themselves to a hospital seeking emergency services and care, the determination that an emergency medical condition exists will be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by another appropriate healthcare professional under the supervision of a physician of the hospital.

The physician or other appropriate healthcare professional treating the member in the emergency scenario will indicate on the member's chart the results of all screenings, examinations, and evaluations. The health plan will compensate the physician for all screenings, evaluations, and examinations that are reasonably calculated to assist the physician or other appropriate healthcare professional in arriving at the determination as to whether the member's condition is an emergency medical condition.



We will not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms. We will not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without a medical record review to determine if the prudent layperson standard was met.

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All coverage and payment for services are contingent on member benefits and eligibility at the time services are rendered.

Amerigroup will cover and pay for emergency services provided inside the United States regardless of whether the provider is an in-network or out-of-network provider. We will reimburse Network Providers based on a negotiated fee schedule, and we will reimburse out-of-network providers the Iowa Medicaid rates current at the time the services are delivered.

We will pay for all emergency services and care in accordance with the DHS contract. We will not deny payment for emergency services and care if, on the basis of presenting symptoms identified by the member, he or she appears to have an emergency medical condition, even if the condition turns out to be non-emergency in nature. Likewise, the health plan will not deny payment if the member obtains emergency services and care based on instructions of a practitioner or other representative of the health plan. When

included in the member's benefit plan, the health plan is responsible for covering emergency transportation without the need for precertification. Notwithstanding the requirements set forth in this section, the health plan will make payment on all claims for emergency services and care by non-participating providers. The health plan will not refuse to cover emergency services and care due to a lack of notification to the health plan. The health plan will provide coverage for pre-hospital and hospital-based trauma services and emergency services and care to members.

If the physician or other appropriate healthcare professional determines that an emergency medical condition does not exist, we will not reimburse providers for non-emergency services rendered in an ER subsequent to these determinations. We will also not reimburse for treatment of conditions that do not meet the prudent layperson standard for an emergency medical condition.

Defining Emergency Medical Conditions

We will not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms. We will not deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without a medical record review to determine if the prudent layperson standard was met. We will not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. Our determination of whether an emergency condition exists is based on the following definition.

“Emergency Medical Condition” means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

This includes cases in which the absence of immediate medical attention would not result in such impairment or dysfunction. We acknowledge that the prudent layperson standard is driven by the member's presenting symptoms and their perception of what those symptoms may mean.

This also includes situations when a representative of the health plan instructs the member to seek emergency services.

We will maintain a foundational list of codes that insure immediate payment on claims that are clearly defined as an Emergency Medical Condition in accordance with State policies. Prudent layperson review will be conducted by a non-clinically trained claims examiner on remaining codes. When an emergency services claim is presented to the Amerigroup claims administration system, the system will pend any claims that do not meet the technical requirements for an Emergency Medical Condition. We then will request medical records will then be requested for the claim. Once we receive the medical records, a claims examiner without clinical training will review the claim and make the determination whether the claim is to be paid as an emergency service. We will not impose restrictions on coverage of emergency services more restrictive than those permitted by the prudent layperson standard. Diagnosis codes will help determine the presence of an emergent condition and whether or not the ER payment reduction applies, but diagnosis codes will not drive reimbursement for outpatient hospital services. APC payment will be based on CPT or HCPCS procedure code.

If an emergency screening examination leads to a clinical determination that an actual emergency medical condition exists, we will pay for both the services involved in the screening examination and the services required to stabilize the member. We will pay for all emergency services that are medically necessary

until the clinical emergency is stabilized. The attending emergency physician or other appropriate healthcare professional actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities responsible for coverage and payment.

Member Liability (3.2.5.3)

We will not hold a member who has an emergency medical condition liable for payment of subsequent screening needed to diagnose the specific condition or stabilize the member. We will not require copayments for emergency services, as judged by the prudent layperson standard. We will comply with all cost-sharing and member liability requirements as further detailed in Section 5. Our Member Services team will also be ready to assist members with questions on billing received from providers and/or remedy services or care billed to the member in error.

Post-stabilization Services (3.2.5.4)

Amerigroup acknowledges that we will be financially responsible for post-stabilization care services obtained within or outside the health plan that are pre-approved by an Amerigroup Network Provider or other Amerigroup representative. We have extensive experience configuring post-stabilization payments in compliance with state and federal requirements in our claim payment system across our state-sponsored health plan affiliates. Our comprehensive process and back-end systems help us provide timely responses to ER providers within one hour, 24 hours a day and seven days a week (24/7).

We will also be financially responsible for post-stabilization care services obtained within or outside the Amerigroup plan that are not pre-approved by an Amerigroup Network Provider or other Amerigroup representative if Amerigroup does not respond to a request for pre-approval within one hour or cannot be contacted. Also, Amerigroup will also be financially responsible if an Amerigroup representative and the treating physician cannot reach an agreement concerning the member's care and an Amerigroup Network physician is not available for consultation. In this situation, Amerigroup will give the treating physician the opportunity to consult with an Amerigroup Network physician, and the treating physician may continue with care of the member until an Amerigroup Network physician is reached or Amerigroup's financial responsibility ends.

Amerigroup understands that our financial responsibility for post-stabilization care services that Amerigroup has not pre-approved ends when an Amerigroup Network physician with privileges at the treating hospital assumes responsibility for the member's care or assumes responsibility through transfer, or Amerigroup and the treating physician reach an agreement, or the member is discharged. Amerigroup acknowledges and agrees that the attending emergency physician or the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge, or whether the medical benefits of an unstabilized transfer outweigh the risks, and that determination is binding on Amerigroup. Amerigroup will negotiate a single-case agreement with out-of-network providers for post-stabilization services for which Amerigroup has financial responsibility.

If our member is admitted to the hospital or for observation, this will be flagged in our census, and we will deploy discharge planning and care coordination through our Utilization Management staff. If the member is released home and we are notified by the hospital, PCP, or member, Case Management will conduct outreach to coordinate required follow-up care and outreach within a week. Our PCP reporting and incentive programs will also enable and encourage providers to reach out to members for appropriate follow up. In addition, our Stabilization Team will facilitate rapid interaction and intervention during emergency department visits and at discharge from inpatient stays to arrange necessary outpatient services to either prevent the need for admission or avoid readmission. Our affiliate plan in Texas developed a rapid response process to avoid any gaps in services upon return to the home. Pharmacy, another area for potential error, is strictly monitored through review of our Pharmacy Benefit Manager's

claims to be sure Members have obtained needed medications upon discharge. Outcome measures for our affiliate's program in Texas reveal that Members with more complex health needs benefit most from the program.

Emergency Room Utilization Management (3.2.5.5)

Question 3.2.5, #5

5. Describe your plans to document a member's PCP referral to the emergency room and pay claims accordingly.

Our claims systems and processes will document PCP referral to ER services.

Our systems have the capabilities to capture a PCP referral field as part of the claim. When the PCP alerts us to this referral, we will document the referral in our system. If a referral from our PCP is attached to a claim, we will pay the claim regardless of whether the situation meets the prudent layperson or other standard and will not conduct retrospective review.

If we see a pattern of referral from a specific PCP where claims do not appear to meet medical necessity, we will reach out to the PCP with education on appropriate referrals. We also survey provider after-hours coverage by secret shopper to understand the guidance providers are giving so we can flag any issues. We encourage providers to work with members to make an active decision versus providing a passive direction.

Pharmacy Services (3.2.6)

Question 3.2.6, #1

1. Describe your proposed approach for delivering pharmacy benefits, including the use of any subcontractors.

Amerigroup's affiliate health plans bring 24 years of experience developing, implementing, and managing pharmacy services programs and benefits. We currently deliver pharmacy benefits to 4.5 million members in state-sponsored programs across 16 states. Our local, dedicated pharmacy services programs, backed by the resources and expertise of our national Pharmacy Department, give us a team of skilled clinical pharmacists and support staff, well-established policies and procedures, and innovative programs designed to maximize quality, safety, and efficiency. Our Pharmacy Director –who will be a local, Iowa-licensed Pharmacist – will work closely with our Pharmacy Benefit Manager (PBM) to confirm that pharmacy services meet all applicable State of Iowa, federal, and Scope of Work/Contract requirements.

Through our affiliates, we have experience delivering pharmacy benefits to all populations in the Scope of Work and know the potential pharmacy issues that can affect certain individuals such as children in foster care, those receiving home and community-based waiver services, or people who are enrolled in both Medicaid and Medicare. For instance, in Indiana, our health plan affiliate collaborates with the state Mental Health Quality Advisory Committee to develop clinical programs that help assure appropriate use of psychotropic agents in children and adults. We utilize mental health quality edits at the point of service to reduce psychotropic duplication of therapy and refine dosing regimens of our Medicaid population, including foster care members. See Section 3.2.6.5 for more information about our psychotropic medication management program for children/adolescents.

Amerigroup subcontracts with Express Scripts, Inc. (ESI) as our PBM. Amerigroup directly manages all clinical functions of our pharmacy program and maintains fully accountability and oversight of all PBM services. As our PBM, ESI will provide a robust pharmacy provider network, claims processing, and administrative services. ESI manages 5.5 million state-sponsored program lives across 23 states through 39 health plans. Of those, 4.5 million are Amerigroup affiliate members. By July 2015, ESI will serve more than 6.5 million state-sponsored program lives across 24 states through more than 42 health plans. As a URAC-accredited organization, they have demonstrated a commitment to quality and have been an excellent partner for Amerigroup in serving our members. Collectively, throughout this response, we refer to the pharmacy team (including ESI) as Amerigroup Pharmacy Services.

Fully Integrated Pharmacy Services

Our pharmacy program is fully integrated across all functional areas using joint operations and clinical meetings and committees, shared data and reporting, shared goals, and pharmacy participation on care teams. For example, our Pharmacy Department has standing meetings with our Program Integrity team to prevent, identify, investigate, and report fraud, waste, and abuse of prescription drugs by members and providers. Additionally, our Pharmacy Department participates on quality committees, performs whole-program utilization reviews, and collaborates with Amerigroup's Medical Director and Case Managers.

As a driving force of our pharmacy program, we support overall health management and optimize therapeutic outcomes through improved medication use and reduced risk of adverse events. Our program focuses on meeting the needs of our members by collaborating with providers and leveraging data to optimize health and safety. To further manage care holistically across the spectrum of physical, behavioral, and social needs, we fully integrate this program into our overall care management and disease management models.

Amerigroup's affiliates managing state-sponsored health programs across the country employ this approach today, and have achieved the following outcomes:

- **Cost-effective physician prescribing practices:** 84 percent generic utilization rate, higher than the Medicaid MCO national average of 80 percent
- **Engaged providers:** Utilization Management of pharmaceutical agents relative to best clinical practices, promoted through peer-reviewed profiles, led to a 10-point increase in quality ratings
- **Controlled resource utilization:** 25 percent reduction in inappropriate utilization
- **Decreased fraud, waste, and abuse:** Pharmacy lock-in program reduced members' inappropriate utilization by 25 percent (30 percent of drug spend)

We will blend the proven processes and monitoring programs currently in place across our affiliates with new programs and best practices based on the expertise of our national Pharmacy Department to address the needs of our Iowa Initiative membership. The result: a comprehensive pharmacy program that includes:

- Pharmacy benefits management
- Formulary and utilization management programs (standard, state-mandated, and custom)
- Retrospective drug reviews
- Medication therapy management
- Prospective and retrospective Drug Utilization Reviews with an educational component
- Lock-in program
- Member education programs to improve medication adherence, assure appropriate utilization, and to drive use of generics and preferred drugs and pharmacies
- Clinical and condition-specific solutions for diseases prevalent in our Iowa Initiative membership
- Proactive communications to prescribers, pharmacies, and members during transition periods
- Customized pharmacy network solutions
- Specialty drug solutions, including specialty step therapy and utilization management edits, medical benefit management, and other programs with Accredo®, ESI's specialty pharmacy

Pharmacy Provider Relations and Prior Authorizations

To provide access to pharmacies and physicians/prescribers, Amerigroup operates a 24/7 toll-free call center. The call center provides access to employees during all hours of operation and processes prior authorization requests received from prescribers by facsimile, telephone, and postal service mail within 24 hours. Additionally, our electronic prior authorization system is available 24/7.

Covered Services (3.2.6.1)

In accordance with Scope of Work Section 3.2.6.1, we will cover all classes of drugs covered by Medicaid Fee-For-Service (FFS), will enforce the rebate requirement and cover the same categories in the excluded/restricted classes as Medicaid FFS, and will cover medications rebated by the pharmaceutical manufacturer (in accordance with Section 1927 of the Social Security Act). We will include in the per diem rate all over-the-counter drugs for members in a nursing facility, psychiatric medical institutions for children, or intermediate care facility for individuals with intellectual disabilities.

Pharmacy Preferred & Recommended Drug List (3.2.6.2)

In accordance with Scope of Work Section 3.2.6.2, Amerigroup will follow and enforce the Preferred Drug List (PDL) and Recommended Drug List (RDL) under the Medicaid FFS pharmacy benefit with PA criteria, including quantity limits and days' supply limitations. We will notify providers of PDL and PA

changes at least 30 days prior to implementation. Drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, and cancer will be excluded from the PDL. We will use DHS's RDL for these drug categories and to inform prescribers of the most cost-effective drugs in those categories. Through outreach and education, we will assure members and providers understand the RDL. We will also train our internal staff to assure they understand the RDL. As there are changes to the list, we will re-educate members, providers, and staff and will make information available on our member and provider portals.

Pharmacy Prior Authorization (3.2.6.3)

Question 3.2.6, #4

4. Describe your plans for responding to all drug prior authorization requests within twenty-four (24) hours and dispensing at least a seventy-two (72) hour supply in an emergency situation.

Amerigroup offers a streamlined process for physicians to complete prior authorization requests. To facilitate member access to the medications they need, we offer physicians the option to submit prior authorization (PA) requests by contacting our toll-free number, submitting the request online, or by faxing the request. We respond to all drug PA requests within 24 hours by telephone or other telecommunication device and dispense/reimburse at least a 72-hour supply of a covered outpatient prescription drug that requires PA in an emergency situation. Our pharmacy PA process will comply with all Iowa and federal requirements and Scope of Work Section 3.2.6.3. Figure 3.2-7 illustrates our pharmacy PA process.

Pharmacy Prior Authorization System

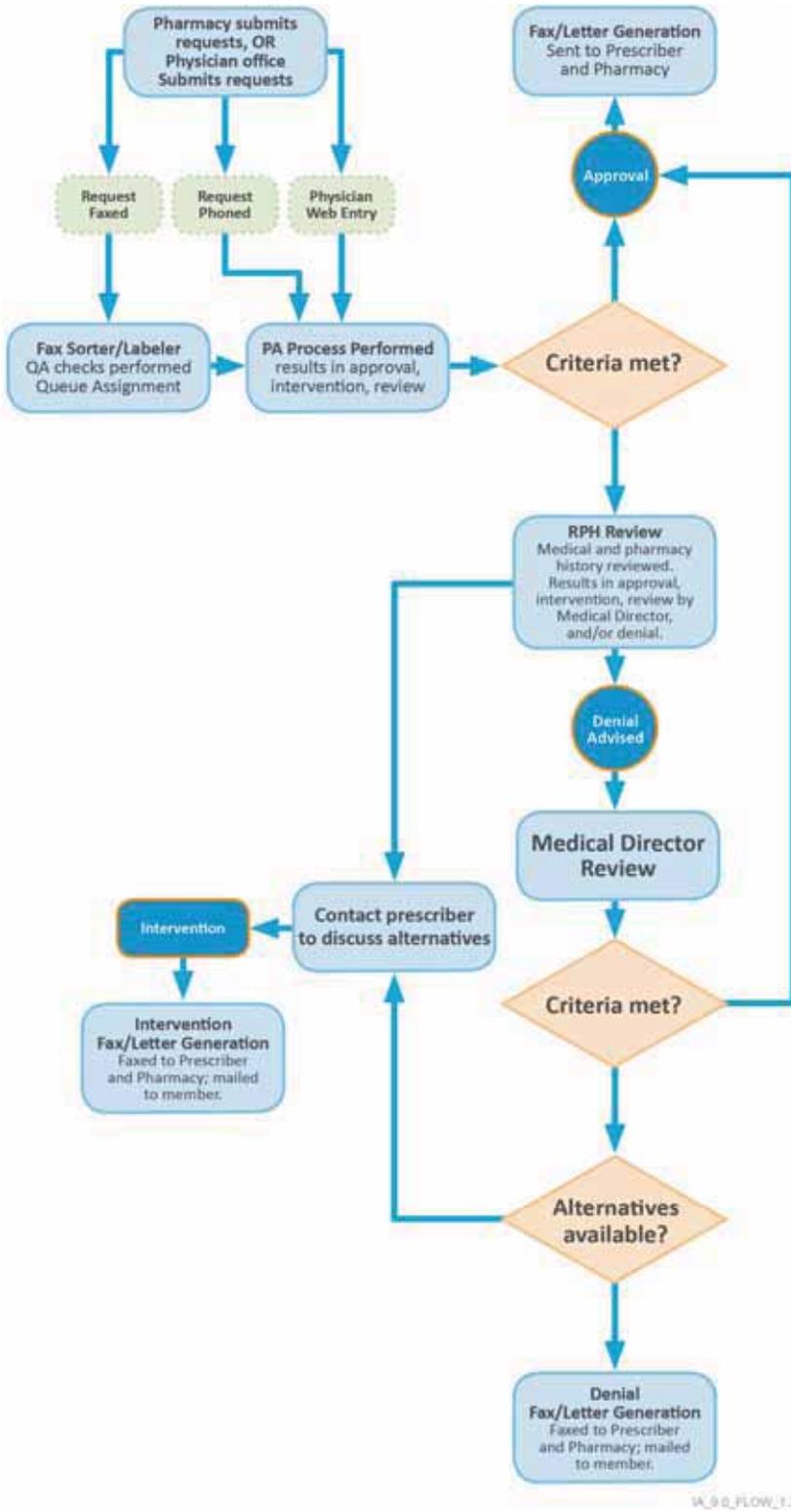
Our Pharmacy PA system supports both automated and manual PA determinations, responses, and reporting in accordance with Scope of Work 3.2.6.3. Through this system, we can examine up to 24 months of administrative data. If the State provides us with this administrative data, we will have this capability upon launch. We will establish a feed and repository of medical data sourced from FFS and MCO claims. We will maintain medical data files and define specific medical data elements and rules to evaluate as a part of the PA process, and we will integrate evidence-based guidelines, peer-reviewed findings, and recommendations of recognized specialists. We will summarize administrative data, along with PA approval/denial outcomes, for our providers on our provider-facing Member 360 platform.

We can also define point-of-sale clinical rules incorporating medical diagnoses in evaluating claims for utilization reviews. We call these special point-of-sale clinical rules Smart PA Rules. As an example of how Smart PA rules work: We will use a potential utilization review edit for Celebrex® dispensed to patients under 65. We may waive a Utilization Management review for patients with a history of Proton Pump Inhibitor (PPI) use within the last 180 days or if they have a diagnosis indicating an ulcer. We can set up a Smart PA rule to require a PA when Celebrex is filled, unless they meet the PPI or ulcer criteria. When a prescription for Celebrex is filled, the Smart PA rule will look back through the member's medication history and check for an ulcer diagnosis before returning a utilization management reject.

The National Council for Prescription Drug Programs (NCPDP) does not currently specify a mandated response time for processing electronic prescriptions, but if a PA exists in our claims system, claims adjudication occurs within milliseconds. After prescribers answer all PA criteria contained within the decision tree presented to them through the electronic PA system, approvals happen in real time.

For prior authorizations via phone and fax, we offer web-based physician and client PA tools to help simplify and speed up the process. The tools will transmit data electronically in HIPAA-compliant transaction formats and in the most current standard. We will comply with other nationally-accepted, industry standard formats as needed.

Figure 3.2-7. Amerigroup Prior Authorization Process and Review Flow



Our physician electronic PA tools streamline the process. Our system complies with the current version of the NCPDP SCRIPT standard and seamlessly works within the physician's electronic prescribing tool to offer prescribers additional flexibility.

Electronic PA can be accessed via an online portal or the prescriber's Electronic Medical Record (EMR) system (assuming the prescriber's EMR has upgraded its software to connect to ESI). The prescriber can also send real-time PA requests and information directly to us via the online portal to receive real-time feedback and approvals.

We will generate and distribute PA Approval and Denial letters to members and applicable healthcare providers. We mail letters to members and mail and fax letters to physicians. We will send these notifications in other languages, if requested.

We communicate our decisions swiftly and clearly. Communications go out the next business day after the decision is made. If required, we can fax notifications to the provider on the same day of the decision. Additionally, providers using electronic PAs receive an electronic notice of the decision.

When we receive a PA, it's automatically loaded for adjudication, and will be paid once processing is complete.

We will provide continuity of care exceptions for up to 90 days upon revisions to the PDL and PA programs. We can include or exclude specific drug categories and therapeutic classes from PA requirements based on the physician's National Provider

Identifier number or the prescriber's American Medical Association specialty code.

Access to Emergency Fills

When the Pharmacy does not fill a prescription at the time it is presented by the member due to an authorization requirement, the pharmacy must contact the provider and dispense a 72-hour emergency supply of the prescribed medication if the provider is unavailable. The pharmacist uses professional judgment to confirm that dispensing the prescribed medication would not jeopardize the health or safety of the member. We instruct pharmacists to enter an override code when dispensing these emergency supplies. Periodic written reminders to pharmacists promote ongoing compliance. Pharmacists can also contact the Pharmacy Help Desk 24 hours a day, seven days a week, 365 days a year for assistance with these overrides and emergency fill requests.

Provider Portal

Our HIPAA-compliant, web-based provider portal allows the provider to automate the PA process. In order to provide easy access for providers, we will place a link on the Amerigroup Provider Portal to redirect prescribers to the PA tool for prior authorizations involving drug therapy. This portal provides a number of benefits for the provider community including:

- Minimizing administrative burden by offering flexibility in submitting the PA (including clinical documentation to support the request) and automating back-end processes to generate the results
- Granting access to electronic health records via a secure login for our provider-facing Member 360, so that providers can see drugs filled, on which we have paid a claim, as well as a member's PA history and claims detail (including other prescribers)
- Providing authorized users access to PA questions
- Enabling authorized users to view approval and denial outcomes
- Electronically and securely submitting PA requests for automated and manual review by examining up to 24 months of administrative data and applying evidence-based guidelines to determine prescribing appropriateness
- Providing clinical guidelines and evidence-based guidelines (for example, the Beers Criteria list) for provider reference on the provider portal

Within our electronic PA system, PA criteria are presented to the prescriber real-time once the patient is identified and it is determined that a PA is required. The PA criteria question set is presented with decision tree logic to ensure that the prescriber only answers the questions required to drive the decision. Once the prescriber answers all of the required questions, he or she will submit the responses so we can evaluate them for an automated PA approval.

Question 3.2.6, #5

5. Describe your method for providing online and real-time rules-based point-of-sale claims processing for pharmacy benefits.

Point-of-sale Claims Processing System

Amerigroup and our affiliates have a long-term subcontractor agreement with ESI to provide network and administrative pharmacy services, including a real-time point-of-sale processing system for drug claims. In 2014, ESI processed 40 million prescription claims for our state-sponsored programs. All of our affiliates' network pharmacies are online and transmit claims electronically, following NCPDP telecommunication standards. The online claims adjudication system operates 24/7. Network pharmacies can transmit claims through any of the major switching companies to our PBM by maintaining a direct link to ESI's data center. Once received, claims are verified for eligibility, drug coverage, plan design,

formulary compliance, and Drug Utilization Review (DUR). In addition, the system applies hundreds of edits within seconds, based on benefit design and eligibility requirements. Concurrently, targeted alert messaging is delivered to dispensing pharmacists. Edits include:

- Participating pharmacy
- Member eligibility
- Drug coverage
- Benefit design edits (quantity, days’ supply, and refill-too-soon)
- Rejection edits for Third Party Liability and Coordination of Benefits
- Formulary and PDL compliance
- Prospective (concurrent) DUR edits
- Step therapy, therapy duplication, and other clinical edits

To promote complete safety before the medication is dispensed, the system alerts the pharmacist immediately to the results of the DUR edits. The system also transmits any applicable member co-pay or co-insurance and advises the pharmacy of the reimbursement amount. All of this activity is completed within seconds. The system also tracks and reports on the member’s usage, manual payments, adjustments, recoupments, and other identifying accounts receivable and claim information.

Prospective Drug Utilization Review

Prospective DUR (proDUR) applies a series of First Data Bank-supplied safety rules, in combination with internal proprietary rules, to review prescriptions for patient health and safety concerns. This provides important information to pharmacists to prevent adverse reactions and improves appropriate prescribing rates, and enables the pharmacist to assist with patient counseling. ProDUR alerts are activated for all prescriptions dispensed. We analyze all incoming prescriptions to prevent the patient from experiencing inappropriate drug prescribing or consumption, medical conflicts, or potentially dangerous interactions.

Through this program, Amerigroup and ESI will determine whether to send a warning (passive alert) or reject message (soft-block alert) for select alerts, including refill-too-soon, excessive dosing, and severe drug interactions. Passive alerts are informational warning messages sent to the pharmacist for evaluation. Soft-block alerts are clinical warning messages sent to the dispensing pharmacist to alert him or her of a potential issue and to prevent claim adjudication until the pharmacist takes appropriate action. Soft-block alerts are built with an override capability that allows the pharmacist to adjudicate the claim if the medication or dose is appropriate. This process requires the pharmacist to acknowledge and resolve each and every alert before the prescription can be dispensed. On average, the proDUR program identifies 12 percent of claims daily that hit a DUR edit resulting in a message to the dispensing pharmacy.

Clinical Edits at the Point-of-sale

We will employ DUR edits and prior authorization policies consistent with the Medicaid FFS proDUR edits. Table 3.2-3 provides an overview of our approach to this proDUR rule set.

Table 3.2-3. ProDUR Rules Support Safety, Quality, and Cost Control

Rule	Description	Example
Severe Drug-Drug Interactions	Identifies the most serious problems with concomitant drug therapies.	When taken together, amitriptyline and Parnate® may cause serious adverse effects that can potentially increase morbidity and mortality.
Drug Interactions	Identifies potential problems with concomitant drug therapies.	Quinidine and digoxin may cause adverse effects such as visual disturbances and hyperkalemia when taken concomitantly.
Drug-Allergy	Identifies potential hypersensitive reaction based on patient reported allergies.	Amoxicillin will cause an allergic reaction in patients allergic to penicillin.
Drug-Disease	Identifies potential contraindications with an existing member’s reported or inferred disease.	Beta blocker in patients being treated for asthma.

Rule	Description	Example
Refill-too-soon	Identifies a member who has more than an adequate supply of medication on hand based on all prior prescriptions filled, not just the last prescription received.	A member regularly obtains refills when 50% of current supply is consumed; by the second refill, the patient has accumulated an extra prescription.
Duplicate Therapy	Identifies the dispensing of two or more drugs within the same therapeutic category for the same patient.	Naprosyn [®] and Relafen [®] , when taken together, may cause increased risk of adverse effects associated with nonsteroidal anti-inflammatory drugs (NSAIDs) and results in no therapeutic advantage to the patient.
Maximum Daily Dose/Excessive Daily Dosing	Identifies a prescription being filled for more than the manufacturer's maximum recommended daily dose. Maximum daily dose rule is based on clinically recommended dosing guidelines.	Vicoden [®] at doses greater than the manufacturer's recommended maximum dosage can potentially cause hepatic toxicity and respiratory depression.
Excessive Dosing	Identifies prescription excessive dosing for drugs that should be dosed on an interval basis.	Chemotherapy medications can accumulate in the body; incorrectly taking doses may result in lethal drug blood levels. Rules look at, for example, single oral dose medications that are administered once every six weeks. The alert is sent to stop a repeat dose sooner than six weeks.
Sub-therapeutic Dosing (Under-dosing)	Identifies prescriptions being filled for less than the recommended minimum daily dose.	Oxacillin at doses less than 500 mg/day for the treatment of cellulitis will not effectively cure the member's condition.
Underutilization	Identifies patients who are non-compliant with their drug therapies.	Cardiac medication refilled after the supply is exhausted may cause an increased risk of adverse events because maintenance medication requires continuous therapy.
Maximum Daily Quantity	Identifies prescriptions for which the daily dose in dispensing units (for example, tablets and capsules) exceeds the quantity recommended for most users.	Hyperlipedemic prescribed at more than the usual daily dose interval (for example, Lipitor [®] prescribed for more than once-a-day dosing).
Minimum Daily Quantity	Identifies prescriptions for which the daily dose in dispensing units (for example, tablets and capsules) is less than the quantity recommended as effective for most users.	A prescription for Precose [®] (acarbose) would present a minimum-quantity-per-day alert, because Precose is typically administered with meals.
Potential Drug Name Confusion	Identifies drugs in the member's history that sound alike or, when written, look alike.	A medication error due to confusion between products, such as the antifungal medication Lamisil [®] , which sounds and looks similar to the anticonvulsant medication Lamictal [®] , can potentially cause confusion and even seizures.
Drug-Age	Identifies drugs that may have been inappropriately prescribed to patients based on their age.	Diazepam [®] for patients age 65 and older may cause increased risk for falls and fractures due to increased daytime sedation from age-related changes.
Drug-Gender	Identifies drugs that may have been inappropriately prescribed to a patient based on their gender.	Proscar [®] provides no therapeutic benefit for females and is used exclusively in males.
Drug-Pregnancy Contraindication	Identifies drugs contraindicated for use by pregnant women.	Isotretinoin [®] (acne medication) taken during pregnancy has been shown to put the fetus at increased risk.
Overutilization/Additive Toxicity	Identifies members exceeding 4 grams/day of Tylenol from multiple prescriptions.	Patient unknowingly takes multiple pain medications containing acetaminophen (APAP).

ProDUR rules also address the special needs of seniors (drug-drug interactions, drug-disease contraindications, drug-age precautions, and maximum daily dose limitations); children (drug-age contraindications and age-dosing issues); and women (drug-pregnancy contraindications). In addition, we offer the following enhanced, customizable proDUR cost-saving programs:

15-day Starter Fill Program

Prescription first-fills for Hepatitis B, Hepatitis C, oral Oncolytic, and atypical antipsychotic agents can be limited to a 15-day supply allowing the member to try the drug and assess tolerance. All subsequent refills will be the full 30-day supply or as deemed appropriate by the provider. Results of a nine-month study of a partial-fill program for 15 oral oncolytics showed that 41 percent of patients discontinued therapy after the first month of the prescribed therapy; nearly 20 percent stopped therapy after one partial fill due to adverse side effects. As many as 40 percent of members do not respond satisfactorily to the first drug prescribed for chronic conditions with agents known to have a high incidence of side effects.

Half Tab Program

Medications may be dispensed at a higher strength (double strength) to allow for the correct dose to be given when the tablet is split in half. This program includes a list of eligible medications safe for tablet splitting and yields a cost-saving opportunity.

Amerigroup and ESI also build utilization management edits into the point-of-sale that minimize inappropriate utilization, including length of therapy edits (to identify use of drugs beyond FDA-approved labeling) and prescriber ID edits (so that claims are not covered for non-par providers, those who demonstrate aberrant prescribing patterns, or are on the Office of Inspector General exclusion list).

Question 3.2.6, #6

6. Describe your plans to implement retrospective drug use review to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

Retrospective DUR: Trending Prescriber Habits and Cost Savings

We review pharmacy and medical claims data to identify potential cases of under- and over-utilization; coordination of care issues; drug abuse or misuse; fraud, waste, and abuse; or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits, or associated with specific drugs or groups of drugs. Our Pharmacy Services team acts on this data to provide targeted interventions. Below are some examples by prescriber:

- **Pharmacy data analysis** identifies providers prescribing outside of peer norms. Examples include prescriptions from out-of-state and non-par providers, a high level of controlled substance prescriptions written by the same emergency room prescriber, members consistently getting prescriptions from non-par providers and whose medical claim history does not support such drug use (which may indicate members paying providers to write such prescriptions), and non-par providers writing prescriptions for drugs with known street value or known diversion. These prescribers can be blocked from the drug claims systems, members can be referred to lock-in, and both prescribers and members can be referred to the national Special Investigations Unit for further review of suspected fraud and abuse
- **Prescriber engagement** urges providers to help us root out abusive behaviors through academic detailing and physician consultation programs. We send notices to prescribers who are multiple prescribers or are treating members with questionable activity. These communications alert

physicians when they or their patients are exhibiting unusual utilization patterns. In many cases, providers are unaware that the member receives prescriptions from multiple other providers.

- **Retrospective Drug Utilization Review (retroDUR) analysis** is performed in collaboration with the State through a review of administrative claims each month. Under Amerigroup's direction, targeted providers receive an alert that includes program description, identified members, a detailed explanation of clinical issue(s) along with suggested course of action and supporting clinical references, and 90-day prescription profile highlighting contributing medications.

Educational Component (3.2.6.4.3)

Amerigroup will conduct physician profiling and education at the State's request. In addition, we educate our network providers during orientation, ongoing, ad hoc, and annual trainings on our expectations, policies and procedures, and best practices in prescribing. Amerigroup's primary goal is to make sure network providers have the information, tools, and support necessary to prescribe medication for the safety, well-being, and improved outcomes of our members. Our Drug Utilization Management Report supports the identification of medications that may be duplicative, contraindicated for the member's age or condition, or over- or underutilized.

Reporting (3.2.6.4.4)

Amerigroup will report proDUR and retroDUR activities/educational initiatives to DHS quarterly and assist in data collection/reporting for CMS' DUR annual report. Refer to the Utilization Management Section 3.2.6.5 below for additional detail on our reporting capabilities.

Drug Utilization Review Commission (3.2.6.4.5)

We will collaborate with DHS on all new additions and changes to existing PA criteria, which will be forwarded for review and approval by the DUR Commission and State staff.

Utilization Management (3.2.6.5)

In accordance with Scope of Work Section 3.2.6.5, we will submit our utilization controls and programs to DHS for review and approval. We use standard utilization controls like prior authorizations and step edits, and also plan to use member education, a psychotropic medication management program, Medical Therapy Management (MTM), and pharmacy lock-in programs to help assure the best care for our members. Pharmacy is a component of our overall Utilization Management Program. Below is an overview of our pharmacy-specific UM programs available to our members.

Member Education

We will provide member education to help assure appropriate utilization and improve adherence. To make sure that our member education efforts are effective and comprehensible, all member materials are culturally and linguistically appropriate, easy-to-understand, and at the appropriate reading levels for the covered populations. Some of the educational programs we will implement include:

- **Gaps in Care Program:** Provides a Consolidated Medication Review, including a cover letter; personalized cover page; recent claims history; general quality and safety messages; important telephone numbers; and access to customized health information from Harvard Medical School. We mail Medication Reviews monthly with up to four messages. For example: members experiencing issues of adherence may receive "Important Tips for Taking Meds", which covers taking prescribed medications, such as when, how long, and when to consult with their provider.
- **Pharmacy Mobile App:** Members can choose to load Express Script's pharmacy application to access the *Medicine Cabinet* feature, which automatically syncs with the patient's prescription drug history for both retail and home delivery prescriptions. Members can easily manage multiple prescriptions with automatic updates to medication history, notifications of possible health-

related risks, reminder alerts for taking medications, notifications for refills, and automatic drug interaction checks for over-the-counter medicines, vitamins, and supplements.

Additionally, members can receive both email and phone refill reminders for prescriptions being filled through Amerigroup's Home Delivery Pharmacy.

Psychotropic Medication Management Program

Amerigroup will deploy a psychotropic drug prescription management program for children, adolescents, and young adults. The use of psychotropic medications is an integral part of treatment for persons receiving care for behavioral health conditions. As such, the use of psychotropic medications must be monitored closely to help assure that persons are treated safely and effectively. The goal of the program is to work collaboratively with prescribers to improve the quality and efficiency of psychotropic drug prescribing patterns and to improve the health outcomes of Iowa Initiative child/adolescent members including foster children. The program will help assure the safety of persons taking psychotropic medications, reduce or prevent the occurrence of adverse side effects, and help the child/adolescent who is taking psychotropic medications function better and achieve positive clinical outcomes.

In this program, drug claims data are stratified to identify prescribing and usage trends. Prescribers will be identified who are not following recommended evidence-based psychotropic treatment guidelines. Prescribers who are identified as deviating from best clinical practices are flagged, and our team follows up with these prescribers through routine alerts, letters, educational materials, and peer-to-peer calls. They will be encouraged to adjust their prescribing habits. The program does not infringe on the prescribers decision-making practice; rather, it is designed to improve behavioral health prescribing practices and patient medication adherence, targeting educational messages to prescribers thereby allowing them to "self-regulate" their prescribing patterns. This avoids the need for many external controls such as prior authorizations or limit of access to psychotropic drugs.

We design educational information to help the prescriber make care decisions based on the latest medical evidence. We monitor claims data to determine whether the provider makes changes after intervention; additional interventions (such as medication alerts, peer-to-peer consultation) are provided as needed to review continued prescribing patterns. Areas for review include multiple medications in the same therapeutic class, medications prescribed without clinical indications, excessive dosing and inadequate dosing, no timely refill (early discontinuation), rapid switching of medications, and patients with two or more physicians prescribing the same medication.

The following parameters will be monitored to make sure that all transitioning and newly enrolled members with Amerigroup have a psychotropic medication management review:

- Higher than recommended dosage of antipsychotic or stimulant medication
- Diagnosis consistent with prescribed medication
- Lower than recommended dosage of antipsychotic or stimulant medication
- Laboratory monitoring as indicated
- Concurrent behavioral health counseling as indicated
- Antipsychotic medication in children less than 6 years of age
- Two or more concomitant antipsychotic medications
- Use of three or more psychotropic medications in youths less than age 26

Lock-in Program

While effectively prescribed and managed medications can offer our members relief from chronic pain, treat disease, and help them maintain independent lives in their communities; inappropriate therapy can result in increased morbidity or mortality. If we identify potentially abusive or dangerous behavior,

members may be restricted to a specific pharmacy for all medication fills. Consideration for lock-in is based on use of multiple pharmacies or multiple controlled substances and/or prescriptions from multiple prescribers, particularly when a supporting diagnosis or medical claim is lacking. Lock-in can occur only following review of the member’s profile by a pharmacist. A lock-in may also occur when a member is receiving drug therapy from multiple prescribers and multiple pharmacies indicating uncoordinated care. Locking the member into a single pharmacy alerts all prescribers and the pharmacy of the coordination issues. The restriction is implemented to promote the member’s safety through coordination of care. The program is based on the member’s utilization of providers, medications, and pharmacies, as well as requests by a provider, outside agency, health plan, or in cases of fraud and abuse.

In 14 states, our affiliates’ lock-in programs offer a variety of tools, resources, and supports that have helped reduce inappropriate member utilization, decrease adverse drug events, minimize the risk of medication abuse and misuse, and achieve cost savings. For example, our Louisiana affiliate saved \$90,326 over 11 months (September 2013 – July 2014), which represents a savings of \$15.65 per enrolled lock-in member per month. During this same time, drug costs averaged \$82.16 per enrolled member per month. National savings reached \$15.14 for all of our markets using lock-in.

Our Iowa lock-in program will meet all applicable DHS and federal requirements, and all lock-in policies, procedures, and criteria will be submitted to DHS for approval prior to program implementation. Our affiliate plans’ lock-in programs (Table 3.2-4) in other states will provide us with additional resources and experience that we can leverage to enhance our local program.

Table 3.2-4. Amerigroup Affiliate Lock-in Programs

State	Lock-in Program
Florida	Pharmacy
Georgia	Pharmacy & prescriber
Indiana	Pharmacy & prescriber, hospital
Kansas	Pharmacy & prescriber, hospital
Kentucky	Pharmacy & prescriber, hospital
Maryland	Pharmacy & prescriber
Nevada	Pharmacy
New Jersey	Pharmacy & prescriber
New York	Pharmacy, alternative pharmacy, primary care physician group, nurse practitioner, clinic, durable medical equipment supplier, dental, dental clinic, podiatry, outpatient hospital, hospital
South Carolina	Pharmacy
Texas	Pharmacy
Virginia	Pharmacy
Washington	Pharmacy
West Virginia	Pharmacy

Our lock-in programs enhance patient safety, improve care coordination, and promote effective oversight by:

- Preventing serious adverse drug events by minimizing members’ use of multiple pharmacies and/or physicians in a short time frame
- Providing appropriate medical oversight and management that facilitates care coordination and connects members with the most appropriate services to meet their needs
- Using a non-judgmental structure so members can obtain needed care from qualified practitioners

- Identifying opportunities to address health concerns and inappropriate prescribing patterns

Medication Therapy Management

Amerigroup's MTM program helps achieve positive outcomes for members with co-morbid conditions who require multiple medications and those with specific chronic illnesses, such as diabetes, asthma, and depression. Our MTM program proactively identifies and engages members (telephonically through case management and face-to-face consultations with a retail pharmacist) who have inappropriate or conflicting drug therapies to prevent negative outcomes. Under our integrated MTM program, a clinical pharmacist will communicate with the member, prescribers, and caregivers to close gaps in care and optimize therapies for those with chronic conditions or complex drug therapies. The goal of this program is to verify that medication is appropriate, effective, safe, and able to be taken by the member as intended.

Once we identify a member as someone who can benefit from MTM, we may discuss program eligibility with the member and/or caregiver during the care planning process. The Case Manager explains the MTM program and available support to the member. If the member agrees to participate, the Case Manager will document this in Amerigroup's care coordination and management system, CareCompass. The Case Manager will then notify the appropriate MTM vendor to arrange for assessment of the member's medication therapies. With the member's input, the vendor will develop the medication assessment plan.

Amerigroup and its affiliates have seen positive results from MTM: Members enrolled in MTM show improved medication adherence rates; participants experienced fewer gaps in care and overall safer, more effective medication regimens; providers showed willingness to take action on sound clinical recommendations; and the program promoted collaboration leading to healthier and engaged members and engaged providers.

Utilization Management Program Reporting

We will provide Utilization Management reports in a DHS-approved format and timeline. Our standard monthly reporting includes program name, target member name, provider name of targeted member, total members opted out, total members qualified, and summary of program interventions. We use two main files to provide member and/or provider detail for members targeted by clinical outreach: a dashboard report (overall program snapshot, as shown in Figure 3.2-9) and outcomes report (overall program impact and effectiveness, as shown in Figure 3.2-10).

Figure 3.2-9. Our Reporting Dashboard Report Gives a Snapshot of the Program

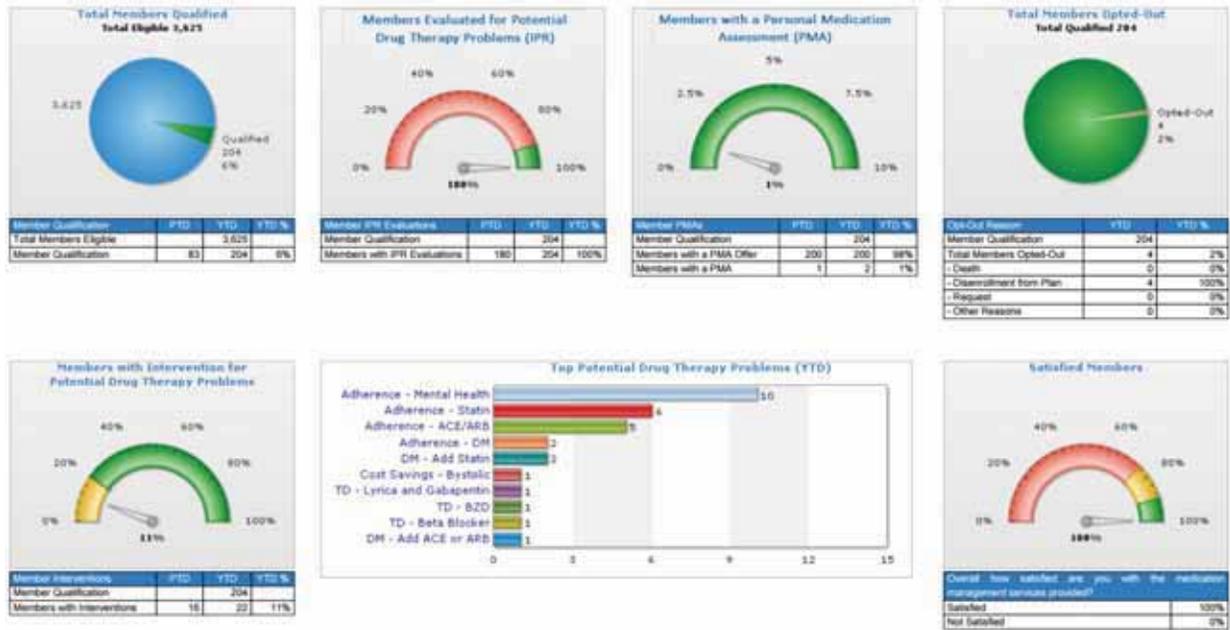
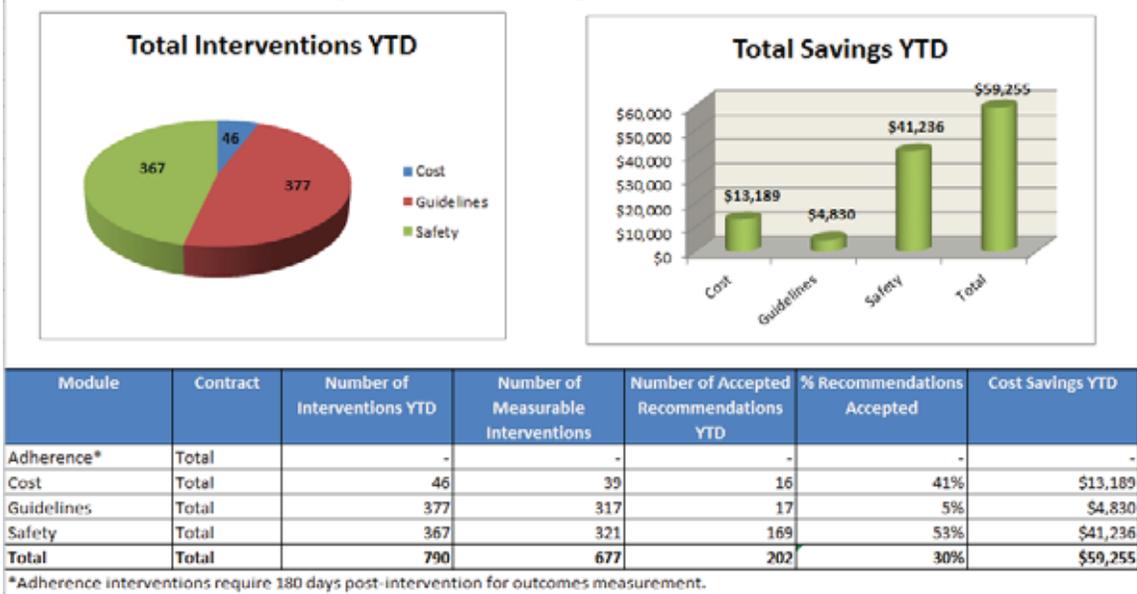


Figure 3.2-10. Our Outcomes Report Details the Program's Success



Question 3.2.6, #7

7. Describe your plan for monitoring your PBM as described in Sections 3.2.6.6.1.3 and 3.2.6.6.1.4.

Amerigroup's proposed PBM is Express Scripts (ESI). Amerigroup does not own ESI wholly or in part. *We place a particular emphasis on member choice and access, offering our members options among retail pharmacies as well as mail order or custom arrangements depending on transportation.* To that end, ESI does not own any retail pharmacies, is not a pharmaceutical manufacturer, and there is no corporate ownership or relationship between Amerigroup and ESI, other than the subcontractor relationship as our PBM. This helps prevent any perceived issues with "steering" business into

corporately-owned pharmacies and removes any potential for conflicts of interest. We will facilitate direct access to ESI for the State, when needed.

Oversight and Monitoring of our PBM

Amerigroup maintains oversight of all PBM services and remains fully accountable for all activities performed. We continuously monitor ESI to verify compliance with Contract requirements. In addition to local oversight through our Quality Management and Vendor Compliance Workgroup, we also have national oversight programs to verify that ESI's performance complies with all applicable DCH, NCQA, and federal requirements and standards. We audit subcontractors, including the PBM, and enforce correction of identified performance deficiencies or termination if deficiencies cannot be corrected. After the subcontractor is operational, we conduct annual audits to monitor compliance with State and federal regulatory and accreditation standards. When formal corrective actions are implemented, we meet biweekly with ESI to review progress. We hold our PBM accountable contractually using a set of performance standards, including maintaining required pharmacy help desk service levels, prompt claims processing, system availability and adjudication response time, PA turnaround times, pharmacy benefit set-up, mail service dispensing accuracy and timeliness, and network pharmacy access. As part of our oversight, we verify that our PBM maintains valid, nationally-recognized accreditations. ESI has achieved multiple URAC accreditations, including Pharmacy Benefit Management, Health Utilization Management, Specialty Pharmacy, and Mail Order Pharmacy.

Oversight Plan to DHS

Amerigroup will provide a specific written PBM Performance Oversight Plan for 2016 within 10 days of Contract execution with the State of Iowa, and will submit a finalized plan (with changes incorporated) to DHS within 30 days after submission of the first plan. Any changes will be submitted to DHS for prior approval before the Plan is updated.

System Requirements

Amerigroup's Pharmacy Services will adhere to all System Requirements outlined in Section 3.2.6.6.1.5, which includes maintaining an automated claims and encounter processing system for drug claims that support Contract requirements and assures timely and accurate claims and encounters processing.

Pharmacy Network (3.2.6.7)

We will provide a pharmacy network that complies with Exhibit B requirements, that includes only licensed and registered pharmacies that conform to the Iowa Board of Pharmacy rules concerning the records to be maintained by a pharmacy. ESI contracts with and maintains a pharmacy network on our behalf that includes more than 66,000 pharmacy providers nationally and over 730 retail pharmacy locations in Iowa, of which nearly half are independently owned pharmacies. Pharmacy accessibility is measured by comparing the member's address to the nearest pharmacy provider. We will meet the requirement to provide at least two pharmacy providers within 30 miles or 30 minutes from a member's residence in each county. In addition to community retail pharmacies, the Iowa pharmacy network will include mail (home delivery), specialty, home health, and long-term care pharmacies.

To promote member choice, we will keep an up-to-date pharmacy provider directory on our website for public access. Members or care providers simply enter their ZIP code or city, and the pharmacies closest to the member will be listed. There is a 24-hour feature allowing the pharmacies to be filtered only for those that can provide 24-hour services.

Pharmacy Access (3.2.6.8)

In accordance with Scope of Work Section 3.2.6.8, we agree that although we may offer mail order pharmacy as an option to beneficiaries, we or our PBM are not allowed to require or incentivize its use.

Our contracted relationships with Specialty Pharmacy Providers within the medical, home delivery, and retail pharmacy channels uniquely position us to provide comprehensive access to 100 percent of all specialty medications on the market. In addition, we offer one of the industry's most comprehensive ranges of specialty health solutions to improve care for members and reduce waste for health plans. To optimize care, we manage specialty medications across both the pharmacy and medical benefits.

Through a coordinated approach with our Specialty Pharmacy Provider, we offer a comprehensive portfolio of products, clinical expertise, and integrated technology to serve Medicaid and other state-sponsored program patients using specialty pharmaceuticals, which often include biotechnological medicines or therapies requiring special handling or administration. Our clinical protocols are drug-specific and based on the latest evidence, allowing them to anticipate the adherence and health challenges patients may face when taking specific medications. Their specialist clinicians and extended care team proactively engage patients, empowering them through education and removing any obstacles that prevent them from getting the most from their medication. They provide proactive therapy management, develop a deeper understanding of each patient through one-on-one consultation, and deliver personalized education so that our members will feel motivated to remain adherent.

Our Specialty Pharmacy Provider's experience in managing specialty pharmacy includes over 30 years of managing specialty pharmacy for thousands of clients of all types. They serve more than 500,000 members annually with complex specialty conditions. Their deep experience and scale enable us to provide a depth of clinical specialization that is at the root of how we provide better clinical care for members, improving health outcomes. Additionally, they support our members with more than 500 field-based nurses specialized to support the most complex members we care for.

Reimbursement (3.2.6.9)

Drug Ingredient Reimbursement

We will reimburse pharmacy providers at a rate comparable to the current Medicaid FFS reimbursement. Reimbursement will be the lower of Iowa Average Actual Acquisition Cost (AAC)/ National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC) if no AAC/NADAC, Federal Upper Limit or Usual and Customary. We will use an average wholesale price methodology to adjudicate a reimbursement equivalent to the Iowa AAC/NADAC or WAC, consistent with the State's clarified RFP requirement that bidders pay a FFS equivalent rate, inclusive of dispensing fee.

Pharmacy Dispensing Fee

We agree to reimburse pharmacy providers at a dispensing fee as determined and approved by the Medicaid FFS cost of dispensing study performed every two years.

340B Drug Pricing Program

We will make sure that all 340B Covered Entities that use 340B drugs and serve Iowa Medicaid managed care enrollees adhere to the "Carve in Iowa Medicaid managed care prescriptions and other products into the 340B program" methodology. We will make sure that the entity:

- Uses 340B drugs, vaccines, and diabetic supplies for all Iowa Medicaid managed care enrollees served
- Informs HRSA at the time of 340B enrollment that the entity intends to purchase and dispense 340B drugs for Medicaid managed care enrollees
- Does not bill Amerigroup for 340B acquired drugs and products if the entities NPI is not on the HRSA Medicaid Exclusion File
- Purchases all drugs and other products billed to Amerigroup under 340B unless the product is not eligible for 340B pricing

- Submits pharmacy claims for 340B acquired drugs to Amerigroup at the entities AAC with values of "08" in Basis of Cost Determination field 423-DN OR in Compound Ingredient Basis of Cost Determination field 490-UE or insert "20" in the Submission Clarification Code field 420-DK
- Submits vaccines and diabetic supply claims for 340B acquired products to Amerigroup at the entities 340B AAC on the UB04 or CMS1500 claim forms

We will make sure that all contract pharmacies using 340B drugs, vaccines, and diabetic supplies carve out Iowa Medicaid managed care prescriptions from the 340B program. We will assure that the entity:

- Purchases all drugs and products outside the 340B program if billed to Amerigroup
- Consults the Iowa Medicaid Managed Care Pharmacy Identification for assistance in identifying managed care enrollees

Refer to Section 3.2.6.11 for further detail on our 340B process.

Drug Rebates (3.2.6.10)

Question 3.2.6, #2

2. Describe your ability and experience in obtaining and reporting drug rebates.

Drug Rebate Strategy

Amerigroup leverages our relationship with ESI, the nation's largest PBM, to provide the most cost-effective network with the best access and availability for our members. Our national Pharmacy Services team has expertise in negotiating competitive drug acquisition prices and dispensing fees, helping assure that Iowa receives the benefit of this relationship in retail, mail, and specialty pharmacy. Our well-established and experienced national Drug Rebate Team routinely handles rebate issues for many of our affiliate health plans across the nation, including 13 states where we manage the PDL for covered populations. They understand the usual reasons for manufacturers to dispute drug rebate invoices, including questions about the invoiced quantity, questions about formulary status, date of formulary status change, and validity of the submitted National Drug Code (NDC).

Each month, we inspect all claims to make sure rebate invoicing was performed accurately. We check claims for the correct contracted rebate rate and immediately report any deviations to our PBM for validation. If an error is found, our PBM corrects the claims and re-invoices them to the manufacturer for adjusted payment. Each month we receive data on the amount of rebates invoiced to pharmaceutical manufacturers for each group, and each quarter we receive data on the amount of rebates collected from the manufacturers. We compare the amount collected to the amount invoiced and investigate any discrepancies. Additionally, we calculate rebate payments to our clients quarterly and re-evaluate them each quarter until collections and payments are complete. Our process to restate a previous quarter's rebates in subsequent quarters eliminates the need for an annual true-up. Due to our depth of knowledge related to industry trends and cost drivers, Amerigroup affiliate health plans achieve a consistent rebate collection rate in excess of 99 percent of forecasts.

Amerigroup believes the best way to manage drug costs is to deploy PDL (formulary) strategies that drive utilization to the lowest net cost alternative. The lowest net cost alternative is usually a generic, but sometimes it can be a brand with a favorable rebate or an over-the-counter product. Amerigroup actively employs these strategies - across all of our affiliate health plans, our 2014 Medicaid Generic Dispensing Rate (GDR) increased to 87.8 percent from 87.1 percent in 2013. The estimated cost of care savings from improved GDR was over \$31 million in 2014, which equates to \$1.35 per member per month. Combined with strong utilization management strategies, our organization has continually maintained a low-cost drug trend year after year. For example, our affiliate plans have shown a negative expense trend of minus

4.1 percent compared to a Medicaid industry average of an increase of 2.3 percent. We have maintained this through a comprehensive review of generic step therapy programs, generic maximum allowable cost programs, and preference of lowest net cost brand alternatives.

Additionally, strategies to maximize rebates focus on lowering unit cost. Manufacturer rebate contracts typically disallow any utilization management controls. Over time, unit cost is lowered, but the increase in utilization outweighs unit cost savings, and the general drug cost trend exceeds budget. Under the Affordable Care Act (ACA), unit rebate amounts have increased, and managed care utilization is now included. However, supplemental rebates have been greatly reduced, requiring even more creativity in developing strategies to maintain low-cost trends. Amerigroup's affiliates have remained successful since the start of ACA in optimizing rebates within the lowest net cost strategy while managing utilization. Finally, Amerigroup is working with an experienced 340B contract pharmacy administrator in the development of a shared savings model that will support the continued availability and viability of safety-net provider services throughout the network.

We recognize the State of Iowa prohibits us from collecting federal and supplemental rebates on Medicaid members. We will report utilization information concerning covered outpatient drugs provided to our members to the State. This reporting will enable Iowa to include our utilization data with its FFS utilization data for covered outpatient drugs so that the manufacturers can pay rebates on these drugs. We will transmit drug claims data in formats and by deadlines established by DHS and will include utilization data for pharmacy services provided through other settings such as physician offices.

Question 3.2.6, #3

3. Describe any relevant experience resolving drug rebate disputes with a manufacturer.

Amerigroup will assist DHS in resolving pharmacy and medical drug rebate disputes and will adhere to State and federal guidelines when resolving disputes. Our proposed process entails the State providing Amerigroup with a list of disputed claims, including NCPDP standard rebate-reject reasons as soon as they are available. Amerigroup's successful process used today with our affiliates in other states includes a pharmacy-designated point of contact to receive information from the State on claims that require correction. Amerigroup will work to resolve all disputes through the PBM and/or directly with the provider within 30 days of receipt, giving the State ample time to submit these disputes to the manufacturer in the required 60-day time frame. Amerigroup works with the PBM or directly with the provider to resolve claims issues. We also support the State's access to network pharmacy providers for verifying information submitted on claims. Our drug encounter process includes corrected claims on the next scheduled data transmission.

Amerigroup does not provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. We will help assure compliance with the Social Security Act, PPACA, and HCERA pursuant to rebates; will provide quarterly utilization reports to DHS; and will not obtain manufacturer drug rebates or other forms of reimbursement on enrollees.

Pursuant to requirements of the ACA, we will provide information on drugs administered/dispensed to individuals enrolled in our plan if we are responsible for coverage of such drugs. Specifically, Section 1927(b) of the Social Security Act, as amended by Section 2501(c) of PPACA, requires the State to provide utilization information for MCO-covered drugs in the quarterly rebate invoices to drug manufacturers and in quarterly utilization reports to the Centers for Medicare and Medicaid Services. We will submit all drug encounters, including physician administered drugs, with the exception of inpatient hospital drug encounters, to DHS or its designee for federal drug rebates from manufacturers. Refer to Question 3.2.6, #2 for additional detail.

We acknowledge that DHS participates in the federal supplemental drug rebate program, and as such, we and our subcontractors, including ESI, are prohibited from obtaining manufacturer drug rebates or other forms of reimbursement on the Medicaid enrollees.

Drug Encounter Claims Submission (3.2.6.11)

We will submit a weekly claim-level detail file of drug encounters to DHS or its designee, which includes individual claim level detail information on each drug claim dispensed/administered to members, including but not limited to the total number of metric units, dosage form, strength and package size, and National Drug Code of each covered outpatient drug dispensed to Medicaid enrollees. We will provide this reporting to the State in the manner and time frame prescribed by DHS, including submission of complete and accurate drug encounter data and a rebate file to the State or its designee. We will comply with all file layout requirements, including format and naming conventions and submission of paid amounts. Our claims detail and encounter files follow the NCDPD D.0 layout and include the units, amount billed/paid, and whether the claim was paid or rejected, among other fields. We acknowledge that a complete listing of claim fields required will be determined by DHS. Refer to Question 3.2.6, #2 for further detail.

Our drug claims process recognizes claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this purpose. Amerigroup Pharmacy Services requires all pharmacies to submit claims in the current NCPDP standard. Where applicable, pharmacies submitting 340B claims for managed Medicaid members must submit claim values required by law or regulation. Upon submission of the claim, pharmacies receive the lesser of the appropriate reimbursement according to the terms of their network contract. In addition, pharmacies may receive reimbursement for a dispensing fee and for professional service fees according to the rates outlined in their applicable pharmacy network contract. In the post-adjudication pharmacy response, Amerigroup Pharmacy Services returns the appropriate Basis of Reimbursement Determination code as applicable to the reimbursement based on the Amerigroup Pharmacy Services contract.

Disputed Drug Encounter Submissions (3.2.6.12)

We will assist DHS or the State's designee in resolving drug rebate disputes with a manufacturer at our expense. Refer to Question 3.2.6, #3 for additional information. We acknowledge that weekly, DHS will review Amerigroup Pharmacy Services' drug encounter claims and send a file back to us of disputed encounters identified through the drug rebate invoicing process. Within 60 calendar days of receiving the disputed encounter file from DHS, we will correct and resubmit any disputed encounters and send a response file that includes 1) corrected and resubmitted encounters as described in the Rebate Section of the Contractor Systems Companion Guide (to be developed and approved by DHS in coordination with its rebate vendor and the MCOs) and/or 2) a detailed explanation of why the disputed encounters could not be corrected, including documentation of all attempts to correct the disputed encounters at an encounter claim level detail, as described in the Rebate Section of the Contractor Systems Companion Guide. Refer to Question 3.2.6, #3 for additional information. We acknowledge that in addition to the administrative sanctions of this Contract, failure to submit weekly drug encounter claims files and/or a response file to the disputed encounters file within 60 calendar days as detailed above for each disputed encounter will result in a quarterly offset to the capitation payment equal to the value of the rebate assessed on the disputed encounters being deducted from Amerigroup's capitation payment.

Amerigroup's affiliates have never had any issues working with states on rebates. As part of our Pharmacy error resolution service, we track client-level encounter acceptance and rejection rates. Across Anthem, the encounter rejection rate for all clients with our error resolution service is 1.86 percent (98.14 percent acceptance rate). Clients enrolled in our error resolution service for six months or more have an average rejection rate of 0.7 percent (99.3 percent acceptance rate).

EPSDT Services for Youth (3.2.7)

Amerigroup will provide early and periodic screening, diagnosis, and treatment (EPSDT) services to all members under 21 years of age in accordance with law. EPSDT services play an important role in the early identification of children and adolescents with specialized needs who may benefit from Case Management interventions or targeted service delivery. Amerigroup shares Iowa’s commitment to promoting preventive healthcare, holistic screening, and comprehensive follow-up for Iowa’s children. We will fulfill all requirements of Iowa’s Care for Kids program and deploy best practice education and outreach to help children and their parents or guardians maximize the benefit from EPSDT services in order to improve health outcomes for the Iowa Initiative’s younger members.

For 24 years, our affiliate health plans have coordinated EPSDT services for children enrolled in Medicaid programs, which has allowed us to leverage best practices to achieve top-quality outcomes for members under 21 years of age that capitalize on our highly coordinated model of care. Table 3.2-6 shows how our affiliates have been recognized by NCQA for achieving top quality outcomes for coordinated EPSDT services.

Table 3.2-6. Our Coordinated EPSDT Services Achieve Top-Quality Outcomes

Affiliate Health Plan	Result (NCQA Quality Compass)
Texas	75 th percentile for Child and Adolescent well-care and children’s access to care
New Jersey	75 th percentile for Child and Adolescent well-care
New York	90 th percentile for Child and Adolescent well-care and children’s access to care

We use our extensive experience to establish policies and procedures for EPSDT services that comply with federal and State rules and regulations related to EPSDT. These policies explicitly state that all EPSDT-eligible members are notified of EPSDT available services; that screening, diagnostic, and



treatment services are available and provided; and that tracking or follow-up occurs to make sure that these services are provided to all of Amerigroup’s eligible Medicaid children and young adults. We recognize that this follow-up is especially crucial for members with disabilities. Our multipronged engagement strategy includes member education (such as our welcome kit and phone call and our member website), member outreach (including our innovative Clinic Days program and incentive programs), community programming (for example, our Head Start immunization program and back-to-school events), and provider outreach (including our PCP orientation and incentive programs).

EPSDT screenings will be performed by providers qualified by the State to perform Care for Kids services. EPSDT services will be provided for new members and on an ongoing basis according to the Care for Kids periodicity schedule. At a minimum, covered screenings will include, but are not limited to:

- A comprehensive health, developmental, and behavioral assessment, updated at each screening examination
- Assessment of Nutritional Status and complete physical evaluation and identification of unusual eating habits, accurate measurement of height and weight, and laboratory testing to screen for iron deficiency
- A comprehensive unclothed physical exam
- Immunizations appropriate to age and health history as recommended by Advisory Committee on Immunization Practices (ACIP)

- Appropriate laboratory tests, lead toxicity screening at 12 and 24 months per current federal requirements
- Health education, including anticipatory guidance and counseling
- Vision and hearing screening
- Dental/oral health screening services furnished by direct referral to a dentist for children beginning at 12 months

EPSDT-related covered healthcare services (not otherwise covered for other populations) may include, but are not limited to, the following services if the services have the potential to correct or ameliorate physical or behavioral health:

- Chiropractic
- Nutrition counseling
- Audiology, including:
 - Hearing screening
 - Audiological assessments; electrophysiological measures such as auditory brainstem response (ABR)
 - Examination, fitting and purchase of hearing aids, including hearing aid accessories and supplies
- Private duty nursing services including:
 - An initial assessment and development of a plan of care by a registered nurse
 - Ongoing private duty nursing services delivered by a licensed practical nurse or a registered nurse
- Durable medical equipment (DME), including assistive devices
- Occupational, physical, and speech therapy services for either habilitative or rehabilitative treatment if the services are not:
 - Specified in the member's individualized education plan or
 - Specified in the member's individualized family service plan and delivered in the schools or through Children's Medical Services community-based providers



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We will partner with local community organizations, schools, and State agencies to provide referrals for services not covered under health plan benefits for members under 21 and their families or guardians. We plan to engage Head Start education programs, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), School Health-Related Special Education Services, vocational rehabilitation, and Maternal and Child Health Services located at local health departments.



IA_3.2.7_COB_2.3

We will use internal systems for tracking EPSDT services and EPSDT outreach and monitoring to engage both members and providers. We will also analyze annual Healthcare Effectiveness Data and Information Set (HEDIS®) rates, which align with the Care for Kids periodicity schedule, against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. We have the experience, technology, and staff to continue to improve EPSDT compliance through strategies that are tailored to meet the unique challenges of Iowa's Medicaid populations. It is important to note that all member populations will

have follow-up care and remediation provided to them through the Care for Kids program; we do not view EPSDT as a simple “check the box” exercise.

By promoting timely, age-appropriate Care for Kids services, we will improve children's health outcomes in a multitude of ways. We will improve children's health by making sure all children under 21 receive needed preventative care. We will boost access to high-quality healthcare by partnering with providers such as PCPs and Public Health Departments on EPSDT initiatives like clinic days, where providers dedicate blocks of time (sometimes during extended evening hours, weekends, or school vacations) to accommodate children and their parents or guardians. We will strengthen the relationship between the child (or his or her parent or guardian) and the PCP and/or Public Health Department. We will reduce inappropriate use of the emergency room by fostering appropriate prevention and primary care.

Autism Services

Through our population assessments, we have the ability to identify members who have been diagnosed with autism spectrum disorder. This is defined as any pervasive developmental disorder defined in the most recent Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. For children with autism or a disability, we will provide physical therapy, occupational therapy, speech therapy, and other related services based on EPSDT findings to help members be as successful as they can be (example shown in Table 3.2-7). We will integrate behavioral health and physical health functions to provide LTSS-like benefits, whether the member is eligible for a waiver or not. Environmental specialists will conduct home assessments to make sure the member can access all needed services and supports.

For autism spectrum disorder, we will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be medically necessary for the screening, diagnosis, and treatment of autism spectrum disorder:

- **Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- **Assistive Communication Devices.** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication.
- **Behavioral Health Treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide this coverage when provided by a licensed provider. Additionally, we will cover applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and is subject to State standards and regulations.
- **Psychiatric and Psychological Care.** We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in Iowa.
- **Therapeutic Care.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder. Additionally, as a Value-Added

Service, we will provide additional transportation services to ensure eligible members and their families have access to therapeutic care.

- **Pharmacy Care.** We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe.

Table 3.2-7. Example of Our Autism-Specific Supports Services

Diagnosis	Examples of Tailored Components	Named Service Coordinator Qualifications	Multidisciplinary Experts
4.3.11.11.a Autism Spectrum Disorder (ASD)	<ul style="list-style-type: none"> • Age-appropriate positive behavioral intervention and strategies • Communication – verbal and nonverbal cues, devices • Strategies for continuity at school and home 	<ul style="list-style-type: none"> • Experience with supporting people with ASD • Knowledge, such as communication disorders, positive behavioral support 	<ul style="list-style-type: none"> • Behavioral Analyst • Autism • Assistive Technology

Screening, Diagnosis, and Treatment (3.2.7.1)

Question 3.2.7, #1

1. Describe your plans to ensure the completion of health screens and preventive visits in accordance with the Care for Kids periodicity schedule.

Through the experience of our affiliate health plans in 19 states, Amerigroup has a fully developed strategy to promote timely EPSDT screenings for our members under 21 and developed best practice methods to enhance Care for Kids outreach. We will maintain extensive educational efforts, including community-based education for members, parents/guardians, and providers. Augmenting this effort, our local Quality and Health Promotion teams will coordinate reminders and follow-ups to confirm compliance with federal and State law regarding the provision of EPSDT services to all members under 21 as part of Iowa’s Care for Kids program.

Amerigroup’s EPSDT DataMart will gather internal and external data to monitor compliance with the Care for Kids periodicity schedule. With this information, we will identify children with upcoming or missed EPSDT screenings and services and communicate with their PCPs. We will then download these data monthly to our Iowa outreach database, which is used by our local Health Promotion Outreach

Specialists to identify member families or guardians who require outreach to follow up on outstanding appointments. We will also analyze annual HEDIS rates, which align with the Bright Futures guidelines, against national benchmarks and State performance goals to identify opportunities to improve clinical care and service.

Each month and as needed, our Quality Management (QM) Department will generate reports that identify EPSDT service gaps and opportunities for member and/or provider outreach. The reports generate actionable information that will enable us to quickly assess the need for follow-up or Case Management interventions and outreach to member families or guardians and PCPs to close gaps in care. These reports are also available to providers.

Each month and as needed, our QM Department will generate reports that identify EPSDT service gaps and enable us to quickly assess the need for follow-up or care management interventions and outreach to member families or guardians and PCPs to close gaps in care.

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Our reports will drive how the quality team monitors, tracks, and conducts outreach to promote EPSDT compliance. These reports will be reviewed regularly by QM employees, with follow-up actions taken as appropriate. Our **pre-service reports** show children who are due for EPSDT services 90 days prior to the due date. These reports are available to Network Providers and are also used internally for outreach to member families or guardians. Our **concurrent reports** display all services, both retrospectively and prospectively, required by an individual child. These reports also include compliance information for overdue services, such as the number of mailed reminders or attempted phone calls. QM employees use these reports to follow up on overdue or outstanding services and identify and address barriers to compliance or reasons past outreach was not successful. Our **retrospective reports** show children who are overdue for EPSDT services. These reports are used to send notices to the member's family, guardian, PCP, or relevant specialist. Amerigroup also runs a variety of **ad hoc reports** based on specific data query parameters. For example, we run reports on EPSDT compliance for a certain age group or geographic area to identify trends in screening rates to help drive outreach and performance improvement strategies.

The EPSDT DataMart aggregates information from several internal data sources, including enrollment and encounter data, to track the provision of EPSDT services. We will supplement internal data with relevant external data sources, such as the Iowa Immunization Registry Information System (IRIS), State fee-for-service and historical member databases, and ongoing claims data for our EPSDT DataMart, and we will regularly train providers on proper coding to boost data integrity. By leveraging all of these data sources, we will identify EPSDT services that may have been delivered prior to enrollment with Amerigroup or delivered through public health departments.

PCPs will typically arrange and provide referrals for children who need follow-up services as a result of EPSDT screenings. The EPSDT DataMart will provide our Health Promotion staff with information to identify and then connect with member families to follow up with the appropriate services in a timely manner. Our Health Outreach Specialist will receive monthly reports to identify children screened and referred for diagnostic and treatment services and to verify if they accessed the services. The Outreach Specialists will then call member parents or guardians for whom we cannot confirm receipt of services. During the call, the Outreach Specialist will work with the parent or guardian to emphasize the importance of follow-up and to address any barriers to obtaining that follow-up care, such as transportation or appointment scheduling.

Our EPSDT DataMart will capture results of lead screening from encounter data when available from labs, allowing us to outreach to the parents or guardians and PCPs of children with positive screens to make sure that they receive follow-up services. These children and their families will be referred for Case Management. Case Managers will facilitate all referrals, coordinate with public health departments, and coordinate a home assessment by an environmentalist.

Amerigroup is committed to promoting a collaborative approach to improving health outcomes for members under 21, and partnering with PCPs and specialists to make sure EPSDT-related health screens and preventive visits are completed is a vital element to achieve that goal. We will maintain processes to monitor provider performance and intervene when we identify improvement opportunities.

Most importantly, we will work with members, parents/guardians, PCPs, and specialists to verify that services are delivered to members. Our Medical Director will consult directly with providers who request treatment or services that do not meet clinical criteria to identify alternatives and explore options that will achieve the optimal outcome for the child. We find this especially important, as many providers are on occasion unclear about the unique criteria for provision of EPSDT-related services. We will continually work with PCPs and any other relevant providers to make sure all required Care for Kids components are addressed, including screens that include health history, developmental assistance, complete physical exam, vision screening, hearing test, appropriate lab tests, immunizations, nutrition screen, and health education including anticipatory guidance, oral health assessment, other tests, and referrals for treatment.

Beyond these data mining operations, we plan to implement various and innovative approaches to member education, member outreach, and provider outreach, to make Care for Kids services widely known, easily accessible, and highly utilized. As an example of these efforts, we will implement our Healthy Rewards program to incentivize members to attend their EPSDT screenings. These financial incentives, coupled with provider incentives for providing complete and timely EPSDT services, are expected to meaningfully impact the rate of EPSDT screens. We discuss these initiatives further in the Section 10.3 Member Incentives.

Reports and Records (3.2.7.2)

We will continually work with the State to provide the required data and reports in the timeline and format specified. We have extensive experience producing or contributing to EPSDT (CMS-416) reports working with our state partners in 19 states.

Our advanced EPSDT DataMart will capture, store, and analyze internal and external data to monitor each member's compliance with Bright Futures guidelines and track EPSDT screenings, diagnoses, and treatment. In addition to claims and authorizations, our EPSDT DataMart will incorporate data from many available sources, including the State and its agents, the Iowa Immunization Registry Information System (IRIS), and lab vendors. We will routinely run reports that identify members for outreach who are due or overdue for EPSDT screenings or who require follow-up treatment services as a result of an abnormal screening. We will send these reports to providers to facilitate appointment scheduling for these services.

Outreach Monitoring, and Evaluating (3.2.7.3)

Question 3.2.7, #2

2. Describe your proposed outreach, monitoring and evaluation strategies for EPSDT.

Amerigroup's affiliate health plans have extensive experience in conducting outreach, monitoring, and evaluation for EPSDT populations that we will leverage for our Iowa program. Our affiliates have successfully implemented member-centric and comprehensive education, incentive, and outreach programs that consistently lead to high levels of enrollment and adherence, such as our New York plan's NCQA Quality Compass rating in the 90th percentile for child and adolescent well care. EPSDT outreach and monitoring are integrated into our quality management function, and we analyze EPSDT performance and HEDIS measures to guide continuous improvement initiatives.

As our affiliates have done in 19 other states, we will establish strong local ties by partnering with community organizations, schools, public health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs), and providers to reinforce high screening rates. In Iowa, we plan to explore partnerships with Easter Seals, the Department of Health, Iowa's Academy of Pediatrics, Iowa Primary Care Association, the Public Health Department Association, Boys and Girls clubs, hospitals or other organizations that offer Lamaze classes, and others.

Member Education, Incentives, and Outreach

We will educate members and their parents or guardians about the importance of preventive healthcare services, actively monitor utilization to verify that members receive timely, age-appropriate services, and employ proven outreach strategies to close gaps.

Education

We will use a variety of education materials, incentives, and opportunities to emphasize to members and their families or guardians the importance of completing EPSDT screenings and any required treatment



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resulting from these screenings. To help assure optimal success in reaching all members, including those hard to reach, we will use a multipronged approach that empowers members, involves families and caregivers, supports providers, and leverages community resources and governmental programs to drive optimal EPSDT screening rates.

New Mom Coach

Our local Health Promotion team calls all new moms within 30 days of birth to educate them about the importance of Care for Kids services such as immunizations and well-child visits. During the calls, we also take the opportunity to talk with them about the importance of a PCP. We will also hold community-based Baby Showers and Diaper Days to educate moms about the Care for Kids schedule and other items.

Taking Care of Baby and Me

Taking Care of Baby and Me is a comprehensive Case Management/care coordination program offering:

- Individualized, one-on-one Case Management support for women at the highest risk
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Prenatal and postpartum packets containing educational materials

Amerigroup will work with hospitals that provide delivery services to assist them in becoming Baby Friendly certified. This certification is the standard for hospitals who wish to be supportive of breastfeeding moms. The Baby Friendly Hospital Designation partnership will provide additional support to breastfeeding moms. Additionally, Amerigroup will offer incentive gift cards to expecting and new moms to keep up with prenatal and postpartum checkups.

Kid-friendly Materials

Our “Captain Amerigroup” brochures and postcards are kid friendly and include well-child schedules and related information in a format that engages both children and their parents or guardian. See Figure 3.2-11 for a sample from our Louisiana affiliate health plan.

Figure 3.2-11. We Utilize Kid-friendly Material to Engage Both Children and Parents/Guardians



New Member Welcome Call

Parents of new members receive a welcome telephone call within 30 days of enrollment, in which we educate them about the importance of preventive care, including EPSDT screening services in accordance with Bright Futures guidelines.

Healthy Families Program

As a Value-Added Service, members can enroll in our Healthy Families Program, which helps educate members and their families about healthier eating habits. The program is available for families with children who are overweight, obese, or have a history of co-morbid conditions. This six-month program includes a ten-week, family-centric program that meets twice weekly and encompasses all family members. The program includes scheduled telephonic contacts based on stratification of needs. Nurse Coaches use Motivational Interviewing (MI) to engage members in behavior change. MI is a client-centered, directive method for enhancing intrinsic motivation for change by exploring and resolving ambivalence. This communication technique is partnered with the Transtheoretical Model of Behavior Change involving progress through a series of five stages: Precontemplation, Contemplation, Preparation, Action, and Maintenance. PCPs are notified at enrollment and with three-month status updates via right fax. Nurse Coaches send educational materials via mail and refer members to online resources and local activities, when available.

The Healthy Families program involves a registered nurse coach who engages with the member throughout the program. Healthy Families connects mind and body, parents and children, to focus on healthy lifestyle choices through:

- A family-centric approach
- Multiple levels of support via the family and community
- Availability of tangible materials for participants
- Web-based resources for additional information

New Member Welcome Kit

Our new member enrollment packet includes information about Care for Kids services. Our member handbook includes information about the benefits of preventive healthcare, the services available under the Care for Kids program, and where and how to obtain these services, including how to obtain transportation assistance.

AmeriTips

We provide fact sheets to member families or guardians about a variety of health topics, including immunizations, lead screenings, and well-child visits (these are also available to providers).

Member Website

Our dedicated member website provides immediate access to member and caregiver education materials designed to support the understanding of Care for Kids services.

Amerigroup's locally based outreach team will also evaluate data and identify new opportunities to educate members and families about Care for Kids.

Outreach

Our member outreach strategy blends innovative and traditional outreach tactics that are designed to increase participation in the Care for Kids program. On a monthly basis, Health Promotion Outreach Specialists will download data on upcoming or missed EPSDT screenings and services from EPSDT DataMart. Health Promotion Outreach Specialists will use the following strategies, which have been proven effective by Amerigroup affiliate health plans in other states, to reach and educate relevant member families or guardians.



Clinic Days

One of our most successful initiatives among affiliate health plans has been Clinic Days held at key provider offices. We will work with high-volume PCP practices to hold open appointments for Amerigroup members within a block of time over the course of one or several days (sometimes extending evening or weekend hours, or holding sessions during school vacations, to maximize parent or guardian availability). Our Outreach Specialists will contact member families or guardians with due or overdue screenings to schedule appointments during these time slots. We will confirm attendance with member families or guardians the evening before and offer small incentives (such as movie gift cards) to complete the appointment. During Clinic Days, our Health Promotion Team will distribute information about lead poisoning, immunizations, and well-child visits and verify that all Care for Kids components such as immunizations and lead screening (in accordance with Bright Futures guidelines) are completed during the appointment.

Incentives

Incentives offered to member families or guardians (or teenage members) will encourage member engagement in Care for Kids services, as well as other preventive care services. Through our Healthy Rewards program, member families can earn up to \$20 in incentive payments on a Healthy Rewards debit card for completion of EPSDT screening services. They are also entered into a monthly raffle in which we give away a birthday party (for ages three to six) or an iPod Touch® or tablet (for ages seven to 21).

Community Outreach

A hallmark of Amerigroup is our commitment to collaborating with community organizations and agencies, which offers an excellent opportunity to promote EPSDT and conduct screenings. Following the example set by our affiliate health plans in other states, we will partner with local organizations to hold community events where we will distribute AmeriTips, which remind families about Care for Kids and the Bright Futures guidelines. We will also distribute Care for Kids reminder packages through schools that have historically had low screening rates. We plan to escalate outreach during summer months, holding Back to School events that promote well visits and EPSDT screening.

As a Value-Added Service, we will also provide our members access to Amerigroup Community Resource link, which is a searchable online resource for local Iowa community-based programs, benefits, and services displayed in an easy-to-use format and searchable with GPS technology. This tool will be a reliable source of information about local programs and services available throughout Iowa.

Care for Kids Telephonic Outreach and Appointment Scheduling

Amerigroup's Iowa-based Health Promotion team will conduct telephonic outreach to member families or guardians who are due or overdue for Care for Kids services, prioritizing outreach to age groups, ZIP codes, and practices with low screening rates. Monitoring tools will enable Outreach Specialists to view all the gaps in care for EPSDT-related services for each member in a household. When we contact the member or family/caregiver, we will "maximize the moment" by working with him or her to schedule all outstanding services, including immunizations, EPSDT screenings, and well-visit exams for all family members. We will work with the member or family/caregiver to identify and address any challenges or barriers that may limit the member's ability to participate in the screening visit. Based on that information, we can concurrently coordinate support services, such as transportation and referrals. In 2014, our Louisiana affiliate health plan made 10,973 interactive calls to the parents or guardians of child members under the age of 2 who were missing immunizations.

To locate members for whom we have incorrect telephone numbers, our outreach database is populated with alternate contact information supplied through the Nexis® database, offering Outreach Specialists additional opportunities to locate members.

- During outreach calls, specialists will query members or their parents or guardians about why they are not obtaining timely EPSDT screens. We track and trend that information, and the data guides our program improvement efforts. For example, our affiliate health plans in other states have found that the most significant barrier for families in scheduling Care for Kids services is typically conflict with work and school. As a result, we expand our outreach staff and increase the number of outreach calls during the summer months, when families experience less conflict with school schedules.

Annual Care for Kids Reminders

Amerigroup will mail an age-specific Preventive Health Reminder 45 days before each member's birthday, which emphasizes the importance of all Care for Kids services and incorporates a complete schedule of Care for Kids services. In 2014, our affiliate health plan in Louisiana sent almost 220,000 EPSDT reminders to members.

Care for Kids Overdue Service Reminder Postcards

We will mail a Care for Kids Overdue Service Reminder postcard to all member families or guardians with an overdue EPSDT screening 90 days after the due date of a missed service (in accordance with the Bright Futures schedule). The postcard will request that the member or parent/guardian contact his or her PCP to make an appointment and instruct the member or family to call the toll-free Member Services telephone number if the member or family/guardian has any questions, is deaf or hard of hearing, needs help scheduling an appointment, or needs transportation assistance. In 2014, our Louisiana affiliate health plan sent 205,013 overdue service reminder postcards to members.

Newsletter Articles

Our newsletters include reminders about timely preventive and well-care services and encourage member families or guardians to call their PCP to schedule appointments.

Community Programming

Like our affiliate health plans in other states, Amerigroup will continue to maintain a highly visible community presence and partner with schools, FQHCs, providers, and community organizations to conduct health fairs and other events that promote Care for Kids education, including distribution of flyers promoting well-child visits and AmeriTips on EPSDT and immunizations.

Head Start: Engaging Young Children and Parents

Working with Head Start programs has a positive effect on immunization rates and other EPSDT-related measures, as many children enrolled in Head Start are also enrolled in Medicaid. Amerigroup will collaborate with Head Start programs to reach and educate parents. Our Health Promotion team will partner with Head Start to present to parents on health topics (including Care for Kids), to educate children and families or guardians about dental health, to conduct on-site lead screening, and to deliver well-baby presentations and baby showers for expectant and new moms. We will also ask Head Start representatives to participate in our Health Education Advisory Committees, which offer guidance and input into, among other areas, Care for Kids education and health promotion.

Back-to-School Events: Engaging School-aged Youth

Annually, we plan to conduct back-to-school events at which we engage with members and their families about health issues, including distribution of Care for Kids educational flyers. This includes our hallmark Repack the Backpack events, in which we provide kids with free backpacks and back-to-school supplies (such as notebooks, pens, and pencils), educate children and their families about preventive health, and conduct free health screenings. As noted below, we also will distribute Care for Kids educational folders in partnership with school districts in ZIP codes with low screening scores.

Teen Engagement Strategies

Teens and adolescents are the most difficult audience to reach to boost EPSDT screening rates. They do not require annual school physicals and often do not show for appointments set by parents or guardians. In our experience, face-to-face education, coupled with appropriate incentives, are vital to boosting screening rates for members age 12 to 21. We will directly interface with and educate these members through community events. For example, our affiliate health plans partner with local Boys and Girls Clubs and the Police Athletic League. As a Value-Added Service in Iowa, Amerigroup will partner with local Boys and Girls Clubs to provide free memberships for Iowa teens and adolescents. We will also work with providers who serve this population to hold evening events and weekend clinic days and coordinate EPSDT screenings with sports physicals. We plan to implement age-appropriate incentives (gift cards and drawings) to contribute to improved adolescent well-visit rates.

In New York, our affiliate health plan has been successful convening a bimonthly Teen Advisory Board to discuss topics that include well visits and screenings and produce a teen newsletter. We will consider deploying this program in Iowa as well.

Provider Education, Incentives, and Outreach

An integral element of our Care for Kids strategy is PCP engagement and education. Timely Care for Kids services strengthen the PCP relationship. Our field-based Provider Relations team and our Health Promotion teams will work collaboratively to build physician and office staff knowledge about Care for Kids services and the Bright Futures guidelines. Most importantly, we will deliver tools that detail PCPs' quality performance metrics relative to their peers and share best practices to improve those metrics.

PCP Orientation

During orientation for PCPs and PCP office staff, we review a training module titled "Improving EPSDT Screening for Members." The training explains EPSDT services, benefits, periodicity schedule and guidelines, reporting and coding, Amerigroup outreach, and links to other support tools.

Physician Outreach

With EPSDT monitoring data, we identify PCPs with poor performance records and focus our outreach efforts on these providers, such as through education with our Chief Medical Officer or QM and Provider Relations staff.

Incentives

Care for Kids services are part of our PCP Quality and Population Management provider incentive program, as described in Section 10.3, to further incentivize PCPs to use the data, tools, and training we provide to close gaps in Care for Kids services. That program includes the HEDIS measures for Well Child Visits (0-15 months of life), Well Child Visits (age 2-5 years), and Adolescent Well Care Visits (age 12-21 years) in the overall measure set for the program.

Engaging School-based Health Clinics

Augmenting our PCP education, Amerigroup will work with school-based health clinics to encourage their involvement in Care for Kids services, which promotes convenience for members and families. Amerigroup is one of the only MCOs to partner with school-based clinics.

Vaccine for Children (VFC) Education

As part of our physician education program, we educate providers about VFC, a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Program grantees like the state health departments and certain local and territorial public health agencies distribute vaccines at no charge to private physicians' offices and public health clinics registered as VFC providers.

Care for Kids Physician Toolkit

Amerigroup's Care for Kids Provider Toolkit includes an overview of Care for Kids requirements, a quick reference guide, a list of preventive care resources, and EPSDT assessment summaries for all age groups.

EPSDT Medical Record Audit

Amerigroup conducts quarterly EPSDT audits to assess PCP compliance with Care for Kids requirements. The results of that audit drive individual as well as network PCP education about Bright Futures guidelines to boost compliance.

Reports

We will deliver actionable information to enable PCP practices to reach out to members to remind them about the need for Care for Kids services and schedule upcoming or overdue Care for Kids services.

Provider reports will include the following:

Pre-service Reports show members enrolled in each PCP practice who are due for Care for Kids services 90 days prior to the due date.

Overdue Care for Kids Service Listing for Members summarizes members with overdue Care for Kids services, including member demographics, services that are overdue, and the date that the service was due. In 2014, our Louisiana affiliate health plan sent 63,519 letters.

Monitoring & Evaluation

Our QM program will monitor and measure the outcomes of clinical care and services by analyzing clinical and service performance indicators and healthcare outcomes to identify and act on opportunities for improvement. The QM team will compare EPSDT and HEDIS findings to results from previous years and to NCQA's National Quality Compass and the federal screening target of 80 percent. We also acknowledge that well-child measures are included in the State's pay-for-performance program.

Together with the Health Promotion and Member Outreach Services Manager, our Health Promotion Consultant will be responsible for continually monitoring EPSDT performance and communicating with the Plan Compliance Officer about any performance risks related to the contract, such as if EPSDT rates fall below required performance standards. Our Health Promotion Manager also reports to the QM Committee, which will oversee all quality operations within Iowa.

Our local QM nurses will review medical records by fax or mail and also conduct education about processes or tactics to improve EPSDT compliance. This audit will verify whether records include documentation that all EPSDT screenings and follow-up visits have been completed.

Improving Performance

Amerigroup will collaborate across multiple functional areas to identify, monitor, and prioritize clinical areas for improvement that result in improvement on targeted clinical measures, including EPSDT rates, from the prior year's rate. We have embedded EPSDT compliance functions throughout our organization, including QM, Provider Relations, Compliance, and Health Promotion staff. For example, during our quarterly EPSDT provider audit, the QM team will randomly select providers to participate in the audit. We will review their medical records to assess their compliance with EPSDT requirements. We will create Corrective Action Plans (CAPs) for providers that fail to meet the minimum standards, educate the provider about Bright Futures guidelines, and re-audit to verify that the provider is now compliant.

When we identify underperforming EPSDT compliance trends (below the 80 percent threshold), we will undertake educational efforts to improve performance. For individual providers, this means



We have embedded EPSDT compliance functions throughout our organization, including Quality Management (QM), Provider Relations, Compliance, and Health Promotion staff.

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education about the requirements and development of a Corrective Action Plan that maps out what the provider needs to do to become compliant with a follow-up audit. More strategically, we will educate all providers about our audit results through newsletters and our provider website to educate them on EPSDT elements that do not meet the 80-percent threshold, reinforcing the screening requirement and tools.

Augmenting audits, we will emphasize provider collaboration to improve health outcomes. PCP practices with a certain panel size (to be determined to include as many providers as feasible while maintaining meaningful data usage) will receive quarterly quality measurement reports that show each provider’s performance relative to key quality metrics, including Bright Futures components such as immunizations, lead screening, and well-child visit rates for children and adolescents. They will be able to see their individual performance relative to the State’s target rate and the health plan’s rate (claims only) and the number of additional members they need to see to hit the target. With these data, our QM and Provider Relations teams can then share information and strategies on how to measurably improve their quality performance.

In addition, our Medical Director will share audit results with the Iowa chapter of the American Academy of Pediatrics so that we can collaboratively educate Iowa pediatricians on EPSDT requirements. This collaboration boosts provider compliance with Bright Futures guidelines for all Iowa children.

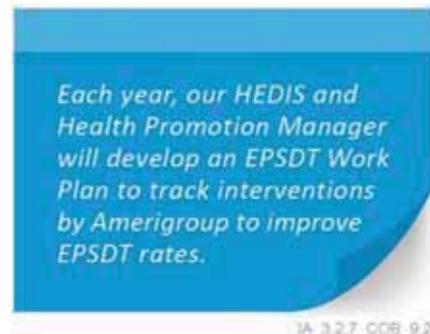
We also intend to collaborate with the State to identify new opportunities to enhance our EPSDT performance. For example, in Wisconsin, our affiliate health plan launched a CAHPS Workgroup project to make contact with members, including members under 21 and their parents or guardians, identified as visiting the emergency room (ER) for non-emergent treatment, without a PCP visit in the calendar year, to provide education on engagement with their PCP to ensure those members receive appropriate health, mental health, and developmental services. The outreach also stressed the importance of consistent checkups to identify problems early and to obtain proper diagnosis and treatment. From December 2014 to March 2015, the health plan connected with 479 members under 21 (or their parents or guardians) and collected information on why they visited the ER. Results are below in Table 3.2-8.

Table 3.2-8. Our CAHPS Workgroup Project in our Wisconsin Affiliate Gathered Data on Reason for ER Visits to Enhance EPSDT Performance

Reason For ER Visit	Member Response Totals	Percent of Responses
PCP Closed	19	4.13%
Urgent Care & PCP Closed	125	26.10%
Referred to ER	46	9.60%
No Appointment Available - PCP	25	5.22%
Didn't know of other options	81	16.91%
Does not recall/Unsure	37	7.72%
Felt ER was best option	146	30.48%

These members received primary care, emergency care, and member service education about:

- Urgent care locations, nurse line services, and alternatives to ER care
- Available support for contacting and attempting to schedule an appointment with a PCP
- Additional information on EPSDT and HEDIS measure–related screenings offered to 264 members under the age of 21 (or head of household)
- Additional support in scheduling preventative screening-



related services with a PCP offered to 106 members under the age of 21 (or head of household)

- Each year, our HEDIS and Health Promotion Manager will develop an EPSDT Work Plan to track interventions by Amerigroup to improve EPSDT rates. The EPSDT Work Plan will tie key performance metrics to outreach and education interventions, assign business owners to each intervention, and set timelines for completion. Amerigroup's Health Promotion Consultants will monitor the status of the interventions and use the information to adjust our Care for Kids efforts accordingly. We will also use an internal tracking software system to track, coordinate, and report events to the State.

Additionally, our Child/Adolescent Domain Workgroup will function as a best practice engine to support Iowa in meeting child/adolescent preventive health HEDIS P4P/VBP/EPSTDT targets and Performance Improvement Plan (PIP) goals. We will develop and share best practice interventions to improve HEDIS and EPSDT rates, as well as member health outcomes, while reducing fiscal and other risks.

Child/adolescent subject matter experts participate and serve as a leader in the identification, research, and implementation of corporate, member, provider, and system interventions. State Health Plan QI leaders and/or designees as well as all interested affiliate health plans will be invited to participate as active contributors to the workgroup to ensure a broad perspective during the entire process from information gathering, analysis, and identification of best practice interventions to pilot implementation.

We are confident that our education, outreach, incentive, tracking, and continuous improvement processes described above will promote comprehensive EPSDT service delivery for Iowan members under 21. We are committed to providing these crucial services to assure optimal member outcomes and cost-effective care and service delivery.

Behavioral Health Services (3.2.8)

Question 3.2.8, #1

1. Describe your proposed approach for delivering behavioral health services, including the use of any subcontractors.

Approach for Delivering Behavioral Health Services

Amerigroup Iowa (Amerigroup) will bring a behavioral health program to Iowa that delivers highly coordinated covered benefits that are fully integrated across our health plan. Amerigroup will directly administer the delivery of mental health and substance use disorder treatment and support services that are localized, customized, evidence-based, and, above all, recovery and resilience-driven. We will not subcontract to a behavioral health organization or affiliate to administer behavioral health benefits and services. ***We will build upon the experience of 15 of Amerigroup's 19 affiliate health plans that coordinate the delivery of fully integrated physical health and mental health and substance use disorder treatment services, and in seven states, long-term services and supports (LTSS).***

Amerigroup affiliates coordinate the full spectrum of behavioral health services, including home and community-based services for children with a serious emotional disturbance. We also currently cover services similar to Habilitation Program services for members with a serious mental illness in many of our health plans, including in Kansas, Tennessee, and Texas. Additionally, we will cover 1915(i) services along with a full spectrum of physical and behavioral services in December 2015 as a Bayou Health Plan in Louisiana and as a Health and Recovery Plan in New York beginning the in January 2016.

Our Recovery-Based, Integrated, Collaborative Approach

Our approach in Iowa will extend the significant work done by the State, advocacy groups, consumers, families, and local providers to further evolve behavioral health services coordination, integration, and delivery. We will combine clinical evidence, member support needs, and State customer needs with our affiliates' deep and extensive knowledge and experience to implement a recovery-based, integrated, and collaborative model that welcomes and engages members in their personal recovery efforts.

- Our staff will **promote recovery and resiliency** throughout the provider network and in our interactions with members and their families with the goal of maximizing community integration. A recovery philosophy that is hope based and focuses on member self-determination; developing empowering relationships; having a meaningful, productive role in society; and eliminating stigma and discrimination is the foundation for collaboration and integration of health services.
- As a leader in offering a **truly integrated model**, we do not separate the management and delivery of mental health and substance use disorder services from physical healthcare, pharmacy services, and LTSS, including social supports. Our highly experienced national behavioral health management team will be a seamless component of the Iowa Initiative, providing national behavioral health expertise. Amerigroup's behavioral health, physical health, and LTSS clinicians will work together as a single team using a single care coordination and management system to deliver fully integrated care.
- We will use the Amerigroup Member 360 capability to **support coordination and delivery of recovery-based, integrated care**. Member 360 is an easy-to-use dashboard that integrates a variety of member data, including HEDIS care alerts, authorizations, prescriptions, lab results, and claims organized by type such as inpatient, emergency room, office visit, and behavioral health services. In addition, each time there is a change in a member's medical or behavioral health condition as indicated by a new or modified authorization for services, our system can automatically generate an email to the Integrated Health Home encouraging them to check Member 360 for updated clinical information so updates can be made to the member's care plan.
- Amerigroup will also deliver an **information-sharing and collaborative platform** where interdisciplinary team participants can review and contribute to the care plan as authorized by the member. The platform is operational today in several states currently serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness.
- We will collaborate **with local and state-based stakeholders** (such as families, natural supports, advocacy organizations, and network providers) to ensure access to integrated mental health and substance use disorder services and to the social supports families and children need to maintain a stable and safe family environment and that adults need to live independently.

We will focus on:

- **Prevention** — Working with providers, the community, and consumers around evidence-based interventions for prevention of behavioral health disorders; for example, evidence-based, targeted, time-limited, parent-infant communication training for at risk families that has a clear connection to improved outcomes
- **Early detection** — Using comprehensive screening programs to identify and treat member's service and support needs early
- **Peer support and recovery** — Growing Iowa's strengths-based program grounded in member choice and recovery

- **Enhanced access to mental health and substance use disorder services** — Through provider development activities and the use of innovative care delivery technologies, including telehealth and online consultation
- **Enhanced access to community supports** — Especially housing, education, and employment through collaboration with community-based organizations (CBOs), county agencies, advocacy groups, providers, and the State
- **Provider collaboration and partnerships to pay for value rather than volume (pay for performance)** — Recognizing that this transition may take more time for some and less time for others. This collaboration is provider specific and takes into account provider experience and preferences.
- **Innovative, integrated physical and behavioral healthcare model design** — Promoting, supporting, and developing additional integrated care model capacity including increasing access to patient centered medical homes (PCMHs), Iowa Accountable Care Organizations (ACOs) and Chronic Condition Health Homes (CCHHs), and Integrated Health Homes (IHHs). For example, one of our recent agreements with a primary care provider (PCP) group includes quality threshold targets for both physical and behavioral measures.

Amerigroup Will Actively Promote Recovery at Every Opportunity

From our experience helping states transition to integrated models, including our collaboration with states such as Tennessee and Kansas, we understand that ground-breaking systems change, such as moving from a behavioral health carve out to integrated services model, requires the involvement of the State, providers, members, advocacy organizations, and other stakeholders. We will work collaboratively to develop Iowa-specific initiatives that build on the existing recovery-based behavioral health foundation.

Amerigroup will work to improve recovery outcomes, including participation in employment and educational opportunities, using a variety of managed care tools and initiatives.

- We will promote recovery in all of our internal, external, member, and provider communications.
- Our Case Managers will work with members, their families and representatives as well as other members of the interdisciplinary team to develop care plans that promote recovery and work with behavioral health providers to align the members' treatment plan and care plan.
- We will evaluate recovery-oriented questions in our annual member and provider satisfaction surveys, analyze the results, and share these with members, providers, and quality committees as described in Section 10.1.
- We will leverage our data analytics to track members' progress on key outcomes, such as employment and education, and develop and share blinded provider profiles displaying member outcomes using provider peer comparisons.
- We will develop a provider scorecard, similar to the scorecards used by our affiliate plans in Florida, Georgia, and Tennessee, that report on key quality and clinical measures and analyzes data trends. Scorecards are an effective way for providers to receive feedback and use that feedback to improve their performance.
- We will tie outcomes to provider incentives described in Section 10.3 of our proposal, such as the Behavioral Health Incentive Program (BHIP), which we have successfully implemented in other states such as Tennessee.
- We will support or provide training and consultation to providers on EBPs that promote recovery and distribute recovery-based clinical practice guidelines (CPGs). We will deliver EBP and CPG training across the State at both individual practices and through group settings. We will also track

EBP implementation and provide additional training and coaching as needed. We will encourage experienced providers who have specialized expertise in the areas of recovery and resiliency to work with less experienced providers.

- We will seek suggestions and input for increasing provider adoption of EBPs from the provider network, DHS members, and other key stakeholders, including from our proposed Behavioral Health Advisory Committee (BHAC).

Behavioral Health Services Will Be Coordinated by a Specialized and Locally Based Behavioral Health Team

We recognize that members with behavioral health service needs require specialized expertise from clinical staff with training, skills, hands-on experience, and extensive local knowledge. We have a proven track record of rapidly recruiting a team with local roots and experience covering services, benefits, and populations served. For example, our Kansas affiliate, which covers a similar array of services and enrolls a similar population to the services and groups included in the Iowa Initiative, completed readiness activities from contract award to implementation in seven months.

Our behavioral health team in Iowa will be uniquely skilled at holistically addressing each member's needs—behavioral, physical, social, and functional. We will recruit Iowa-based behavioral health staff including:

- Behavioral Health Medical Director (an Iowa licensed psychiatrist)
- Iowa-licensed, behavioral health managers
- Behavioral health licensed staff, such as psychologists, social workers, and psychiatric nurses with specialization in in child, adolescent, and adult mental health and substance use disorder treatment
- Family and peer specialists who will be Iowa-certified peer support specialists
- A behavioral health network management specialist

We will also identify members of our behavioral health team who will provide specialized expertise in a variety of areas, including:

- Recovery and resiliency
- Intellectual or developmental disabilities
- Trauma-informed care
- Housing and employment
- Forensics and juvenile justice
- Quality improvement

A health home manager and dedicated staff, including peer specialists, will work with contracted health homes including IHHs collaborating with the behavioral health team to support the delivery of evidence-based, integrated care.

Our Iowa-based team will be supported by the national resources of our parent company and affiliate health plans, including clinicians with expertise in child psychiatry, eating disorders, and addiction medicine.

Collaboration Will Drive Increased Access to Integrated and High-Quality Recovery-Focused Services

We will collaborate with local and state-based stakeholders, including members and their families, advocacy organizations, network providers, CBOs, and county and state agencies, to provide access to the

full continuum of integrated physical health, mental health, and substance use disorder treatment services, as well as community-based supports for members with long term services and support needs.

Our affiliate health plans are collaborating with and implementing innovative provider arrangements that recognize the importance of offering members readily accessible primary and behavioral healthcare in a single location. For example, we are working with integrated provider systems in California, Florida, Georgia, Kansas, Maryland, New York, Tennessee, Texas, and Virginia. These integrated arrangements take a variety of forms, including integrating primary care into community mental health centers (CMHCs), and providing PCPs with in-office behavioral healthcare coordination and consultation services. Dedicated Amerigroup staff are supporting and promoting PCMHs and health homes. Reimbursement includes incentive arrangements that promote the provision of high-quality, integrated, and coordinated care such as the BHIP described in Section 10.3.

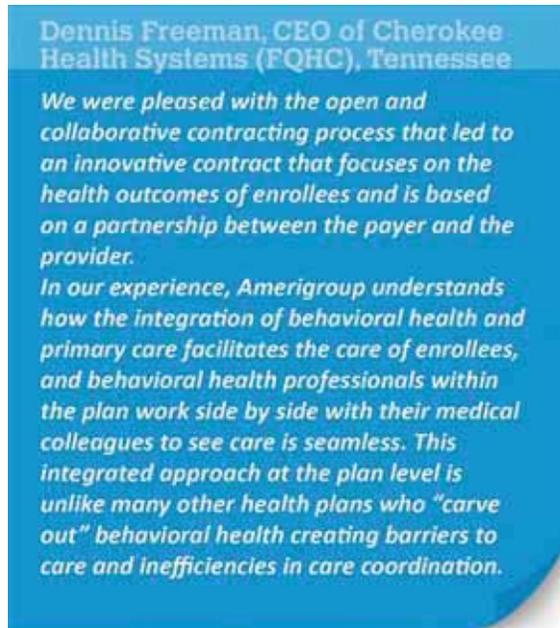
We fully support initiatives like Iowa's IHHs and have already begun work to develop additional integrated provider options in Iowa, which will be a primary focus for Amerigroup. For example:

- We have held discussions with 36 CMHCs and executed Letters of Intent (LOIs) with 16.
- We are discussing integrated care opportunities and look forward to extending and deepening those conversations. For example, we will contract with Eyerly-Ball CMHC and its co-located PCPs.
- We have also executed a LOI for inclusion of Stead Family Department of Pediatrics at the University of Iowa and its 14 Title 5 clinics that will provide IHH services for children with special healthcare needs.
- We are in discussions with the Iowa Primary Care Association to develop, with their agreement and DHS' authorization, an innovative, value-based agreement similar to the one implemented with Cherokee Health Systems of Tennessee, considered one of the premiere integrated models in the nation. This agreement rewards improvements in quality and improved care outcomes, shifting the provider incentive universe from volume to value.

We will also partner with local communities to identify and develop additional services and supports that enable members to live and participate fully in the community, such as innovative housing arrangements and employment options.

Our Integrated Care Model

Amerigroup will provide fully integrated physical health, mental health, and substance use disorder, and LTSS care management using our proven interdisciplinary team infrastructure, processes, and technology tools, promoting high quality, cost-efficient, and well-coordinated care. We serve our members through a "whole person" approach that supports members' physical, behavioral, cognitive, functional, and social strengths and support needs across the full spectrum of healthcare settings and living arrangements. Our person-centered model helps members optimize their benefits and available services to get the high-quality healthcare and support they need. Our care coordination and integrated care model is described in detail in Section 9.0 and summarized here. Members enrolled in the Habilitation Program or Children's Mental Health Waiver and an IHH will have an IHH care coordinator



who works closely with Amerigroup Community-Based Case Managers and the behavioral health team. The IHH care coordinator will provide care coordination and service planning, as described in Section 3.2.11.

Our interdisciplinary team, which will include physical health, behavioral health, and Community-Based Case Managers and specialists, will work together on a day-to-day basis and during joint rounds to design and execute a single, person-centered care plan based on members' holistic support needs and goals. Behavioral health Case Managers will work with adult members with serious mental illness and/or substance use disorder and child and adolescent members with a serious emotional disturbance with case management and care coordination needs.

Behavioral health Case Managers will also review whether the member is enrolled in an IHH or CCHH, and if not, evaluate a referral to an IHH or CCHH. If the member is enrolled in either, the case manager will work in concert with the IHH or CCHH care coordinator, member, and family to support the member's recovery journey.

Members and families will receive the level of case management and care coordination support needed. Case management includes complex case management for members who have more intensive care coordination needs and specialized interventions during transitions among different levels of care and life transitions (pre-school to school age, adolescence, transition to adulthood and adult systems of care, and aging). Members are identified for case management through risk stratification (described in Section 9.1.4) based on specific events, such as inpatient admission, and through referrals, both internal (from other areas of the health plan such as member services and utilization management [UM]) and external (from families, providers, schools, social services agencies, and State agencies such as corrections).

Complex Case Management

Members are prioritized for specific levels of case management support based on the intensity of their needs. Members with the highest intensity needs are enrolled in complex case management.

Case Managers work with the member to complete a recovery-focused, comprehensive, person-centered assessment that forms the foundation for the development of a person-centered care plan. The case manager focuses person-centered planning on the member and member's family and includes others of the member's choosing, including the member's PCP, behavioral health providers, community-based support providers, schools, and others involved in the member's life. For example, for a child in foster care, the team might include the child's foster care parents, a school representative, and representatives from the appropriate State and local agencies and organizations.

The care plan documents the member's goals, including recovery-oriented goals, and includes physical health and behavioral health benefits as well as non-Medicaid funded services. The team reviews the member's health status and works with the member and, as appropriate, family and others of the member's choosing to identify any potential gaps in service or barriers to success. LTSS benefits and case management interventions are also integrated into the care coordination and management system supporting development of an integrated care plan/service plan for members with long-term care needs.

After soliciting feedback from other members of the team, including providers, the care plan is finalized. The completed care plan is shared with involved parties (as well as being visible in Member 360) and becomes a dynamic document, evolving as the member progresses, with ongoing input from members of the interdisciplinary team.

The member remains enrolled in complex case management until they have achieved their recovery-oriented goals and may transition to care coordination or determine they no longer need care management.

Episodic Case Management

Some members and their families need case management during specific events including during life transitions, such as transition from childhood to adolescence and transition to adulthood; transitions in levels of care, settings, or providers; and during and following an acute episode of care. We describe specific types of episodic case management in Section 9.0. Examples of case management strategies for members with behavioral health needs that we will implement in Iowa include:

Case Management for a First Episode of Psychosis

Members experiencing a first episode of psychosis (FEP) will receive comprehensive case management and referral to resources that provide recovery-oriented support services for young people who are experiencing a FEP. Members who are hospitalized with a FEP will receive discharge planning and transition support from a behavioral health case manager, including referrals and follow-up to help ensure they are receiving essential behavioral health and wraparound services. A member with a FEP is an ideal candidate for an IHH with an emphasis on self-care and health promotion activities as well as linking and coordinating with other health and community-based service providers.

Inpatient Discharge Planning and Transition

We will implement field-based case management to coordinate discharge planning for high-risk members who are in jeopardy of long lengths of stay or who may be at risk for readmission. If the member is enrolled in a health home, our behavioral health case manager will collaborate with the member's health home care coordinator to support discharge planning and transition.

Field-based Case Managers or a peer specialist will engage and assess members in inpatient settings, evaluating member strengths, the member's support system, and available resources. We will work with the member, health home as applicable, and other members of the interdisciplinary team to establish short-term goals based upon outcomes from the visit and update the plan of care identifying needed services and supports to achieve timely discharge and help ensure stability in the community. We will collaborate with the inpatient facility discharge planner, advocate on behalf of the member, schedule follow-up outpatient visits, and arrange for necessary support services such as housing or transportation. We will document findings and outcomes in our care coordination and management system, which is visible in Member 360.

We will also engage, where clinically indicated, our Bridge on Discharge providers who initiate contact with the member while in the inpatient unit and schedule a first transition outpatient visit. Together, we will work with members to develop comprehensive relapse prevention plans that address member goals in the community and development of a crisis plan.

Additionally, as Value-Added Services, we will provide a post discharge kit and free home-delivered meals to eligible members and their families. The discharge kit provides tools for family members and caregivers to successfully help transition members from hospital to home, aid in recovery, and help decrease the chances for readmission. The meal program provides nutritious home-delivered meals, which allows members to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare them.

Transition Age Youth

Transition Age Youth with serious mental illness are three times more likely to be involved in criminal activities than adolescents without mental illness. They are also four times less likely to be engaged in any gainful activities including employment or enrollment in college or trade school. Our strategies for supporting Transition Age Youth include evaluating for inclusion in complex case management, transition planning assistance from a care coordinator and case manager who help ensure continuity of care and services providers.

In addition, as part of our integrated approach to care, our medical Case Managers evaluate adolescents in complex case management when they reach the age of 18. The purpose of this evaluation is to determine

the need for any additional behavioral health support secondary to the combined stress resulting from youth to adult transition and the stress associated with a complex medical condition (such as diabetes or sickle cell disease). This evaluation also takes into account the member's eligibility for a health home or current enrollment in a health home.

We will work closely with State, local, and community programs that provide related educational, health, and social services to youth-in-transition members. Together, we will promote access to available services and resources for the youth, their involved biological family, foster family, and adoptive family as requested. We will work with these organizations to coordinate care with providers who can help equip youth to develop self-care skills to transition to adulthood successfully. Case Managers will also develop a transition plan and contact current treating providers to confirm that an appropriate plan is in place for coordinating the child's integration into the adult service delivery system. Because the children's system of care typically offers a greater array of publicly funded services, our Case Managers work with involved state agencies, local services agencies, and CBOs to identify ways to bridge service gaps using community-based services.

Case Rounds

Regular case rounds assemble the regional team, with the medical director and behavioral health medical director, to address member's complex care needs. For example, our New York affiliate identified a member with repeated emergency room use who refused to participate in care coordination and whose family also refused. The medical director contacted the member's PCP who had a long-standing relationship with the member and working through the provider was able to engage the member in care coordination and address avoidable emergency room use.

Coordination with Integrated Health Homes or Chronic Health Homes

Behavioral health case management and care coordination will always involve careful evaluation of the member's eligibility for, or current enrollment in, either an Integrated Health Home or Chronic Health Home. If a member is eligible, we will discuss potential enrollment in either an IHH or CHH. If the member enrolls, we will carefully align and coordinate the services provided by Amerigroup with the services being provided through the IHH or CHH. In this way, we help ensure non-duplication of services and the most efficient use of resources. We will document this coordination in our care coordination and management system.

Additional detail about the coordination with IHH and CHH is included in Section 3.2.9 and 3.2.10.

Question 3.2.8, #2

2. Describe how your proposed approach will incorporate the values outlined in Section 3.2.8.1.

We will extend the significant work done by the State, advocacy groups, consumers, families and local providers by collaborating to evolve behavioral health services. We will combine clinical evidence, member needs, and State customer needs with Anthem's extensive knowledge and experience providing integrated, high-quality behavioral health and physical health services.

Amerigroup affiliates adhere to the principles included in SOW Section 3.2.8.1, and we will build upon the existing programs and policies of our affiliate health plans to implement these principles. Our philosophy in the design and delivery of behavioral health services and supports incorporates our values of integration, collaboration, and recovery.

Our Approach Is Built on a Recovery and Strengths-Based Foundation

Our coordination and delivery of behavioral health services are recovery and strengths-based and built upon Amerigroup's guiding principles.

- **Members are empowered with voice and choice to be in control of their health and health supports.** This person-centered philosophy emphasizes self-direction, responsibility, and independence and recognizes that there are many pathways to recovery, resiliency, and wellness.
- **Acceptance, respect, responsibility, and hope are essential to health.** Hope is fostered based in the knowledge that personally valued recovery is possible.
- **We value diversity.** We are responsive to cultural, ethnic, and racial differences consistent with the needs and desires of the members we serve, and we uphold their rights, dignity, and self-determination.
- **Health is not just the absence of illness.** Health is a state of complete physical, mental, and social well-being.
- **There's no health without mental health. Mental health and physical health are not and cannot be separate.** A whole-person approach implies a unified system of care and works to positively shape and strengthen mental, social, cultural, political, and economic environments.
- **Our role is to collaborate with providers. Without healthy and robust provider partnerships, we cannot succeed.** Our providers have the ability to engage our members in a way that can alter the course of our members' lives.
- **Enhanced quality and outcomes.** Our goal is to provide tools, support, and incentives to our providers to help them deliver optimal care and, at the same time, enhance quality and outcomes.
- **We do the right thing.** By supporting members on their journey to health wellness, healthcare resources are used more efficiently, members achieve better outcomes and maintain community tenure, and the system as a whole benefits.

Our behavioral health team will use evidence-based practices to provide the level of support most appropriate for each member based on the member's desired outcomes, identified needs, and personal recovery efforts. A recovery philosophy—hope based and committed to member self-determination, empowering relationships, and a meaningful productive role in society while eliminating stigma and discrimination—is the foundation for our work.

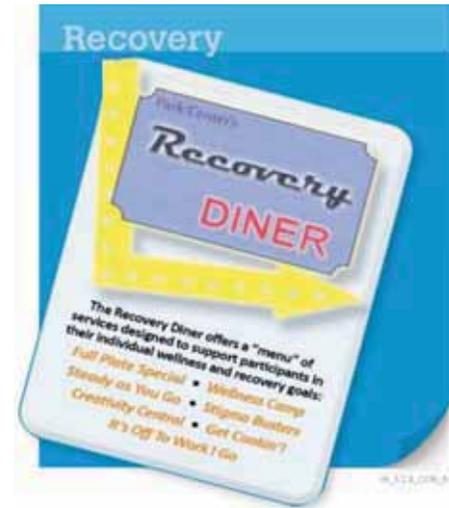
Services will be managed and coordinated by a team that involves the disciplines necessary to meet the member's needs holistically and which allows us to share a comprehensive view of the member's health, functional status, and recovery. Overlaying these efforts is our absolute commitment to putting the member and, as appropriate, caregivers, at the center of the process and fully engaging the member in treatment.

We collaborate with providers, members and their families, and stakeholders to deliver and continually advance a recovery-oriented system of care.

- **We will evaluate our provider network's use of EBPs.** We promote adoption of key EBPs, and our clinical team is trained in EBPs. Our EBP strategy is to collaborate with providers and the larger stakeholder community to identify the EBPs most likely to have the greatest clinical impact on the largest number of members given current practice patterns and practice capabilities. This approach is consistent with the State's promotion of EBPs, such as IDPHs' program that trains and disseminates information to providers to promote adoption of Multi-Dimensional Family Therapy for adolescents involved with the justice system.

- **We will train our provider network and staff on mental health awareness.** We will implement and promote mental health awareness month activities, in partnership with local advocacy groups. For example, a local NAMI representative or other advocacy group representative, usually either a family member or a person with lived experience, will meet with members and health plan staff who interact with members to discuss mental illness/substance abuse and the barriers individuals with mental illness/substance abuse face in healthcare and community living.
- **Increasing access to recovery-focused community services will be a key goal for Amerigroup, Iowa.** Our affiliate health plans, supported by national resources, have a long history of piloting new innovations to address local needs and to drive improved outcomes; successful programs are quickly implemented on a large scale. For example, our Tennessee affiliate health plan recognized the need for more recovery-oriented services and asked Park Center’s leadership to partner with us to increase access to wellness and recovery services for adults. *“Recovery Diner” shown in Figure 3.2-12, serves as a best practice in the areas of psychosocial rehabilitation, supported housing, and supported employment.*

Figure 3.2-12. Recovery Diner Offers Services Designed to Support Participants in Their Wellness Goals



Park Center enhanced its model by implementing the evidence-based Dartmouth model for supported employment. The model demonstrates that when individuals who are interested in working receive supported employment services, even when they are experiencing symptoms of serious mental illness or substance use disorder, they can get better when they work, no matter where they are in their recovery journey. Park Center reported positive recovery outcomes. They found that 88 percent of the Amerigroup adult members with psychiatric disabilities who obtained a job retained it for 90 days. Amerigroup and Park Center are working to expand the current arrangement to formalize our joint focus on outcomes measures. We look forward to creating similar programs in Iowa.

- **Members with a mental illness or substance use disorder, their families, providers and other key stakeholders will be active participants in our program development and quality improvement activities.** We will form a Behavioral Health Advisory Committee (BHAC), similar to the ones we have implemented in New York and Tennessee, and comprised of members, family members, providers, and advocates. BHAC informs our overall approach to recovery-focused treatment, provides guidance, oversight, and evaluation for our programs, including EBP access to care, stigma cultural competence, and health disparities. The BHAC is a best practice used by our affiliates and meets quarterly. *For example, our Tennessee affiliate’s BHAC has 45 participants of which 53 percent are member and family representatives and 23 percent are providers specializing in substance abuse services.* The geographically, culturally, and racially diverse BHAC (half the participants are non-Caucasian, and six Tennessee counties are represented) meets quarterly and is facilitated by our Statewide Director of Wellness and Recovery, a self-identified consumer of mental health services. Subcommittees on policy development, service planning, service evaluation, and member, family member, and provider education are each chaired by a BHAC member and attended by an Amerigroup employee. BHACs provide feedback to the health plan to enhance services for members. For example, BHAC recommendations resulted in

developing family support services for children and adolescents and their families and a frequently asked questions tip sheet for members "Making the Most of Your Behavioral Health Medications."

- **Amerigroup will implement multiple strategies to engage members in treatment.** We will support providers' treatment services through integrated care planning that implements a member-directed and recovery-focused care plan for members enrolled in case management aligned with the provider's treatment plan and coordinated across settings and providers. We will also proactively identify members who appear to have a history of inconsistent engagement in treatment from a review of encounter data to identify gaps in services, from available assessment information, and from provider calls or notification that they have been unable to engage the member consistently. *A behavioral health case manager will engage the member using EBPs such as motivational interviewing and the Patient Activation Measure or PAM[®].* PAM is a tool used to assess members' level of knowledge, skills, and confidence regarding their health condition. The assessment results help the case manager identify the types of interventions most likely to help the member progress to the next stage of self-management. Use of the PAM by Amerigroup Case Managers has improved quality by decreasing inpatient admissions and ER visits while increasing PCP and specialist visits, all in the broader context of reducing overall cost of care. We will incorporate relevant EBPs, such as the PAM, to help members become more active participants in their healthcare and behavioral health treatment. If a member has no prior engagement with a case manager, the behavioral health team will contact the member to initiate the care planning process that will include strategies for engagement in treatment. Outreach may include:

- Making telephone calls to the member, including repeated attempts at varying times of the day, in accordance with State access standards
- Making personal visits to the member by field-based employees or by our providers who will offer home-based services
- Placing behavioral staff in high-volume PCP offices
- Mailing written information to the member asking them to contact us for more information and providing contact information for the local behavioral health team
- Contacting the member's providers, particularly PCPs, to find and connect members, leaving information with the provider and obtaining an alternate telephone number and address.

We will also identify opportunities to partner with health homes, CBOs, and county agencies to locate hard to find or reach members.

If a member continues to decline treatment, we monitor their service utilization, contact providers we identify from the claims data, and identify opportunities for contact based on specific events like ER use, inpatient admission, or a change in healthcare status.

- **We fully support the State's goal of maximum community integration.** Through collaboration with community-based organizations, members access services and supports to maintain their home environment, education, and employment. The primary focus of our integrated approach to service delivery is promoting members' recovery. Members diagnosed with serious mental illness or serious emotional disturbance are typically the highest cost and highest needs members and therefore have the greatest opportunity to benefit from integrated, coordinated, and recovery-focused healthcare. We are passionate about developing and implementing strategies for members in this priority population that minimizes hospitalizations and residential treatment while increasing community tenure. We will consider individual member choice and community-based alternatives whenever feasible (within available resources).
- In addition to our clinical case management approach, other key elements of our strategy involve:
 - Collaborating with other systems including housing, school, and supported employment

- Incorporating social/recreational opportunities to increase community participation and connectedness
- Providing Value-Added Services as part of the overall clinical intervention, such as paying for membership fees for local Boys and Girls Clubs or providing financial assistance for utility deposits, household goods or rent to support a member's reintegration into their community
- We support the use of enhanced staffing to help members reside safely in a community-based setting and will build upon affiliate experience and policies to help assure covered benefits are provided at the right level of intensity to meet members' needs. ***We will also authorize cost-effective supplemental services for members who would otherwise require a higher level of care to help members remain in the community.*** We will develop Iowa-specific policies and procedures for supplemental service authorization based on our history of developing collaborative, innovative solutions to address member supports needs.
- **We are committed to implementing services that uniquely address children's behavioral health needs and preserve the integrity of their family environment.** For instance, ***in Tennessee, our affiliate health plan implemented the Family Connection Program developed by Tennessee Voices for Children, a statewide agency.*** The program was a cost-effective alternative used exclusively by Amerigroup and now broadly available statewide. Family support providers are trained parents or caregivers with first-hand experience raising a child with emotional, behavioral, or mental health disorders who have successfully navigated the system to access services and supports. They provide support to other families and work with a behavioral specialist, the child, and his or her parents to identify child and family strengths and needs, connect the child and family with services, and build necessary skills to maintain the child at home, in school, and in the community.
- **Amerigroup will leverage technology to increase access to services and improve member outcomes.** We will leverage the substantial telehealth services currently available in Iowa (for example, through the University of Iowa) and provide additional telehealth platforms for behavioral health. Amerigroup will offer a web-based behavioral telehealth solution that provides members in geographically remote areas with access to qualified behavioral health providers and services. This technology has been successfully launched across the nation supporting critical communications between members and qualified providers. ***Surveys show that overall member satisfaction is 87 percent with 50 percent of those responding reporting that they would not have access to a behavioral health provider without this innovative technology.*** Amerigroup will identify strategic geographic locations such as local Community Mental Health Centers, Public Health Department locations in local communities, and other places that to provide telehealth technology that can be easily accessible to our members in a private setting.

We will also leverage technology to address a common barrier to a member's improved symptomatology and function—lack of medication adherence—through automated medication reminders. Amerigroup will bring this newly created secure online and mobile platform focused on medication adherence through electronic pill dispensers paired with member-specific automated reminders to the Iowa Medicaid market. This interactive application is capable of managing and dispensing medication and tracking medication adherence, with robust reporting, through a cloud-based portal. Through this portal, members and caregivers can access medication-related information that can be used to inform decision-making and treatment plans. Key features of this technology solution include:

- Member autonomy through electronic medication reminders
- Real-time medication adherence data
- Secure social support engagement platform for members and caregivers

- Real-time care management monitoring to mitigate adverse effects of missed medication

Amerigroup has partnered with *Careticker, an innovative web and mobile platform that enables a family member and/or family caregiver to track and report caregiving activities provided to a member.* In addition, the family members can submit daily notes and observations regarding their loved one. This information is reported back to the case manager in real time. The case manager can then communicate and interact with the family member and provide the necessary support or guidance to the family member during the course of care for their loved one.

Question 3.2.8, #3

3. Describe how your proposed approach will engage families, natural supports, advocacy organizations and network providers in the behavioral health care planning and care delivery process.

Engaging Families and Other Stakeholders in Behavioral Health Planning and Care Delivery

Families, other natural supports, advocates and providers—along with members—are key components of a recovery-oriented, strengths-based approach to behavioral health. Our approach to care planning and care delivery recognizes that inclusion of family members and other natural supports, including friends and advocacy organizations in which a member participates, is key to supporting a member's sustained recovery.

Care planning, which we make a collaborative interactive process with the member, member's family, health plan, and others designated by the member, aims to provide the appropriate level of support to the member, family and other natural supports, and providers in the development and implementation of a recovery-focused and strengths-based personal care plan. The resulting care plan is developed during meetings that are convenient and accessible—through the use of toll-free conferencing or face-to-face participation at a convenient location, typically at a member's home, in a service site like a clinic or day program, or at a community-based location that provides appropriate facilities. Likewise, Case Managers will help the member identify and invite the network providers, including primary behavioral health providers, who will be a part of the interdisciplinary team. We will also work with IHH care coordinators to help assure adherence to member-driven, family-focused, and inclusive interdisciplinary care planning.

Family members and friends may benefit from training and ongoing support to help them actively participate in the care planning process. Our family and peer specialists will provide the level of support each family member and friend needs to participate in care planning and will connect them with additional, specialized programs such as the University of Iowa's Family Navigator Network and adult peer support program. In addition, we will build upon the work of our affiliate health plans that have developed a number of family psychoeducation programs to meet the needs of our diverse members. While health plan-specific models differ in their formats (whether they use a multi-family or single-family format), duration of treatment, member participation, and delivery locations, we will promote the use of the SAMSHA-approved EBPs Family Psychoeducation (FPE) and corresponding Family Support (FS), approaches used to develop a working alliance with consumers and families, by network providers and connect members and their families to providers trained in the use of these EBPs. Formal research shows consumer outcomes improve if families receive these sorts of EBP interventions.

We will collaborate with Iowa-based providers currently delivering similar services and identify opportunities to support, supplement, or build upon their current efforts. We will assess the current use of FPE through meetings with county mental health agencies and providers, including IHHs, and discuss

methods to increase adoption. Based on this evaluation process, we will work with providers to expand the use of family psychoeducational programs. In addition, our Case Managers and UM staff will also identify opportunities for FPE during development and ongoing review of care plans and work with providers to revise these plans when appropriate to make sure this modality is available. Examples of how we might promote adoption include:

- Distributing FPE EBP materials to existing network providers, posting them on the provider website, and announcing adoption in newsletters, broadcast faxes, and special mailings
- Including FPE EBPs in provider education
- Promoting adoption during case conferences, record reviews, and other interactions with providers
- Supporting member and family engagement in FPE with select, high-volume providers by sponsoring initial member engagement activities such as a dinner meeting to introduce FPE to members and families

Individual Service Coordination and Treatment Planning Requirements (3.2.8.4)

We will require providers to develop a wellness and health promotion-oriented treatment plan for members engaged in care that meets applicable Iowa Administrative Code requirements. Each treatment plan should include a crisis plan or relapse management plan that addresses the member's self-identified triggers and that is consistent with the member's care plan. We will communicate this expectation:

- As part of the contracting process and during initial provider orientation
- In our Provider Manual
- During routine meetings with providers
- Whenever we identify a treatment plan that does not include required elements
- During routine audits

Our approach to making sure providers are meeting contractual requirements and performance expectations is built on collaboration and support. If we identify a need for individual or group provider education to strengthen service coordination and treatment planning, we will make this education available through webinars, in-person educational sessions, and educational materials disseminated on our website and through fax blasts.

Covered Mental Health and Substance Use Disorder Services (3.2.8.5 - 3.2.8.6)

Amerigroup will deliver behavioral health services in accordance with the scope of covered services outlined in Iowa Administrative Code 441 Chapter 78, the Iowa Medicaid State Plan, and waivers.

Fifteen of Amerigroup's 19 affiliate health plans currently coordinate and manage the delivery of a full range of behavioral health services, expanding to 17 health plans by January 2016. Our affiliate health plans also have extensive experience partnering with states to administer publicly funded substance use disorder programs and services. Our local affiliates provide substance use disorder benefits in 13 states expanding to 14 of 19 health plans by January 2016.

Amerigroup will comply with covered services requirements: We understand that medically necessary mental health services will be provided to meet the individual's service needs whether or not they are court ordered or are provided to children in need of assistance or adjudicated delinquent. We will provide

SUD services described in Exhibit D of the RFP to IDPH participants in accordance with SOW Section 3.1.1.1.

Iowa Health and Wellness Plan (3.2.8.7)

We understand that members enrolled in the Iowa Health and Wellness Plan, with the exception of Medically Exempt members, are eligible for the services covered under the Iowa Wellness Plan Alternative Benefit Plan State Plan Amendment and will comply with the requirements of the SOW Section 3.2.8.7.

Question 3.2.8, #4

4. Describe your proposed peer support/counseling program.

Amerigroup recognizes the value of peer supports for our members, and seven affiliate health plans—in Florida, Georgia, Kansas, Kentucky, Nevada, New York, and Tennessee—either currently cover this benefit (with West Virginia soon adding this service as a covered benefit) or actively recruit and hire team members as peer support specialists. We will build upon affiliate experience and the excellent work the State has done, partnering with the provider community and the University of Iowa's Center for Child Health Innovation to grow the current training capacity for peer support/family support certification.

We will work closely with IHHs and their peer support and family support specialists. In addition, we will credential and work closely with other certified peer support specialists to make their services available to members and families. *We recognize the important contributions that peer recovery specialists make* and want to assure that these services are widely available to our members. To that end, *we will pay the State certification fee of \$100 for up to 100 peer support specialists seeking first-time State certification.* We will also contract with organizations that provide family and youth peer support services for high-risk adolescents and young adults.

Peer Recovery Specialist Certification

We will collaborate with DHS and the University of Iowa, and potentially other Iowa-based organizations, to support the current Iowa-specific service description and training for Peer Recovery Specialists, including substance use disorder peer support/counseling coaching that includes practitioner qualifications, and assist in increasing access to peer recovery specialists who will work with members with an SUD. We will actively look for opportunities to support the State and other health plans with trainings around the State, providing technical assistance and financial support for trainings offered statewide. The training will also focus on developing expertise in substance use disorder awareness and treatment and health and wellness issues, such as preventable, premature death; eight wellness dimensions; habits to support physical wellness; nutrition and diet; physical activity; and sleep and rest. Sponsorship will include underwriting of the cost of the trainings.

Peer Support Innovations

Amerigroup is constantly exploring innovative methods to outreach to, engage, and support our members in their recovery journey.

Careticker

Careticker, described previously in Section 3.2.8.2, includes a virtual caregiver social network that enables family members and caregivers to connect and provide peer support to one another. Caregivers can reach out based on locations (those that are in their community) and to those who may have similar conditions.

Veteran Peer Supporters

We will implement a program in Iowa that recruits veterans to create a peer support network that incorporates national best practices while meeting the needs of the local community. We will recruit veteran field medics with medical experience who will become peer support workers conducting outreach activities and collaborating with providers and community-based agencies in veteran centers, agencies serving significant populations of veterans who are homeless, and neighborhoods where hard-to-reach members will be connected to services.

Self-advocacy Group Memberships

Amerigroup will also offer self-advocacy memberships as a Value-Added Service for members interested in developing skills to advocate for themselves through training, resources, and participation in advocacy groups. Members will be eligible to receive membership in one of four national advocacy groups: the National Center for Independent Living; TASH; the American Association for People with Disabilities; Self-Advocates Becoming Empowered and the Autistic Self Advocacy Group. We will also sponsor member attendance to a conference or event sponsored by organizations such as Iowans with Disabilities in Action, NAMI-Iowa, Area Agencies on Aging, the Developmental Disabilities Council, and Iowa Foster and Adoptive Parents Association.

Question 3.2.8, #10

10. Describe how you will provide care that addresses the physical and behavioral health needs of members in an integrated manner.

Integration is at the heart of our philosophy and approach to the delivery of benefits and services. Our comprehensive approach to providing care that addresses a member's physical and behavioral health service needs in an integrated manner includes integrated healthcare system planning combined with Amerigroup's implementation of our fully integrated managed care model in Iowa. We know that the separation of behavioral and physical health benefits is inefficient and does not meet the holistic needs of members. In fact, the linkage between behavioral health conditions and physical health conditions is very strong. Attending to behavioral health conditions and health behaviors provides increased opportunity for member stability and recovery, as well as achieving efficiencies in service delivery.

- We will work with members, providers, advocacy organizations, county mental health agencies, State representatives, and other stakeholders to help implement integrated, managed physical and behavioral healthcare in a way that is sensitive to the service needs of local communities. We propose joining with other health plans to form a working group on integrated care to:
 - Address the communities' short-term needs related to transition from Magellan's management of behavioral health services to the health plans'
 - Identify barriers to integration that exist today and ways to remove these barriers
 - Identify approaches to continued evolution of integrated care rooted in EBPs
- We actively support development of integrated and chronic condition health homes and other approaches to the delivery of integrated care as described in Section 3.2.4., including colocation of primary care and behavioral healthcare providers, as we have successfully done in other states (see Section 3.2.9 and 3.2.10). We will also provide telepsychiatry consults and consults with other specialists for PCPs through the use of telehealth and online consultations, including consultations with addictionologists, to address pain management, opiate addictions, and other substance use issues. We will closely collaborate with FQHCs in their integrated care efforts as we recognize the value that they bring to treating the continuum of behavioral conditions from mild to complex.

- We will implement our fully integrated care management program described in Section 3.2.8.1. Behavioral health Case Managers will work in regional interdisciplinary teams that include the disciplines required to meet the holistic service and support needs of members including physical health, LTSS, and social supports such as housing and employment. Our behavioral health team provides the level of support members and their families need, including care coordination and complex case management, and address member's complex needs as part of the interdisciplinary team process.
- Amerigroup will implement integrated mental health services and supports that include informal supports provided by family members, friends, and community-based organizations into member's behavioral health treatment plans to help members remain in or return to their home. Amerigroup will provide compensation for informal supports as supplemental services when the support is needed to avoid higher cost care and helps the member remain in the community, including at home with family members. Supplemental services are individually identified services not available from any other source authorized to meet a member's preferences and support needs. Informal supports will be tracked and reported using Careticker, described previously in Section 3.2.8.2.
- Case Managers will engage members and their families in recovery- and resiliency-focused care planning that includes the member, family members/representative, health home representatives for members enrolled in health homes, the member's PCP, behavioral health treating providers and other services providers, and others chosen by the member or involved in the member's daily living. We will work with members and their families to identify their services and supports, including informal supports and services reimbursed from other funding streams.
- Amerigroup will promote recognition of mental health and substance use disorder issues that can complicate receipt of healthcare services by offering Mental Health First Aid training to non-emergency transportation providers and other systems (such as EMS, police, and school systems) that routinely come in contact with members with behavioral health issues. This will build on the current foundation of Mental Health First Aid training offered in Iowa. Mental Health First Aid is a ground-breaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Those who take the 12-hour course learn a five-step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. We will also collaborate with organizations such as the Iowa Primary Care Association, Iowa Department of Human Services, Division of Mental Health, Iowa Department of Education, Iowa Department of Public Health, NAMI, and Iowa Law Enforcement Academy by sponsoring training for other providers and community agencies that serve our members.
- We will implement Member 360, a member dashboard, and an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, each described previously in Section 3.2.8.1.
- We will reward the provision of high-quality and integrated care through provider incentives, described in Sections 3.2.8.1 and 10.3. We will identify additional innovative pay for performance opportunities working in collaboration with the State and providers as the managed care delivery system matures.

Prevention and Early Intervention (3.2.8.10)

Question 3.2.8, #5

5. Describe your services for prevention and early intervention.

Amerigroup will implement a comprehensive array of services that build on initiatives implemented by affiliate health plans with demonstrated value in identifying members who can benefit from preventive and early intervention services. Screening for emerging or unrecognized mental health and substance use disorder treatment needs is an important component of our program and key to achieving positive integrated health outcomes. We will give providers screening tools and training to support early detection of member's behavioral health needs so that members and their families receive preventive and early intervention and work with providers to support screening and early intervention at every opportunity.

Prevention and Screening Approaches for PCPs

An important aspect of early intervention is detection of developing issues at the earliest possible time. PCPs are often the first healthcare professionals to identify an issue during an office visit. We expect PCPs to screen our members for behavioral health conditions, and we will provide them with the tools and expertise to complete these screenings. We will provide PCPs with tools and on-site support to facilitate detection of mental health and substance use disorder issues.

- **Amerigroup will build on the work of the Iowa Chapter of the American Academy of Pediatricians (AAP)** to provide PCPs with tools and training for screening and detecting emotional disorders, mental health conditions, and substance use among their child and adolescent patients and for connecting children and their families to early intervention programs and our behavioral health team. For example, we will promote use of the Behaviorally Effective Healthcare in Pediatrics (BEHIP) protocol developed by AAP. BEHIP provides training for pediatricians in screening for behavioral health issues using recommended standard tools such as MCHAT for autism spectrum screening, the pediatric symptom checklist, Strengths and Difficulties questionnaire, PHQ-9 modified, and CRAFFT. BEHIP also offers coding and reimbursement training for using these screening tools and offers videos that are targeted at helping increase the comfort level of the pediatrician in identifying and initiating treatment of behavioral health issues. This is especially important in the adolescent population where the pediatrician has to be fully prepared to explore essential behavioral health issues. For many teens, this may be one of the few opportunities for screening and intervention.
- We will provide evidence-based screening tools for adults and children such as the PHQ-9, AUDIT-C, and Mood Disorders Questionnaire; educate providers on their use; and develop policies and procedures to guide administration, intervention, and follow-up. We will also distribute information and materials for screening and prevention throughout our contracted network of providers. We will encourage providers to contact the behavioral health team or make a referral to us for help identifying providers of behavioral health assessment and treatment services and to identify other services or programs that will help address the member's and family's support needs, including health education, disease management, care coordination, and complex case management.
- **We will implement innovative models**, such as co-location of behavioral health staff in a PCP's office, that further support screening and early intervention. Over half of patients seek treatment for behavioral health conditions from their PCPs, and non-psychiatrists write more than three-fourths of antidepressant prescriptions. We propose to implement the Amerigroup Primary Care Integrated Screening, Identification, Treatment, and Evaluation of Depression and Substance Use Disorders (PC-INSITE) program to improve the detection, diagnosis, treatment, and ongoing management of

persons experiencing depression and/or a substance use disorder (SUD). PC-INSITE creates supports within the primary care setting to enhance the PCP's tools to diagnose and treat behavioral health conditions such as depression and substance use disorder. This whole-person approach utilizes social workers, psychologists, and professional counselors to perform screening, assessment, and brief solution-focused interventions in the primary care clinic. Psychiatrists provide consultation and support to the PC INSITE team and both formal and informal consultation with PCPs regarding medications.

- **We also propose to implement the new Amerigroup PC INSITE program for children and adolescents in conjunction with the AAP.** The program includes two main elements: behavioral health coach interventions and the BEHIP protocol. The behavioral health coach interventions engage the physician, child/adolescent, and family members in determining a course of intervention—behavioral health coaching, psychoeducation and parent coaching, psychotherapy, antidepressant medications, or some combination of these interventions. The behavioral health coach employs techniques and approaches consistent with motivational interviewing and cognitive behavioral treatment (CBT). Activities may include the following EBPs:
 - Relaxation techniques
 - Focusing on pleasurable activities
 - Addressing negative thinking patterns
 - Social skills training
 - Problem-solving
 - Strategies for maintaining gains
- **Reimbursing for screenings during primary care visits.** We will reimburse PCPs for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for members with substance use problems. This model screens for substance abuse and supports brief counseling and treatment. It also includes a pathway for referral for more in-depth evaluation and/or treatment for members needing more intensive support. We will include screening requirements and information on how to refer a member to a behavioral health provider in our provider contracts and Provider Manual and review this information during provider orientations. Our PCPs can access online training on screening tools and on-site technical assistance from Provider Services Staff. Medical practice consultants with behavioral health experience will be on-site at key primary care and PCMH locations to support PCPs in recognizing the importance and application of screenings. Provider newsletters, bulletins, and alerts will also educate providers on screening for behavioral health conditions.

Health Plan Screening and Outreach

In addition to screening completed as part of our New Member Welcome Call and identification of members for early intervention using claims and other data analysis, we will screen members engaged in our disease management and care coordination programs during initial assessment and follow-up contacts, as clinically indicated. The assessment will incorporate, as appropriate, the PHQ-9 and the Mini Mental Status Examination. Screening questions address behaviors, medical and behavioral co-morbidities, mood, cognitive abilities, social adjustment, and substance use (including tobacco) and are part of our overall disease management and care coordination tools. Depending on responses to questions, our assessment tool probes into more than 20 potential clinical areas for risk factors, including depression, psychosis, anxiety, suicidality, attention deficit hyperactivity disorder (ADHD), autism, and Asperger syndrome. We will use this information to help us determine the member's need for a referral for further assessment by a mental health or substance use disorder provider as well as their need for other services and supports based on complexity, severity, intensity, and risk.

We will also conduct targeted outreach to members at-risk for a first time behavioral health admission. Using a predictive modeling program developed by our national Health Care Analytics team, our system ranks our members 0-100 (low to high) on their risk of a first-time admission for a mental health or substance use disorder condition within the coming two months. Members who score 10 or more who are not currently participating in care coordination (or their families) receive outreach calls from our behavioral health clinical team to assess their need for care coordination or complex case management and provide them with information regarding housing, transportation, and other services available. This program is currently being used in Florida, Georgia, Kansas, Louisiana, Maryland, New Jersey, New Mexico, Nevada, New York, Tennessee, Texas, and Virginia and has shown success in reducing first time admissions. Specifically, those **members able to successfully engage in this program are twice as likely not to have a first-time behavioral health admission.**

Court-Ordered Mental Health and SUD Services (3.2.8.14)

We will be responsible for the provision of covered and required mental health and substance use disorder services ordered for members through a court action as specified in the SOW Sections 3.2.8.11 and 3.2.8.12. Our affiliate health plans routinely collaborate with and coordinate covered court-ordered services and actively work to improve service outcomes and efficiencies. We will work with the court system to develop care plans and appropriate interventions for members with court-ordered services. We will also provide education about our health plan, integrated care coordination model, interdisciplinary team planning and care plan development, and our approach to substance use disorder treatment coordination and service delivery, to further support court orders and desired outcomes.

We also plan to implement a unique program, designed after a program originally conceived in Georgia, in which we integrate advice from a group of Iowa expert judges with deep content knowledge on the specific program and services. Amerigroup Georgia currently provides training for Law Enforcement Officials and Judges across the State on the Georgia Families 360 (foster care) program. The health plan provides detailed training to judges in various jurisdictions making courtroom visits to educate judges and their staff on a range of topics including care coordination and psychotropic medication oversight. In addition, Amerigroup Georgia distributes a Juvenile Court Judge and Law Enforcement Primer to every judge and juvenile court system in Georgia. The primer includes training resources, frequently asked questions, a court system specific presentation, and a contact list. We look forward to working with the Iowa judicial system and law enforcement representatives to develop and implement a similar program that is specifically tailored to meet their needs

We also look forward to working with court system, IDPH, and the State on developing any needed, evidence-based interventions that have demonstrated effectiveness with this population such as Multi-Dimensional Family Therapy (MDFT) and other interventions for families and youth at risk and other juvenile offenders. Amerigroup can provide EBP support and training, either through one of our national provider relationships or through an Iowa-based practitioner with the required expertise.

Services at a State Mental Health Institute (3.2.8.13.1-3.2.8.13.2)

We will authorize payment for inpatient treatment at State mental health institutes for members as specified in SOW Section 3.2.8.13. Our UM system and precertification criteria enable us to identify admissions by facility type and age of the member. Our UM team receives ongoing, rigorous, and State-specific training that helps ensure access to appropriate services and timely authorization in accordance with DHS requirements. For more information on our UM process, please refer to Section 11.

We understand that the State's Mental Health Institutes have been an important part of the system of care and will work collaboratively with DHS and other stakeholders to meet the needs of members admitted to and discharged from these facilities. We also understand the role of the State's Mental Health Institutes will inevitably change, and we will work collaboratively with stakeholders to assure that our processes

and procedures align with any changes. We are aware of the significant efforts of the Mental Health and Disabilities Services Redesign group and look forward to participating in this important initiative to improve behavioral health services and outcomes. We will bring to this process our national expertise, along with our Iowa-based behavioral health experts.

Members admitted to, and discharged from, State Mental Health Institutes will be enrolled in care coordination and followed by their assigned care coordinator throughout their stay. Amerigroup care coordinators will participate in the member's treatment planning as requested by facility staff and will be actively engaged in discharge planning.

We will build on the experience of affiliate health plans to support discharge to the community and implement innovative programs to increase community tenure. For example, our Tennessee affiliate, in partnership with the local community, developed an innovative community-based alternative housing and treatment service for members who had been in long-term institutional care together. Amerigroup Tennessee collaborated with a CMHC, Mental Health Co-op, and a local business person to find housing and coordinated extensive wraparound services for them to be successfully integrated into the community and in many instances reunited with their families.

Question 3.2.8, #7

7. Describe how you will support IDPH-funded Women and Children services.

Supporting IDPH-funded Women and Children Services

We will collaborate with IDPH across the wide range of Women and Children services and programs it offers to IDPH-eligible members, coordinating access to IDPH-funded substance use disorder treatment services and making sure IDPH substance use providers are reimbursed timely. We will provide training to IDPH and providers on claims submission and provide a designated point of contact within our claims and provider relations team available to assist with billing and reimbursement issues. We have already begun meeting with IDPH-funded providers who specifically provide care for women and children. We value and understand the services delivered by IDPH, such as WIC, that are important to Medicaid-covered women and children and that may represent an opportunity for the early identification of pregnant women with substance use disorders. We will assure that our Amerigroup Case Managers are aware of the scope of services, the covered IDPH benefits, and how to refer and coordinate with IDPH providers.

Ensuring Pregnant Women with SUD are Prioritized

We recognize that pregnant women with substance use disorders are a priority for identification and rapid engagement in treatment. Amerigroup will implement processes and programs used by our affiliate plans to make sure that we prioritize pregnant women with substance use disorders. We also recognize that the treatment of substance use disorders in pregnant women is a specialty unto itself. We have outreached to providers with this level of expertise such as Heartland Family Service, Crossroads Behavioral Health Services, and Jackson Recovery Centers.

Pregnant members enrolled in care coordination or complex case management are screened for substance use and when identified enrolled in the appropriate level of care management based on their individualized needs. Our Taking Care of Baby and Me program is a comprehensive maternal and child health program and provides high-risk pregnant members, including members with a substance use disorder, with obstetric (OB) case management. Our Taking Care of Baby and Me program, including the OB case management component of the program, is described in Section 9.0 Care Coordination.

Our ongoing training and support for our OB/GYN network providers includes information on the importance of screening for substance use disorders in pregnant women. In addition, we provide information, tools, and education on the use of standard substance use screening tools.

We will promote the use of the most effective interventions for women who are pregnant and opiate addicted. For example, in Tennessee, we have adopted the most recent and effective standard of care for pregnant women with opiate addiction who are admitted for detox at Vanderbilt. Amerigroup Tennessee coordinates access to Subutex through a specialty vendor. Subutex is a safer addiction medication that has fewer long-term effects on the fetus than other medication alternatives. The health plan worked with the State to obtain authorization to pay for a dosage that is beyond the member's covered benefit as a cost-effective alternative. This solution offers pregnant women who are addicted to opiates the opportunity to safely reach a level of stability on medication that protects the health of the fetus, avoids the neonatal abstinence syndrome that would occur if she were using, and promotes her ability to be drug-free or at the lowest level of maintenance possible. In coordination with DHS and with local provider expertise, we will leverage best practices from Tennessee and other plans in our Iowa program.

Our healthcare analytics capabilities identify women with potential substance use disorder. Providers are contacted by Amerigroup clinical staff to get a complete clinical picture of their identified members who have received narcotics prescriptions from more than three providers in a 90-day period. Based on the information and supplemented by information gathered in a call to the members, we determine the nature of the needed clinical intervention and create a case management plan to effectively treat members with a confirmed substance abuse disorder.

Outreach Services for IV Drug Users (3.2.8.15)

Question 3.2.8, #6

6. Describe how you will ensure providers conduct outreach activities for IDPH participants who are IV drug users.

We will train and educate providers and periodically conduct monitoring to confirm that they are outreaching to and actively seeking to treat IDPH IV drug users. We will collaborate with the State and other health plans to develop provider training materials and help providers complete required activities through the provision of technical assistance and consultation. We will conduct an annual audit of provider outreach activities to confirm completion and linkage to appropriate treatment programs and, where outreach is not occurring or is ineffective, work with the provider to develop a corrective action plan.

Tuberculosis Services (3.2.8.16)

We will make tuberculosis services available for IDPH participants through our contracts with the IDPH substance use disorder provider network. We will train and educate providers and periodically conduct monitoring to confirm they are implementing infection control procedures and protocols provided by the DHS and IDPH and testing for tuberculosis in the populations identified in the SOW Section 3.2.8.16. We will collaborate with the State and other health plans to develop provider training materials and help providers complete required activities through the provision of technical assistance and consultation. We will conduct an annual audit of provider activities to confirm adherence to these requirements.

Maintaining and Updating a Compendium of Evidence-Based Mental Health Practices (3.2.8.17)

Amerigroup maintains EBPs and emerging best practices for mental illness and substance use disorders that reflect optimal treatment protocols and incorporates these into our CPGs. We use EBPs and emerging best practices recommended by the:

- American Psychiatric Association (APA)
- American Academy of Child and Adolescent Psychiatry (AACAP)
- Substance and Mental Health Services Administration (SAMHSA)
- National Institute of Mental Health (NIMH)
- American Society of Addiction Medicine
- National Institute on Drug Abuse
- National Alliance of Mental Illness
- United States Department of Health and Human Services

Examples of EBPs for mental illness and substance use disorders we maintain include:

- ACT–SAMHSA
- Illness Management and Recovery — SAMHSA
- Supported Employment (Individual Placement and Support) — SAMHSA
- Integrated Dual Disorder Treatment for co-occurring disorders —SAMHSA
- Family Psychoeducation — SAMHSA
- Tobacco Cessation
- Motivational Enhancement Therapy — SAMHSA
- Twelve-step Facilitation
- Cognitive-Behavioral Therapy For SUD
- Medication-assisted Recovery for SUD

Examples of behavioral health clinical practice guidelines maintained by Amerigroup include:

- Behavioral Health Screening, Assessment, and Treatment
- Bipolar Disorder in Adults
- Bipolar Disorder in Children and Adolescents
- Schizophrenia
- Antenatal Depression (AND), Post-partum depression (PPD), and Post-partum psychosis (PPP)
- Preferred Practice Guidelines, Identification and Treatment of Adult Depressive Disorder
- Attention Deficit Hyperactivity Disorder in Children (ADHD)
- Preferred Practice Guidelines, for the identification and treatment of Substance Use Disorder (SUD)

EBPs are selected by each health plan based on the characteristics of the local market. We will identify EBPs for Iowa based on analysis of member needs, service utilization, and provider practices. We will consult with the local providers on their use of EBPs, analyze responses, perform data analysis, and gather input from DHS and our subject matter experts to compile a compendium of EBPs for Iowa for initial implementation. We will annually and on an ongoing basis assess the consistency of EBP use and

advise the State of needed changes to support increased utilization and consistency with established EBPs.

Question 3.2.8, #8

8. Describe your screening and treatment protocol for children with serious behavioral health conditions. Provide a sample crisis plan and describe how you will work in collaboration with local school systems.

Screening/Treatment Protocol for Children with Serious Behavioral Health Conditions (3.2.8.18)

Amerigroup screens children for serious behavioral health conditions at every opportunity and expects pediatricians and behavioral health providers to identify and screen children with serious behavioral health conditions that if left untreated may cause serious disruption in a child’s development.

We are sensitive to the expertise and individualized practice patterns for screening and treatment protocols for children. Our conversations with Iowa practices (individual, group, FQHC, and university based) regarding their approaches to screening children revealed a broad variety of legitimate approaches. A screener appropriate for a busy pediatric practice will, of necessity, be very different than a screener for a behavioral health practitioner. We therefore suggest a nuanced approach to standardized screening.

For example, for a pediatric practice, we propose the use of the following tools:

- The Children with Special Health Care Needs Screener (CSHCN) operationalizes the Maternal Child Health Bureau of the Health Resources and Services Administration’s definition of CSHCN. This screener focusses on the health consequences a child experiences as a result of having an ongoing health condition rather than on the presence of a specific diagnosis or type of disability. This screener has broad applicability and is easy to use.
- The Pediatric Symptom Checklist-17 is the short version of a validated, reliable instrument that assesses child psychiatric symptoms and identifies those in need of a more in-depth assessment.
- The Vanderbilt Assessment Scale provides a measure of symptoms assessment and impairment of performance.

We propose a set of broad guidelines for behavioral health providers that start with approaching the child as a person living within broader systems that have a significant impact on overall health. These guidelines suggest that screening conducted by a behavioral health provider address the following:

- DSM diagnosis
- Current and historical symptoms:
 - Suicidality
 - Psychosis
 - Potential of harm to self or others
 - Eating disorder
 - Substance abuse
- Functional impairment
 - Self-care
- Community (juvenile justice and child welfare)
- Social relationships
- Family
- School (learning disorders)
- Family, psychosocial, and developmental history
- Medical history, including medications
- Cultural and spiritual

Given the various legitimate tools for screening and understandable provider concern regarding potentially having to implement multiple “standardized” protocols, we recommend a collaborative approach. This approach includes stakeholders, providers, members and families, child welfare, the Mental Health and Disability Services Regions, and other health plans along with DHS to determine the standardized screening and treatment protocol for children with serious behavioral conditions for network providers (physical and behavioral). This collaborative effort can minimize administrative burden while at the same time assuring, to the greatest extent possible, standardized clinical evaluation of children with serious behavioral conditions.

This collaborative approach would bring together Iowa providers, stakeholders, managed care organizations, and DHS. The goal is to determine via dialogue a mutually agreeable, clinically effective screening tool and treatment protocol for use in Iowa.

Amerigroup Screening

Amerigroup also screens for serious childhood disorders in a variety of ways:

- During the new member Welcome Call made to the child’s family, the family is asked to respond to an automated brief telephone screen and given the option to speak to a Member Services Representative. Positive screens are batched and distributed in a daily notification file for screening by our behavioral health team and for further clinical evaluation.
- During a discussion with a Member Services Representative, the family may indicate their child has or appears to have a behavioral health need. The family is warm transferred to a behavioral health call center representative and connected to the local behavioral health team or to the on-call behavioral health clinician for screening.
- Our predictive modeling process uses claims and encounter data to continuously identify members for care coordination and other programs. The system considers member historical information, including diagnosis and demographics, to predict future outcomes. Our process produces two predictive scores: the Chronic Illness Intensity Index (CI3) and a Likelihood of Inpatient Admission (LIPA). Our predictive modeling system synthesizes member data, such as diagnoses, hospitalizations, emergency room encounters, expenditures, and demographics, to develop individualized risk profiles. Children identified as high-risk, including at risk for a first time admission with a primary behavioral health diagnosis, are referred to the behavioral health team for screening.
- Children who have an acute episode of care and who are not engaged in case management are also referred to the behavioral health team for screening.
- Our pharmacy management system proactively identifies children being prescribed psychiatric medications by a non-psychiatrist. These data are used for further outreach and exploration, often leading to the identification of children with emerging serious psychiatric conditions who are in need of specialty care.
- We accept referrals from any source, subject to privacy requirements. Referrals for children with a suspected serious behavioral health condition from physicians and other providers, State and local agencies, including schools and community-based organizations, are accepted by the behavioral health team. Referrals may also originate within the health plan. For example, a child enrolled in case management with a primary medical diagnosis may exhibit behavioral health issues and be referred for screening following a case conference.

Complex Case Management and Social Services Collaboration

Network providers, upon completion of a child's screening and development of a treatment plan, contact behavioral case management staff to collaboratively determine the need for enrollment in complex case management or enrollment in an IHH. Behavioral health Case Managers proactively follow up with the provider to understand the outcome of the evaluation and plan next steps.

The behavioral health case manager working with the member, family, and provider determines if additional assessments are needed, completes referrals for these assessments by qualified providers, and initiates care planning as described previously in Section 3.2.4 that includes the requirements specified in the Scope of Work. The care plan identifies the child's treatment needs as well as the need for other services and supports designed to help the child remain at home or in a community setting (which may include CMH Waiver services described in Section 3.2.11) and a crisis plan. The crisis plan is developed during care planning and is designed to help the family, child, and others working with the child proactively plan for crises by identifying the child's triggers, child/family strengths, immediate child/family needs, safety concerns, and treatment choices. Key contact people are also identified, including the care coordinator, treating behavioral health provider, and others involved with the child and family such as schools, child welfare, and juvenile justice providers and systems.

Collaboration with schools, child welfare and juvenile justice providers and systems, and others involved with the child and family uses an interdisciplinary planning process that supports alignment of the member's care plan, treatment plan, IEP, and family safety plan to identify wrap around services and supports including informal supports such as family peer supports that are effective at maintaining children at home, in school, and participating in community activities such as sports and other enrichment programs.

A sample crisis plan is provided as Attachment 3.2.8-1 Sample Child Crisis Plan.

Reserved (3.2.8.19)

The State has marked this RFP requirement as "Reserved."

Parity (3.2.8.20)

Question 3.2.8, #9

9. Describe how you will ensure compliance with the Mental Health Parity and Addiction Equity Act.

Amerigroup has created a multi-departmental work group that includes senior leadership to evaluate and continuously monitor program compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The work group also provides ongoing guidance on parity between physical health and behavioral health services for members in the states we serve. This includes several committees that help promote compliance across organization initiatives. We will include, on contract award, the Amerigroup Behavioral Health Medical Director of the Iowa Health Plan.

We follow parity requirements and guidance as they are released, including guidance provided in the "CMS Letter RE: Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans SHO # 13-001 ACA #24." We are reviewing the proposed rule recently issued by CMS that addresses application of certain parity requirements to coverage offered by Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and Children's Health Insurance Programs and will make any required revisions to our practices to help ensure continued compliance following rule finalization.

Amerigroup follows federal and State parity laws (for example Timothy's Law), including quantitative and non-quantitative limits for network contracting and reimbursement. We do not place annual, episode, or lifetime quantitative limits on benefits unless imposed by the State. We also do not place prior authorization requirements on routine outpatient behavioral health services. Health plans cannot impose a non-quantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification.

Mental Health, Physical Health, and SUD Integration (3.2.8.21)

Question 3.2.8, #11

11. Describe your mechanisms for facilitating the reciprocal exchange of health information between physical and behavioral health providers and methods for evaluating the effectiveness of such strategies.

We will utilize Member 360 and data exchange systems to facilitate the exchange of information across providers. Furthermore, we will incorporate performance measures such as HEDIS and gaps in care or services to track provider success within the program and will also track utilization of system features to confirm that providers are using the system. These measures will guide future improvements.

Sharing Information through Provider Reports and Tools

One of the most valuable supports we offer our providers is access to the wealth of data we have for our members who access healthcare services. To foster continuity of care and to reduce duplication of services and waste, we collaborate with our providers through sharing data through reports and a secure provider portal. The type of provider drives the type and amount of reporting and access we offer, with PCPs prioritized for information sharing. We also facilitate information-sharing and collaboration among treating providers, offering technology that strengthens the role of the PCP and other providers involved in member care. We believe that communication with our providers needs to be two-way—creating what we call a “clinical data ecosystem” in which clinical data are captured and transformed into actionable information that can be used to improve member health outcomes. The main system that we utilize to facilitate the exchange of data amongst providers is Member 360:

Our integrated care management platform, Member 360, combines member data and information from various sources into a single record to provide a holistic picture of the member's utilization, care management services, and gaps in care. Member 360 includes such information as member health risk assessments, care plans, longitudinal member health records, pharmacy data, and clinical data. Through the provider view of Member 360 located on our secure provider portal, providers who have members attributed to them can see member records giving them simple, easy-to-access data and information to assist them in engaging members in their health and well-being. This view enables any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve care coordination and collaboration between providers through this one-source clinical data repository. We will utilize this tool across provider/member populations.

The provider view of Member 360 also enables providers to understand their members from a population health perspective, how their members are doing, and more importantly, provide information that helps them achieve better results. Member 360 will support providers in achieving the quality incentives defined in our quality programs. With appropriate releases, a PCP will be able to view their members with diabetes to view their most recent HbA1c test results and, at the same time, see members who need to have HbA1c testing done. Additionally, the PCP will be able to view behavioral health treatments, medications, admissions, care plans, goals, and outpatient visits. The tool will take the providers to the next level by delivering much more than data; instead it displays information that is synthesized in a succinct view to create obvious, actionable items. Member 360 will allow PCPs to support recovery efforts, be alert to potential drug interactions, and more effectively coordinate care.

We offer our providers an array of additional data and resources such as the following:

- Interactive provider website with links to a variety of resources, such as Amerigroup Patient and Medical Supports, Clinical Practice Guidelines, and Office Support. The provider website includes online copies of provider manuals, orientations, and training materials.
- Reports to providers on their overall panel allowing them to view their success at meeting certain quality measures. A HEDIS Quality Measurement Report Card enables us to engage in improvement discussions with providers and enables providers to track and improve on clinical measures that are part of behavioral quality incentive programs (such as follow-up after hospitalization rates, HEDIS, ADHD, and antidepressant medication management scores).
- Preferred Provider Scorecard, a tool we developed to enable staff to implement member service referrals to high-quality providers—those with proven records of quality service and outcomes, such as annual quality audit scores, complaint counts, potential quality of care counts, and critical incident handling timeliness.

Availity Improves Provider Satisfaction

To make it easier for our providers, we are making claims status, eligibility, and enrollment information available via Availity, a multi-payer portal. The Availity secure health information network gives providers an easier solution by making data from multiple health plans available to them in one standardized, simplified interface.

Additionally, we will enable two-way information-sharing with providers to exchange admission, discharge, and transfer (ADT) data to be integrated into our care management process and Member 360 integrated platform. ADT data provide Case Managers with a wealth of information interceding and facilitating more timely transitions, more effective communications with the member's PCP, and better coordination of member care. As additional clinical and administrative data sources are available from large Iowa providers and through Health Information Exchanges (HIE), we will continue to enrich the Member 360 environment. We will work with the Iowa HIE to implement a DIRECT secure email gateway between large contracted PCPs and Amerigroup.

Post-launch, we will facilitate additional data-sharing between providers. If the State approves and providers attest that they have permission to share protected information, we will provide HIV, SUD, and mental health information through Member 360. This will give providers the ability to see the entire clinical picture and intervene with the "whole person," in mind. We have mechanisms to help assure that this data exchange is leading to positive outcomes.

Through Member 360, we will track information on gaps in care, HEDIS measures, and others that will enable assessment of physicians' performance over time. Practices with a fully implemented Member 360 that successfully and actively use it are typically the best performing practices from a quality and clinical perspective (highest HEDIS scores and lowest re-admit rates). Additionally, we will track utilization of the various data sources (for example, number of views by data type, time spent on Member 360) to

assess interaction and engagement with the systems. We aim to make data exchange a very measurable, scientific process that leads to empirical, positive outcomes. We are particularly excited about the opportunity to wed our leading-edge information technology clinical platforms with the excellent work that Iowa has done creating IHHs and Chronic Health Homes. An additional opportunity to leverage this technology platform is with behavioral health provider groups who have either implemented integrated care models or are in the process of doing so. We have raised this possibility in several Iowa meetings and have been greeted with widespread enthusiasm.

We also have standard policies and procedures that providers follow regarding reciprocal information-sharing. These policies indicate the required release of information needed and suggest standardized forms for ROI and information-sharing that meet applicable State and federal privacy guidelines and requirements.

To assess the effectiveness of data-sharing, we take several approaches. First, we survey our PCPs on the degree to which they inquire about behavioral health treatment services their members are receiving. Then, we gather information on the extent to which the PCP outreaches to the behavioral health practitioner and the frequency with which they report receiving information from the behavioral health providers. We do a similar survey for behavioral health providers, asking them the frequency with which they reach out to PCPs and the response rate from primary providers. We use this information to communicate with our provider network.

In addition, we will track the utilization of Member 360 at the individual provider level and use this information to work collaboratively with providers to improve performance. Our work in other states has demonstrated that the provider use of Member 360 greatly improves quality and clinical outcomes, and we look forward to demonstrating similar results in Iowa.

Sharing Information for Specific Populations

Delivering Data to Strengthen the Integrated PCP Practice

We will deliver quality management reports to integrated PCP providers to help them better understand the health status and needs of their member panel and provide training and support to improve practice patterns and outcomes. They will be supplied with a suite of monthly reports via the provider website to help them proactively manage the care of their members. These reports include the following, which will be stratified to include members with co-occurring behavioral conditions:

- Monthly Member Listing of members currently assigned to the practice
- Monthly New Member report of new members added to the PCP's roster in the current month
- Daily Inpatient Census of their members currently in an inpatient setting, both physical health and behavioral health admissions
- Weekly Emergency Room (ER) report of their members for whom Amerigroup received an ER claim in the previous week
- Monthly Chronic Illness Intensity Index report showing the relative risk ranking of their members in terms of likelihood to use significant medical services resources in the future
- Monthly Potential Missed Care Opportunities report showing which members have not yet had the test, screening, or visit for various quality-of-care indicators
- Quarterly Medical Cost Management and Shared Savings Reconciliation reports listing opportunities for the practice to manage their members' care more efficiently
- Collaborating with Behavioral Health Providers to Improve Results

For high-volume behavioral health providers as well as health homes, Amerigroup will provide monthly member-level view and total population view reports such as:

- Monthly Member Listing of members currently assigned to the practice
- Monthly Inpatient Report, which is a census of their members with an admission in the past month to include both physical health and behavioral health admissions
- Monthly ER report of their members for whom Amerigroup received an ER claim in the previous month
- Monthly Chronic Illness Intensity Index report showing the relative risk ranking of their members in terms of likelihood to use significant medical services resources in the future
- Monthly Potential Missed Care Opportunities report showing which members have not yet had the test, screening, or visit for various quality-of-care indicators

Using the above reports, Amerigroup will work with these providers to improve quality and health outcomes.

For hospitals, Amerigroup will provide a Behavioral Health Facility Report Card that reports utilization trends on our highest volume inpatient acute facilities and will share this for discussion in our quarterly meetings with these providers. We will also discuss quality issues, including HEDIS measures, and share any relevant data with the group. The meeting is an opportunity to brainstorm with providers on ways to improve quality and member outcomes.

Integrated and Chronic Condition Health Homes (3.2.9 - 3.2.10)

Health Homes are an emerging best practice to address members with chronic health conditions, a serious mental illness (SMI), or serious emotional disturbance (SED). Based upon our organizational experiences and expertise, Amerigroup is prepared to continue Iowa's work in evolving health homes for members with two or more chronic conditions (chronic condition health homes) and integrated health homes for members with SMI/SED conditions. Our responses to 3.2.9-3.2.10 address both types of health homes in outlining:

- Philosophy, health home models, and experiences
- Approach for implementing health homes
- Strategies to increase health homes participation
- Financial model
- Methods to ensure non-duplication of payment for similar services

Our Philosophy

In Iowa, the health home services already exist as a core component of Iowa's medical assistance programs that encompass integrated health homes (IHH) focused on adults and children with serious mental illness. Chronic condition health homes (CCHH) are established for adults and children with at least two chronic conditions or one chronic condition and who are at risk for developing a second. Iowa is one of 16 states that have adopted the Health Home (HH) model. ***We acknowledge the State's consistent track record of innovation and are excited for the opportunity to push this innovation forward.***

Given the State's efforts in establishing HHs thus far, our goal is not to develop, but to improve upon the HH model. We will seek to inform and engage members experiencing multiple occurring conditions in working with the healthcare team to utilize community resources and incorporate hope, personal responsibility, and self-advocacy to achieve functional and clinical outcomes. With IHHs, we will also

focus on building upon the provider network given in the bid library, while working to fill regional gaps (primarily in rural counties), in establishing a consistent, coordinated network. With CCHHs, we understand that regional coverage has additional gaps in available health home providers. We will be proactive in conducting outreach and assisting interested parties in becoming health homes. This includes working with the Iowa Primary Care Association and their member health clinics. With both models, our philosophy is to engage in collaboration with health home providers to evaluate what is working, and what can be improved and enhanced to aid health homes in driving quality and innovation of this evolving health services model.

Amerigroup is committed to supporting DHS’s goals to expand and evolve health homes to reduce fragmentation in care and enhance access to services that address the holistic service needs of members experiencing serious mental illness, serious emotional disturbance, or chronic health conditions by increasing care coordination, facilitating transitions in care, promoting self-care and health promotion, and linking to community services and supports. In establishing the rationale and goals for the health home, we embrace the principles that the individual is front and center in addressing his or her preferences, self-identified needs, and health goals consistent with the member’s cultural values and beliefs. It is important for the health care system to evolve into one that reduces fragmentation in attending to the physical, behavioral, and social needs of the individual.

Health homes are established to evolve the health services system of care in promoting collaboration, coordination, and accountability between health service providers that establishes a person-centered health services plan with person-centered health goals and objectives. Health homes establish a health services team with a health professional champion for the member. The individual is engaged as an active participant in their health to take actions in addressing chronic health conditions. Health homes support the individuals’ self-care as well as making referrals to community services and supports. Health information technology (HIT) facilitates care coordination as well as tracking of health service and ongoing recommended health visits. In addition, our integrated information system can supplement the health homes’ HIT by providing alerts on service gaps to help the team proactively address predictable health service events. Decision supports and evidence-based practices establish the foundation of quality health care enhancing personal health, reducing premature mortality, and gaining efficiencies in health service costs by reducing unnecessary emergency room utilization and inpatient admissions. HIT enables a population health orientation in providing information to direct health services to members at-risk.

Amerigroup’s affiliates have a strong history in promoting holistic systems of care such as health homes, patient-centered medical homes (PCMHs), and other health home-like programs and services; all of these systems are important in establishing an integrated health services model that enhances quality care in addressing physical and behavioral health conditions.

As illustrated in Table 3.2-9, we believe a true transformation to an integrated model of care requires a systemic change from the traditional way of delivering health care services to providing long-term solutions that meet the biopsychosocial needs of members.

Table 3.2-9. Provider Transformation to a Health Home Care Delivery Model

Move From Traditional Care Delivery Model	Move To Health Home Care Delivery Model
Admit, discharge	Engage and follow-up
Focus on the immediate needs	Incorporation of short- and long-term care needs and goals into a single plan of care
Treatment of a single presenting condition	Holistic, biopsychosocial approach to the member’s well-being (mind and body)
Compliance	Adherence
Physician decision-making	Shared decision-making
Passive patient	Active and engaged, voice and choice of the member

Move From Traditional Care Delivery Model	Move To Health Home Care Delivery Model
Episodic documentation	Registries, alerts, and reminders
File audits, episodic events	Focus on outcomes, including member, clinical, and financial
Disease coping	Chronic Condition/Disease Management, including member education on healthy behaviors, health promotion, lifestyle choices, and self-care responsibilities
Individual providers	Integrated Care Teams
Fee-for-service volume-based model	Shared-risk and reward, value-based model

We look forward to working closely with DHS and our network providers to refine and build on lessons learned for health homes to meet the diverse and unique needs of our members in the Iowa Managed Care program. Our IHHs and CCHHs will follow the guidance described in the Centers for Medicare and Medicaid Services State Medicaid Directors’ Letter #10-024.

Core Services

Health homes, whether for persons with severe mental illness, or with two or more chronic health conditions, or with one chronic condition and at risk for a second chronic condition, are responsible for six core health home services, as identified by CMS. DHS has defined these services within the provider agreement, and Amerigroup will include these definitions in health home agreements:

- Comprehensive Care Management.** Providing for all health care needs/arranging care and services, developing a Continuity of Care Document (CCD), and implementing a formal screening tool for behavioral health
- Care Coordination.** Assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes; utilizing health information technology (HIT) to facilitate the processes and communicate results
- Health Promotion.** Coordinating/providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety, and an overall healthy lifestyle; using Clinical Decision Support within the practice workflow; and implementing a formal Diabetes Disease Management Program
- Comprehensive Transitional Care (including appropriate follow-up from inpatient to other settings).** Transitioning patients from inpatient to other settings; confirming receipt of updated information through a CCD and receipt of information needed to update the patient’s care plan; and following up with the patient after transition
- Individual and Family Support Service (including authorized representatives).** Communicating with the patient, family, and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions



- **Referral to Community and Social Support Services.** Coordinating or providing recovery services and social health services available in the community (for example, understanding eligibility for various health care programs and disability benefits and identifying housing programs)

Working Together

We will leverage the state-sponsored health program experience and that of our affiliate health plans in refining Iowa's health home program. Our collective knowledge will be invaluable *in engaging current health home providers and building on their experiences* to address the biopsychosocial needs of members through a single, individualized, and integrated care and service plan. Our established tools, technology, processes, policies, and procedures will support our providers at their level of health home sophistication and drive their learning, evolution, and commitment to a model of care coordination which promotes provider communication, collaboration, coordination, and accountability.

Experience Across the Nation

While we recognize health home programs are a relatively new service model, Amerigroup and our affiliate health plans have been active leaders in implementing health homes and systems of care that reduce fragmentation and promote a holistic focus on person-centered, well-coordinated care across the service delivery system. We have the following *experience in other states*:

- Establishing Patient Protection and Affordable Care Act (PPACA) Section 2703 health homes consistent with Center for Medicare and Medicaid Services (CMS)-approved State Plan Amendments in our New York, Washington, and Kansas affiliates for populations with a broad spectrum of chronic or complex conditions; taken together, we have engaged over 8,000 members in HH services in less than two years – in Washington, we went from a 5 percent participation rate in 2013 to 23 percent in 2014 (over 300 percent increase)
- Working directly with state-operated health homes in West Virginia, Maryland, and Wisconsin to support coordination of care activities
- Providing support and consultation to state entities for planning and developing health homes in California, Kentucky, and Tennessee
- Implementing an alternative health home model, Enhanced Care Coordination (ECC), in Virginia and Indiana that is focused on member engagement, care coordination, and health promotion, leading to member-desired health goals

Chronic Condition Health Homes

Chronic condition health homes (CCHHs) are a refinement to the Patient Centered Medical Home (PCMH), in which the core principles of the PCMH are to attend to the holistic needs of individuals, as well as coordinate with other health services providers. Additionally, the PCMH seeks to build a relationship with individuals served in the clinic to be a resource over time to ensure health promotion and wellness activities, as well as addressing health conditions over the long term. The health home model refines this focus to narrow and intensify the activities for individuals with two or more chronic conditions or one chronic condition and at risk of a second chronic condition. There is a continued focus on a team-based approach, care coordination, and health promotion.

Important in evolving the chronic condition health home is the development of a team-oriented clinic culture that integrates knowledge and expertise to address physical and behavioral health services. This includes a number of important tasks, such as:

- Screening individuals for depression, substance use disorders, and other mental health conditions. Tools to support screening might include: PHQ-9, Audit-C, Pediatric Symptom Checklist, Adverse Childhood Events, Patient or Caregiver Activation Measure

- Implementing procedures to monitor and follow up with members with chronic conditions and experiencing a co-morbid mental health or substance use disorder
- Alerts (generated from providers' EHR) used to provide notification of predictable times for interventions (e.g., eye and foot exams and monitoring of A1C for a person with diabetes)
- Altering interventions when the individual is not responding (stepped care)
- Health promotion and self-care programs
- Timely follow-up after an emergency room or inpatient admission
- Facilitating other transitions in care
- Addressing social and community elements of health, such as housing, transportation, meaningful inclusion in the community, employment, education, recreation, and social supports

For many clinics, this involves a significant investment to redefine processes and procedures and requires addressing the individual professional's willingness and aptitude to adjust the way he or she carries out his or her roles.

We will leverage our affiliates' experience guiding clinics in becoming PCMHs or HHs through education, training, and support in moving to a service model that addresses physical and behavioral conditions utilizing team-based approaches. Chronic condition health home providers will integrate behavioral health expertise to conduct screenings and assessments, provide interventions, complete referrals to the most appropriate specialist, coordinate these services, promote self-care, and work as a team to engage individuals over the long-term.

Integrated Health Homes

Integrated health homes, or in some states identified as behavioral health homes, are intended to increase access to physical health services, lead to less fragmentation, and increase collaboration between Providers. Just as important, integrated health homes seek to engage members and their families in self-care by developing a personalized holistic health services plan that is reflective of the member's and his or her family's health and resiliency and recovery goals. Outcomes reflect on expected program goals, including reduced hospital admissions, reduced hospital length of stay, reduced emergency room (ER) service utilization, reduced pre-mature mortality, increased health status, and increased member and provider satisfaction.

For integrated health homes, in contrast to chronic condition health homes, the challenge for the behavioral health provider (Community Mental Health Center) is addressing the member's physical health issues. For many behavioral health professionals this is new territory; thus, training and consultation on co-morbid health conditions such as congestive heart conditions, diabetes, hepatitis, COPD, HIV/AIDS, cancer, and the interaction of severe mental illness or a substance use disorder are necessary to facilitate effective interventions. In addition, evidence-based practice informs interventions and the role of health care team members in assisting the member develop self-care knowledge, skills, and confidence in addressing his or her health conditions. In developing the integrated health home network, a readiness review evaluates the organization's use of screening instruments and evidence-based practices employed to address health conditions. For example, a tobacco cessation program might employ one of the following three Evidence-based Practices: "Peer-to-Peer Tobacco Dependence Recovery Program," "Learning about Healthy Living," or "Intensive Tobacco Dependence Intervention for Persons Challenged by Mental Illness: Manual for Nurses."

Taken together, we will leverage our experience to educate, train, and support our health home providers in establishing a health home service model that addresses physical and behavioral health conditions. Our IHH model addresses the care coordination needs of members enrolled in 1915 (i) and 1915 (c) waiver programs (Section 3.2.11). Screening instruments will inform chronic health home providers of potential

behavioral health issues while screening for co-morbid medical conditions such as hypertension, diabetes, and BMI and will focus integrated health homes on physical health conditions. This increased holistic focus provides a foundation to enhance shared treatment planning, care collaboration and coordination between health service providers. Outcome monitoring and reporting on population measures such as inpatient and utilization will inform health homes on the effectiveness of their programs.

Question 3.2.9, #1

1. Describe your proposed approach for implementing health homes.

We will promote health home transformation through a holistic orientation that recognizes the importance of integrating primary and behavioral health services while coordinating linkages to long-term community services and supports. Member choice and person-centered care will be emphasized. We believe the crux of health home operations will be based on the following:

- Implementation of health homes will reflect our core values of person-centered, family focused, community-based, and culturally competent care; we will be responsive to the member's racial and ethnic identity values and beliefs
- Engaging Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), primary care, social workers, and other community-based organizations that are currently engaged with members who would benefit from the services and supports of the health home; the engagement process includes a "readiness review" to establish resources in place and ones to be developed in evolving a health home model of care
- Identifying members meeting diagnostic criteria and acuity parameters through claims analysis and the algorithm established for Iowa consistent with the Iowa State Plan Amendment; using the Chronic Illness Intensity Index (CI3), the predictive modeling program developed by our national staff in Health Care Analytics that examines claims history, we will rank our members, e.g., 0-100 (low to high) on their risk of a first-time admission for a mental health or substance use disorder condition within the coming two months. HH will be notified of members who score 10 or more, as well as provided ongoing information on HH members' risk status by type of health condition. Refer to Section 9.1 for further detail on our predictive modeling capabilities
- Enrolling members in the health home that aligns with member choice and condition needs
- Sharing clinical information with health home providers regarding utilization and acuity risk scores
- Monitoring and supporting members by identifying gaps in and access to care
- Engaging in ongoing quality improvement to maximize member outcomes and satisfaction

Working with Providers

The core of Amerigroup's health home design will be a professional-led approach that incorporates coordination between providers that engages the member, family members, providers, and natural supports in developing an integrated care plan that incorporates the member's holistic needs. This includes physical health, behavioral health, and socio-economic issues related to housing, employment, natural supports, and meaningful community participation. In addition to the health home core services listed above, health homes provide traditional health services such as primary care services, specialty services (including psychiatric services), tests and procedures, emergency services, and facility/inpatient services.

A central component for the health home will require our providers to engage members in their own healthcare, conduct care coordination between physical and behavioral health professionals, including specialists, and facilitate continuity in services during transitions between levels of care.

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A central component for the health home will require our providers to engage members in their own healthcare, conduct care coordination between physical and behavioral health professionals, including specialists, and facilitate continuity in services during transitions between levels of care. Effective care coordination will address barriers to service access and gaps in care and promote self-care and member responsibility in decision-making regarding health status and condition management. Shared treatment plans reflect development of member-centric goals, as well as primary responsibility in addressing goals. Treatment planning specifically takes into consideration medication prescribed by all providers with notification of all providers of all prescriptions. Health plan care coordinators may facilitate this process as well as remind health home providers of clinical information available in Member 360. Providers will also be responsible for providing members with information about health promotion such as healthy habits, including exercise, nutrition, and medication adherence. To accomplish these tasks, our health home contracts include requirements for face-to-face meetings, as well as a minimum number of contacts based on the tier a member is assigned. Additionally, we have established guidelines for reporting delivery of health home services reflecting the provision of one of the six core services.

We believe the care coordination role is crucial to the integrated and chronic condition health home and will be further defined for health home providers during the implementation process. Health home care coordinators will have the requisite experience and licensing, as appropriate, to conduct some or all of the following types of activities:

- Coordinating physical and behavioral health care, including referring to specialty providers as needed
- Participating in developing and updating a person-centered care plan based on a biopsychosocial assessment and member progress inclusive of health service providers involved in the member's care
- Developing crisis plans that are integrated into the care plan and readily accessible by all involved team members
- Providing individual and family support
- Educating members, family members, and caregivers on wellness, healthy habits, and personal responsibility in maintaining the member's health
- Facilitating communication, sharing of information, and collaboration between providers
- Helping assure initiation of identified services and supports
- Providing medication reconciliation information to all providers to prevent duplication or contraindication
- Assisting with transitions between levels of care, including follow-up appointments
- Collaborating with the Case Manager on challenging or complex conditions
- Linking, referring, and facilitating access to community-based services

To effectively onboard new health home providers, we conduct a comprehensive health home readiness review. This process scores providers across a number of categories, including: administrative leadership and support, staffing (including definition of team member roles), electronic health record (EHR) capabilities, and clinical processes—procedures for conducting assessments and developing health action plans, processes to collaborate with hospitals, evidence-based treatment protocols, and quality improvement processes. In this way, we are able to assess the provider's capacity to provide integrated care, both from a clinical and an administrative perspective. Support is provided in sharing best practice, evidence-based practice protocols to enhance quality, as well as guidance on early intervention and prevention of behavioral health conditions (See Section 3.2.8). Given our experience with this process, we are positioned to identify and recruit the best providers to serve as health homes.

Engaging Providers through Education

We plan to work with the University of Iowa's IHH learning collaborative, the MHDS Regions for Mental Health, and the Iowa Primary Care Association to facilitate ongoing health home services and enhance provider collaborations. This robust program identifies and engages providers that are ready to embrace a progressive approach to delivering member-centric, meaningful, and cost-effective care to their members. We have a number of educational and incentive approaches that start with assessing a provider's readiness for transformation to a multi-disciplinary team-based coordinated care model. We will work to engage providers across a continuum of key program features essential to the delivery of care that is well-coordinated and integrated and results in positive outcomes for members.

Two main strategies are important to inform providers about program requirements and expectations:

- Promoting collaborative learning communities
- Leveraging our experienced Iowa-based employees

Collaborative Learning

Providers and their care teams participating in the health home will be required to make best efforts to participate in our collaborative learning series, such as participating in live webinars, listening to educational recordings from our library, and completing virtual training sessions designed to assist in practice transformation and maintenance. Attendance will be tracked and assessed to monitor ongoing participation and compliance. We will design a transformation education series to help support provider success in improving quality of care, reducing costs, and managing high-risk members. For example, collaborative learning events might involve a variety of different virtual learning opportunities, including monthly webinars, local virtual office hours that provide extended access for providers and their care team who may have questions, and community-based forums for sharing best practices.

Leveraging best practices from the University of Iowa, our collaborative learning topics will include how to reduce unnecessary hospital readmissions and emergency room visits and how to increase access to care. This includes care coordination for complex conditions such as diabetes; chronic obstructive pulmonary disease (COPD); asthma; coronary artery disease (CAD); congestive heart failure (CHF); and behavioral health conditions, including serious mental illness (SMI), severe emotional disorder (SED), and substance use disorder (SUD).

In building the health home network, new community-based organizations are recruited through directed outreach efforts. When interest has been determined, the provider organization completes a readiness assessment. This assessment identifies key program features and asks the organization to identify the resources currently in place or ones that need to be developed to evolve the service delivery system to one that achieves the goals of a health home. Additional activities dedicated to enhancing the network of IHH and CCHH include:

- Practice consultants and liaisons — dedicated resources
- Regional provider meetings to provide clinical and administrative information on program components, vision, goals, and objectives
- Distribution of a Provider Manual detailing the program
- Webinars and conference calls to address program implementation issues
- Support of multi-payer learning collaborations
- Encouraging and notifying providers of opportunities to evolve their clinical model; for example, the National Council for Behavioral Health calls for organizations to participate in a national learning collaboration for behavioral health organizations to build integrated care capacity—this opportunity addresses such topics as:

- Developing high-functioning primary care teams
- Integrating behavioral health in the primary care setting
- Integrating chronic case/disease self-management in behavioral health settings
- Integrating population health management in behavioral health settings
- Identifying who is responsible for care coordination
- Monitoring and program review of service provision through report cards, including areas such as:
 - Engagement
 - Gaps in care
 - Follow-up after discharge for any type of admission
 - Premature mortality

Leveraging Experienced, Iowa-based Employees

We will make several program resources available to support and collaborate with DHS to achieve successful outcomes and reach program goals. The following information describes the types of roles we will develop in order to support the program. The patient-centered care support roles and contact information will be available via our provider portal prior to the program launch. Some roles may vary, and the level of interaction of the support team may vary based on the needs of the provider organization. Our intent is to make other roles available as necessary to develop health home practice-ready expertise such as:

- **Health Home Leadership** — David Johnson, MSW, ACSW, provides leadership for our national health home program with over 35 years personal experience, with 15 of those years in developing and implementing integrated models of care. For the past two years he has led Amerigroup's health home programs
- **Patient-centered Care Consultant** — Our dedicated regionally based Patient-centered Care Consultants (PCCCs) will focus on program models and structure that include defining work flows and process improvement initiatives. These team members use reports to help focus on interventions that improve population health outcomes by maximizing available practice resources and establishing quality improvement structures. The PCCC works collaboratively to establish transformation action plans.
- **Provider Clinical Liaisons** — Our dedicated Provider Clinical Liaisons (PCLs) will support provider organizations' development of care coordination skills, interpretation of reports, and identification of members who can benefit from a care plan. These individuals also educate providers and staff around the elements of a care plan and assist in care plan creation, coordinating and monitoring care, and establishing processes to facilitate transitions in care. Additionally, the PCL helps organizations manage care for members with more complex needs by leveraging available health plan programs while promoting seamless coordination between the PCP and health plan-sponsored programs
- **Peer-to-Peer Physician Consultation** — Our physical and behavioral health clinical leadership will provide oversight of holistic care plans and actively collaborate with team members and providers as necessary to engage members and their families to enhance self-care. This effort will incorporate clinical rounds with a multidisciplinary team of professionals. Weekly chronic condition rounds include our medical and behavioral health Medical Directors, Utilization Management Nurses, subject matter experts on issues with children or individuals who are aged or with disabilities, a pharmacist, and Disease Managers. These team members prepare and present concerns and complex situations at rounds for validation of the care plan and to obtain suggestions on how to improve the member's care. The team discusses available community resources and receives input from the Medical Directors regarding medical management, medications, and suggested modifications to the care plan

Supporting Providers through Information Sharing

Practice transformation is a process that incorporates quality improvement methodology and practice-level data to drive change that impacts quality, cost, and member experience. It is expected that health home providers will have access to health information systems that include Electronic Health Records (EHR) with preferred functionality including: alerts, patient registries, decision-supports, secure communications with patients and other providers, and reporting on clinical outcomes. Additionally, in order to drive practice improvement, physicians participating in the health home will have access to a series of web-based tools and data platforms.

We are advancing our providers' ability to deliver quality care through care coordination and collaboration that is supported by access to member healthcare information that is holistic, timely, and accurate. Our integrated care coordination platform, Member 360, combines member data and information from various sources into a single view of the member's health services experience to provide a holistic picture of the member's utilization, care coordination services, and gaps in care. Member 360 includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data. Through the provider view of Member 360 located on our secure provider portal, providers who have members attributed to them can see the member record via our provider portal giving them simple, easy-to-access data and information to assist them in engaging the member in his or her health and well-being. This view enables any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing his or her ability to reduce duplication and improve care coordination and collaboration between providers through this one-source clinical data repository.



The provider view of our care coordination platform, Member 360, enables any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing his or her ability to reduce duplication and improve care coordination and collaboration between providers through this one-source clinical data repository.

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The provider view of Member 360 also enables an understanding from a population health perspective, informs how his or her members are doing, and provides information that helps the provider achieve better results. Member 360 will support providers in achieving the quality incentives defined in our quality programs. With appropriate releases, a PCP will be able to view his or her members with diabetes to view their most recent HbA1c test results and, at the same time, see members who need to have HbA1c testing done. The tool will take the providers to the next level by delivering much more than data; instead, it displays information that is synthesized in a succinct view to create obvious, actionable items. Refer to Question 3.2.8, #11 for more information on information sharing between providers.

As described in detail in Section 10.3.2 Provider Incentive Program, Amerigroup will also deploy to PCPs a proprietary on-line reporting tool that allows providers to see actionable, member-specific information. **Using alerts, dashboards, and reports, this tool will give PCP provider practices the information they need to manage their members' health.** It will help practices stratify their membership based on risk and prevalence of chronic conditions, and it will offer actionable clinical insights such as care gap messaging and preemptive flagging of members with high risk for readmission. Functionality will include provider- and member-level drilldown capabilities into quality performance metrics and identification of cost-of-care savings opportunities such as emergency room avoidance.

Monitoring Outcomes and Effectiveness of Interventions

Our health home program evaluation will be comprised of clinical quality measures such as the delivery of integrated physical and behavioral health care coordination and preventive care, as well as utilization measures, including appropriate emergency room utilization, inpatient admissions, and generic dispensing rates for select sets of drug classifications.

In addition to serving as a basis for incentive calculations, these measures will be used to establish a minimum level of performance expected of our providers and encourage improvement through sharing of information. It is important to develop measurements based on criteria that “measurement informs practice.” The following types of measurement criteria guide the identification of measures, including, but not limited to the following:

- Measureable and reportable in order to maintain focus on priority areas where the measurement demonstrates an impact on the care delivered
- Useable and relevant to assure providers use the results to support practice improvement
- Feasible to collect, using data that is readily available for measurement and retrievable without undue administrative burden on our providers

Amerigroup is aware of the six CMS core health home services and will define our quality measures for health home providers to be aligned with these measures, including topics such as screening for behavioral health conditions like depression and SUD, reducing unnecessary emergency room utilization and hospitalization, and following up on members after hospitalization.

Determining How to Make Improvements to the Health Home

Amerigroup will work closely with a variety of health home participants, including members, family members, providers, Patient-centered Care Consultants (PCCCs), and Provider Clinical Liaisons (PCLs), as well as utilize relevant goal achievement data to continually monitor the performance of health home providers. This will include but not be limited to the following:

- Member and provider satisfaction survey results
- Member call center reports
- Transition between program reports
- Member grievances and appeals
- Healthcare Effectiveness Data and Information Set (HEDIS®) outcomes such as emergency room utilization, readmission, and follow-up appointment adherence
- After-hours and weekend appointment availability surveys

Based on this information, Amerigroup will define and drive improvements to the health home through interventions and education with targeted providers who have unique or outlying issues or identified trends for multiples provider groups. Additionally, we will supply all providers with a dashboard that shows population-wide HEDIS scores, gaps in care, emergency room visits, daily census reports for inpatient admissions, etc. member-level data and reports will be available through Member 360 for provider reference.

Question 3.2.9, #2

2. Describe strategies proposed to increase health homes participation.

Member Education

As described in detail in Section 8 (Member Services) and Section 6.1.6 (Provider Relations and Communications) of this response, we will inform all members of our specialized programs, including the health home, through our comprehensive Member Education program that includes the following:

- Member handbook
- New member welcome call
- Member portal
- Care Management and Disease Management employees
- Member Services and Nurse HelpLine employees
- Member advocate

All members who are enrolled in the health home will receive a letter mailed directly to their place of residence outlining the member's rights and responsibilities and program benefits.

Our Patient-centered Care Consultants (PCCCs) and Provider Clinical Liaisons (PCLs) will provide education and training to health plan employees and network providers on the goals and functioning of the health home through the Member Education program, as well as one-on-one consultation as needed. Amerigroup will establish written processes, policies, and procedures for educating members, providers, and health plan employees on what the health home brings to the Iowa High Quality Healthcare Initiative.

Member Outreach and Incentives

Under current processes, members will be referred to chronic condition health homes (CCHHs) by the health home and referred to integrated health homes (IHHs) by Amerigroup. Should the State change this process, we are prepared to identify members' status via claims history/enrollment reporting, which will enable us to attribute the member to a health home based on geographic residence and "provider loyalty," providers/clinics where the member has previously received services. We will also collaborate with providers and care managers to identify new members providing for provider or member self-referral for health home services. We will proactively enact strategies to identify, reach out to, and encourage participation of members who are eligible for enrollment in a health home. The following activities reflect our experience working in collaboration with our health home providers in implementing innovative, creative strategies to increase member participation. We will evaluate strategies that are being used in Iowa as well as ones that might be utilized to enhance engagement, for example:

Daily Hospital Census

- Provide Daily Census to health home that includes admits/discharges
- Obtain weekly feedback from them regarding follow-up

Incentive Program

- Develop incentives for members completing their Health Action Plans, e.g., a prepaid debit card for member completing health action plan

Increase rate for Health Action Plan completion

- Pay providers a higher rate for Health Action Plan completion

Member Outreach

- Assist in member outreach

- Create collaterals and mailers that will increase engagement for health homes to use and reminding members to update their contact information
- Update member website with health home information
- Bad Contact Information : Obtain a list, scrub the data and return an updated list back to the HH

Staffing Support for Health Homes

- Co-locate a nurse in the CMHC (IHH)
- Co-locate a behavioral health professional in primary care setting (CCHH)

Early feedback from potential CCHH providers in Iowa suggests that they have a difficult time seeing the value of CCHHs and that they perceive barriers to enrollment. To address these concerns, we will obtain additional feedback on provider concerns to develop program modifications to enhance provider participation. We will bolster our efforts to clearly articulate the value proposition of CCHHs to the provider community.

Question 3.2.9, #3

3. Describe your proposed reimbursement structure for health homes.

Iowa establishes tiers based on the number of chronic conditions (for CCHHs) or intensity of care (for IHHs) for a per member per month (PMPM) rate by tier. For base health home services reimbursement, we will contract with health homes at the going Medicaid FFS PMPM rates:

CCHH Rates		IHH Rates	
Tier 1 (1 to 3 Chronic Conditions)	\$12.80	Tier 5 (Adult)	\$127.97
Tier 2 (4 to 6 Chronic Conditions)	\$25.60	Tier 6 (Child)	\$127.59
Tier 3 (7 to 9 Chronic Conditions)	\$51.21	Tier 7 (Adult with Intensive Care Management)	\$347.97
Tier 4 (10+ Chronic Conditions)	\$76.81	Tier 8 (Child with Intensive Care Management)	\$347.59
		Tier 9 (Member Outreach, 3 months only)	\$102.40

As rates are changed by the State, Amerigroup will implement such changes within the required timelines or per the provider contract.

CONTAINS CONFIDENTIAL INFORMATION

CONTAINS CONFIDENTIAL INFORMATION**Question 3.2.9, #4**

4. Describe how you will ensure non-duplication of payment for similar services.

We believe care coordination activities promote continuity and consistency of care provided for our members. However, a potential for service duplication may occur in moving between programs and specifically HCBS waiver services in which a member is receiving targeted case management services. In such situations, a member will only be enrolled in one program; health homes as DHS indicates that children served under CMH Services under the 1915(c) waiver will be enrolled in integrated health homes and not targeted case management. If a member qualifies for both an integrated health home and a chronic condition health home, the member may choose in which health home to enroll, but may only enroll in one health home. Members participating in other HBCS programs are not eligible for IHH services.

Additionally, if a member meets the criteria for our complex Case Management, as determined by our algorithms, to be managed by Amerigroup's complex Case Managers, while also being eligible for chronic condition or integrated health home services, the health plan complex Case Manager will specifically coordinate with the health home care coordinator. Our complex Case Manager is alerted to health home enrollment through our data systems, which track members assigned to a specific health home, as well as the member's primary care physician with enrollment dates. The collaboration and coordination with the health home care coordinator facilitates a robust care coordination plan without duplicating activities and services.

We will include communication and collaboration responsibilities in our provider agreements. Our complex Case Managers will also determine member enrollment activity and guard against duplication of services. Leveraging our claims system, we will verify billing for targeted Case Management and health home services. We will also track member participation in services and supports and movement between programs through our care coordination program, Member 360, described above. In summary, our health homes will collaborate regularly (at least quarterly) with targeted Case Managers, other Case Managers, or DHS service workers for each member receiving Case Management services; these interactions will be aided by the criteria, contracts, oversight, and systems we have in place.

Additional strategies for identifying which programs our members with complex and specialized health care needs are enrolled in and potential or actual duplication of services include the following:

- Reaching out to members identified with high needs, helping them understand the goals of each program and assisting with selecting the one that best meets their preference and support needs
- Collaborating with health home providers to identify and develop information-sharing strategies to help assure members are not receiving duplicate services
- Utilizing the State-provided health home report to identify and designate our network providers that also serve as health homes

- Monitoring our data tracking systems to identify members who receive services through health home providers
- Working directly with network providers to help them understand the differences between the programs and identify and refer members who may benefit from one of the programs to the most appropriate program
- Connecting providers with our peer-to-peer consulting opportunities to assure members are referred to the most appropriate program

Our strategies to prevent duplication of efforts will be documented upon request and include elements such as records of joint staffing meetings where a member's medical needs, current activities, and HCBS waiver services needs are reviewed and appropriately updated. Amerigroup supports DHS' approach to delivering care that is holistic, integrated, and well-coordinated for members in the Iowa High Quality Healthcare Initiative. Health homes are an important aspect of providing continuity in health services, engaging members in self-care, and promoting recovery and resilience. We look forward to sharing our plans and working with DHS to continue our efforts toward our common health home goals.

Question 3.2.10, #1

1. Describe how you will fulfill the requirements of this section in addition to the general Health Homes requirements.

Amerigroup will:

- Develop a network of health homes which meet the requirements established in the State Plan, building on what the State has implemented, and filling regional gaps as detailed in the "Our Philosophy" portion of this response.
- Establish care coordination for members enrolled in health homes through collaboration with community-based organizations at the point-of-care in the community
- Provide training, technical assistance, expertise and oversight to health homes, that reflects quality-driven, cost-effective health home services in a culturally competent manner that addresses health disparities and improves self-care as detailed in Question 3.2.9, #1
- Identify eligible members for enrollment, as detailed in Question 3.2.9, #2
- Perform data analysis at the member level and program-wide to inform continuous quality improvement, as detailed in Question 3.2.9, #1
- Reimburse providers according to a reimbursement methodology proposed by the Contractor and approved by the Agency, as detailed in Question 3.2.9 #3
- Develop an incentive payment structure, for the Agency's review and approval, that rewards health homes for performance based on quality and outcomes, as detailed in Question 3.2.9, #3
- Monitor quality and outcomes and report on measures as detailed in Question 3.2.9, #1

1915(i) Habilitation Program Services and 1915(c) Children's Mental Health (CMH) Services (3.2.11)

Question 3.2.11, #1

1. Describe your proposed approach for delivering these services.

Proposed Approach for Delivering Services

Amerigroup Iowa (Amerigroup) will build upon the experience of 15 of Amerigroup's 19 affiliated health plans that coordinate the delivery of fully integrated physical health and mental health and substance use disorder treatment services, and in seven states, Long-Term Services and Supports (LTSS). Our Kansas affiliate administers Kansas' Serious Emotional Disturbance (SED) Waiver services. In December 2015, our Bayou Health Plan affiliate in Louisiana will also begin covering 1915(i) services. Beginning January of 2016, our New York affiliate will cover 1915(i) services along with a full spectrum of physical and behavioral services as a Health and Recovery Plan (HARP) for adults and in 2017 will cover those services for children as well.

Amerigroup will coordinate delivery of Habilitation Program and CMH Waiver services working in partnership with members, their families, Integrated Health Homes (IHHs), other providers, and community supports to meet members' individual needs supporting resilience and recovery. Our proposed approach recognizes that:

- An effective program embraces principles that reflect hope, voice and choice, and empowering relationships that create an expectation that resilience and recovery lead to meaningful participation and an active role in society
- Effective coordination of children's mental health services is child and family focused: children with a SED and their families need intensively coordinated in-home and wraparound services to support successes at home and school, and in the community
- Adults with serious mental illness and substance use who have a history of homelessness, unemployment, and poor social functioning benefit from intensively coordinated community-based service options to reside successfully in home and community-based settings
- Ongoing provider and health plan staff education and training in evidence-based practices and developments in the field of mental health and substance abuse treatment are essential elements of a high-quality program
- Stigma and discrimination takes many forms including children being bullied by other children and youth: working with schools and community groups is an important aspect of habilitation programs and services
- Evolving and emerging technologies, such as telehealth and web-based communications, are used to increase access to services helping to maintain members in their homes and communities
- Systematic tracking of progress and outcomes informs shared decision-making and is an important aspect in the implementation of evidence-based treatment programs and services

Amerigroup clinicians and support staff, drawing upon our national and affiliate health plan resources, will be fully prepared to assume responsibility for:

- Identification of members who may be eligible for Habilitation Program and CMH Waiver services
- Assessment of needs based eligibility
- Service plan review and authorization

- Claims payment
- Provider recruitment
- Provider agreement execution
- Rate setting
- Provision of training and technical assistance to providers

Amerigroup will assign community-based case managers dedicated to working with IHHs, who with our Provider Clinical Liaisons (described in Section 3.2.9) and Provider Relations Team, will support health homes integration of primary and behavioral health services while coordinating LTSS. Community-Based Case Managers will focus on members who receive HCBS, including members enrolled in IHHs who are eligible for the Habilitation Program or CMH Waiver services.

Provider Clinical Liaisons will:

- Oversee the Community-Based Case Manager
- Consult with the case manager and IHH care coordinator as needed to help assure the member's total needs are met

Integrated Health Homes will:

- Integrate Treatment Plans from across the system of care
- Establish a Care Coordination Plan
- Provide care coordination – physical health, behavioral health, Habilitation Program and CMH Waiver, and social supports
- Develop the service plan for members enrolled in the Habilitation Program or CMH Waiver
- Monitor quality indicators and outcomes to help assure plan implementation

Community-Based Case Managers, with oversight from Provider Clinical Liaisons, will:

- Complete initial assessments and reassessments
- Assure person-centered planning
- Review and authorize service plans
- Work closely with IHH care coordinators to help support creation of an integrated care plan that includes the service plan and to facilitate coordination with other areas of the health plan as needed

Amerigroup's Provider Relations Team with Community-Based Case Managers and Provider Clinical Liaisons

- Identify and recruit Habilitation Program and CMH Waiver providers
- Coordinate credentialing with the Amerigroup credentialing team
- Facilitate provider agreement execution
- Develop and implement provider training and technical assistance
- Monitor claims payment

Our approach to provider support recognizes the nuances of contracting and supporting non-traditional providers to verify that they fully understand the Iowa Initiative and Amerigroup's policies and procedures. Highlights of our approach with LTSS providers will include:

- Providing proactive provider education that addresses Habilitation Program and CMH Waiver providers' needs and requirements, including the changes that will take place transitioning from fee-for-service to managed care

- Implementing sound reimbursement practices, including prompt and accurate claims payment
- Developing collaborative relationships, including extensive, one-on-one outreach
- Providing technical assistance in collaborating with Habilitation Program and CMH Waiver providers promoting program and individual success such as proactively contacting providers if we identify possible claims submission errors during our weekly claims review
- Implementing practices to simplify and minimize administrative burdens

The Community-Based Case Manager with the Provider Clinical Liaison and Provider Relations Team will develop and implement provider training and technical assistance using our collaborative learning approaches described in Section 6.1.

We will work closely with each IHH to implement approaches that meet the needs of members in the local community. We will solicit input to guide continual enhancement of IHHs in carrying out this role in the delivery of HCBS from the Stakeholder Advisory Committee and a Behavioral Health Advisory Committee comprised of members, family members, providers, and advocates, as described in Section 3.2.8. We will work with members, their families or representatives, Agency staff, and advocacy groups to continually evaluate and refine our approach in Iowa to support the delivery of comprehensive and integrated services that improve members' health outcomes and functional capacity and support members to live in the community in the most integrated setting.

Level of Care and Needs Based Eligibility Assessments and Annual Support Assessments

Identification

Amerigroup will build upon affiliate health plan experience to develop and implement policies and procedures for ongoing identification of members who may be eligible for Habilitation Program and CMH Waiver services. We understand these policies and procedures are subject to Agency review and approval. Amerigroup will:

- **Process referrals from a member's providers:** Providers will be able to make referrals directly to our clinical team by phone, email, or fax or using an online referral form.
- **Process member self-referrals:** We will implement a no-wrong-door policy for referrals. In most instances, members will contact the health plan through the single, toll-free number and speak to a Member Services Representative. The representative will contact the case management team while on the phone with the member and connect the caller with a member of the team, or if not immediately available, leave a message for the team. Calls will be returned no later than the following business day.
All health plan staff who interact with members and their families will also be trained to accept a self-referral or family referral and the process for doing this. Examples of staff who may receive these requests include health plan case managers, utilization management, disease management, and health education and outreach professionals.
- **Incorporate hospital admission notifications:** Hospitals will be required to notify us of unplanned admissions within 24 hours of the member's admission. Planned admissions are prior authorized and we are notified upon admission. We will also collaborate with the Iowa Health Information Network to identify methods to receive real time or near real time hospital admissions data. Notification of hospital admission data will be aggregated and a hospital census report generated twice daily. A case manager will notify the IHH of the admission and the IHH care coordinator will contact members or their families to initiate discharge planning and schedule a date, time, and location for completion of an assessment.

- **Perform ongoing review of claims data:** Amerigroup will perform ongoing review of claims that alone or in combination with other information, such as diagnosis or assessment information, indicate a potential need for Habilitation Program or CMH Waiver services. Examples include members who have an SED or behavioral health diagnosis and have:
 - Gaps in services
 - Frequent Emergency Room (ER) use
 - Inpatient readmissions
 - Unusually high or low service utilization

Upon identification, a Community-Based Case Manager will contact the member or member's family to schedule a date, time, and place for completion of an assessment. We will refer individuals who are identified as potentially eligible for LTSS to the State or its designee for level of care determination, if applicable.

Assessment and Annual Support Assessment

Amerigroup will develop policies and procedures for administration of the InterRAI Home Care (or subsequent tool specified by DHS) and level of care for members identified through any of the processes described previously due for a reassessment. The assessment will also be used to identify the member's needs and goals for specific services and will include an assessment of the individual's ability to have his or her needs met safely and effectively in the community and at a cost that does not exceed limits established in the Habilitation Program or CMH Waiver.

We will conduct a thorough interview with the member, and family or representative as applicable, during the needs assessment process that helps build trust with members, their providers and natural supports. This trust is tantamount to person-centered care planning. Community-Based Case Managers will also conduct a risk assessment to determine if the member's preferences, needs and goals can be safely addressed in the setting they choose. The Community-Based Case Manager carefully reviews any identified risks with the member and family, as applicable, and develops a risk agreement that addresses steps that will be taken to mitigate those risks. The Community-Based Case Manager will also make sure the member and family is fully aware of any potential outcomes that may occur if the risk is not addressed.

Assessments will be performed face-to-face with the member by a Case Manager trained to administer the InterRAI Home Care. The Case Manager will also solicit input from the member's family (or representative), caregiver, or others as requested by the member and review additional relevant information, such as previous assessments, to gain a complete understanding of the member's needs and goals.

The reassessment will be completed at least annually, when we become aware that the member's functional or medical status has changed in a way that may affect level of care eligibility, and when a member, family member or member's representative, requests a reassessment.

Conflict-Free Assessment

Amerigroup recognizes the importance of providing a needs assessment in accordance with conflict-free principles and practices. ***Amerigroup case managers are strictly prohibited from being involved in service delivery to prevent any conflicts of interest.*** To further assure that needs assessments are conducted in accordance with all Balancing Incentive Program requirements relating to conflict-free case management, we will develop policies and procedures to implement safeguards that include:

- Community-Based Case Managers may not deliver covered services.
- Community-Based Case Managers will be required to report any conflicts of interest they may have to the Long Term Care Manager. Potential conflicts of interest include but are not limited to, familial and personal relations with the member, their family or representatives, or any paid personal care

attendants or other support workers and/or the provider agency that may compromise their ability to evaluate member needs and goals objectively.

- Amerigroup policy clearly articulates that case managers and other staff making coverage decisions are strictly prohibited from financial incentives or other rewards for limiting care or services. Likewise, we affirm that decisions about hiring, promoting, or terminating case managers or other staff is not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits or services. To reinforce the importance of conflict-free case management, all employees will sign a Compensation Policy Statement upon hire that affirms this policy. We will retain the signed Compensation Policy Statement in the employee's personnel file or other file as deemed appropriate.
- Our grievance policies and procedures will include the right to a conflict-free assessment as well the right to file a grievance or appeal concerning dissatisfaction with choice, quality of services, eligibility decisions, service provision, or outcomes. We track grievance and appeal data to help identify and implement necessary operational changes or enhancements.
- Case management supervisors will monitor case manager performance and audit a random sample of member records to verify case managers' compliance with all program requirements including conflict of interest requirements. We will investigate and initiate corrective action when a conflict of interest is confirmed, including assigning a different case manager who has no conflict of interest to the member.
- Amerigroup will review conflict free assessment requirements and our safeguards with a broad array of stakeholders to gain their input into ways to strengthen these safeguards. Our Stakeholder Advisory Board and Behavioral Health Advisory Committee (described previously in Section 3.2.8), will provide input into our safeguards initially (following contract award) and at least annually thereafter as part of our quality oversight process.

Assessment Timeframes

We understand the timeframe for completion of assessments and reassessments will be finalized with DHS through the Contract negotiation process. We propose the following timeframes:

- We will complete an **initial needs assessment** within 30 days of identification of a member who appears to need or requests Habilitation Program or CMH Waiver services. We will identify these members from analysis of historical claims data or other data when available. We will also identify members who may need these services during completion of the Welcome Call screening or from referrals from inside or outside the health plan, including self-referrals and family referrals. When the member has an urgent need for services covered under the Habilitation Program or CMH Waiver, we will assess the member within 72 hours of learning of an urgent need, except when there are extenuating circumstances such as severe weather. In extenuating circumstances we will complete the assessment as soon as circumstances permit.
- We will complete annual reassessments within 30 days prior to the 12-month anniversary date of the previous initial or annual assessment.
- We will complete reassessments related to a change in the member's needs or circumstances within five days of learning of the member's change in needs. Members who have urgent needs will be reassessed within 72 hours of learning of an urgent need, except when there are extenuating circumstances such as severe weather. In extenuating circumstances, we will complete the assessment as soon as circumstances permit. Amerigroup may authorize interim services pending completion of the assessment.

Once the assessment is completed, we will submit the level of care or functional eligibility assessment to the State in the manner prescribed by DHS for a determination of eligibility to receive Habilitation Program or CMH Waiver services.

We will also make sure the member is receiving additional non-waiver services and supports, including state plan behavioral health services and community-based supports, any applicable Value-Added Services, and other needed supports, which may include care coordination and case management.

We understand the Agency will approve the mechanism and the timeline in which the needs assessments will be administered. We will adhere to these requirements and will seek approval from DHS for any proposed changes to the mechanism or timeline.

Documentation Requirements

We will maintain all reassessments in the Amerigroup care coordination and management system, which will include the results, recommended level of care, and date of the reassessment. Our system will maintain all level of care or needs-based eligibility reassessment data, including but not limited to, the date the reassessment was completed. Our system has the capability to generate routine and ad hoc reports to meet DHS' needs.

We will submit reassessments to the Agency in the timeframe and format specified by the Agency for members who have a change in their level of care. We will maintain documentation for members with no change in level of care or needs-based eligibility and make this available upon request from the Agency.

Appearance of Ineligibility

If during the assessment process we determine the member does not appear to meet criteria for Habilitation Program or CMH Waiver services, we will advise the member and/or family of this, of the member's right to continue the assessment, and to continue to pursue eligibility. The member or family may elect to terminate the assessment at this time or at any time during the assessment. If they make this decision, we will document the decision in the member's record and obtain the member's or representative's signature. We recognize a member's right to request services without limitation, and Amerigroup will not encourage a member or the representative to discontinue the process. We will provide documentation of members or representatives who decide to terminate assessment to the Agency within the timeframe and in the format specified by the Agency.

Waiting List for CMH Waiver

Amerigroup understands there may be a waiting list for the CMH Waiver at the time of a member's initial assessment. The Community-Based Case Manager will advise the member, family member, or representative there is a waiting list and they may choose to receive other support services until a waiver slot is made available by the Agency. In the event there is a waiting list, and the member is not identified as having access to a reserved waiver slot, we will make sure the member is receiving additional non-waiver services and supports, including state plan behavioral health services and community-based supports, while on the waiting list. If a member is in a facility and qualifies for a reserved capacity slot, we will work with DHS to determine when the member may access CMH Waiver services and inform the member and family or representative, if applicable, of the timeline and process for enrollment into the CMH Waiver. We will complete an assessment with the member when the member is notified of an available waiver slot.

We may also elect to authorize supplemental services to meet the member's identified needs and goals and will not hesitate to authorize these services to prevent the need for higher cost care, including institutionalization. We will develop policies and procedures, based on the experience of affiliate health plans, that specify how and under what circumstances supplemental services will be determined necessary for those waiting for a waiver slot.

Service Plan Development and Person-centered Planning

Following completion of the assessment and prior to authorization of services, we will develop a service plan using a person-centered planning process led by or with the member and family or representative, depending on the member's age and preference. The service plan development process will meet all contractual requirements as well as state and federal regulations and policies as described in this section. Amerigroup will develop policies and procedures to guide service planning in accordance with these requirements and train IHH care coordinators on these policies and procedures.

Amerigroup's approach to service planning emphasizes member choice, self-determination, and community integration. We work with the members and/or families/representatives to determine how they want to live their lives and identify the supports they need to achieve their goals. Our Community-Based Case Managers will work with the member's IHH care coordinator and make sure the member's team uses a person-centered planning process to develop the member's service plan.

The Community-Based Case Coordinator will help assure the person-centered service planning process:

- Reflects cultural considerations, including the member's primary language or method of communication, cultural beliefs, and preferences
- Uses plain language that is transparent and easily understood by the member and family member/representative
- Addresses conflicts or disagreements, including divergent recommendations among team members with priority given to the voice and choice of the member and family
- Adheres to conflict of interest guidelines
- Assures informed choice and decision-making for the member regarding the services and supports they receive and from whom

Service Planning Team

A Community-Based Case Manager will work with the member and family to identify a service planning team as specified in the Scope of Work. The team will include people chosen by the member.

Team members will include professionals and non-professionals with adequate knowledge, training, and expertise surrounding community living and person-centered service delivery. At a minimum, the team will include the member and as applicable, the member's family and/or legal representative, service providers, and others directly involved in the member's care, including input from the member's PCP, specialists, and behavioral health providers.

The member or family will select a team lead from among the team members. If the member does not select a team lead, the service planning team will make the selection. If the team lead is not the member's Community-Based Case Manager or IHH care coordinator, the Community-Based Case Manager or IHH care coordinator will assist the team lead as needed with the person-centered service planning process.

Following identification of team members, the team lead and member or family will identify the ***member's preferred location, date, and time for service planning and assure the date is timely.***

In preparation for service plan development a Community-Based Case Manager with the team lead and IHH care coordinator, if not the team lead, will:

- Review the results of the member's assessment, including the member's identified strengths, needs, preferences, goals, and support needs
- Review other relevant information, including Individual Educational Plans for children in school, previous assessments and service plans, medical records including the member's treatment plan, the member's current claims and encounter data, and authorizations
- Consult with the member's PCP to help assure the member's medical needs, including preventive health needs, are being met

- Review the Habilitation Program and CMH Waiver cost cap
- Identify and arrange any accommodations needed by the member or other team members to participate in service planning, such as interpreter services and visual cueing
- Notify team members of the date, time, and location of service planning and methods for participation (in-person, by phone conference, and through written input)

Amerigroup will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the service plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions. The team lead will document the review and findings using this platform, which allows input by all members of the team.

The team lead, with the assistance of the Community-Based Case Manager, will actively engage the member throughout the service planning process.

- They will help the member or family drive the person-centered planning process that emphasizes ***member choice, the independent living philosophy, and the principles of self-determination.*** Service planning will be conducted in the member's primary language or method of communication, and will incorporate the members/family's cultural beliefs and preferences.
- The team lead, with the assistance of the Community-Based Case Manager, will provide information in plain language that is transparent and easily understood by the member and member's representative and is accessible to individuals with disabilities and persons who have limited English proficiency, consistent with 42 CFR 435.905(b). The planning approach will also recognize a child's developmental age and stage – information will be shared with children and adolescents in a way that they can understand it.
- The team lead will review the service planning process with the member, member's family or representative in preparation for the service plan meeting and provide the level of support and information needed throughout the meeting to help the member exercise informed choices and decisions.
- The team lead will ***also provide necessary information and support*** to assure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

The team lead will address ***conflicts or disagreements***, including divergent recommendations among team members, with priority given to the voice and choice of the member and family/representative. Clear conflict of interest guidelines will be provided to all participants.

The team lead will help the member and family, working with other team members chosen by the member, identify the member's individual support needs, goals, and desired outcomes. The service plan will include an emergency plan that identifies the back-up providers and natural supports available to meet the member's needs when no approved service plan exists and which, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage as specified in the SOW Section 3.2.11.2.9. In addition, the service plan addresses life transitions including pre-school to school age, adolescence, transition to adulthood and adult systems of care, and aging.

The team identifies the services and supports from all sources, paid and unpaid, that together can meet the member's identified needs and goals and support achievement of the member's desired outcomes, considering the member's health and welfare needs, as well as the availability and appropriateness of services. ***Members will be offered choices that improve quality of life and integration into the community.*** These include Medicaid State Plan services including Habilitation Program services, CMH Waiver services, and services from other programs or agencies such as school-based services, vocational

rehabilitation services, community-based resources including children's resources, behavioral health resources, social support services, and natural supports such as family supports. The team will review identified service needs to assure that services are not duplicative with services available from other sources such as those under the Individuals with Disabilities Act or the Rehabilitation Act of 1973.

Amerigroup will also offer Value-Added Services described in Section 3.2.14 (when not available from another source) such as assistive devices, additional hours of respite and self-advocacy memberships to help the member to continue to live at home or reside safely in a community setting.

The team identifies the amount, duration, and scope of needed Habilitation Program and CMH Waiver services, helping to assure these services do not duplicate other available services and do not exceed service-specific limits specified in the waiver, state plan amendment, Iowa Administrative Code or other guidance issued by DHS. The team also calculates the service plan cost and compares the cost to the member's cap. If the cost for requested services exceeds the cap, the team identifies ways to adjust the service plan while continuing to help assure the member's health and welfare.

The Community-Based Case Manager ***identifies authorized and available HCBS waiver service providers and provides information about potential providers.*** Members who require a home- and community-based residential setting and/or services delivered outside their home, such as in a supported employment setting, and their families or representatives, review available options that comport with federal HCB setting requirement regulations, with assistance from other team members. They may arrange a visit with the help of the Community-Based Case Manager or IHH care coordinator prior to selecting a setting. The Community-Based Case Manager or IHH care coordinator also provides information about the benefits of integrated residential and service settings and offers the member and family opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, and with community providers, and identifies and addresses any concerns about the setting.

Each residential or service setting considered by the member and family is documented in the service plan. In addition, the discussion and options provided for meaningful day activities, employment, and education opportunities are documented.

The member's IHH care coordinator ***completes the service plan and includes notes summarizing the meeting, including participants, method of participation, and any outstanding items that require follow-up in the IHH electronic medical record for the member.*** The member or family member is asked to indicate agreement with the final service plan by signing the printed service plan. A paper copy of the service plan is provided to the member/family and other designated people involved in the plan. The care plan is also available to IHH care coordinators and providers in the member dashboard, Member 360°. The completed service plan is provided to Amerigroup for review and authorization as described in the next section.

Members may request an update to the service plan at any time by contacting their Community-Based Case Manager or IHH care coordinator.

Service Authorization and Initiation

IHHs will submit service plans for members enrolled in an IHH to the Community-Based Case Manager. The Community-Based Case Manager will review service plans within five calendar days of submission. Amerigroup may authorize interim services while the service plan is pending when essential to maintain the member at home and to help assure the member's health and welfare.

- The Community-Based Case Manager is responsible for confirming:
- The completeness and accuracy of the final service plan
- Requested services will help the member achieve his or her desired goals identified in the service plan

- Requested services meet the necessity requirements specified by DHS in the HCBS Waiver Provider Manual, Habilitation Program 1915(i) State Plan Amendment, Iowa Administrative Guide, and any other guidance or rule specified by DHS
- Requested services do not duplicate other services the member receives
- All sources of available coverage have been identified and the requested services are not otherwise available or covered
- Requested services are covered in the amount and for the duration requested and do not exceed cost limits established by the Agency
- The requested services, in combination with all other services and supports, paid or unpaid, permit the member to remain at home or in a community setting and help assure the member's health and welfare
- The member will receive, at a minimum, one billable unit of service per calendar quarter and needs Habilitation services or CMH Waiver services on a regular basis
- The providers chosen by the member or family/representative are authorized providers and are in good standing (that is, not under corrective action)

In the event any condition specified above is not met, the service plan is pended, and the IHH care coordinator is notified of Amerigroup's findings. The Community-Based Case Manager and the IHH care coordinator will then work with the member or family and team members to resolve the issue.

In the event the issue cannot be resolved, the Agency will be notified and Amerigroup will work with the Agency to determine the most appropriate course of action. In the event a requested service is denied or reduced or the final determination constitutes an adverse action, the member or family will receive a Notice of Action and may exercise their right to appeal as described in Section 8.15.

The service plan is then sent to the prior authorization team to review and authorize the services and funding amount within the core operating system. If additional benefits are identified by the team and included in the service plan, these will be reviewed and authorized by the Amerigroup prior authorization team or Utilization Management (UM) Manager. The UM Manager will consult with the Community-Based Case Manager, and Medical Director and Behavioral Health Medical Director, when needed, to confirm necessity for additional benefits.

Upon authorization of services, the providers selected by the member receive a service authorization number, a written or electronic service authorization, and a copy of the member's service plan. The IHH care coordinator is also notified of service authorizations.

Services may be initiated following receipt of the service authorization number.

The service plan will be reviewed and revised: (i) at least every 12 months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.

Emergency Plan Requirements

The team develops an emergency plan that identifies the supports available to meet the member's needs in the event of an emergency, including when an unpaid caregiver is suddenly unavailable to meet a member's essential daily needs, or when there is no approved service plan in place. The emergency plan will also include the member's risk assessment and the health and safety issues identified by the member's team; the emergency backup support and crisis response system identified by the team; and emergency backup staff designated by providers for applicable services.

Home Based Habilitation

For members in a home-based habilitation service setting, the team includes in the service plan:

- The member's living environment at the time of Habilitation Program enrollment

- The number of hours per day of on-site staff supervision needed by the member
- The number of other waiver consumers who will live with the member in the living unit
- An identification and justification of any restriction of the member's rights, including but not limited to maintenance of personal funds or self-administration of medications

Amerigroup will build upon the experience of affiliate plans that deliver LTSS to develop policies and procedures that address these requirements including determination of the hours per day a member needs on-site supervision and application of restrictions, including safeguards.

Refusal to Sign

Amerigroup will develop and implement DHS- approved policies and procedures that describe the measures we will take to address instances when a member refuses to sign the service plan. We describe our proposed approach below:

In the event the member or family/representative declines to sign the service plan, the team lead discusses alternative supports, services, or service settings that can meet the member's needs and assure the member's well-being, and if agreeable to the member, revises the service plan. If the member is unwilling to accept the alternatives offered, the Community-Based Case Manager will discuss the situation with the Long Term Care Manager, and develop a risk mitigation plan with the member. The risk mitigation plan identifies the services and supports that will be available and the plan to mitigate any identified risks that could arise and documents the refusal to sign in the care coordination and management system.

Amerigroup notifies DHS of the member's, or as applicable, family's or representative's refusal to sign the service plan.

Compliance with Home and Community-Based Setting

Amerigroup will assure Habilitation Program and CMH Waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities We mine claims to identify instances when providers bill for delivery of HCBS while a member is in an institutional setting and recoup the payment when appropriate.

As part of Amerigroup's education plan for Habilitation Program and CMH Waiver providers, we will continue to educate and remind them that they cannot bill for services while the member is inpatient in a facility.

We will also assure non-institutional LTSS are provided in settings which comport with the CMS home and community-based setting requirements as defined in regulations at 42 CFR 441.301(c)(4) and 42CFR 441.710(a) and as specified by DHS in rule or policy. We will cooperate fully with DHS in the assessment of a HCBS setting upon request of DHS.

Disenrollment

Amerigroup will track information that pertains to ineligibility or potential ineligibility for Habilitation Program or CMH Waiver services and notify the State, in the manner prescribed by the Agency, when we identify such information. For example, this may include instances where a member is hospitalized beyond 30 days, or fails to receive the minimum billable unit of service, or appears to have a change in functional or medical status that could make them ineligible. We understand the State has sole authority for determining if the member will continue to be eligible under the Habilitation Program and CMH Waiver and will comply with the State's determination.

Minimum Services Requirement

Amerigroup will track and notify the State of any instance when a member enrolled in the Habilitation Program or CMH Waiver does not receive at least one billable unit of service under the waiver per calendar quarter. We will provide notification of such instances in the manner prescribed by DHS.

Frequency of Care Coordination Contact

Amerigroup will develop policies and procedures for frequency of care coordination contact. IHH care coordinators will be required to contact members receiving Habilitation Program or CMH Waiver services at a minimum monthly, either in person or by telephone, with an interval of at least 14 calendar days between contacts. Members will be visited in their residence or location of services face-to-face at least quarterly with an interval of at least 60 days between visits and more frequently when necessary. Policies and procedures will include the scope and method of each contact, documentation of the contact, and the process to be followed when a member has experienced a change in need(s) or requests an update to his or her service plan.

Amerigroup has partnered with Careticker, an innovative web and mobile platform that enables real time communication with members and monitoring of the provision of in-home services. We will work with IHHs to determine a method to arrange access to Careticker so that IHH care coordinators may connect with members receiving Habilitation Program or CMH Waiver services in real time from anywhere.

Monitoring Receipt of Services

Amerigroup will adapt processes implemented successfully in other states where affiliates deliver HCBS to monitor the provision of services in Iowa. Our system is already configured to support oversight and monitoring and includes the capability to compare service delivery against authorized services and providers. ***Careticker enables a family member or caregiver to track and report any and all caregiving activities provided to a member.*** In addition, users can submit daily notes and observations. This information will be made available to the Community-Based Case Manager. Careticker also enables monitoring of provision of services and detailed reporting regarding the type and level of services provided to member. The Community-Based Case Manager can then communicate and interact with the family member and IHH care coordinator and provide needed support.

IHHs will maintain the member's service plan in the electronic medical record and a copy will be stored in the Amerigroup care coordination and management system. Service authorizations will be stored in the Amerigroup authorization and claims system. IHH care coordinators will call members within five business days of service authorization to confirm initiation of authorized services and that these services are meeting the member's individually identified needs and goals specified in the service plan. If services have not been initiated or are not satisfactory to the member, the IHH care coordinator will identify the reason for this and the intervention needed to resolve the problem and coordinate the solution with the community-based case manager.

Services will also be monitored monthly as part of the required monthly contact by the IHH care coordinator, which includes at least one face-to-face visit with the member. Prior to contact with the member, the IHH care coordinator will review Habilitation Program or CMH Waiver claims submitted and claims paid, compare claims amounts to the member's cost cap, and match claims to the service plan to identify any apparent discrepancies between services authorized and services billed, including under or over billing. Any discrepancies will be reported to the Community-Based Case Manager for follow-up and remediation. During the monthly contact with the member, or at any time the IHH care coordinator or Amerigroup identifies or is notified of a service gap, the Community-Based Case Manager and IHH care coordinator will review the service gaps, identify the cause of the gaps, and determine if intervention is needed. For example, claims may be missing if a member is sick and misses scheduled days of service that would have otherwise been provided, but these missed services might not constitute a service gap that requires intervention. Other reasons for service gaps that require specific intervention include:

- The provider failed to show up as scheduled, and the member did not notify Community-Based Case Manager or IHH care coordinator
- The member or family declined authorized services
- The provider is no longer available, and the member has not selected a new provider
- The provider is unable to meet the member's needs because of a change in the member's needs and the Community-Based Case Manager or IHH care coordinator were not notified of the change in needs
- The authorized services are not meeting the member's needs, addressing the members individually identified goals, or helping the member achieve desired outcomes

The IHH care coordinator will gather information from the member/family and the provider to determine reasons for the service gap and develop solutions, including ways to avoid the situation in the future.

Interventions include:

- Completing a member reassessment to confirm the member's needs, individually identified goals, and desired outcomes and identify any changes.
- Revising the member's service plan to address changes in a member's needs, individually identified goals, and desired outcomes
- If the provider failed to deliver services as authorized, initiating a corrective action plan with the provider, which must be successfully completed within the timeframe agreed to or additional corrective actions may be imposed, including suspension or termination as a HCBS provider
- Offering the member and family the choice of a different provider
- Updating the member's risk assessment and agreement to prevent a recurrence of the gap

Claims Payment

Claims are processed daily, and payments are made twice a week on Tuesday and Friday nights. We encourage providers to participate in electronic funds transfer, which clears in two days. Prompt and accurate payment is vital to the continued operations of LTSS providers. We will make every effort to resolve claims questions from providers quickly and efficiently. Our specially trained LTSS Provider Services Staff and other staff will answer provider calls and address questions, assist with claims questions and problem solving, and provide further education during the call. For those issues that are not resolved during the initial call, Amerigroup will maintain an internal service escalation process to make sure that provider issues are researched and prioritized for quick resolution.

We will review weekly claims provider impact reports to identify possible provider submission errors, including denied claims, and provide technical assistance. For example, if we see an increase in denied claims, our representatives will promptly contact providers to educate them and facilitate correct submission and payment.

In addition, we will provide a daily file of pre-adjudicated shadow claims data to the State as required under Section 13.4.1 of the Scope of Work.

Provider Recruitment

Amerigroup has already created a target list of LTSS providers, including Habilitation Program or CMH Waiver providers, for recruitment using the State provider listings. We are in the process of obtaining letters of interest and have met with provider associations and advocacy groups to discuss potential additional providers of Habilitation Program or CMH Waiver services. Provider recruitment is an ongoing process, and as we accelerate our outreach to provider associations, advocacy groups, and individual providers, we will learn of additional providers we should invite to join our network. Collaborative relationships with all system stakeholders are crucial to developing and maintaining a comprehensive

provider network. We will continually monitor the adequacy of the provider network and develop additional capacity through identification of new providers entering the service area or becoming newly qualified as a provider of Habilitation Program or CMH Waiver services. We will meet with stakeholders and DHS to develop methods to grow the supply of qualified providers. Community-Based Case Managers will alert the Provider Relations Team when additional providers are identified for recruitment. In addition, they will work closely with the Provider Relations Team should they identify a shortage of a specific type of provider or the need for a provider with additional specialized skills, and will develop a provider recruitment plan.

Rate Setting

We will reimburse Habilitation Program or CMH Waiver providers at least at the State Medicaid rate.

Provider Training and Technical Assistance

Amerigroup will provide comprehensive training to providers, including Habilitation Program and CMH Waiver providers. Our affiliate health plans have existing provider training materials and programs that will be adapted for Iowa. In addition, we will seek a contract with the University of Iowa to provide Iowa-specific training including training for Habilitation Program and CMH Waiver providers.

We will provide training via webinar and in-person, and will include dedicated and ad hoc training sessions. Amerigroup Provider Relations staff, with oversight by a specialty Provider Relations Manager responsible for behavioral health and LTSS providers, and clinical staff, will provide training on the full range of covered services, including person-centered planning, self-direction, integrated care coordination, service authorization, claims coding, and billing support, as well as state rules and regulations, and much more. More information on provider training can be found in Section 6.

Providers new to managed care typically need hands-on assistance following training. We will offer on-site assistance to providers through our regional Provider Relations Teams that will include staff whose sole focus will be supporting behavioral health and LTSS providers. Face-to-face assistance will be especially helpful to providers new to managed care, including smaller providers, and is part of our standard provider orientation and training.

Community-Based Case Managers and IHHs will assist the Provider Relations Team with the development and provision of training materials and sessions, and may make joint visits to providers when needed to provide additional or more in-depth training.

Integrated Health Home Training

Amerigroup will provide comprehensive orientation and training to IHHs that will equip all care coordinators with the core competencies required to address the diverse physical, mental health, substance abuse, and social support needs of each member.

Question 3.2.11, #2

2. Describe your experience serving similar populations, if any

Experience

Amerigroup's seven affiliate health plans have 15 years of experience coordinating LTSS, including HCBS Waiver and state plan services, and currently do so for over 202,000 members nationwide, including over 18,000 children and adolescents, 106,000 non-elderly adults, and almost 77,000 adults 65 or older. 16 affiliate plans coordinate behavioral health services for over 520,000 members nationwide. Waiver target populations include frail elders; individuals with physical disabilities, traumatic brain injury, HIV/AIDS, intellectual and developmental disabilities; and children with a serious emotional disturbance. Over 30 distinct HCBS are coordinated by our affiliates.

Our Kansas affiliate administers Kansas' SED Waiver services, which provides wraparound facilitation, short-term respite care, attendant care, independent living/skills building, parent support and training, and professional resource family care (intensive family-based support) to children who are experiencing an SED and are at risk for inpatient psychiatric hospitalization.

Beginning in 2016, our New York affiliate will cover 1915(i) services along with a full spectrum of physical and behavioral services as a Health and Recovery Plan (HARP) for adults and in 2017 will cover those services for children as well. In December 2015, our affiliate Bayou Health Plan in Louisiana will also begin covering 1915(i) services.

Our New York affiliate will coordinate the delivery of recovery-oriented HCBS designed to assist adults and children with significant behavioral health needs living in the community. All HARP members will be enrolled in a health home and receive services not currently available such as psychosocial rehabilitation, peer supports, family support and training, and employment supports.

In addition, affiliate plans in New York, Kansas, and Washington have extensive experience working with fully integrated health homes, and we will build upon this expertise to support the delivery of integrated physical health and behavioral health services, including Habilitation Program and CMH waiver services, through Iowa's IHHs.

Family Planning Services (3.2.12)

Amerigroup will provide Iowa members with unrestricted access to family planning services, supporting members to self-refer to any DHS Medicaid provider, including providers not in our contracted network. Our affiliate health plans currently provide family planning services as a covered benefit for over 5.2 million state-sponsored program members across 19 states. We will form partnerships with Iowa's providers and educate members to promote access to family planning services in order to support member health and well-being, reduce risks associated with unplanned or closely-spaced pregnancies, and improve pregnancy and birth outcomes.



Amerigroup promotes access to family planning services by educating members about their family planning benefits and engaging them in active decision-making prior to increasing their family size.

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Access to Family Planning Services

To enable broad access to family planning services, our Iowa network will include federally qualified health centers (FQHCs), rural health clinics (RHCs), local public health departments, and family planning clinics funded by Title X money.

We will also provide members direct access to a network women's health specialist for covered women's routine and preventive health care services. In addition, a member may choose a primary care provider (PCP) or an OB/GYN as their PCP.

Members may receive family planning services and related supplies from Medicaid providers outside of our network without restrictions and have access to contraceptive counseling as desired. We do not exclude coverage of any service on moral or religious grounds. Members have access to all methods of contraception approved by the Federal Food and Drug Administration, including long-acting reversible contraceptives (LARCs). LARCs are available as a pharmacy benefit or are reimbursable to providers for placement during a postpartum stay.

Family Planning Education

Amerigroup promotes access to family planning services by educating members about family planning benefits and engaging them in active decision-making prior to increasing their family size. That includes helping members achieve birth intervals of at least 18 months, which has been proven to reduce risks associated with a subsequent pregnancy too soon after delivery.

We encourage our members in the inter-conception period to obtain a comprehensive medical history and physical examination annually – or more often when indicated. We require providers to include anticipatory guidance and reproductive health education in annual physical exams. We also provide information about family planning in our member handbook, on our member website, and through one-on-one family planning counseling with case managers.

Enhanced Services

Mothers with Pre-term Labor

Amerigroup has a process in place whereby we identify members with a prior pre-term delivery during our OB High Risk Screen. If a member responds that she has had a prior pre-term delivery, a baby delivered at least 3 weeks before her due date, or a low birth weight infant, she is logged in a Provider Alert file. The Case Management team monitors the file twice a week for updates and sends providers an alert notice when one of their members is identified as a candidate for Makena or 17P. We provide providers with a process and order form to request the medication to be sent to their office or to request a home health provider to provide the medication in the member's home. If a member is placed on the medication, we provide weekly follow-up to make sure the member is compliant with her provider visits or her health home visits.

Specialized Populations

Our national Maternal Child Behavioral Health (MC BH) specialist will be available to work with case managers and at times will co-manage members with behavioral health-related issues like depression, substance use disorders, and mental health disorders. The national MC BH program team members actively collaborate with the health plan's OB and behavioral health teams.

Provider Incentives

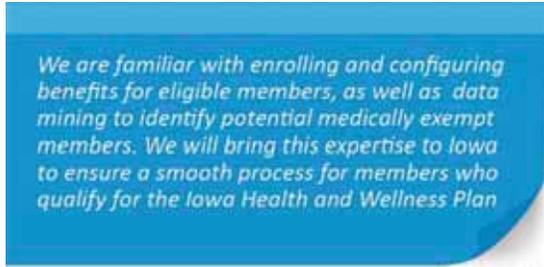
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Iowa Health and Wellness Plan Benefits (3.2.13)

Amerigroup recognizes wellness and prevention as a critical aspect of improving member health outcomes and reducing the overall cost of care. Accordingly, we will deliver Iowa Wellness Plan benefits to members eligible for the Iowa Health and Wellness Plan in accordance with the Alternative Benefit Plan coverage option as described in Exhibit D of the Scope of Work. Through our affiliates, we have experience administering programs for Medicaid expansion populations and alternative Medicaid expansion programs like the Iowa Health and Wellness Plan and its innovative approach to promoting member engagement in positively affecting their health outcomes.

For example, our Indiana affiliate serves the State of Indiana in administering HIP 2.0, which shares many similarities with the Iowa Health and Wellness Plan. HIP 2.0 is an ACA Medicaid expansion alternative plan for adults who are not disabled with income up to 138 percent federal poverty level (FPL) in Indiana. HIP 2.0 includes 19 different benefit packages and a Personal Wellness and Responsibility (POWER) account funded by the member and the State to pay healthcare costs.

From this experience, we are familiar with enrolling and configuring benefits for eligible members, as well as data mining to identify potential medically exempt members. We will bring this expertise to Iowa to help assure a smooth process for members who qualify for the Iowa Health and Wellness Plan.



We are familiar with enrolling and configuring benefits for eligible members, as well as data mining to identify potential medically exempt members. We will bring this expertise to Iowa to ensure a smooth process for members who qualify for the Iowa Health and Wellness Plan

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Medically Exempt Members (3.2.13.1)

Question 3.2.13, #1

1. Describe how your proposed approach will ensure Medically Exempt members will receive State Plan benefits

We understand that the State will identify Medically Exempt members through the member survey and attestation and referral form. When we receive notification from the State that a member is Medically Exempt via the 834 file, we will enroll the member in the Medicaid State Plan by default. If we receive notice, via the 834 file, that the member has opted out, we will enroll the member in the Iowa Wellness Plan.

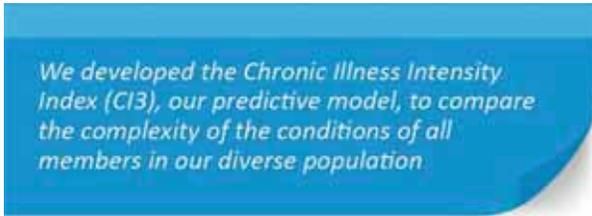
The Plan indicated on the 834 will be transferred into our system of record, which will indicate the benefit package and the member's eligibility. Members will be able to reference the benefit package they have selected and for which they are eligible in the member handbook, and will receive an ID card and complete welcome packet for their plan of choice. Utilization Management staff will have easy access to the benefit package and eligibility information for the member through our internal systems, as detailed and illustrated in Section 3.2.2. When members need services, they will present their membership card, which will indicate to the provider the benefits for which the member is eligible.

Question 3.2.13, #2

2. Describe your proposed strategies for implementing retrospective claims analysis to determine if a member is Medically Exempt.

We will use a proprietary predictive modeling system to identify members who may be Medically Exempt through data mining and retrospective claims review. When we identify members who fit into the Medically Exempt criteria, we will submit this information to the State in the form and format required. We understand Medically Exempt determinations are subject to DHS approval.

We developed the Chronic Illness Intensity Index (CI3), our predictive model, to compare the complexity of the conditions of all members in our diverse population. This allows us to stratify all members appropriately, thus identifying members with the most complex needs/conditions requiring intensive case management. In Iowa, we will also adapt the CI3 model to flag diagnoses or other criteria from claims that could be used to identify potential members who may be Medically Exempt, according to the federal definition of "medically frail" as detailed in the SOW.



We developed the Chronic Illness Intensity Index (CI3), our predictive model, to compare the complexity of the conditions of all members in our diverse population

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The CI3 is based on the Johns Hopkins ACG Predictive Risk Scoring Model. Our predictive modeling system uses member data including diagnoses, demographic information, and recent inpatient and emergency room utilization history from claims to measure risk level, likelihood of admission, and in the case of Iowa, qualification for medical exemption.

All members have a clinical profile generated on a monthly basis to track changes in status and meet members' changing needs swiftly. These individualized clinical profiles contain information about each member including: demographics, contact information, risk and likelihood of admission scores, coexisting conditions, utilization data, and recent case management information. Case Managers access member profiles via a powerful tool that is easily navigated and prioritizes the member profiles based on

predicted level of case management need. We will utilize this monthly profile to identify members who may be medically exempt and pass that information along to the State in the form and format required.

Value-Added Services (3.2.14)

Question 3.2.14, #1

1. Describe any proposed Value-Added Services. Include in the description:
 - a. Any limitations, restrictions, or conditions specific to the Value-Added Services;
 - b. The providers responsible for providing the Value-Added Service;
 - c. How the Value-added Service will be identified in administrative (encounter) data;
 - d. How and when providers and members will be notified about the availability of such Value-Added Services while still meeting the federal marketing requirements; and
 - e. How a member may obtain or access the Value-Added Services.

Amerigroup works with our state partners to assess the greatest needs of the community's various stakeholders, and then develops innovative, sustainable solutions to drive positive outcomes where results are needed most. By providing certain benefits above and beyond the required core services, we believe we can achieve lasting and measurable improvements in the behavioral and physical health and welfare of the diverse Iowa Medicaid population.

By offering expanded programs and services, we provide opportunities to help care for the whole person and better address the specific needs for each segment of the population. Our offerings take a multifaceted approach to improving member health and well-being, providing members with enhanced wellness and prevention benefits and expanded Home- and Community-based Services (HCBS) and supports. To help care for the whole person and address the specific needs for each population segment, we have developed three unique and specialized packages, or 'suites' of benefits that will enhance care, promote healthier outcomes, and increase member satisfaction.

We will submit our proposed Value-Added Services to the State for approval and will provide them at no additional cost to the State or the member. We understand that the costs are not reportable to the State as allowable medical or administrative expenses, and we will not pass the costs to providers. We will share Value-Added Service data in the form, format, and timeframe requested by the State.

Amerigroup will maintain records on each Value-Added Service that allow us to track member participation and monitor program effectiveness. For some of our Value-Added Services, we will receive claims from providers that we can identify by CPT code. Depending on DHS requirements, we can either submit these as encounters or exclude them from our encounter submissions, as we do in some affiliate health plans. For non-medical Value-Added Services, such as Boys and Girls Club memberships and personal backpacks, we will maintain information in a designated general ledger account as an administrative expense that we can submit to DHS in the requested format.

We have grouped our 24 Value-Added Services into three suites tailored to specifically address population-specific needs such as additional education opportunities, additional services for waiver populations or specific goals set by the State of Iowa, like reducing tobacco use and obesity. Our first suite is focused around Health and Wellness programs, the second suite encompasses training and various support programs and the third suite is meant to enhance independent living skills. Each benefit grid addresses each of the five components, a through e, of question 3.2.14.1.

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Question 3.2.14, #2

2. Provide any applicable data on improved outcomes linked to Value-Added Services you have implemented in other states.

Our experience shows Value-Added Services that motivate members to adopt healthier lifestyles are effective in improving health outcomes. We are confident that our tailored Suites of benefits will deliver meaningful additional value to our members and reinforce achievement of the Iowa Initiative program goals.

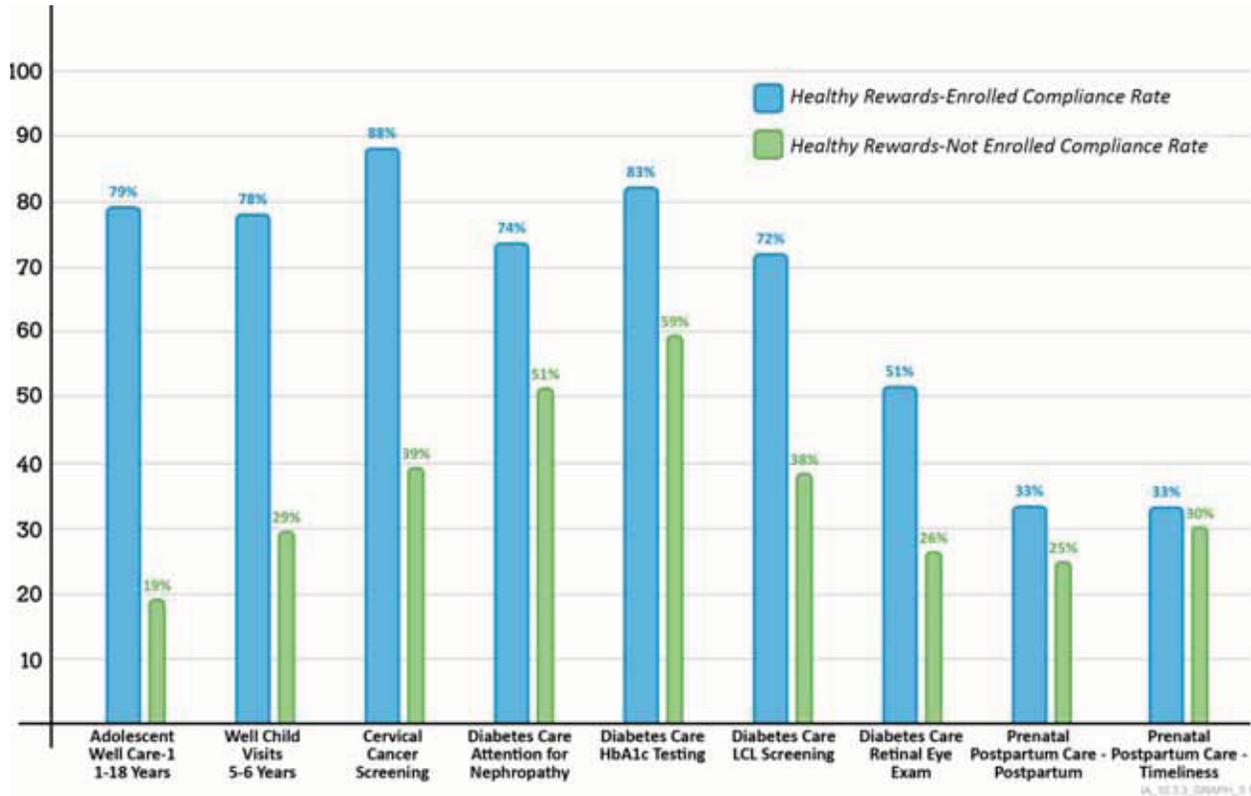
Amerigroup and its affiliates have implemented and refined Value-Added Services across many states. We constantly measure our programs as we work to enhance their efficacy. The following details our outcomes experience for three of the most important programs planned for deployment in Iowa: the Healthy Rewards Member Incentive Program, Tobacco Cessation Program, and Healthy Families Nutrition and Fitness Program. We anticipate similarly strong member outcomes as a result of these programs in Iowa.

Healthy Rewards Member Incentive Program

Amerigroup will offer our Healthy Rewards member incentive program for Iowa members. In many of our affiliate health plans, our Healthy Rewards program is offered as a value-added service. In Iowa, we will offer the program as a core benefit. Healthy Rewards offers members the opportunity to accumulate credits by obtaining targeted preventive care services and screenings for chronic conditions, including HEDIS measures. We fully integrate Healthy Rewards with our comprehensive case and disease management programs. When we've offered the program as a value-added service in our affiliate health plans and the program has demonstrated measurable quality gains.

Our Healthy Rewards Program, offered as a value-added service in Kansas, has proven effective at boosting quality metrics. For example, our Kansas affiliate's HEDIS 2014 measures demonstrate the strong impact of member incentives on results. For example, Healthy Rewards enrollees had 79 percent compliance with adolescent well care visits, while non-enrollees had 19 percent compliance. These and other measures are illustrated in Figure 3.2-12.

Figure 3.2-12. Healthy Rewards Drive Improved Quality Scores for Our Kansas Affiliate (August 2014)



Tobacco Cessation

Amerigroup will offer smoking cessation coaching as a value-added benefit as well as a \$30 Healthy Rewards incentive for members who use tobacco to quit smoking through Amerigroup’s value-added Smoking Cessation Program. Together with coverage of smoking cessation medications on the Iowa Medicaid formulary, these programs will help establish Iowa Medicaid as a best practice State for smoking cessation.

In a recent participant survey, 31.75 percent of Amerigroup member respondents receiving coaching and medication achieved the six-month quit metric.

Healthy Families

This value-added program includes education and counseling on nutrition and fitness. Nurse coaching over a six-month period helps families explore and set goals, resolve ambivalence, develop small doable steps, and remove barriers. Motivational Interviewing and Stage-Based communication strategies drive conversations for member-centric goal setting and building on successes.

The Healthy Families Program has been highlighted by Medicaid Health Plans of America as a Diabetes Care Best Practice program. It is currently deployed in our affiliate health plans in Florida, Kansas, Kentucky, Louisiana, and Washington. Results among children ages 7-13 are shown in Figure 3.2-13.

Of note, program participants increased their fruit/vegetable intake, a key goal of Iowa’s Healthiest State Initiative, by 57 percent. See Section 10.2 for more details.

Figure 3.2-13. Healthy Families Program Encourages Healthy Behavior



Administration of Covered Benefits (3.2.15)

Medical Necessity Determinations (3.2.15.1)

Our utilization management (UM) procedures determine the medical necessity of care or services on a case-by-case basis in accordance with State and federal laws and regulations. Our process is grounded in nationally recognized, evidence-based criteria and guidelines. We form our Medical Policies and Clinical Guidelines through a rigorous, clinically driven process with external providers in the community and academic settings providing input and approval. However, we are acutely aware of and responsive to the differing needs and situation of each unique member. UM staff considers the severity of illness, presence of multiple conditions, and episode- and person-specific variables when applying criteria to determine medical necessity of care or services. In addition, all of our delegated vendors undergo strict oversight and maintain adherence to NCQA standards while basing their medical necessity decisions on Amerigroup’s evidence-based clinical criteria and case-by-case individual considerations. Our member-centered, holistic approach enables members to receive necessary care, support, and services within a safe setting that promotes optimal health and well-being.

- We have extensive experience working with state-defined medical necessity criteria in our affiliate plans, and we are ready to work with DHS to implement any Iowa-specific criteria or process guidelines. We understand that DHS will provide UM guidelines for many services (such as EPSDT and family planning) and determine specific UM parameters for aspects of the services (for example, the PDL for Pharmacy) in others, as specified in Exhibit D

- For medical and pharmacy State plan benefits, we will use nationally accepted, evidence-based medical necessity criteria. We do not place quantitative or other utilization control guidelines unless supported by an individualized determination of medical necessity that is based upon the specific needs of the member
- For behavioral health State plan benefits and substance use disorder services, we will use UM guidelines established and approved by DHS. We will also develop psychosocial medical necessity criteria specific to the Iowa Initiative
- For EPSDT services for members under 21, we will comply with State requirements to provide any services that could correct or ameliorate physical or behavioral health
- For emergency services, we will not impose restrictions on coverage that are more restrictive than those permitted by the prudent layperson standard. We will have our non-clinical staff review emergency services claims using the prudent layperson standard and make individualized determinations of medical necessity

LTSS Determination

Our affiliate health plans have 17 years of experience managing LTSS benefits and Amerigroup will adhere to Iowa's criteria and methodology regarding the reasonableness and volume of services selected for inclusion in the member-centered care plan by the member and service coordinator. For Long Term Services and Supports (LTSS), we will not use medical necessity criteria, however, we will use functional necessity criteria. The provision of LTSS and related DME will be determined and approved through the member-centered care planning and assessment process in consultation between the member, their family, legal representative or care giver, and the community-based case manager. Spending on covered services must fall within the budget cap. We plan to partner with Telligen on a consultative basis during the implementation period to understand the existing assessment process and criteria for LTSS in Iowa to promote consistency and continuity of care through the transition. Our affiliates' experience in managing the LTSS determinations in our other markets (including Florida, New Jersey, New York, Tennessee, Kansas, Texas, and California), coupled with Telligen's Iowa experience and contribution in establishing the local criteria, helps assure our member-centered care plans and assessments will adhere to Iowa methodology while benefiting from our deep experience.

Coverage Changes

We will not limit or reduce coverage unless supported by individualized determination of necessity based on the specific member situation. We will apply appropriate medical necessity criteria to physical



We will not limit or reduce coverage unless supported by individualized determination of necessity based on the specific member situation.

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and behavioral State health plan services based upon individual member needs and a thorough assessment of specific services available within the local delivery system. Through our affiliates, we are experienced working with LTSS members and their families, legal representatives or caregivers to make decisions about services as part of the member-centered assessment and resulting care planning process.

During periods of transition, we will not reduce or deny members continuing access to their providers, services, or care until we are able to conduct a full assessment and develop a care plan. During

contract implementation and transitional periods, we will honor existing prior authorizations for at least 90 days in the first year and at least 30 days thereafter, and will allow members to continue accessing their current providers, care, and services for the required timelines to ensure a seamless experience and continuity of care.

Cost-effective Services

Our UM program is based on clinical evidence and factors in person-specific considerations on a case-by-case basis to achieve cost efficiency. Our UM and case management staff will refer members to cost-effective alternative services when appropriate to meet the member's needs. We will also train providers to help direct members to the most cost-effective and appropriate option for their situation. For example, through our PCP network, the Nurse HelpLine, and member materials, we encourage members to use urgent care instead of the emergency room if their condition is not an emergency. In addition, we may require providers to document attempts to use a more cost-effective drug or therapy before we authorize a more costly drug or therapy if there is reason to believe the lower cost option will meet the member's need as well as or better than the higher cost alternative.

Amerigroup has a successful history of promoting cost-efficient care coordination programs with significant cost savings in our affiliate plans.

In our Maryland affiliate, our pharmacy lock-in program with care coordination for prescription opiate users resulted in a 36 percent decrease in inpatient days, a 17 percent decrease in admits and emergency room visits, and a 20 percent decrease in prescriptions.

We consistently demonstrate our leadership in communities to promote medically appropriate, cost-effective services and our ability to impact positive policy change. We achieve this through our compilation and communication of evidence-based mental health practices and identification of provider delivery practices inconsistent with these practices.

For example, in Tennessee, our health plan affiliate developed medical necessity guidelines to address the high use of a community-based case management service provided by the Community Mental Health Centers called Level II Case Management. Once the guidelines were approved by TennCare, the State Agency responsible for Medicaid services, we developed an authorization process to establish consistent criteria for who should receive the services and under what circumstances. Further, we worked with the other health plans and the State to better define the benefit and tailor its design to medical necessity. While some providers have resisted this more specific definition of Level II Case Management, the Governor and the TennCare Bureau advocated for this position to address the need for cost-effective and efficient service delivery with demonstrable positive impact on healthcare outcomes. We continue to set the standard for services in Tennessee under TennCare.

Second Opinions (3.2.15.2)

Our members have the right to ask for a second and third opinion about the use of any healthcare services, at no cost to the member.

Second opinions, which are described in our member handbook, may be requested and obtained by members in situations where there is a question concerning the diagnosis or the options for surgery or other treatment of a health condition. The member, parent, and/or legally appointed representative are entitled to obtain a second opinion from a Network Provider or an out-of-network provider (if a Network Provider is not available). There is no cost to the member for obtaining a second opinion. At the member's choice, we allow members to receive a third surgical opinion provided by a third provider if the second opinion fails to confirm the primary recommendation that a medical need exists for the specific surgical operation. Additionally, there is no cost to the member for obtaining a third opinion. This policy applies consistently to all member populations for all medical, behavioral, and LTSS services.



Our Members have the right to ask for a second and third opinion about the use of any healthcare services, at no cost to the member.

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Cost Sharing and Patient Liability (3.2.15.3)

We acknowledge that any cost-sharing imposed on Medicaid and CHIP members must be in accordance with State and federal policy and will not hold members liable outside of what is required by law. We will not hold members liable in the event of insolvency or non-payment by the State to Amerigroup Iowa. Our provider contracts also prohibit charging members for missed appointments.

Members who receive covered services are not to be held liable for:

- Non-payment to Amerigroup by the State
- Non-payment to the provider by Amerigroup or the State
- Amerigroup’s debts in the event of insolvency

Our provider contract states that our members will be held harmless in the event of insolvency and shall not be charged for missed appointments. We protect members from situations in which a provider bills them for services for which they have no liability, also called balance billing. We have an established policy and procedure for handling member calls regarding provider bills. We support proper provider billing practices by educating providers and members, maintaining a documented process for handling balance billing resolution, and monitoring provider compliance.

As the State notifies us of applicable patient liability amounts for members living in an institutional setting, we will have policies and procedures in place to implement mechanisms to communicate the liability amount to providers and shall delegate the collection of patient liability to the Network Providers. We will then pay the providers, net of the applicable patient liability amount.

We have a strong track record of managing member liability for members who reside in facilities. We have nearly ten years of experience across several of our affiliate health plans, including California, Tennessee, New Mexico, and Kansas, and are confident in our ability to implement similar processes in Iowa to assure providers are appropriately paid and members not overcharged. We will work with nursing facilities that have members or personal representatives who refuse to pay member liability, as we have done successfully in our affiliate plans.

Continuity of Care (3.3)

Question 3.3, #1

1. Describe your strategies to ensure the continuity of care of members transitioning in and out of the program, and transitioning between Contractors and funding streams.

If a member is requesting services or has historically been receiving services from an out-of-network provider, our provider relations team works with the provider to secure the provider’s participation in our Network.

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One of our organization’s core competencies is our ability to seamlessly support continuity of care during member and provider transitions with new program implementations. Amerigroup Iowa’s (Amerigroup) care planning process, staff training, policy, procedure, and technology are designed to seamlessly transition members while assuring that continuity of care and services comply with all applicable State and federal requirements. We recognize that any type of transition can potentially be stressful for members, so we work with them every step of the way to make sure they have the information and supports in place to prevent disruption in care.

Over 24 years of providing services to Medicaid and other state-sponsored program populations, our organization has developed comprehensive policies and procedures

that provide the structure and resources needed to effectively transition to or from another managed care entity, another provider, between programs within a state, or from fee-for-service Medicaid. We will work closely with the member's new MCO, program administrator, and/or providers to facilitate a smooth transfer of prior authorization information, care plans, treatment plans, and other pertinent information.

Additionally, we are in the process of developing a long-term partnership with a current DHS contractor, Telligen, which will allow Amerigroup to combine Telligen's robust and extensive expertise and experience with the State's waiver programs and populations with Amerigroup's innovative care model. Through this partnership we intend to learn from and leverage the most impactful elements of Telligen's Iowa experience, enhancing our ability to fully understand the programs and processes that have served these members historically. Telligen's experience in contributing to the development of the State assessment tool criteria for waiver and LTSS benefits will complement and inform Amerigroup's existing care model, and allow us to more effectively provide seamless continuity of care for our most vulnerable members on day one. Additionally, we are exploring opportunities to utilize Telligen resources to support Amerigroup's care coordinators and their activities under our proposed care model and programs.

Member Transitions from Fee-for-Service to Managed Care

Amerigroup knows that engaging members early on enables us to better achieve improvements in health outcomes. Through early identification, assessment, and care plan development, we can successfully transition new members to managed care. Our processes for transitioning new members include:

- Informing new members of program benefits through DHS-approved welcome materials and outreach
- Conducting follow-up welcome calls to engage new members and identify immediate or existing health care needs – an opportunity to engage, build a relationship, and obtain health-related information
- Holding town hall meetings throughout Iowa communities to engage members and their families, giving them the opportunity to be introduced to Amerigroup, ask questions, or voice concerns
- Evaluating members quickly to determine their medical, functional, and behavioral health status
- Prioritizing outreach and assessment according to the member's risk levels (so that those with the most imminent needs are assessed quickly)
- Identifying the appropriate level of care coordination stratification and engagement
- Identifying members' primary care provider or connecting them to one
- Obtaining and incorporating existing care plans and other information such as previously completed assessments into our clinical system
- Establishing interdisciplinary care teams as part of our Care Management model
- Developing the member's comprehensive person-centered care plan using the multidisciplinary care planning process
- Identifying and coordinating care for members who have special health care needs
- Providing for care coordination through our physical or behavioral health Case Management programs or through our LTSS process
- Offering single case agreements with non-participating providers to facilitate ongoing care
- Ensuring continuity of access to prescription drug treatment and refills
- Providing for care coordination and information sharing with home and community-based providers and others central to members with specialized support needs or who are participating in Waiver programs

- Addressing care coordination across agencies and providers for children in foster care

We have a process in place that supports seamless transition of members with pre-existing care plans. When we receive information on approved prior authorizations and current care plan, we incorporate this information into the member's record to help our clinical staff determine continuity of care needs and support meeting Iowa transition of care requirements. Should DHS provide us with historical claims and authorization data for FFS members, we will incorporate that data into our continuity of care efforts in order to assure that we are delivering the right care at the right time in the right place.

Member Transitions from One MCO to Another

Coordinating care is a critical part of a member's treatment. When a member transitions from Amerigroup to another MCO, we work with the plan to provide a clinical summary of information that includes:

- The member's care plan, if he or she is enrolled in case/disease management
- A listing of prior authorized services
- The member's medication summary
- The member's primary care physician's or any other specialty providers' contact information and treatment plan summary



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Our interdisciplinary team coordinates benefits and services across managed care plans to verify that all gaps in care and services are identified and resolved, regardless of which plan pays. This includes coordination of shared case planning and regular care conferences to sync services for each member as needed. We are already adept at such coordination for members with special health care needs, whom we serve today, and collaborate with the other benefit plans in our regions to develop a plan for seamless transition and coordination of care.

When a member transfers from another MCO to Amerigroup, we will:

- Obtain notification of the member's transfer from the MCO
- Evaluate the member's immediate health care needs through outreach and screening, then implement coordination and care management, as needed
- Review clinical information received from the MCO
- Contact the member's primary care provider or specialty provider to coordinate care
- Document the member's information in our clinical management system

Upon notification of the member's transfer to Amerigroup, we will begin establishing a positive relationship with the individual. ***Our goal is to quickly engage members in the services and supports they need, encouraging appropriate utilization of services, and giving them the information they need to learn to self-manage.*** Amerigroup will pay a newly enrolled member's existing out-of-network provider for medically necessary covered services until that regimen of care is completed. The member's records, clinical information, and care can then be transferred to an Amerigroup provider. Payment to out-of-network providers will be made within the same time period required for those within the network. We will make all reasonable attempts to contract with these out-of-network providers.



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We will base the length of transition on the severity of the member's condition and the amount of time reasonably necessary to ensure a

safe transfer to an alternative provider. Determinations on appropriate transition periods will be made on a case-by-case basis in accordance with what is best for the member’s treatment.

Amerigroup has standardized policies and procedures to identify existing PA decisions at the time of member enrollment and will provide PA decision data (in addition to current service authorizations, utilization data, and other clinical information) to other MCOs upon member transition. We have systems in place and experience orchestrating these structures through our affiliates in 19 markets, which will help provide seamless transitions for our prospective, current, and former members.

While our procedures for MCO and fee-for-service (FFS) transitions are very similar, we realize members and providers who have not previously participated in managed health care may experience a higher level of anxiety and stress associated with the transition. As a result, we provide detailed, accessible information about the member’s option to remain with an out-of-network provider until we can contract that provider into our network or complete a comprehensive assessment and help identify a new one who can meet the member’s needs.

Promoting Continuity of Care during Transition

For Amerigroup, continuity of care does not merely mean honoring the services the member is receiving at the time of transition. It means identification and delivery of care that is holistic, continually assessed for appropriateness, adjusted as necessary, and monitored for outcomes. Our established continuity of care guidelines include systems and processes for facilitating seamless member transitions from FFS to managed care, one MCO to another MCO, from program (funding source) to program(funding source), or from one provider to another. We describe each of the critical components of our approach to facilitating continuity of care for all members in Table 3.3-1.

Table 3.3-1. The Multiple Components of Our Effective Continuity of Care Program Helps Us Deliver High Quality Care and Prevent Disruption in Care

Component	Description
Authorizations	We honor all existing authorizations, including those with external organizations providing carved-out services and frequency of service identified on the member’s care plan for up to 90 days following enrollment. There are exceptions to this rule that allow for longer transition periods with which we work within. During this time, Case Managers complete an assessment as needed and develop a new care plan with the same or alternate services and supports based on the member’s holistic needs. Case Managers continually monitor the member’s progress and continued need for authorized services. Clinicians complete necessary prior authorization requests to prevent disruption in care.
Transportation	To support a smooth transition and minimize potential anxiety, Amerigroup clinicians discuss the need for transportation with the member and family or caregivers during the transition call or case management assessment. Our clinicians arrange for initial and/or on-going transportation through our non-emergency medical transportation (NEMT) vendor and add the service to the member’s care plan.
Non-Contracted Providers	Our clinical team identifies members receiving services from out-of-network providers and contacts our Provider Relations department for outreach and contracting. If we are unable to contract with the provider for any reason, we work closely with the member to choose another provider or, if it is in the best interest of the member, we work with the provider to establish a single-case agreement to provide ongoing care. We do not enter into single case agreements with any provider who has sanctions.
Care Plans	Case Managers review new members’ care plans for appropriateness of care, arrange for all medically necessary services, and identify any gaps in care. Case Manager’s review and honor new members’ care plans. We complete a thorough review that supports the existing care plan or work with the member, family members, caregiver, and providers to develop a new care plan. We identify any gaps in care and refer the member for additional services, if needed.
Multidisciplinary Clinical Rounds	Under the direction of our Chief Medical Officer, our clinical case rounds include multidisciplinary participants from departments across the health plan, including Utilization Management, case

Component	Description
	<p>Management, chronic Case/Disease Management, and behavioral health Case Management. Case rounds are conducted weekly to discuss complex cases, identify gaps in care, obtain clinical consultation from our Chief Medical Officer and Behavioral Health Medical Directors on chronic conditions and address barriers to access.</p>
Behavioral Health Rounds	<p>In addition to complex case rounds, our Behavioral Health Medical Director leads clinical rounds biweekly. During these rounds, complex cases are reviewed to make sure interventions are appropriate and timely. The team evaluates each case to identify and resolve any barriers to reaching goals, such as co-occurring conditions, language, medication adherence, transportation, or family issues.</p>
Timely and Accurate Information	<p>Our clinical support tool, Member 360, combines member data and information from various sources into a single record to provide a holistic picture of the member’s utilization, care management services, and gaps in care. It includes such information as member Health Risk Assessments, care plans, longitudinal member health records, and clinical data.</p>
Dedicated Case Managers	<p>During the initial assessment, Case Managers take time to get to know the member; learn about his or her preferences, family, and supports; and identify and understand the member’s needs. By proactively obtaining a copy of the member’s plan of care, past assessments, and open service authorizations and through outreach to the providers with established relationships with the individual, the Case Manager lays the foundation for continuity of care.</p>
Transition from Inpatient Facilities	<p>We recognize that members who are transitioning between plans during an inpatient stay are faced with an additional challenge to coordination of care. Amerigroup currently co-locates Utilization Management Nurses at key hospitals to work closely with Case Managers assigned to members upon hospitalization to initiate discharge planning. Upon identification of a member who is hospitalized, our co-located Utilization Management Nurse conducts the following activities:</p> <ul style="list-style-type: none"> • Notifies the Case Manager • Initiates concurrent review • Works closely with the care team, including the member, family, caregivers, hospital employees, the Case Manager, and providers to develop a discharge plan • Meets with the Case Management team twice weekly to discuss the member’s progress • Identifies any gaps in care and barriers to accessing the services needed to support a safe and timely transition to the community. <p>The Case Manager is responsible for confirming completion of the discharge plan, identifying any gaps in services and supports, scheduling post-discharge follow-up appointments, and participating in the member’s transition home or to the community as needed.</p> <p>To further support members transitioning from inpatient facilities, Amerigroup will provide two Value-Added Services, home delivered meals and a post-discharge stabilization kit, for eligible members. The meal program provides members with relief to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare meals and the discharge kit provides tools for family members and caregivers to successfully help transition members from hospital to home, aid in recovery, and help decrease the chances for readmission.</p>
Waiver or Residing in Nursing Home	<p>For members participating in a Waiver or residing in a nursing facility or other institutional facility, we will employ a collaborative process that supports and assists the member through the transition period. Specific activities include:</p> <ul style="list-style-type: none"> • Supporting member representation and advocacy • Participating in assessments and completing a LTSS assessment • Educating the member regarding key contacts at the health plan and for transportation and other providers; valued-added services; validating receipt of the New Member Packet and ID card

Component	Description
	<ul style="list-style-type: none"> • Arranging and coordinating community-based LTSS • Authorizing services consistent with the care plan in place at the time of the transition to Amerigroup • Monitoring the member satisfaction with service providers and/or the provision of services to ensure they are in accordance with the care plan • Exploring community-based alternatives to nursing facility or services consistent with member preference • Exploring alternatives with members for whom community-based services are becoming inadequate to meet their needs

Engaging Providers in Transitions to Support Continuity of Care

Amerigroup collaborates with providers to assure continuity of care during a member’s transition period. We facilitate confidential exchange of information between PCPs and specialty providers, including behavioral health. We support effective communication and appropriate information sharing through:

- **Promoting Provider Coordination of Care.** We encourage and work with providers to communicate clinical findings, treatment plans, prognosis, and the member’s psychosocial condition as part of the coordination process. Our clinical team reviews member and provider requests for continuity of care and facilitates continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner.
- **Encouraging Communication among Providers.** Our clinical team coordinates care and facilitates communication and information sharing among PCPs and specialists, as well as external Case Managers. Our Case Managers will link multiple providers and make sure that all care is coordinated and documented in our clinical system as part of our interdisciplinary team process.

Throughout the transition, Case Managers involve the current and new providers in developing and implementing the member’s transition plan. It clearly outlines the responsibilities of each provider and timelines for completing member transition activities, facilitating a seamless transition for the member.

Prior Authorizations (3.3.1)

Honoring Prior Authorizations and Treatment Plans

In accordance with the Scope of Work, Amerigroup will honor outstanding authorizations for non-LTSS services for a minimum of 90 calendar days. LTSS services will be authorized for a full year or until a new assessment can be completed. We will honor existing exceptions to policy granted by the Director for the scope and duration designated. Following the first year after the Contract start date, Amerigroup will honor all outstanding authorizations for 30 calendar days. Upon receiving notice of the existing prior authorization from the provider, former plan, or the member, we will build an authorization within our medical management system. Based on the member’s preferences and support needs, we may extend authorization beyond these days to assure continuity of care.

Additionally, we will maintain an individual’s care management stratification until a new assessment is completed when a member transitions from another program or MCO.

We have an effective process in place that supports seamless transition of members with pre-existing care plans. When we receive information on approved prior authorizations and the member’s current care plan, we incorporate the information into the member’s record to help Care Managers identify the member’s continuity of care needs and honor any existing prior authorizations. We also review the results of the member’s screening and assessments and current care plan to determine ongoing and additional service and supports as part of the development of a person-centered care plan.

For members transitioning from Amerigroup to another MCO, we will provide the new MCO necessary information to facilitate the transition of the member, including: current service authorizations, utilization data, and any applicable clinical information such as disease management or care coordination notes.

Provider Continuity

Our staff will also assist members who have a current provider who is not participating in the network. During the first 90 days of enrollment, members may continue receiving services from a non-network provider. In these cases, we will establish single case agreements with the providers and make all reasonable attempts to contract with the provider from whom an enrolled member is receiving ongoing care. If the provider does not wish to join our network, we will work with the member to select a new provider able to meet his or her preferences and support needs and collaborate with the previous provider to develop an individualized plan to transition the member to the selected participating provider.

Transition Period – Out of Network Care (3.3.2)

Amerigroup will build and maintain a robust provider network that offers an array of services and promotes member choice. At times, a member may need or may already be receiving services from a provider who is not currently in our network. If a member requests services or has historically been receiving services from an out-of-network provider, our Provider Relations team will work with the provider to secure the provider's participation in our Network.

To facilitate continuity of care, Amerigroup will (with the exception of LTSS, residential services, and certain services rendered to dual diagnosis populations):

- Reimburse out-of-network care for the first 90 calendar days of the contract
- Provide out-of-network care if there is no provider within 60 miles of the member's residence
- Amerigroup would not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the Amerigroup, regardless of whether such services are provided by an in-network or out-of-network provider; however, Amerigroup may require prior authorization of services beyond 30 calendar days.

Transitions during Inpatient Stays (3.3.3)

We recognize that members who are transitioning between plans during an inpatient stay are faced with an additional challenge to coordination of care. When a member in an inpatient setting disenrolls from our plan, we will continue to provide care coordination until the date of discharge from acute care or for 60 days after disenrollment, whichever is less, unless the member is no longer eligible for Medicaid. In this case, we will maintain financial responsibility for all hospital charges incurred up to the date of discharge, including the Hospital Diagnosis Related Group (DRG) payment. We will already be in the process of providing concurrent review and discharge planning for that inpatient stay. Upon learning of the disenrollment, our Utilization Management Nurse will notify the facility of the change in enrollment, advising the facility to submit their claim for the admission to us, but that as of the new MCO effective date, the physician services will be billed to the new MCO. We will reach out to the new MCO to coordinate the discharge planning for this member, as the new MCO will be responsible for the post-discharge care. Amerigroup will share clinical, administrative, and care planning data needed by the new MCO to ensure the member continues to receive the necessary services. Our care coordinators will work collaboratively with the new MCO, treating providers, and the inpatient facility to confirm appropriate discharge planning takes place, including a scheduled follow-up appointment with the appropriate provider.

On the other hand, when we learn of a member newly enrolled with us who is currently in an acute care setting, we will reach out to the facility and advise that the physician services as of the effective date of the member's enrollment with us will be billed to us for the admission, but that the current MCO will be

responsible for the facility charges. We will reach out to the current MCO to coordinate discharge planning for the member with the understanding that post-discharge services will now be our responsibility. We will coordinate with the MCO for data to assist us in assuring the member's safety and continuity of care under Amerigroup.

We recommend that all participating MCOs coordinate to create a FAQ document for providers in order to coordinate care management, payment, and discharge. The aforementioned data sharing plan for MCOs will be instrumental in facilitating this process.

Long Term Services and Supports (3.3.4)

We will not reduce, modify, or terminate LTSS services unless the change is supported by an up-to-date assessment and level of care determination for DHS or its designee. Members receiving LTSS will be able to see all prior providers and continue receiving the same services documented on their existing approved service plan at the time of enrollment, even if the provider is out of network, until a new service plan is completed and either agreed upon by the member or resolved through the appeals or fair hearing process and implemented. We will honor existing exceptions to policy granted by the Director for the scope and duration designated. We will honor authorization of LTSS from a non-contracted provider as necessary to ensure continuity of care in order to facilitate a seamless transition in development of the plan of care without any disruption in services.

Residential Services (3.3.5)

Year One and Ongoing Operations (3.3.5.1-3.3.5.2)

In accordance with the Statement of Work, Amerigroup will support members in residential settings at the time of enrollment to maintain their access to the facility provider for up to one year during the first year of the Contract, even if the provider is not part of the network. During this period, the member's current providers will be reimbursed at the FFS rate, and existing prior authorizations will be honored.

After the first year of the Contract, members using residential providers, as defined in Section 3.3.5.1, we will not transition them to another residential provider unless all three of the following conditions are met:

1. The member or his/her representative specifically requests to transition
2. The member or his/her representative provides written consent for the transition based on quality or other concerns raised by Amerigroup, which shall not include the residential provider's rate of reimbursement
3. The residential provider has chosen not to contract with Amerigroup

We will work to contract with appropriate contractors in order to deliver the right care for our members in the right place at the right time. For residential providers who have chosen not to contract with us, we will authorize continuation of the services for at least 30 days pending facilitation of the member's transition to a contracted provider, subject to the member's agreement with such transition. We may continue to reimburse non-contract provider services when that provider is able to best serve the member's support and service needs.

When a member is transitioned to a contracted provider, we will assure that the member receives the appropriate continuity of care and a seamless transition to a new provider, even when that requires us to extend the authorization of services beyond the minimum 30 day requirement.

Members with dual diagnoses of an intellectual and/or developmental disabilities a behavioral health conditions are provided with the choice of remaining with their current residential providers for at least one year. In addition, these members will be offered the opportunity to stay with their inpatient psychiatric provider as long as the services continue to be medically necessary, regardless of the providers' network status.

Pregnancy Continuity of Care (3.3.6)

We are eager to work with DHS to develop our continuity of care policies for pregnant members. We will plan to seek DHS's review and approval for all continuity of care policies for pregnant members, both as they are developed and if/when they may be updated.

If a member is pregnant at the time of enrollment and has a current relationship established with an out-of-network provider from a previous pregnancy or from the early stages of the pregnancy, we will support member choice to remain with the established provider through the entire pregnancy until the standard post-partum period is complete.

Dual Diagnosis Continuity of Care (3.3.7)

Continuity of care is critical in the treatment of members with dual diagnosis, as this clinical condition is often among the most difficult to engage in the treatment process. In fact, treatment engagement is considered by many the key component in treatment success. Therefore, Amerigroup always emphasizes continuity of care when evaluating this clinical situation. Our overarching goal is to maintain all outpatient relationships that are effectively treating dual diagnosis conditions. We take several approaches to reach this end. First, we make every effort to contract with providers identified in these situations. Second, we will look to maintain that relationship via a single case agreement. Through either of these pathways, we will then support the ongoing therapy relationship until the episode of care is completed.

If we are unable to contract with the provider or reach a single case agreement, we will at a minimum allow three months of medically necessary treatment and at the end of this period of time evaluate the situation clinically to determine the need for continued treatment. Our bias at the end of this three-month period is clinical. That is, if treatment is progressing, the relationship between provider and members is good, and the treatment remains medically necessary, then we strive to find a pathway with the provider that allows for the episode of care to reach a successful clinical conclusion. It has been our experience that in the vast majority of cases, we are able to reach an arrangement with the provider that allows clinical determinants to be the criteria by which the episode of care is evaluated, rather than a specific, defined time period.

Coordination with Medicare (3.4)

Question 3.4, #1

1. Describe your proposed approach and strategies for coordinating care for duals (members with both Medicare and Medicaid coverage).

Our organization routinely manages the coordination of Medicare and Medicaid services and Medicare cost-sharing for dual-eligible members. ***Our affiliates have coordinated Medicare and Medicaid benefits for our Medicaid members since 1998. Nationwide, our affiliates serve more than 680,000 Medicare Advantage members and more than 160,000 dual-eligible members.*** We are familiar with system requirements and processing of Medicaid secondary crossover claims, and we will configure our Iowa benefit and claims systems to administer these wrap-around services and cost-sharing according to the Contract in order to ensure the Iowa Initiative is only paying its fair share for services.



Amerigroup will be a responsible steward for Iowa DHS while helping members access all necessary care and services covered under Medicaid and Medicare. In 2014, our national cost-containment activity generated \$487 million in savings by identifying and coordinating benefits with Medicare, other health insurers, and liable third parties. Of that, 89 percent was identified prior to claims payment, minimizing the need for more difficult and costly post-payment recoveries. Almost 97 percent of total savings resulted from coordination of benefits (COB) with other insurers including Medicare fee-for-service (FFS) and Medicare Advantage plans. COB and third party liability (TPL) are core competencies of our organization, and we will deploy our capabilities to deliver significant value to the State of Iowa.

We also have extensive experience working with providers to make sure members can access necessary care and services through either Medicare or Medicaid benefits. We work with providers to ensure that members are not billed for services for which they are not liable. We will bring our provider training and communication strategies to Iowa.

In addition, we train our member and provider services, utilization management (UM), and case management staff to problem solve for members with Medicare and Medicaid benefits. This allows us to promote a seamless member experience and comprehensive access to benefits without paying for claims for which we are not liable. Our local affiliate health plans have been pioneers in coordinated programs for dual-eligible individuals, and we look forward to partnering with the State on innovative strategies to coordinate and integrate care.

Following execution of the Contract, Amerigroup will obtain DHS approval of our proposed plan to coordinate care for dual-eligible members. We will implement and adhere to DHS-approved plan. We acknowledge that changes to these plans must receive DHS's prior approval.

Wrap-around benefits

Our Case Managers work to complement the member's Medicare benefits with Medicaid benefits and services that address support needs not met through Medicare. If a medically necessary service is not covered by Medicare but is a Medicaid benefit, we will cover the service. If a Medicare-covered service has a limit (such as skilled nursing or DME supplies) and a member exhausts the Medicare benefit, we will coordinate the member's Medicaid benefits to follow the Medicare benefit and continue care when medically necessary.

Member Billing and Cost-Sharing

Our provider contracts contain "hold harmless" provisions that prohibit providers from charging members for cost-sharing or sending members "balance bills." We have an established policy and procedure for handling member calls regarding provider bills. We support proper provider billing practices by educating providers and members, maintaining a documented process for handling balance billing resolution, and monitoring provider compliance as illustrated in the following scenario:

A member calls the health plan and speaks to the Member Services Representative or member advocate regarding a bill they received from a provider that has been turned over to collections. The Member Services Representative or member advocate would collect all the information relating to the concern and, if possible, obtain a copy of the bill that the member received. The Member Services Representative or member advocate would engage an associate with the health plan's Provider Relations Department. The Provider Services Staff would contact the provider or collections company to discuss the "balance bill" and educate them regarding the prohibition on balance billing so that the provider can update the member's account. Once the provider corrects the member's account, the Provider Services Staff would communicate the correction back to the Member Services Representative/member advocate. The Member Services Representative/member advocate will then follow up with the member to communicate that the bill they have received was in fact an error and has been corrected by the provider.

Care Coordination for Dual-Eligible Members

Amerigroup affiliates have coordinated and authorized services for dual-eligible members since 1998, and have offered Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) starting in 2006. These programs have strengthened our experience serving dual-eligible members, with Amerigroup affiliates now operating D-SNPs in 11 states. Equipped with information readily available through screenings and assessments, claims, and prior authorized services analysis, the Service Coordinator conducts a comprehensive review of the member's medical and long-term support needs and authorizes appropriate services.

Regardless of the Medicare plan (FFS or Medicare Advantage) chosen by the member, we will offer the same intensity of care coordination and case management; only the operational details differ. During the care coordination or UM process, our Case Managers and UM staff will monitor the authorization of services to make sure that the correct payer source is accessed in each case.

Case Manager Roles and Responsibilities

Our Case Managers who work with dual-eligible members in Iowa will have Medicare and Medicaid experience and receive continual training to ensure their comprehensive understanding of Medicare and Medicaid requirements and coverage. Consequently, our Case Managers will be able to analyze Medicare and Medicaid data to identify gaps in care and collaborate with members and their PCPs or other providers to close these care gaps, whether Medicare or Medicaid pays for the care or service. Staff will also respond to HEDIS[®] alerts in our care coordination and management system, CareCompass, for gaps in care for both Medicaid and Medicare covered care or services.

Authorization for Community-Based Services with Medicare

Amerigroup understands the critical importance of coordinating services for dual-eligible members and strongly supports DHS's mission to coordinate services between Medicaid and Medicare managed care products for dual-eligible members. Amerigroup will coordinate the care for the dual-eligible population the same way we do for non-dual members, which includes coordinating with the member's Service Coordination Team and providers. Members enrolled with us for both Medicare Advantage and Medicaid programs benefit from integration and coordination of the spectrum of their health, pharmacy, and long-term support benefits. We use available information from both programs to identify member support needs to make this seamless for the member.

Dual-eligible Members enrolled in Fee-for-Service

Members enrolled through Medicare FFS will require additional assistance because the Medicare FFS program does not provide a Case Manager or single point of contact for care coordination. In the absence of a PCP under the Medicare FFS program, the Amerigroup Case Manager identifies the member's PCP or one or more treating physicians, works with the providers to obtain additional necessary information, and explains the community-based services available, the process for authorization of Medicaid covered services, and the details of Amerigroup care coordination.

Dual-eligible Members enrolled in another HMO

Our Case Managers for dual-eligible members enrolled in another HMO coordinate services in full compliance with the Medicare Improvements for Patients and Providers Act (MIPPA). For members who are receiving services from a Medicare HMO, our Service Coordinator works directly with the HMO Case Manager to discuss identified needs for the dual-eligible member.

Discharge and Transition Planning for Dual-eligible Members

When a dual-eligible member is hospitalized, we will engage with the discharge planning process to confirm necessary Medicaid covered benefits and services are in place at discharge to complement Medicare services; for example, home and community-based services or non-emergency transportation to post-discharge medical appointments. We will engage with providers to manage other care transitions in a similar manner to help assure provision of complementary Medicaid services.

Coordination of Benefits

Experience with Medicare and Medicaid Coordination of Benefits

Organization wide, we have significant experience supporting the various components of wrap-around services, including:

- Medicaid-only services (services that do not have a corresponding Medicare service)
- Medicare services that become a Medicaid expense because the benefit limit on the Medicare side is reached. This includes the member exhausting any life-time maximums or annual maximums in either Medicare Advantage (Part C), FFS Medicare benefits (Part A and Part B), and Medicare Drug Benefits (Part D)
- Medicare services that become a Medicaid expense due to co-insurance, deductibles or copayments (true crossover claims)

Our guiding principle is that member access to needed medical, behavioral, LTSS, and social services is paramount. Consequently, our COB approach minimizes the impact on members. Our processes are virtually invisible to members and their families as we prospectively work directly with providers and other carriers to resolve COB and TPL cases. In 99 percent of these cases, our affiliates accomplish our objectives with no member involvement. We augment our COB efforts by working with Network and out-of-network providers to identify and resolve the root causes of inappropriate billing.

We educate all of our Network Providers about hold-harmless requirements and the prohibition against billing members for covered services through the Provider Manual, provider orientations, and individual discussions with our Provider Services team. Our provider contracts also include hold-harmless provisions. When we identify an issue with an out-of-network provider attempting to bill a member, Provider Services staff work with the provider to resolve the issue and prevent a recurrence. Members who have cost-sharing or billing concerns may contact a Member Services Representative or speak with their Service Coordinator or member advocate for assistance resolving these issues. These Amerigroup team members will coordinate with our Appeals and Grievances Department to make sure we are appropriately coordinating benefits with Medicare FFS and Medicare Advantage.

We approve all needed services, regardless of payor, to make sure services are available to the member. Our protocols are designed to track members' other insurance for covered benefits as primary and that covered benefits are secondary if there is benefit overlap. Systems and procedures are in place through the claims adjudication process to recoup Medicaid monies if Medicare is the primary payor for the service(s) rendered. For instance, if we discover that we have paid a claim for a member who has other insurance, we will go back to the carrier to obtain reimbursement, not to the provider, so that the provider is spared the burden of having to file for reimbursement with the other carrier.

Identifying Medicare and Other Health Insurance Information

Amerigroup is committed to maximizing the identification of Medicare coverage, Other Health Insurance (OHI) coverage, and liable third parties; avoiding claims payment when there is evidence of alternate payment responsibility; and recovering any and all overpayments. We are experienced using a multipronged approach for our affiliate health plans. All of our solutions are HIPAA-compliant with strong administrative, technical, and physical safeguards to maintain patient privacy. Our cost-containment efforts foster member satisfaction as we work directly with carriers and providers to coordinate benefits, minimizing required involvement from members and their caregivers or families.

Amerigroup identifies Medicare and OHI coverage for members through multiple avenues, such as:

- Claims-mining processes performed on all inbound claims
- Providers indicating this information on or with claim submissions
- Vendor partnerships for acquisition of Medicare and OHI information
- Medicare/dual-eligible status information available on the Iowa eligibility file
- Daily Medicare, OHI, and TPL leads received throughout the company from members, providers, and internal customer service and care coordination staff
- Daily automated CMS Coordination of Benefits Agreement (COBA) files that identify Medicare primary payments for our Iowa Medicaid membership

Our vendor partnerships provide us access to extensive data repositories to identify OHI information that may be new or modified, as well as OHI that has been terminated for members. We supply weekly demographic information on our members to the Council for Affordable Quality Healthcare (CAQH) and obtain weekly results after it is compared with information stored in their registry from other participating major health plans. We also provide monthly member demographics to HMS and receive results back biweekly after our information is compared to its data repository from more than 150 health insurance organizations. Once a member is in our system, their demographics are included in the next scheduled data extract that is provided to each vendor for OHI identification. We thoroughly validate all Medicare/OHI leads we identify and receive internally as well as results we receive from our vendors.

We will include all of the above processes for identifying Medicare and OHI coverage information in our Iowa operations.

Validating Other Health Insurance

We will submit all potential leads for Medicare and OHI to a dedicated team within our national Cost Containment Department. Employees on this team will conduct daily review of leads received from Iowa eligibility file feeds, members, providers, and other sources, including our claims-mining processes. Employees will verify the accuracy of the other coverage information and also make sure that the coverage data are accurately and completely documented in the member record of our claims processing system.

Our team will also thoroughly validate any Medicare/OHI leads we receive through our partnerships with CAQH and HMS. Results from these vendors initially go through an automated validation process designed to help identify potential errors in the data as well as potential conflicts of information that may require additional manual verification. We will use our business standards for an OHI record to validate results prior to loading. For any data not meeting the business standards, our cost containment team will investigate prior to loading. Once validated to be accurate and complete, an employee will manually add the record into the system.

We have extensive experience validating OHI through our health plan affiliates, as evidenced by our success generating savings through our COB and TPL processes.

Integrating COB with Claims Adjudication

Our claims processing system is fully integrated with our COB and TPL processes to:

- Capture Medicare or OHI information contained on the claim to help assure payment accuracy
- Evaluate Medicare flags or OHI flags stored on the Amerigroup member eligibility records to determine Medicare/Medicaid COB
- Suspend claims where Medicare, OHI, or TPL is indicated to make sure coordination of Medicare/Medicaid benefits is accurate and consistent

Our claims process in Iowa will effectively support COB management by automatically incorporating a series of edits that prospectively identify and correct potential overpayments based on current Medicare/OHI information housed in a member's record.

During adjudication, our claims processing system will compare the submitted Dates of Service (DOS) to the effective and termination dates of the OHI coverage (Medicare Coverage) in the member record. If the claim DOS are within the effective and termination dates, we will suspend the claim for additional analyst review. When analysts identify claims as eligible for COB, they will coordinate the claims based on Iowa COB guidelines. For example, if we identify a Medicare source, but the required Explanation of Benefits (EOB) is not attached to the claim, we will notify the provider that the claim must be submitted to the appropriate third party to determine the Medicare paid amount. If the required information is attached to the claim, we will suspend the claim for additional analyst review before final adjudication. We use this information to assure that the total benefits issued by the primary carrier and Amerigroup Iowa do not exceed the allowed amount and are coordinated correctly and applying lesser of rules CFR 42.

While our practices support prospective identification of Iowa members with Medicare coverage, we will also coordinate benefits with the provider or alternate carrier before claim payment, when appropriate. We also conduct post-payment reviews and work directly with providers and carriers to recoup payments when the Medicare/OHI eligibility data are not present at the time of initial claims payment.

Question 3.4, #2

2. Explain how your staff will be trained to assist dual-eligible members with questions about benefits, appeals, grievances, and other topics where Medicare and Medicaid policies may differ.

Knowledgeable staff are critical when communicating with members about complex matters, such as benefits and processes between Medicare and Medicaid programs. We will train our staff across member and provider services, provider relations, claims, UM, and care coordination to assure that we can address all questions from dual-eligible members and promote comprehensive access and coordination for Medicare and Medicaid benefits. As part of new hire training we train our staff on Medicare and Medicaid benefits and policies, then based on their functional area, relevant in-depth training on Medicare and Medicaid. For example, UM and Care Coordination teams must understand which benefits that are Medicare primary and do not require an authorization by the provider. In addition, they are trained to coordinate care with other providers to ensure that Medicare benefits are exhausted prior to initiating Medicaid coverage. Provider Relations, Member Services, Claims and Appeals and Grievance staff need to understand the benefits, payment and payment coordination along with the rules and regulations for claims, appeals and grievances.

Initial training is conducted through a combination of class room and computer based training (CBT) and tracked by the manager to ensure that their staff has completed the training curriculum. In addition we provide ongoing training and updates to our staff through team meetings, CBTs and lunch and learns.

We will train staff to assist dual-eligible members with their questions about benefits, appeals, grievances, or other topics that arise from the differences between Medicare and Medicaid policies and processes. We will ensure that our dual-eligible members understand how their Medicare and Medicaid benefits work together and work with members to understand details of their Part A, Part B, Part D, or Part C coverage. Our staff has access to dedicated subject matter experts that specialize in Medicaid and Medicare and assist in creating training, updating policies and procedures, claims processing, managing system configuration changes, and ensuring compliance.

We have extensive experience coordinating care for the more than 160,000 dual-eligible members we serve today across our organization's affiliate state-sponsored program health plans. Nationwide, our affiliates have 48,918 members enrolled in Medicare Advantage D-SNP plans in 11 states and 23,496 members enrolled in Dual Eligible Demonstration programs in four states. Our health plan affiliates are industry leaders and among the first plans to offer these comprehensive, integrated dual-demonstration programs. We will bring this perspective and the best practices gained from these experiences to Iowa and look forward to collaborating with the State to further integrate and coordinate Medicare and Medicaid benefits and drive optimal outcomes for dual-eligible members.

Long Term Services and Supports (4.0)

Amerigroup’s fundamental approach to long term services and supports (LTSS) is founded on person-centered principles and practices to facilitate member- and family-driven services and supports that are responsive and meaningful to evolving preferences, support needs, and personal goals. We are dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in communities of their choice, we also help states achieve cost efficiencies.

Through our affiliate health plans, Amerigroup has over 17 years of experience supporting more than 200,000 members living in their communities and those residing in facilities, as demonstrated in Figure 4.0-1. **Amerigroup has a depth and breadth of LTSS expertise that few other health plans can bring to Iowa.** Our affiliates manage fully integrated Medicaid LTSS programs in seven states and offer LTSS services as part Medicaid Covered Benefits in several other states. We have extensive expertise serving diverse members comparable to Iowans eligible for the State’s LTSS program. Our person-centered philosophy, coupled with a strong focus on quality improvement, has led to refinement of processes to better serve members to maximize informed choice and independence. Our member survey results consistently show scores of **over 90 percent on key member satisfaction metrics across our affiliates**, including, but not limited to Community-Based Case Manager performance, adequacy of services and supports, and degree to which members’ overall needs are met.

Figure 4.0-1. Amerigroup Affiliates Have Significant Experience Serving Members in LTSS Plans

State	Members Eligible for LTSS	Populations Served	LTSS Start Year
California	48,379	Seniors, Adults with Disabilities, SSI recipients	2014
Florida	6,869	Seniors, Adults with Disabilities	2003
Kansas	11,563	Seniors, Adults with Disabilities, TBI, IDD, Autism, Pediatric Technology Assisted Waiver	2013
New Jersey	1,659	Seniors, Adults with Disabilities, IDD*, Children with Disabilities, SSI Recipients	2014
New York	2,864	Seniors, Adults with Disabilities	2005
Tennessee	5,136	Seniors, Adults with Disabilities, TBI, IDD*, “At Risk of Meeting NF LOC” groups	2010
Texas	125,619	Seniors, Adults with Disabilities, IDD*, SSI recipients, Pediatric Populations (<21, voluntary enrollment)	1998
Total	202,089		

*LTSS Services Not Included in Managed Care

Amerigroup Iowa (Amerigroup) has already begun engaging Iowan advocacy groups, provider associations and community based organizations and stakeholders and will continue to do so using a number of strategies that have proven track records in other states. In the coming months we will continue our discussions and outreach efforts with them to gain better understanding of what is working and not working within the current LTSS system. Upon Contract award, we will establish an advisory committee comprised of diverse individuals from across the state representing future members and families, providers, and community-based organizations to tailor our approach and model specifically to Iowa. In addition, we will partner with DHS to hold regular community forums to hear from a broader audience, and we will participate in relevant local and statewide conferences to identify system of care gaps to

develop strategies to close those gaps and build consensus and innovative solutions related to issues and concerns.

Person-centered Case Management Model

Our approach utilizes regional case management teams with multifunctional expertise to assist Community-Based Case Managers, members, families, representatives, and members' interdisciplinary teams in the development of person-centered service plans and *serve* as an ongoing resource to meet the varying needs of members to support health, well-being, independence, and community living in the most integrated setting such as employment and participation in community activities. Our case management model involves a continuous process of communicating, coordinating, delivering, monitoring, and assessing services and supports and progress toward achieving member goals to optimize person-centered service delivery. The core components case management model will include:

- ***Matching our members to the right Community-Based Case Manager*** by carefully considering member diagnoses, complexity of medical and/or behavioral health conditions, and intensity of service and support needs to identify a Community-Based Case Manager on our team with appropriate experience, knowledge, and skills
- ***Person-centered planning*** through partnership and collaboration with members, their natural supports, and member-identified interdisciplinary teams who will consider members holistically using discovery and assessment results to make sure that medical, behavioral, social, and educational needs are addressed to maximize health, well-being, and independence in the development of a comprehensive, person-centered service plan
- ***Coordination and collaboration across member systems of care*** to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services, and increase cost efficiencies
- ***The continuous process of delivering, monitoring, and assessing interventions*** designed to meet the members' goals defined in person-centered service plans, as well as other care/treatment plans, as part of their system of care to maximize individual health, well-being, and quality of life.
- ***Technology and innovations*** to improve member and natural support experience, expand the tools to enable collaboration among multiple stakeholders, enhance our members' ability to self-direct services and supports, provide real-time member information, and improve provider and system performance
- ***Ongoing stakeholder engagement*** at the member and system levels to build consensus, innovative solutions related to issues and concerns, and facilitate continuous program improvements to better serve members

We look forward to the opportunity to partner with the State of Iowa and the Department of Human Services in LTSS system transformation to better align funding decisions with member needs and to enhance access, quality, and accountability while promoting member informed choice, independence, and community integration.

General (4.1)

Question 4.1, #1

1. Explain how you will ensure that individuals are served in the community of their choice and that funding decisions take into account member choice and community-based resources.

Amerigroup's fundamental approach to long term services and supports (LTSS) is to identify with each member the services and supports they need and prefer to maximize choice and independence. We are committed to assisting all members in exploring options for community integration in accordance with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in the communities of their choice but also help states to achieve cost-efficiencies.

To support our approach, we continuously inform our members regarding available services and programs in lieu of institutional care, assure member needs and preferences drive service plan development, and provide support to help assure that the service plan is effective in helping our members remain in the community.

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As a result of our approach, we achieved significant successes in our affiliate health plans managing LTSS, including consistently achieving over 90 percent member satisfaction rates in our LTSS programs. Moreover, in 2014 our affiliates successfully transitioned more than 630 members from facilities to home- and community-based care. Simultaneously, we kept readmission rates low. For example, 90-day facility readmission rates in Texas were less than 3 percent in 2014. These results demonstrate our commitment to person-centered service planning and health literacy of practices and principles that support our members in the most integrated home- or community-based setting, which we will leverage to serve our LTSS members in Iowa.



These results demonstrate our commitment to person-centered principles and practices to identify with members the services and supports they need and prefer to maximize choice and independence; we will leverage our expertise to fully support community integration in accordance with the personal goals of our Iowa members and the Olmstead Decision.

Supporting Member Education and Informed Choices

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of supports, and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving member experience, adherence to the service plans, and overall outcomes.

Initial Discovery, Assessments, and Informed Consent

Once a member has enrolled in our LTSS program, our Community-Based Case Management team contacts the member and begins the educational process regarding our role, program services and benefits, and resources and options available to promote integrated coordination. During this conversation, the member receives an overview of the core service planning and case management processes including all applicable assessments. This comprehensive orientation allows us to align with the member on his or her preferences and confirm the member's interest in LTSS.

During face-to-face assessments, we engage members, their interdisciplinary team, member-selected participants, and natural supports, including family, in a highly individualized conversation to identify needs and preferences for building out their service plan. While outlining the benefits included in the LTSS program, we remind members of their right to choose their interdisciplinary team members, Case Managers, and services including the option to self-direct their services through the CCO. If members choose the CCO, we provide training and administrative support to bolster member confidence in self-directing while preventing gaps in services. Amerigroup helps assure that all processes, such as selecting providers and developing a service plan, reflect and honor the member's strengths, goals, and preferences.

Person-Centered Service Planning

Our Community-Based Case Managers work collaboratively with members to develop a service plan that emphasizes and supports member choice and individual goals. During service plan development, we continuously engage members and their family or representatives about needs and preferences. Our Community-Based Case Managers work with members, their family or representatives, and their providers to identify all available services and supports, including but not limited to covered benefits, community and State agency resources, Value-Added Services, health insurance coverage options (such as Medicare), and natural supports. Our Case Managers reside in the same communities as our members and therefore have detailed knowledge about the community, local provider network, other community resources available, and Medicare, Medicaid, and LTSS benefits. Finally, our Case Managers are also culturally diverse. We train our Case Managers in cultural competency to help assure that members have every opportunity to comfortably express preferences and communicate with their Case Manager.

Ongoing Communication

Our focus on member education and engagement continues through regular, ongoing communication with members. First and foremost, we solicit feedback on providers during regular in-person and telephonic conversations. This helps us understand whether current providers are meeting member needs and whether a change in providers is warranted. Whether or not the providers are meeting the Amerigroup network provider standards, we inform our members of all new and alternative resources that are relevant to their needs and preferences, spanning both covered services and non-covered services available through community resources. These regular conversations provide members with the personalized information they need to make informed decisions and direct their care and service plans.

At Amerigroup, we are committed to providing members with educational opportunities and information beyond that available through case management contacts. We make use of multiple alternative forums, including but not limited to community events, new member trainings, mailed collaterals, and our member portal accessed through our website or via a mobile application. We believe that providing members multiple venues to learn about Medicaid and LTSS services helps maximize members' engagement, self-advocacy, and active participation in their care and service plans.

Incorporating Member Choice in Funding Decisions

As members request adjustments to their service plans based on changing circumstances or new information, our Community-Based Case Managers honor their preferences, unless a requested service is unavailable. If a service could potentially pose a health or safety issue or is not a covered benefit, the Community-Based Case Manager will work to educate the member and revise the service plan to address all concerns and preferences. Our Community-Based Case Managers assure that all approved services are consistent with the member's level of care and waiver designation as applicable. We further assure that the member does not exceed his or her established cost limit. Throughout this process, we will put our members' needs and preferences first and will not hesitate to deploy creative strategies to help support our members.

Supporting Members in the Homes and Communities of Their Choice

Developing a Broad and Comprehensive Provider Network

At Amerigroup, we understand that developing broad and diverse provider and service networks, particularly in rural areas, is key to assuring member choice, access, and independence. This approach supports the State's goals of complying with new federal regulatory requirements, such as the CMS HCBS Settings regulation. We work very closely with our providers and establish provider incentive programs to encourage the capacity building of needed services and supports in the geographic areas around the State. Amerigroup and our affiliates are experts in developing comprehensive networks that meet and often exceed state requirements. Our local teams entrench themselves in the communities we serve, meeting face-to-face with both traditional and non-traditional providers and associations to build trust, open communication, and develop collaborative relationships.

Our approach to provider network development focuses on the entire array of services that our members may wish to access reflecting our member-centric, locally based approach to care and service delivery. *We understand the nuances of developing and maintaining a broad network that maximizes provider and service diversity as well as geographic coverage, access, and diversity of services and supports.*

Highlights of our service approach include:

- Proactive education that addresses LTSS provider needs and requirements
- Sound reimbursement practices, including prompt and accurate claims payment, encouraging enrollment for ERA/EFT
- Collaborative relationships, including extensive one-on-one outreach



- Technical assistance to support LTSS providers, such as proactive outreach if (through our weekly claims review) we identify possible provider submission errors
- Practices to simplify and minimize administrative burdens
- Provider incentive programs that reward high-quality service and outcomes and member satisfaction

As a result of our affiliates' success in developing and maintaining LTSS provider networks, our providers consistently report high satisfaction rates. *In several markets, more than 8 in 10 providers consistently report that they would recommend our health plans to other providers.* These results demonstrate our ability to support our members with broad, diverse provider networks that can deliver reliable and effective services for our members in their homes and the community.

Providing Value-Added Services



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Engaging Community-based Resources

Occasionally, members have needs that may not be immediately met through our existing provider network or may not be a covered service. To support these members to remain in the community of their choice, Amerigroup engages all existing community resources to provide solutions. We know that healthcare providers or MCOs cannot operate in isolation from the community, and thus, we have a rich history of actively engaging community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for members requiring a service that is not otherwise a covered benefit. For instance, one of our affiliate health plans had a member who required home repairs that fell outside of the defined home and environmental modifications benefit available to her to safely remain in the community. Our Case Manager worked with Catholic Charities to facilitate the needed repairs to the rear door of the house as well as the member's bedroom windows, free of charge, alleviating the safety concerns. Amerigroup will not hesitate to help members find creative solutions like these that encompass community inclusion, employment, social supports, and non-covered benefits.

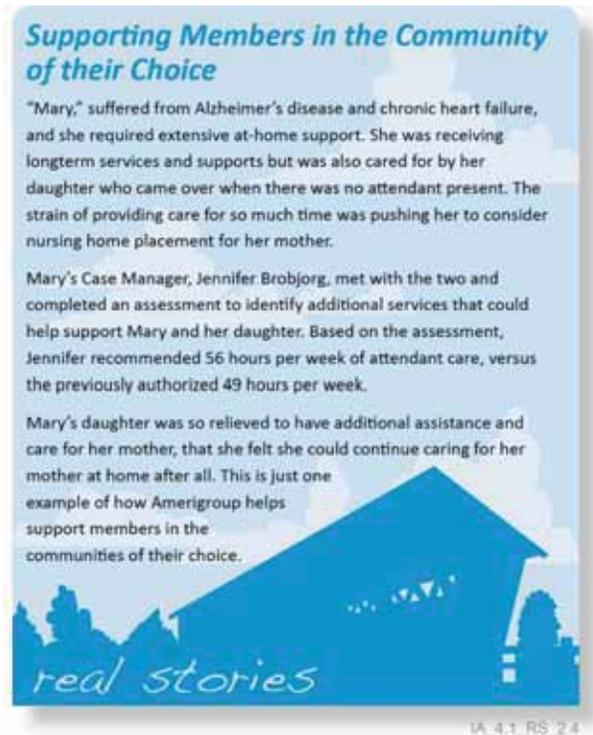
When building new relationships in our service areas, we identify community organizations that are integral to delivering non-covered services that have the potential to address unmet needs of our members. We use a variety of strategies and actions to introduce Amerigroup to the community by engaging in outreach and awareness activities, such as sponsoring and participating in health fairs, provider training, and giving back to the community through our corporate volunteer program. We strive to develop lasting relationships with local leaders and work to foster a common vision that promotes the well-being of the broader community and facilitates access to non-covered services for our members. Once we determine how best to work together, we invite organizations to contract with us or sign a statement of intent.

We have already begun to develop relationships with key community partners relevant to our LTSS membership in Iowa, including but not limited to:

- **Brain Injury Alliance of Iowa.** The Brain Injury Alliance of Iowa supports individuals with acquired brain injury and their families through services such as legal advocacy, PCA trainings, and community events.
- **The Iowa Developmental Disabilities (DD) Council.** The DD Council pursues projects and activities that influence public policy and attitudes toward those with DD, build the ability of Iowans with DD to lead independent lives, and support Iowans with DD to be advocates in their own care.
- **The University Center for Excellence in Developmental Disabilities** The University Center for Excellence in Developmental Disabilities partners with Iowans with disabilities, their family members, providers, State and local agencies, and many others to improve the health and full community participation of persons with disabilities and to advance the community supports and services on which they rely.
- **The University of IA Center for Child Health Improvement.** The University of IA Center for Child Health Improvement provides Iowa's children and their families communities with the necessary knowledge, skill, and resources to achieve their optimal potential. Their aim is to provide a coordinated network of resources and services centered on the child and family and improve population outcomes for children by improving access to services, expanding the array of community-based services available on a local level, and working to increase collaboration among the systems.
- **Centers for Independent Living.** The Centers for Independent Living create opportunities for independence for people with a variety of disabilities through independent living skills training, individual and systems advocacy, peer counseling, and transition services.
- We will continuously establish strategic partnerships with agencies that serve our LTSS members in Iowa—agencies that members already trust and respect. Our goal is to leverage existing community supports to enhance their capabilities and provide members with choice and consistency in their service delivery and relationships.

Supporting Members with Enhanced Staffing Needs

As part of our commitment to our members and to maximize our results related to community-based alternatives inclusion, Amerigroup has established mechanisms to assure that enhanced staffing or supports are driven by functional status and abilities of our members, are provided to support members' ability to be served in the community of their choice, and are not reduced arbitrarily. Our Case Managers vigilantly monitor changing circumstances through member and family feedback; ongoing contact with the member, family members or representatives, providers, and community supports; and review of claims history.



If our Case Managers suspect a change in the member's status, they do not hesitate to initiate a reassessment. Reassessments go through multiple levels of review by the member's interdisciplinary team to confirm accuracy and are documented in CareCompass Mobile. We ask members to approve adjustments to the service plan only when reassessments indicate a change in functional status that impacts the volume or type of services. Case Managers follow established processes in this regard that include advising members of appeal and Fair Hearing rights should a difference in opinion arise over a specific request from the member. Amerigroup strictly enforces adherence to these policies through ongoing case management audits and reviews and will work to assure that members receive the type and frequency of service that they prefer and need to safely live in the community of their choice.

Supporting Members and Preventing Facility Admissions

To further support members' ability to remain in the community of their choice, we engage in several processes to maintain members' health and independence and prevent admission to nursing facilities, intermediate-care facilities for individuals with intellectual disabilities (ICF/IDs), and State Resource Centers (SRCs). During our service planning process, we conduct assessments to identify any concerns associated with the member's choice to live in a home- or community-based setting and work with the member to identify solutions to mitigate concerns. We also work with members to develop back-up plans that help prevent service disruptions if scheduled providers can no longer serve the member. Collectively, these actions support Olmstead compliance and uphold the principles of self-determination while securing members' well-being. We work with all of our members to describe to them the possibilities of community living and the services and supports that would be available to them through the waiver program. We partner with community organizations, trusted members of their support team, and peers who have already transitioned to clearly define for them and show them real situations in the community of an integrated and meaningful life.

Prior to engaging in service planning, our Case Managers conduct a comprehensive assessment process to identify and address any safety concerns associated with a member's choice to be served in a home- or community-based setting. This process involves reviewing previously available medical history, enrollment file data, hospitalizations and institutionalizations, mental health conditions, substance use disorders (SUDs), behavioral challenges, and chronic illnesses. With approval from the member, Case Managers will actively engage with the member's community supports, including but not limited to schools, neighbors, places of worship, and community organizations, to help identify risk issues that have recently emerged. Most importantly, this process involves an open and honest dialogue between Case Managers and members to help identify any member concerns associated with the home- or community-based services. Case Managers then work with the member, family members, representatives, providers, and community-supports to identify solutions that could alleviate safety concerns by considering both covered and non-covered options.

Case Managers will also work with members and their family members or representatives to develop a back-up plan to prevent any service disruption that may jeopardize members' ability to be served in the community of their choice. During this process, Case Managers and members will identify back-up providers who can be contacted in the event that the scheduled provider fails to provide necessary services. In creating the back-up plan, we will consider providers who are able to deliver services on short notice as well as those in proximity to the members' residence. We will review back-up plans annually at least to assess changes in provider availability and will update them more frequently if a listed provider can no longer deliver a service or if the member's needs change.

Coordinating Seamless Transitions

Transitioning from Facility Care to Less Restrictive and More Integrated Settings

A strength of which we are very proud is our ability to facilitate transitions from facility settings to the community enabling greater independence, increased integration, and an enhanced quality of life. As with all Amerigroup case management activities, member choice is the most important factor in facilitating member transitions. Our Community-Based Case Managers work closely with each member residing in a nursing facility to assess interest in transitioning to a more independent setting. In addition to ongoing communication with our members to assess interest in transition, we will formally identify interest in transition during initial admission and at least annually thereafter.

We will convene a transition case conference to help support the development of a transition plan that meets the member's needs and preferences. The conference is a cornerstone of the process and includes an interdisciplinary team consisting of Case Managers, specialty providers, social workers, RNs, therapists, current and prospective PCPs, and the member, family, and other representatives. The conference is convened to identify medical follow-up, psychosocial or behavioral health issues, housing, social goals, and other waiver benefits that will require attention at transition to build the transition plan. To assure comprehensiveness, the transition case conference completes a transition checklist that includes items such as deposits, furniture, appliance, and linens that help the team identify additional supports that the member may require. Through continuous member engagement and support from the transition case conferences, we are able to support successful transitions for our member.

Our Case Managers remain engaged with the members and anyone they include in their personal network throughout the process. The Case Manager conducts a final discharge planning meeting through which the interdisciplinary team finalizes the transition plan, verifies that each step is clearly addressed, and resolves any open questions or concerns. Within 48 hours following the member's transition from the facility, the Case Manager conducts an in-person visit to confirm that all services and supports have been initiated as outlined in the member's transition plan. The Case Manager will remain in close communication with the member and family members or representatives post-discharge to address any emerging barriers and adopts a less intensive engagement as the member successfully reintegrates.

Transitioning from the Hospital to Less Restrictive Settings

For members who have recently been hospitalized, we are committed to ensuring that their transitions back to the community are supported while minimizing the risk of readmission. To this end, Amerigroup has a transition of care program that outlines best practices for care transitions. The transition of care program facilitates member access to outpatient services by connecting the member with these services prior to discharge. Our case management approach integrates the transition of care model, working in collaboration with members, family members, representatives, and clinicians located on-site at specified hospitals. Key components of this model include pre-transition visits, follow-up care arrangements, post-discharge check-in, medication reconciliation, member education, disease-specific interventions, and discharge plan reminders. For members with complex functional needs, we will also discuss with the member their option to consider transitioning to a less restrictive facility such as a nursing home, ICF/ID, or SRC before completing a full transition to the community. Through these proven processes, our affiliate health plans have reduced admission rates while emergency room rates have remained flat, evidence that we are engaging members in their service plans and facilitating access to the right care, in the right place, and at the right time.

Amerigroup understands the unique challenges members can face when transitioning back home from a hospital stay. To further assist members and help make transitions as smooth as possible, we will provide a post discharge kit and free home-delivered meals to eligible members and their families as Value-Added Services. The discharge kit provides tools for family members and caregivers to successfully help

transition members from hospital to home, aid in recovery, and help decrease the chances for readmission. The meal program provides nutritious home-delivered meals, which allows members to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare them.

Level of Care and Support Assessments (4.2)

Amerigroup's affiliates have 17 years of experience supporting our members living in their homes and communities and those residing in facilities through Medicaid long term services and supports (LTSS) programs. Our quality improvement activities lead to ongoing refinement of processes to better serve members as they transition through various life stages. This includes but is not limited to early identification of member service and support gaps that signal need for LTSS; open communication with members and families to make sure the member and family supports provided are meaningful and include social, education, and employment goals; eligibility screenings prior to referral to our state Medicaid partners for eligibility and initial level of care determination; and ongoing monitoring and tracking to make sure member needs are fully addressed and reassessments are completed in a timely fashion in order to avoid service interruption and gaps in care.

Our Community-Based Case Managers are trained to administer state-adopted standardized assessment tools to protect inter-rater reliability along with other oversight functions to check the integrity of information gathered during the discovery process with the member and applied throughout the ongoing assessment process. Additionally, our team has extensive experience with the Preadmission Screening and Resident Review (PASRR) screening processes and working in collaboration with our state partners or their designees to provide a seamless experience for members. We understand the importance of a comprehensive approach to align funding decisions with member strengths, goals, needs, and preferences. Engaging the members and those who know them best provides our Case Managers with the opportunity to engage in follow-up questions and answers to compliment the assessment results prior to the development of the person centered service plan. Additionally, Amerigroup has administrative and quality assurance oversight processes in place to protect conflict-free case management in accordance with state and federal regulations.

Initial Determination for Non-members (4.2.1)

Through our affiliates, Amerigroup has significant experience working with state partners who retain responsibility for Medicaid eligibility and level of care determination for enrollment in nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IDs), or 1915 (c) Home and Community-Based Services (HCBS) waiver programs. We will coordinate with the State to obtain and include level of care determinations and initial assessment and reassessment results from the administration of the InterRAI-HC and Support Intensity Scale (SIS) tools, as well as other pertinent member specific information as part of the person-centered planning process. We support the State's commitment to use its adopted core standardized assessments to promote fair and equitable allocation of funding resources based on each member's individual support needs. This process will inform the development of person-centered service plans based on the individual member's selected services and personal goals within HCBS waiver cost limits. Amerigroup recognizes the value of streamlined assessment and documentation across all waiver populations and programs and will work in collaboration with DHS to achieve the State's goals. We will not revise the adopted assessment tools or use other tools without State approval.

Level of Care Assessments and Annual Support Assessments (4.2.2)

Identification (4.2.2.1)

Amerigroup has developed operational protocols, policies, and procedures to promote early identification of member service and support gaps that may signal emerging needs that are better addressed through LTSS programs to enhance member health, well-being, and independence. All Community-Based Case Managers are trained to recognize indicators that suggest a member may benefit from and meet LTSS program enrollment criteria. Amerigroup will train all Community-Based Case Managers on LTSS eligibility criteria established by Iowa Medicaid Enterprise (IME) so that timely action is taken in coordination with DHS. Our Community-Based Case Managers engage and inform members regarding all available LTSS options. After conducting initial assessments for interested members using a state-approved tool, Amerigroup will refer all potentially eligible members to the State or its designee for level of care determination. Through this process, we are better able to align services and supports with member strengths, needs, and preferences to accommodate periods of transition that all people and families experience

Processing Referrals to LTSS

Amerigroup's "no wrong door" approach provides a single point of entry for LTSS program referrals from end to end. All member-facing staff accept self-referrals from members or referrals from their families, support networks, service providers, or health professionals. Training includes respect for the member's own advocacy and self-direction, active listening skills, how to gather situational facts, accurate documentation of essential information for follow-up, and proper routing of requests to the LTSS case specialist or the assigned Case Manager or care coordinator. In each instance, staff will work in consultation with the case management team manager to link the member with a Community-Based Case Manager. The member's Case Manager or care coordinator will work in tandem with the newly assigned Community-Based Case Manager to facilitate continuity and integration of all service and support needs in the process described below. In the event that a member has not been linked to a specific Case Manager or care coordinator, the newly assigned Case Manager will consult and engage team members with relevant expertise throughout the process detailed below:

- Regardless of the referral source, the assigned Case Manager will contact the member and, as appropriate, their family or representative to learn more about the member's needs and concerns. The Case Manager will discuss the request and the required steps prior to LTSS program referral to the State or its designee. If the member has an established relationship with another Case Manager or care coordinator, he or she will facilitate the introductory call. The Case Manager will describe LTSS options and discuss interest in receiving LTSS. During the initial call the Case Manager will also perform a brief telephonic screening to determine level of urgency to prioritize access to services and the face-to-face assessment.
- If it is determined that the member has an urgent need compromising health and safety as a result of a recent change in daily living circumstances or health-related conditions, the Case Manager will authorize medically necessary interim services and schedule and complete a face-to-face screening assessment no later than seven days from the date of referral.
- If the results of the telephonic screening indicate that the need for LTSS is not urgent, the Case Manager will work with the member and as appropriate the family or representative to schedule and complete the face-to-face assessment no later than 30 days from the date of referral.

Referrals received after hours will be routed through our 24/7 Member call center. The call center representative will have access to our core operating system and will enter a detailed message that tasks

the member’s Community-Based Case Manager for follow-up with the member the next business day. When indicated, the call center representative will also be able to connect the member to an on-call Community-Based Case Manager after hours. For members in crisis, a referral will be made immediately to emergency services. In the event of a medical emergency, our members are encouraged to call 911; our call center representatives will assist as requested to facilitate the call.

Ongoing Identification of Members Who May Be Eligible for LTSS

In addition to processing all inbound referrals, Amerigroup’s person-centered approach uses an array of ongoing discovery and assessment strategies to facilitate proactive identification of members who currently need additional resources available through LTSS programs and those with risks factors that signal signs of instability in life circumstances such as physical and/or behavioral health conditions that may result in a change that leads to LTSS eligibility. Our comprehensive approach emphasizes an integrated model that utilizes our collective expertise of our health plan employees and the interdisciplinary team to develop a holistic view of each member’s evolving life experiences and service and support needs across physical, behavioral health, and social service delivery systems. Table 4.2-1 below outlines our processes to identify members potentially eligible for LTSS programs.

Table 4.2-1. Amerigroup Seeks to Identify All Members Who May be Eligible for LTSS

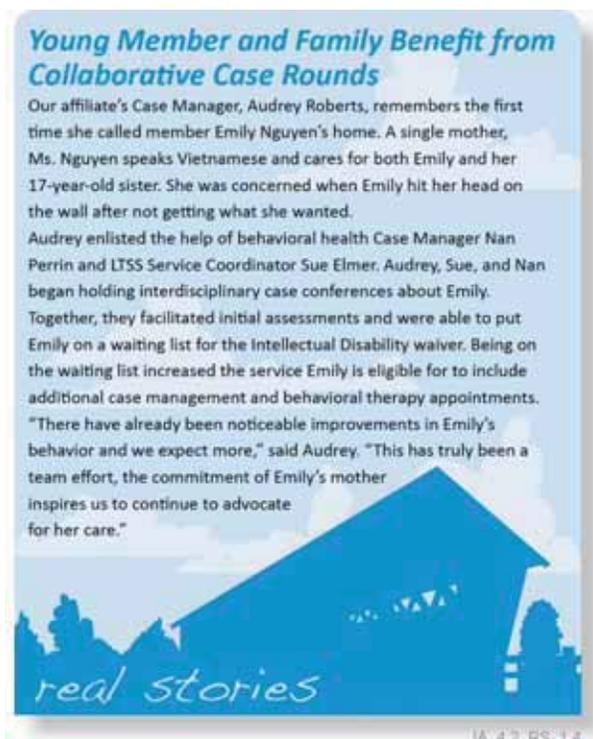
Method:	Process we will use to identify Iowa High Quality Healthcare Initiative (HQHI) members for LTSS:
Claims Analysis and Predictive Modeling	Our predictive modeling process facilitates prospective identification of members who may meet HCBS Waiver program or Nursing Facility and ICF/ID eligibility through medical and behavioral health conditions and/or developmental factors of elevated risks through analysis of claims data to identify conditions and prioritize outreach and assessments, for example, emergency room use, hospitalizations, and prescription drug utilization.
Review of State Enrollment Files	Files provided by the State will be used to identify members enrolled in LTSS programs, those on waiver waiting lists and others that may be at risk of institutionalization or in imminent need of HCBS waiver supports. Community-Based Case Managers will expedite informal and State-approved initial screening assessments to facilitate proactive eligibility referrals to the State or its designee.
Telephonic outreach and screenings	Screenings will be used to quickly identify potential unmet needs or specialized needs for newly enrolled Amerigroup members, including potential stressors and challenges in members’ natural support systems. This information will identify members for initial screening assessments for LTSS eligibility and specialized services that the member may require.
Review of other care or service plans, treatment plans, and medical records	Prior service documentation, medical necessity determinations, authorized care, and treatment plans are examples of other documentation we will review to identify specialized and/or complex needs. We will also review member records on an ongoing basis, including, as applicable, person-centered service plans, State-adopted assessment results, other assessments, medical records, and Individual Education Program plans. All documentation is uploaded to the member’s CareCompass file with member and/or representative consent to inform ongoing service planning and collaboration.
Referrals	Members will be prioritized for outreach and assessments to determine needs through self-referrals and referrals from family or representatives, support network, early intervention programs, schools, service providers, physicians, and/or other health professionals.
In-person Initial Assessment Processes	In-person initial assessments using State-adopted tools will be administered face-to-face with the members and, as appropriated, their families or representatives to identify clinical and functional reasons for referral to the State or its designee to determine eligibility and level of care.

Method:	Process we will use to identify Iowa High Quality Healthcare Initiative (HQHI) members for LTSS:
Ongoing Monitoring	Amerigroup's regional case management teams further encourage communication between non-LTSS and LTSS case managers to proactively identify additional members who may be in need of LTSS. Specifically, non-LTSS case managers can easily communicate with other team members, including LTSS case managers, regarding specific members formally during case rounds and on an as-needed basis. This level of coordination makes sure that members with LTSS needs are promptly identified and referred to the State for level of care determination and sets the foundation for integration across physical health, behavioral health, and social service delivery systems.

Through internal and external collaboration and coordination we are able to maximize available State, regional, and community resources to eliminate service and support gaps promoting member health, well-being, and independence. For example, our physical health, behavioral health, and LTSS leadership and teams are co-located to facilitate an internal referral process to address unmet needs. So, as behavioral health Case Managers become aware of changing needs with a member, they can consult and refer the member to their LTSS colleagues to provide all needed supports. Additionally, the teams conduct a variety of internal collaborative case rounds to build immediate and long-range solutions for our members with the most complex needs, including integrated rounds for members with co-occurring conditions, complex case rounds for LTSS members with medically fragile conditions, and nursing facility reintegration rounds for members we are assisting in repatriating to the community. Our Case Managers navigate delivery systems and coordinate with our State and regional partners, contracted providers, and community resources to link members to needed services and supports that are brainstormed through our collaborative processes.

Initial Assessment and Annual Support Assessment (4.2.2.2)

As described in Section 4.2.2.1, the Community-Based Case Manager will contact the member by phone. If the member has an established relationship with another Case Manager or care coordinator, he or she will facilitate the introductory call. During this call LTSS options will be described and discussed to determine interest in available services and supports and moving forward with the eligibility process. The Case Manager will discuss the request and the required steps prior to LTSS program referral to the State or its designee. During the initial call the Case Manager will also perform a brief telephonic screening to determine level of urgency to prioritize access to services and the face-to-face assessment. If the member wants to move forward with LTSS eligibility, the Case Manager will schedule an in-person initial assessment using the State-approved tool. For urgent requests, Case Managers will schedule and complete the in-person assessment within one week, if at all possible. Case Managers will schedule and complete initial in-person assessments within 30 days for all non-urgent referrals. In the event that a member does not



appear to meet LTSS eligibility criteria for LTSS enrollment, Amerigroup will notify and advise the member and, as appropriate, his or her family or representative of the right to continue or discontinue the process as outlined in Section 4.2.3.

Question 4.2, #1

1. Describe your ability and process for conducting level of care reassessments and tracking and determining when a reassessment is required.

Our affiliate health plans have a strong track record of successfully implementing all state-appointed assessments in their LTSS markets and have completed assessments using state-appointed tools for over 25,000 members across their LTSS programs.

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Amerigroup has established processes and protocol in place requiring timely completion of all reassessments with a proven tracking system that has demonstrated effectiveness. **Amerigroup affiliates have consistently achieved near 100 percent compliance with timely reassessment as measured by state quality audits.** We generate daily reports for our Community-Based Case Managers to track reassessments to make sure assessments are scheduled in a timely fashion to prevent gaps in care and services and that a member's service plan addresses any changes in medical or functional status.

Amerigroup has developed innovative solutions that support our successful reassessment process. Using our innovative iPad-based CareCompass Mobile technology, our Case Managers are able to conduct reassessments effectively and efficiently. We will leverage

our innovative approach and experience in Iowa to support accurate, complete, thorough, and timely reassessments for our members.

Tracking Reassessments
Annual Reassessment

For all our LTSS members, we will perform reassessments when a member experiences a significant life change or at least every 12 months to capture any changes in medical and functional status that cause a change in level of care. To conduct timely reassessments, Case Managers download regularly updated reports regarding all upcoming reassessments as required to meet the ongoing needs of our members. We generate reports on the CareCompass platform daily that are easily customized to include all reassessment due dates in 30-, 60-, 90-, 120- or 180-day increments in the format in Figure 4.2-1. These reports are accessible by Case Managers, as well as regional managers in the case management program. This assists Case Managers to plan reassessments in advance and prioritize needs and provides regional managers the ability to provide timeliness of reassessment oversight.

Figure 4.2-1. CareCompass Report Manager Produces Daily Reports to Track Reassessment Needs

Member LOC Indicator (e.g., interim)	Member Group ID	Effective Date	Term Date	Last Contact Date	Last Contact Note Type (e.g., on-going, annual assessment)	Last Contact Type	Next Contact Due Date	Next Contact Type (e.g., telephonic, face-to-face)

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Changes in Member Need

As stated above, we identify significant changes to life circumstances and functional and/or medical needs that trigger a reassessment. Changes indicating a need for reassessment include but are not limited to:

- Increased frequency in hospitalizations
- Inability of primary natural support to care for the member
- Change in medical conditions like uncontrolled seizure activity or disease progression such as HIV/AIDs
- Home environmental factors placing the member at undue risk

To help identify changes in member circumstance, Case Managers continuously monitor the adequacy of members' service plans through regular in-person and telephonic communication with the members, their family or representatives, and providers. Case Managers also continuously monitor medical claims data via Member 360 to identify members needing an early reassessment. Member 360 provides Case Managers with a member dashboard that displays HEDIS[®] care alerts; authorizations; prescriptions; lab results; and claims organized by type such as inpatient, emergency room, office visit, and behavioral health. It also provides a timeline of clinical events for the member across a number of domains, including diagnosis, providers, and medication history. Member 360 provides a complete overview of members' medical care to help inform reassessment decisions.

Conducting Reassessments

Through our affiliates, Amerigroup has significant experience conducting reassessments for our LTSS populations and a proven track record of consistently complying with reassessment timelines in all states of operation. Through our experience, we created well-defined policies and procedures and innovative systems to conduct reassessments as an essential component of meaningfully informed service plan development.

During reassessments, we will administer the Supports Intensity Scale (SIS) for ID populations and InterRAI-HC for all other LTSS populations to help support State efforts to achieve uniformity in assessments across LTSS programs to promote the alignment of funding resources to member needs. Amerigroup brings demonstrated experience implementing standardized assessment tools, including modified versions of the InterRAI-HC in other states. Given our experience, we are confident we will be able to successfully and consistently use InterRAI-HC and SIS to support level of care assessments.

To supplement the InterRAI-HC and SIS tools, we will use our proprietary needs assessment called the Universal Assessment Tool (UAT). Amerigroup developed the UAT specifically for our LTSS members so that Case Managers may fully understand of the member's functional, physical, behavioral, and support status, as well as self-reported needs. The comprehensive nature of the UAT provides the Case Manager with a full picture of the member's health status. As part of the UAT, Case Managers will probe the member and, as appropriate, family or representative perspectives on member strengths, needs, and preferences. For example, through these tools, the Case Manager will determine if frozen, hot, or personal care attendant (PCA)-prepared meals would work best for the member (documenting the need for gluten free, vegetarian, diabetic-free, heart healthy or renal meals). The assessment uses branching logic based on member responses triggering exploration of the most relevant areas, resulting in highly individualized conversations to help tailor services and supports based on identified member needs across physical, behavioral, and social delivery systems. To avoid duplication of efforts between assessments and re-asking members and families the same set of questions, we will directly incorporate all relevant member responses from the State-adopted assessment tools into the UAT.

To facilitate successful reassessments, our Case Managers will be equipped with our proprietary iPad-based tool, CareCompass Mobile. CareCompass Mobile will be programmed with all necessary

reassessment tools, including the InterRAI-HC, SIS, and UAT. The technology reduces administrative burden and creates efficiencies by automating transfer of information that, in turn, facilitates Case Managers to directly focus on the needs and concerns of members by involving members in the service-planning process. Given our experience incorporating several assessments into our CareCompass Mobile Technology as demonstrated in Table 4.2-2, we are confident we will be able to leverage our innovative CareCompass Mobile solution in Iowa.

Table 4.2-2. Amerigroup Affiliates have Significant Experience Implementing State-designated Reassessment Tools in States that Require Use of Specific Tools

	State-designated assessment tool	Technology platform used to administer	Reassessments completed
Florida	701B	CareCompass Mobile	6,300
New Jersey	NJ CHOICE*	CareCompass Mobile	3,470
New York	Uniform Assessment System	Laptops for login to state system	3,350
Texas	Medically Necessary and Level of Care	CareCompass Mobile	13,598
Total			26,718

*State-modified version of InterRAI-HC

Question 4.2, #2

2. Propose the approach by which needs assessments will be administered in a conflict-free manner consistent with BIP requirements.



Amerigroup recognizes the importance of providing need assessments in accordance with conflict-free principles and practices. Conflicts of interest can arise and impede the person-centered planning process that facilitates the identification of member-specific strengths, needs, and preferences in the development of the service plan. ***At Amerigroup, our Case Managers are strictly prohibited from being involved in service delivery to prevent any conflicts of interest.*** To further help assure that needs assessments are conducted in accordance with all BIP requirements relating to conflict-free case management, Amerigroup developed policies and procedures to provide comprehensive Case Manager training such as prohibition of incentives, required mechanisms to report grievances, and oversight processes through Case Manager performance reviews and quality improvement programs.

Case Management Processes

Case Manager Training

To help assure adherence to BIP requirements, Case Managers undergo rigorous training to promote conflict-free needs assessments and overall case management. During general orientation for new employees, Community-Based Case Managers are required to complete online learning modules on policies and procedures related to ethics, including standards for conflict-free case management.

Core competency training includes specific modules for the State-adopted standardized assessment tool. Core modules include but are not limited to Member-Centered Principles and Practices, Motivational Interviewing Techniques, Member Rights and Conflict-Free Case Management, and Amerigroup’s approach. During assessment training, we further emphasize that Case Managers must protect the integrity of the standardized assessments through prescribed protocols for administration along with other oversight to check result accuracy against information gathered during discovery process to guard against over- or underreporting of member service needs. Our Case Managers receive annual and targeted training to maintain core competencies and professional development. Ongoing training also covers

conflict-free assessment techniques on an as-needed basis. Further information on our training processes for Case Managers can be found in Section 4.3.

Conflict of Interest Policies

In accordance with Amerigroup policies and procedures, Case Managers are required to report to their Long Term Care/Care Coordination Manager any conflicts of interest they may have, including but not limited to familial and personal relations with the member, his or her family or representatives, any paid PCAs or other support workers, and/or the provider agency that may compromise their ability to evaluate member needs objectively. In addition to reporting conflicts of interest as they arise, our Case Managers are required to formally attest that they have no conflicts of interest on an annual basis. If a Case Manager reports a conflict of interest, the Long Term Care/Care Coordination Manager will reassign the member's case to another Community-Based Case Manager within the region.

Financial Compensation

To further adherence to conflict-free case management, Amerigroup policy clearly articulates that financial incentives or other rewards to Case Managers for limiting care or services for members is strictly prohibited. Likewise, we affirm that decisions about hiring, promoting, or terminating Case Managers or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits or services. To reinforce the importance of conflict-free case management, all employees sign a Compensation Policy Statement upon hire that affirms this policy. We retain the signed Compensation Policy Statement in the employee's personnel file.

Grievance Reporting and Tracking

Amerigroup's "no wrong door" approach provides a single point of entry for grievances, complaints, and appeals from end to end. All employees are trained on standards for managing member inquiries, grievances, and appeals. Typically calls from members, families, or representatives are received by our Member call center representatives, regardless of the point of entry, and grievances and complaints are recorded and routed to the Grievance and Appeals Unit. We focus on responding to members in a courteous and professional manner and make every effort to resolve any issues that may arise through a well-defined and documented process that supports the member every step of the way. We maintain robust and effective procedures and systems for tracking and monitoring member inquiries, grievances, and appeals from initial receipt to escalation processes and resolution time frames to investigation processes and follow-up responsibilities. Staff members do not review or make decisions on cases where they were involved in previous levels of review or decision-making. For example, Case Managers performing the State's adopted needs-based assessment are prohibited from involvement to protect the integrity of the process. Section 8.15 provides a description of Amerigroup's processes and timelines.

In addition to Amerigroup's Welcome Packet and information on the member website, Member Services representatives, Case Managers, and Utilization Management staff are trained to inform members of their rights and responsibilities during each contact when a member, family, or his or her representative expresses dissatisfaction with any aspect of care or services. During the initial assessments and reassessments, members are also informed of their rights. We affirm with our members and their families or representatives their understanding of our internal grievance, complaint, and appeal processes. Additionally, we make sure members and their family or representative are fully informed and understand State Fair Hearing processes and provide support as needed so that they are able to exercise their full rights.

Based on the results of the internal investigation, the decision may, for example, result in a directive of reassessment by a different assessor, member assignment to another Case Manager in the geographical region with relevant prior experience specific to the member's needs, or other actions as needed.

Oversight

Case Manager Performance Reviews

Our affiliates have established principles and practices within our “Ethical Framework for Case Management Practice” that include core policies that define clear expectations regarding case management performance. These standards of practice are foundational to conflict-free case management and service delivery. Case Manager and non-case manager quality case reviews are completed by the Quality Management and Improvement (QM/QI) Committee quarterly on a random selection of open and closed case records from within the medical management system. Quality case reviews are based on objective quality indicators as specified in applicable policies and evaluate whether a Case Manager has been operating in a conflict-free manner. This includes evaluating Case Managers for consistent implementation and documentation of all components of the case management process, including case initiation, assessment, planning, coordination, monitoring, and evaluation.

If it is suspected that a Case Manager has a conflict of interest, the QM Committee will meet with the Case Manager to discuss an action plan for improvement. The action plan may include:

- Providing education and/or counseling to the employee until improvement is noted
- Conducting quality case reviews on a more focused basis (for example, weekly or biweekly) until achieving a consistent score at or above the designated minimum threshold
- Conducting manager ride-a-longs through which Long Term Care/Care Coordination Manager can observe Case Managers directly and help remediate any concerns

The QM/QI Committee reviews aggregated quality review results for trending and analysis to support continuous quality improvement in the case management program.

Annual Review of Case Management

On an annual basis, the plan national Quality Improvement Committee (QIC) will evaluate the case management program to confirm that the scope, goals, performance measurements, and planned activities are consistent with national and business strategic plans and the national case management standards of practice. This process includes but is not limited to an evaluation of:

- Aggregate findings from the quality case review process described above
- Aggregate data from member satisfaction survey reports and complaints, including but not limited to needs assessments

If there are any concerns relating to conflict-free case management, Amerigroup will develop an action plan to address the concern that may include training, team restructuring, and additional audits.

Engaging All Stakeholders in Oversight

Amerigroup also engages community stakeholders in continuous improvement of our LTSS program practices and processes through input gathered in open forums that are convened on a routine basis. In all our markets, we establish both a Member Advisory Board and a Provider Advisory Board with diverse membership to augment oversight through the review of policies and procedures, as well as issues raised by members, their families, natural supports, providers, and community supports. Active engagement of our stakeholders gives Amerigroup insight needed to improve policies meant to protect member rights, including but not limited to conflict-free case management, assessments, and service delivery. Section 8.12 describes our advisory board composition and processes.

We will review with both the Member and Provider Advisory Boards the specific policies and procedures and give the members and providers the opportunity to ask questions and give input to us. The board members may request that we consider making some changes to our policies and procedures, in which case we will track those requests that will go to the plan leadership for review and consideration. We will

continually update the board members on our changes and innovations and the conflict-free needs assessment process and will give the members an opportunity to bring issues and complaints to the board meetings for consideration and review. We welcome and value the input and advice from our stakeholders and understand the vital role they have in assisting Amerigroup in having the best performance and outcomes possible.

Question 4.2, #3

3. Propose a timeline in which all assessments shall be completed: a) Upon initial enrollment with the Bidder b) When the Bidder becomes aware of a change in the member’s circumstances which necessitates a new assessment and c) At least every 12 months

Assessment Timelines

Amerigroup recognizes the need to conduct timely assessments and reassessments to make sure members do not experience a gap in care or services and that their member-centered service plans reflect current service and supports needs across physical health, behavioral health, and social delivery systems. Based on our experience, we propose the timelines listed in Table 4.2-3 to support timely completion of initial assessments and reassessments, as well as assessments related to urgent and non-urgent LTSS referrals.

*Table 4.2-3. Proposed Timelines for Assessments and Reassessments**

	Upon Initial Enrollment or Non-urgent Referral	Upon Discovery of a Change in Circumstance or Urgent Referral	Annual Level-of-care Reassessment
Ongoing Basis	Within 30 Days	Within 7 days	60 days prior to expiry
At Contract transition (Implementation)	Within 90 Days	Within 7 days	Prior to authorization expiry

**All timelines reflect minimum standard; members with higher levels of need will be prioritized.*

Based on effective processes and protocols in other state LTSS markets, Amerigroup proposes timelines for the completion of initial assessments, significant changes signaling reassessment, and annual reassessments as follows:

- From the date of initial enrollment, identified as potentially eligible for LTSS or non-urgent referrals initial assessments will be completed within 30 days. This expedites referrals to the State for LTSS eligibility and level of care determinations and provides the Case Manager with needed information to support the member in his or her community through non-LTSS services and community resources until services can be secured through LTSS programs for eligible members.
- Annual reassessments will be completed no less than 90 days prior to the expiration of the member’s service plan to avoid any gaps in care and services and to incorporate current information as part of development of the person-centered service plan to align funding decisions and support needs within waiver cost limits.
- When members experience significant changes in life circumstance or medical and/or behavioral health status, initial assessments based on urgent referrals and reassessments will be completed no later than seven days from the date of notification. We understand that significant changes in the member’s circumstances, such as loss of a family member who served as a primary support or a behavioral health crisis, can dramatically impact the health, safety, and well-being of our members, often requiring immediate intervention to avoid nursing home or ICF/ID placements. New level of care information provides the Case Manager with needed information to support the member, his or her family, and the interdisciplinary team with person-centered planning to close gaps in care and services.

Meeting Member Needs Through Timely Reassessments

As discussed under Question 4.2, #1, Long Term Care/Care Coordination Manager are able to access customizable reports updated daily through CareCompass Report Manager that provides a summary of all reassessments due in 30, 60, 90, 120 or 180 days. Through these reports, Long Term Care/Care Coordination Manager are able to monitor reassessment timelines for all members and are empowered to intervene where necessary to help provide for timely reassessments. Additionally, LTSS Case Managers stay well-informed to concerns or issues that may impact member support needs through monthly monitoring and quarterly face-to-face meetings and continuously monitor our members' reassessments needs. Case Managers will make best efforts to schedule reassessments during regular in-person visits and telephonic conversations with the member. If necessary, Community-Based Case Managers will supplement routine conversations with additional telephonic contact to schedule reassessments. Case Managers will make their initial request for reassessment well in advance of the due date to help assure timely reassessments.

If a member cannot be reached through three telephonic contacts, we will deploy creative strategies, including but not limited to:

- Sending field-based Case Managers to the member's home address to establish contact
- Leveraging assistance from other members of the regional case management team in locating and engaging members
- Reaching out to members' providers and asking providers to relay the need for reassessment to the member and family members or representatives
- Reaching out to pharmacies where our members fill prescriptions to obtain updated contact information
- Reviewing all claims data that may have been paid on the member's behalf and reaching out to those providers who have been paid to seek additional information

To help assure that member contacts are made to schedule an appointment, our Long Term Care/Care Coordination Manager will provide continuous oversight unto the reassessment process.

In the event that a reassessment timeline is missed due to mitigating circumstances such as a hospital admission, Amerigroup will work diligently to prevent any gaps in care for our members. We will continue to work with members and their family members or representatives to complete a reassessment at the member's earliest convenience and will carefully document all efforts to conduct a reassessment in a timely manner. Finally we will not hesitate to extend a member's authorized services as needed to help assure member health, safety, and well-being.

Documentation Requirements (4.2.2.3)

Question 4.2, #4

4. Describe your plan to track and report level of care reassessments.

Amerigroup has established processes and protocols in place requiring timely completion of all reassessments with a proven tracking system that has demonstrated effectiveness. State quality audits consistently report nearly 100 percent compliance with timely reassessment in our affiliate health plans. Our innovative CareCompass technology and robust reporting systems reduce administrative burden and create efficiencies by automating the transfer of information.

Tracking and Reporting Reassessments

After reassessments are completed, Case Managers will record the results, including the determined level of care, in CareCompass Mobile. All assessments and forms completed on the iPad are electronically dated and archived in CareCompass for future reference in accordance with all applicable privacy regulations, including HIPAA. Archiving reports in CareCompass reduces administrative burden and creates efficiencies by automating the transfer of information. Through CareCompass archives, we are able to make reassessment records available quickly and easily to the State upon request.



If the needs assessment indicates a change in level of care, Case Managers will forward all documentation of the reassessment and the results to the State within the time frame defined by DHS. We can easily customize the CareCompass reporting format as needed to meet DHS reporting requirements for assessments indicating a change in level of care.

Incorporating Reassessment Outcomes in Service Plans

Once we receive member level of care determinations from DHS, we will coordinate with members and families to schedule the annual service planning meeting with the interdisciplinary team. We will engage the member and the interdisciplinary team to review the current service plan; revisit member strengths, preferences, and support needs; and discuss the level of care determination incorporated into the updated service plan along with all service authorizations. We will also mail a copy of the updated service plan to the member and, as authorized, to the primary care provider (PCP). Our members are able to view their service plan through Member 360. Contracted providers have access to service plans of the members they support through provider facing Member 360.

Preadmission Screening and Resident Review (4.2.2.4)

Question 4.2, #5

5. Vendors must work with the State or its designee responsible for implementing the PASRR process. Propose strategies to ensure members receive the specialized services and supports indicated by the PASRR level 2 screening.

Amerigroup has vast experience coordinating with states throughout the PASRR process. Just as we do in other states, we will work closely with the State of Iowa and/or its designee in the step-by-step completion of PASRR Level I screenings and Level II evaluations. Our policies and procedures adhere to federal regulations and will be modified to comply with Iowa-specific rules and regulations.

Prior to members' involvement in the PASRR process, Community-Based Case Managers work closely with our members and their interdisciplinary team through the member-centered planning process to develop a service plan that maximizes available resources through Medicaid, other State and local programs, our Value-Added Services, family and natural supports, and community resources with the goal of remaining in the community. These efforts take place when members have experienced significant life changes that require additional home and community-based services and supports to divert potential institutional placement or when a member expresses the desire to reintegrate into the community. For example, if a member is hospitalized, we work closely with the discharge planner to make sure services and supports needed in the home are in place prior to discharge.

Promoting Timely Completion of PASRR Screenings

Case Managers communicate directly with nursing facilities and other entities that are required to complete and report PASRR Level I screenings and Level II evaluations within State and federal timelines. Upon notification that a member on the LTSS waiting list or participating in one of the State's HCBS waiver programs has been admitted to a nursing facility, Case Managers promptly confirm completion of the Level I PASRR. The Case Manager will request confirmation from the State or its designee to make sure a quality review of the Level I screening have been completed accurately and prior to admission. If the member is deemed to meet nursing home admission criteria, the Case Manager will request Level I results to make sure that all PASRR requirements have been met. For example, in the event that a member with ID or SMI is approved for admission, a Level II evaluation will be triggered to identify needed specialized services.

In the event the State or its designee does not have record of the member's Level I screening, the Case Manager will work collaboratively toward accurate and timely completion as directed. Through contractual agreements with nursing facilities, we require compliance with federal and State PASRR rules and regulations, including but not limited to Level I screening completed prior to admission.

Providing PASRR-identified Specialized Services

Amerigroup contractual agreements with nursing facilities also include compliance with federal and State regulations that require a Level II evaluation for all members with ID or a behavioral health disorder to make sure identified needed specialized services are completed as part of preadmission screening. For all other members suspected to have a diagnosis of ID and/or a behavioral health disorder post admission or who have experienced a change in conditions, PASRR Level II must be completed to identify and address specialized needs.

Amerigroup will conduct regular facility record audits to monitor PASRR compliance. If a nursing facility is found to be in violation of contractual requirements, we develop a Corrective Action Plan. During this process we will work directly with the nursing facility to address any barriers to compliance. After repeated violations, we will reserve the right to terminate authorization for payment, open a quality of care investigation, and/or work with the applicable State agency on enforcement. In these circumstances, we will work with the member and interdisciplinary team to identify a new facility for the member.

For members with ID and/or behavioral health conditions, we will monitor for improvements in the medical and/or functional status suggesting that they may no longer meet PASRR admission criteria. In the event that the Case Manager questions appropriateness, we will request the completion of applicable PASRR Level I and/or Level II screening to determine ongoing eligibility. We will work to identify similarly inappropriate circumstances for all members indicating care and service needs could be adequately met through HCBS waiver programs coupled with natural supports and community resources.

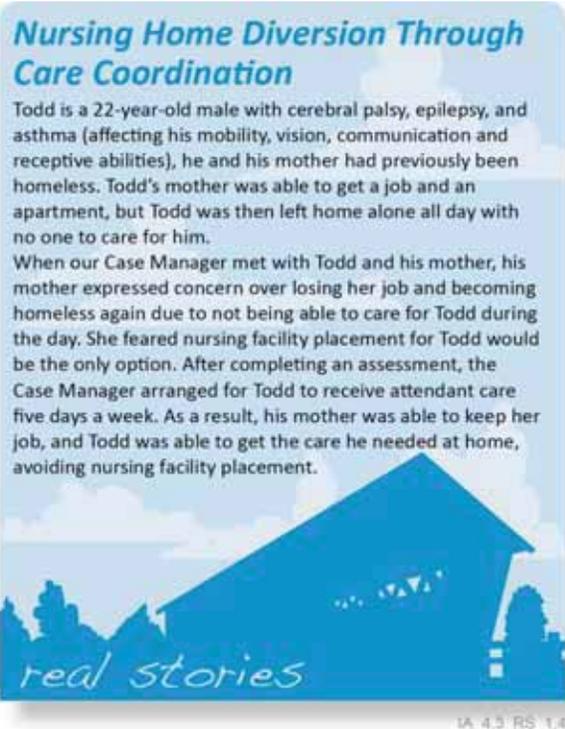
For those with ID or behavioral health conditions that met PASRR screening for admission; whose functional or medical limitations have subsided; and for whom we have concerns that ongoing institutionalization is related only to the behavioral health, ID, or other similarly inappropriate circumstances, we will require the nursing facility to have applicable PASRR screening completed to determine ongoing eligibility for the nursing facility. ***We will work with all our members to continually inform them of community-based options and identify opportunities for reintegration into the community through the person-centered planning process.***

Appearance of Ineligibility (4.2.3)

Amerigroup's affiliates have extensive experience working with members who may appear ineligible for LTSS programs based on state-specific criteria. Our policies and procedures are compliant with applicable federal Medicaid managed care requirements and will be modified to meet Iowa-specified time frames and requirements for noticing, monitoring, and reporting. In the event that a member does not appear to meet LTSS eligibility criteria for LTSS enrollment, Amerigroup will verbally notify and advise members and, as appropriate, their family or representative of the right to continue or discontinue the process. When the decision is made to proceed with the assessment process, we will follow the processes within specified timelines for completion of the initial assessment and the submission of documentation and results within DHS established time frames. If the member or, as appropriate, family or representative decides to discontinue the process, Amerigroup will formally document the decision in CareCompass, including the authorizing signature and date. Amerigroup will adhere to State-designated timelines for providing DHS with documentation of termination. The use of our CareCompass technology to record all assessment results and relevant documentation allows for electronic transfer of data regarding the appearance of ineligibility to DHS in a manner prescribed by DHS.

Waiting Lists (4.2.3.1)

We are committed to creatively supporting our members who are on the waiting list for HCBS programs to prevent out-of-home placement in a nursing facility, an ICF/ID, or a Psychiatric Medical Institution for Children (PMIC). If an HCBS program is not immediately available, we will inform our members of their right to be served in a facility setting and will provide additional non-waiver supports and services. We will offer Value-Added Services such as community reintegration, additional respite care, PCA services, and assistive devices as described in Section 3.2.14. We will also work with the State, as our affiliates do in other states, to achieve successful implementation of Iowa's Olmstead Plan to support rebalancing efforts to shift away from nursing facility, ICF/ID, or PMIC beds reliance to less costly HCBS waiver programs in an effort to reduce waiting lists and keep members in their homes and communities. Additionally, we support our State partner in the implementation of needs-based assessments with resource allocation methodologies to align resources with needs and help assure that access to LTSS is provided equitably and based on member need. We will work collaboratively with the State through LTSS access meetings to manage overall access to LTSS services.



Community-Based Management Requirements (4.3)

Question 4.3, #1

1. Describe your proposed model for delivering LTSS care coordination services.

Amerigroup's case management model is founded on person-centered principles and practices to make sure that services and supports are tailored to the individual needs of all members. Our approach utilizes regional case management teams with multifunctional expertise to *assist* Community-Based Case Managers and members and their families, representatives, and interdisciplinary teams in the development of person-centered service plans and *serve* as an ongoing resource to meet varying needs of members to support health, well-being, independence, and community living and in the most integrated setting such as employment and participation in community activities. The member's assigned Case Manager serves as the team lead to enhance positive member experience and optimize person-centered service delivery.

The fundamental role of Case Managers is to serve as the main point of contact for the member and his or her family or representative as an advocate and a navigator across systems of care. The Community-Based Case Manager serves as a communicator and coordinator of all activities associated with the development of the member's service plan, monitoring services and supports (paid and unpaid) to measure quality, clinical, and functional outcomes. Through this role, the Case Manager serves as a collaborator, solution seeker, and community builder to better serve the member, support the family, and other unpaid supports. Our case management model enhances the alignment of resources to address unique and varying complexities of member needs. Service plans are considered to be living documents tailored to reflect services and supports that are responsive to the evolving development and changing needs of our members and their families and unpaid supports.

Coordination and collaboration are essential across systems of care. In addition to leading the member's interdisciplinary team in the development of the person-centered service plan and its implementation, we work closely with care teams of members residing in nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IDs) to coordinate care delivery and align facility-based care plans with the member's comprehensive services plan. ***For our members who receive care coordination through an Integrated Health Home (IHH), the assigned Community-Based Case Manager communicates and supports the implementation of the member's care plan as appropriate.***

Person-centered Case Management

A person-centered approach is essential in the development and implementation of a comprehensive service plan designed to integrate and coordinate services and supports across an array of service delivery systems and programs. Amerigroup's case management model involves a continuous process of coordinating, delivering, monitoring and assessing services and supports and progress toward achieving member goals. The person-centered service plan is an evolving document that may need to be evaluated and re-negotiated based on the member's level of progress and satisfaction with services and supports or due to significant changes in the member's needs. During the planning process, the member and family or representative are informed of the various services and supports available and the requirements of each service to support member choice and to better align service resource to need. Facilitating alignment of allocated resources to member needs requires partnership and collaboration with the member, family or representative, the assigned Community-Based Case Manager, and the interdisciplinary team to address

the preferences, needs, and goals of the member within long term services and supports (LTSS) program cost limits. Negotiable and non-negotiable preferences and service and support needs of the member are identified. Services and supports considered to be non-negotiable are medically and functionally necessary with direct impact on the health, safety, and well-being of the member to remain in his or her home and to prevent unnecessary out-of-home placements and/or hospitalizations. ***Our person-centered approach includes case management practices that protect member rights through adherence to State and federal requirements, including Amerigroup's conflict-free case management guidelines and policies as described in Section 4.2.2.2***

Matching Members with the Right Case Manager

Amerigroup's quality improvement activities are geared toward enhancement of member experience; we continually refine our case management approach using person-centered practices and principles. Upon receipt of a new member's enrollment file, our regional case management team determines if additional discovery information is needed prior to the assignment of the Case Manager. ***Community-Based Case Manager experience, knowledge, and skills are matched with our members based on diagnosis, complexity of medical and/or behavioral health conditions, and intensity of service and support needs.*** Our regional case management teams serve as an additional resource to help Case Managers, members, and families identify and assess services tailored to the specific needs of the member, align resources for specific condition or diagnosis, and respond to the member's preferences, strengths, and goals.

Member Services Call Center

Through our extensive experience, our members and, as appropriate, their families/representatives or unpaid supports develop trusting relationships with their Case Managers often seeking guidance and support as service needs naturally ebb and flow with the changing schedules and demands of daily life. ***Our members are able to contact their Community-Based Case Managers via our Member call center; members receive a warm transfer to their Case Manager for seamless connection.***

If the Case Manager is out in the field or it is after hours, the member will have the option of leaving a message for return no later than the following day or speaking with the on-call Case Manager and/or case specialist to expedite resolution of issues or concerns. Through our proprietary care coordination and management system, CareCompass, the on-call Case Manager and/or case specialists is able to quickly view the member's personal record to readily address concerns or issues.



Person-centered Service Planning Process

Amerigroup's case management approach is founded on member-centered principles and practices to identify with members the services and supports they need and prefer to maximize choice and independence. We are committed to assisting all members in exploring options for community integration in accordance with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in the communities of their choice, but we also help states achieve cost efficiencies.

Community-Based Case Manager Role in the Creation of the Person-centered Service Plan

The assigned Community-Based Case Manager works closely and collaboratively with the member, his or her family representative, and the member's identified interdisciplinary team to develop ***a comprehensive person-centered service plan that considers each member holistically to make sure that medical,***

behavioral, social, and educational needs are addressed to maximize health, well-being, and independence. Through conversations with the member and his or her family or unpaid natural supports, the Community-Based Case Manager carefully plans coordination processes and activities responsive to identified strengths, preferences, and needs. The Community-Based Case Manager’s roles and responsibilities are the following:

- Serve as the main point of contact for the member to help assure covered, non-capitated, and non-covered services and supports that are included in the service plan reflect individual preferences and needs
- Help the member and his or her family drive the service plan development process and ongoing direction of his or her service delivery
- Support children and youth as they gain independence and take a more active role in directing their care
- Oversee the development, collaboration, and coordination of the service plan and make sure it reflects the member’s system of care by integrating medical, behavioral, and functional community-based services and supports, covered services, non-capitated services, and non-covered service from all resources
- Help assure families that the person-centered service planning process is member- and family-oriented, including all needed services and supports such as inclusion activities, employment assistance/supported employment services, adaptive aids, and durable medical equipment
- Monitor monthly services and supports cost limits to make sure the member does not exceed his or her cost limit based on individual level of care determination and waiver specific cost caps.
- Reassess regularly and revise the member’s service plan based on monitoring, changes in health status, or requests from the member and his or her family or representative
- Provide information or training as needed to the member and his or her family or representative to maximize access, resources, and progress toward personal goals
- Involve and share information with the member’s primary and specialty care providers as appropriate to enhance the integration of services and supports into the member’s systems of care

Person-centered Service Plans

Our person-centered planning process includes essential steps to optimize delivery and integration of services and supports across the member’s systems of care. The process begins with discovery activities and standardized assessments that build a holistic picture of the member’s preferences, supports, needs and goals; development of the person-centered service plan in partnership with the member and his or her self-selected interdisciplinary team; service plan implementation; and ongoing monitoring as described in Table 4.3-1.

Table 4.3-1. Creation of the Person-centered Service Plans

Service Plan Discovery Process
Gathering information about the member takes place prior to the development of the person-centered service plan. Our model supports a shift from typical methods of case management and serves to create real opportunities for partnership and trust with the member, family, representatives, and unpaid supports. The discovery activities include:
Program Welcome, Introduction, and Screening Call. The assigned Community-Based Case Manager telephonically welcomes and introduces the member or family to Amerigroup’s LTSS program. An initial screening is completed along with conversation to identify preferences, strengths, and needs and review authorization timelines to prevent service gaps. The initial and reassessment processes and timelines are discussed as described in Section 4.2.2 Level of Care Assessments and Annual Support Assessments.

Review of Member-specific Information. The Case Manager reviews notes from the welcome call, enrollment files from DHS, claims information, the current service plans and authorizations, service plans from other programs, previous assessment results, school records and the Individual Education Plan (IEP) if available, medical provider treatment plans, and social service related records as available for historical background.

Completion of Face-to-face, Appropriately Timed State-adopted Assessment and Other Assessments. The InterRAI- Home Care (InterRAI-HC) or Supports Intensity Scale (SIS) will be completed along with complimenting assessments. The interview includes clarification, observations, and professional assessments such as behavioral health, occupational therapy, physical therapy, speech therapy, and adaptive equipment assessments. The Case Manager talks with the member and family using open-ended questions to get to know the member and family, understand how to work together, build trust, and support active involvement in decision-making, planning, and implementation of the service plan. The Case Manager provides information and talks about Consumer Choices Option (CCO), Freedom of Choice Form for community-based services, providers, and nursing facilities; and ICF/ID provider options to support informed member, family, or representative decision-making.

Documentation. All assessment notes, contacts, and actions are recorded in the electronic member file.

Person-Centered Service Planning Preparation

After the completion of discovery activities and identification of member's interdisciplinary team, the case manager prepares for the meeting and completes the following actions:

Identification of the member's interdisciplinary team in partnership with the member and his or her family or representative; scheduling and coordinating attendance at the service planning meeting; establishing ground rules, reviewing LTSS programs, Consumer Choice Options and the Freedom of Choice form and arranging accommodations to support engagement and meaningful participation.

Consultation with the primary care provider (PCP) and relevant specialists telephonically regarding medically necessary physical, behavioral, and functional needs.

Person-Centered Service Planning and Development

The case manager serves as the meeting facilitator and is responsible for managing meetings, keeping conversations on track, and supporting input from the member and family or representative and other individual members of the interdisciplinary team. The case manager uses motivational interviewing, redirection, conflict resolution, and consensus-building methods to enhance the person-centered planning process. Service Planning and Development includes:

An overview of information gathered during the discovery process, such as level of care determination from the State or its Designee, results from State-adopted and other assessments, information gathered regarding the service and support preferences and covered services, and description of non-covered services, as well as Value-Added Services that benefit the member.

Leading the interdisciplinary team discussion along with the member, and family or representative to *maximize health, well-being, independence, and adult transition planning when appropriate*. Member-Centered Service Planning and Development includes:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Identification of member strengths, opportunities, challenges, and solutions • Availability of natural supports such as family, unpaid supports, and community resources • Review of roles and responsibilities of member, family, or representative, unpaid supports, Home and Community-based Services (HCBS) or facility service providers, and other key contributors such as schools, vocational rehabilitation counselors, and Amerigroup • Development of short- and long-range service plan strategies and goals • Identification of services and the amount, frequency, duration, service delivery schedule, provider type, and provider selection within LTSS program specific cost caps • Review of the completed service plan to make sure the member and family or representative understand and agree | <ul style="list-style-type: none"> • Agreement on current and recommended covered, non-covered, and non-capitated services and supports to meet the member's preferences, needs, and goals • Description of methods to coordinate and integrate care between providers of covered and non-covered services • Completion of the comprehensive service plan with simultaneous entry into the member's electronic record • Copy of the service plan provided as agreed on via certified mail or secured email • Verification that authorizations are consistent with continuity of care and that no gaps in care will be experienced as outlined in Section 3.3 Continuity of Care. • Notification to current and new providers that service authorizations are viewable in Member 360 • Submission of identified services that require health plan administrative authorization |
|--|--|

Person-centered Service Plan Implementation

The service plan is a living document with specific services activities, timelines, objectives, and goals coordinated and monitored by the case manager. Activities include:

Continuous Engagement. The case manager works with the member, and family or representative to identify solutions to new or emerging issues and make changes as necessary to better address service plan goals. The member's assigned case manager will monitor authorized services and supports through monthly telephone calls and four in-person contacts per year as specified in Section 4.4.6 Frequency of Community-Based Case Manager Contact or more frequently as needed or requested by the member, and family or representative.

Evaluation of Services and Supports in the Service Plan. Our case management model involves a continuous process of delivering and monitoring supports and interventions designed to meet the member's preferences, health and well-being, and personal goals. The service plan is an evolving document that may need to be evaluated and re-negotiated based on the member's progress toward identified goals. In the event of a significant life change a reassessment will be conducted for the State or its designee to determine level of care. Amerigroup will make sure needed services and supports are in place until service plans and association authorizations are adjusted.

Monitoring and Evaluation of Progress to Service Plan Goals

Our case management involves a continuous process of delivering, monitoring, and assessing interventions designed to meet the goals of the person-centered service plans, as well as other care/treatment plans, as a part of the member's system of care to maximize individual health and quality of life outcomes. The service plan is an evolving document that may need to be evaluated and renegotiated based on clinical and psychosocial level of progress toward set goals. Service plans will be adjusted within the member's level of care determination and associated cost limit as needed to promote attainment of goals. ***In the event that the member has experienced a significant life change, a reassessment will take place as described in 4.2.2.2. Amerigroup will make sure that needed services and supports are in place to address any health and safety concerns while waiting for the amended level of care determination.***



Avoiding Duplication of Efforts

Amerigroup has established policies and procedures that guide coordination of care and services for members who are dually eligible for Medicare and Medicaid to help assure that Medicaid is always the payer of last resort. Coordination begins with the State-adopted comprehensive member assessment (or reassessment, depending on the specific situation) and identification of the member's needs and desired outcomes. Community-Based Case Managers work with the member and, when appropriate, family or designated representatives and other members of the care team and/or interdisciplinary team, including consultation with member's PCP or treating provider, to develop a person-centered service plan. The service plan identifies the member's currently authorized or accessed services and supports, including but not limited to Medicare and Medicaid wrap-around services, services outlined in the IEP, and benefits available through Care for Kids, as well as non-capitated services. The Community-Based Case Manager coordinates authorization of covered wrap-around services as needed, depending on the type of service(s), and helps the member, their family, or representative identify available and preferred providers. Community-Based Case Managers and, when appropriate, Utilization Management nurse help assure services are coordinated and wraparound services are available to meet the member's changing needs. The Community-Based Case Manager shares information as authorized with the member's PCP or treating provider and other program providers.

Technology and Innovations

We continuously seek innovations to enhance our care coordination and case management systems and support our members. We have been leaders in offering innovative solutions to continuously improve our model and ultimately better meet our members' needs.



Care Coordination and Management System. Our proprietary tools, *CareCompass*, *CareCompass Mobile* and *Member 360*, comprise our clinical care coordination and management solution. They integrate seamlessly with our core operations system, Facets, and represent the system of record for member care coordination and case management information.

CareCompass collects, organizes, and presents information enabling management and coordination of member care, services, and supports and facilitates communications among participants of the member's care team and/or interdisciplinary team. Care coordination data such as claims history, pharmacy, authorization, immunization records, lab results, and care and disease management data are readily available in an organized format with tools for Community-Based Case Managers to identify and manage members' needs. Member 360 delivers a comprehensive view of member data to approved Network Providers within the member's system of care.

CareCompass and CareCompass Mobile

CareCompass Mobile is an innovative and proprietary iPad-based tool that facilitates our person-centered approach to case management services for members participating in HCBS and facility-based LTSS programs. To facilitate person-centered service planning, Community-Based Case Managers who administer the InterRAI-HC or SIS, as well as other assessments, are equipped with CareCompass Mobile, which guides and documents assessments. The tool syncs with our care coordination/case management system, enabling access to the data by the Case Manager assigned to the member and by our case management and utilization teams. If the member is referred to an IHH based on criteria outlined in 3.2.10, the IHH provider and its care coordinator will have HIPAA-compliant access to Member 360, which allows them password-protected access to the IHH member.

The Case Manager is able to view discovery information such as the member's historical utilization data, preference summaries, assessment outcomes and other information to support the development of the person-centered service plan. The assessment details are combined with other clinical information and the member's historical utilization data. Through CareCompass Mobile Case Managers are able to create a holistic view of the member, enter the service plan in real-time as it is developed, easily access the full picture of each assigned member's care and services, and evaluate and monitor service plans and progress toward individual goals. The technology reduces administrative burden, creates efficiencies by automating transfer of information, gives the Case Manager tools to efficiently coordinate services and supports and record case notes in real-time, and facilitates the ability to dedicate more direct time focused on members' lives leading to improved outcomes and quality of life

Member 360

As an adjunct to CareCompass and CareCompass Mobile, Member 360 will be a vehicle to facilitate the transfer of health information to all providers involved in the member's care as shown in Figure 4.3-1. Authorized providers will have access to a single view that displays member specific data in an easy-to-navigate dashboard, including HEDIS[®] care alerts, authorizations, prescriptions, lab results, and claims organized by type, such as inpatient, emergency room, and office visits. Member 360 combines various data into a single holistic picture of the member's use, case management services, and gaps in care and/or services and supports. It organizes information into a timeline of clinical events representing a longitudinal member record across a number of domains, including diagnosis, providers, and medication history. *It will organize care coordination and case management information under a single tab,*

including information such as the member's service plan, health risk assessment, level of care and related assessments, goals, interventions and outcomes milestones, and a list of chronic conditions.

To further support providers in serving our members, we recently implemented additional online technology. Through the provider facing Member 360 tools, authorized providers can see their members' service plans and other relevant screens and records determined by provider type via the Amerigroup website, giving them simple, easy-to-access data and information. This helps providers improve quality of care and services. Our platform supports providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, a provider supporting a member to control diabetes can search for his or her Amerigroup patients with diabetes to see their most recent HbA1c results. The provider is then able to identify with the member, natural supports, and personal care attendants (PCA) the barriers in diet and exercise that are negatively impacting the member's health status.

CONTAINS CONFIDENTIAL INFORMATION

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Question 4.3, #2

2. Propose the required qualifications, experience and training requirements for community-based case managers.

Amerigroup will hire Community-Based Case Managers who live in the communities we serve, who have strong engagement and relationship-building skills, and who have experience working with specialized populations served through Iowa's HCBS waiver- and LTSS facility-based programs as specified in all applicable State and federal regulations. We actively seek individuals who bring a passion for our organizational mission and a commitment to helping members and their families or unpaid supports improve their own health, make informed choices, self-direct services, gain independence, and take

responsibility in the achievement of personal goals. Additionally, we will invest in comprehensive training and professional development programs to equip our employees with additional knowledge and skills to enhance member experience and achieve the goals of the Iowa Initiative.

Qualifications

Through our affiliates’ experience serving over 200,000 members comparable to Iowa’s LTSS populations for 17 years, we have maintained rigorous recruitment and hiring standards for our Community-Based Case Managers. Professional qualifications in accordance with 641 IAC Chapter 80.6(1) are detailed below in Table 4.3-2.

Table 4.3-2. Community-Based Case Manager Qualifications and Requirements

Qualifications		
Requires a registered nurse (RN) or licensed practical nurse (LPN) licensed to practice in Iowa with a minimum of one year relevant experience serving populations representative of members eligible for Iowa’s LTSS programs. Specialized knowledge and associated skills related to Medicaid HCBS waiver programs, nursing facilities, and ICF/IDs preferred.	Requires a BS in a related field (including but not limited to psychology, social work, mental health, counseling, nursing, education, occupational therapy, marriage or family therapy, and recreational therapy) with a minimum of one year of relevant experience in the delivery of services and supports in community-based and/or facility-based settings representative of the populations eligible for Iowa’s LTSS programs. Specialized knowledge and associated skills related to Medicaid case management in relation with HCBS waiver programs, nursing facilities, and ICF/IDs preferred.	Requires a home health aide with an equivalent of two years of relevant experience in the delivery of services and supports in community-based and/or facility-based settings representative of the populations eligible for Iowa’s LTSS programs. Specialized knowledge and associated skills related to Medicaid case management in relation with HCBS waiver programs, nursing facilities and ICF/IDs preferred. May provide case management services under the delegation of a qualified RN, LPN, or case manager with a BS degree.
Amerigroup Case Management Requirements		
<ul style="list-style-type: none"> • We will hire case managers who live in the communities we serve with two to five years of experience in providing integrated case management services to populations similar to those in the DHS LTSS Programs • Case managers will have expertise necessary to maximize member health, well-being, and independence such as experience with populations with chronic and complex physical and behavioral conditions • Case managers will have specialty expertise such as case management of spinal cord or brain injuries, members with Autism, behavioral health, mechanical dependencies, cancer, HIV, or intellectual or developmental disabilities to best meet the needs of members receiving LTSS waiver services • All clinical and non-clinical case managers will successfully complete competency-based case management program training and participate in mandatory professional development trainings as terms of employment as described in Table 4.3-3. 		
Iowa Initiative-specific Case Management Skills and Knowledge		
<p>Our case managers will have expertise and specialized knowledge matched to the diagnoses and varying complexities of the members in LTSS programs. Case managers and/or regional case management teams will have competence in supports areas such as integrated supported employment; self-direction programs; community alternatives and LTSS community resources; person-centered planning; conflict-free case management practices; State-adopted assessment administration, evaluating physical, behavioral, and social needs; community options counseling, diversion strategies and transition planning to support community reintegration.</p>		

Amerigroup supports members and families in other state markets that have elected to self-direct services through programs similar to the CCO. We will recruit and hire Community-Based Case Managers who have experience working in partnership with members and, as appropriate, their families participating in self-direction through the CCO. Members in CCO self-directing their waiver services and supports will be matched with a Community-Based Case Manager with CCO or other self-direction experience. All of our Community-Based Case Managers will receive CCO-specific training and ongoing learning opportunities to promote a best-in-class approach to supporting members in taking greater control and responsibility of their services and supports.

We will recruit and hire Community-Based Case Managers with diverse backgrounds that meet the standards, qualifications, and skills necessary to meet the varying medical, behavioral health, educational, and social support preferences and needs of members participating in one of the HCBS waiver programs. Additionally, we will hire Community-Based Case Managers who have experience supporting members residing in nursing facilities and ICF/IDs and who have community reintegration skills to support members who have decided to transition to the community of their choice.

We will match members to Community-Based Case Managers with specialty expertise to enhance positive member experience; optimize member-centered service delivery and maximize health, well-being, self-growth, and independence.

Training

We will require all case managers and health plan staff to undergo comprehensive training. Our program-specific training curriculum builds the skills and knowledge required to address the diverse preferences and needs of our members participating in HBCS waiver programs and those residing in nursing facilities or ICF/IDs. Our training experts are clinical and non-clinical employees who are knowledgeable and have field experience in intellectual and developmental disabilities, behavioral health disorders, gerontology, child development, complex medical conditions, social supports, and systems of care to better meet the needs of our diverse membership. Additionally, we contract with subject matters experts, advocates, and community organizations to augment our training programs.

Competency-based Training

Over a period of several months, Amerigroup conducts formal training required of newly hired Community-Based Case Managers, regional case management team members, and support staff to verify that they meet measurable competency standards. Competency tests will be used to validate training effectiveness. To monitor the effectiveness of training, we will conduct a 90-day evaluation (or sooner if necessary) to determine the need for additional training. The structured course curriculum for community-based case managers will include training areas and topics found in Table 4.3-3.

Table 4.3-3. Initial and Ongoing Training for Case Managers for Iowa-specific Case Management Program

New Hire Training Curriculum	
Introduction to Amerigroup	
<ul style="list-style-type: none"> • Mission, values, and principles • Ethics, privacy, information security, and compliance; State, federal, and Contractual requirements • Medicaid and Medicare programs and benefits • Provider roles and responsibilities 	<ul style="list-style-type: none"> • Fraud, Abuse, and Waste program, HIPAA • Quality assurance and performance improvement • Conflict-free case management • Cultural competency • Member rights and responsibilities

Community-Based Case Management Skills and Processes	
Introduction to LTSS	
<ul style="list-style-type: none"> • LTSS vision — people, processes, and tools • Overview of Iowa DHS and applicable HCBS waivers • Covered, case-by-case added, Value-Added Services, and non-covered benefits (for example, through community-based organizations) • Preadmission Screening and Resident Review (PASRR) federal and State requirements 	<ul style="list-style-type: none"> • Consumer-direction/self-direction option for members • Member Advisory and Advocacy Group • Grievance, Complaint, pre-appeal, and appeal process, including the role of the member advocate • Motivational interviewing techniques, active listening and observational skills
LTSS Community-Based Case Manager Role	
<ul style="list-style-type: none"> • The LTSS Community Based Case Manager role and responsibilities • Coordination processes and outreach • General overview of coordination processes for facility settings (for example, options counselling, transition activities, etc.) 	<ul style="list-style-type: none"> • Communication processes — correspondence telephonically, via emails and faxes • Employment and vocational support • General overview of coordination processes for home- and community-based settings (for example, available home and community-based services, self-direction, etc.)
Assessment and Service Plan Development Training	
<ul style="list-style-type: none"> • Training on level of care assessments and needs assessments, including InterRAI-HC, SIS, and Universal Assessment Tool (UAT) • Service development, planning, and implementation, including setting goals, monitoring, and reporting 	<ul style="list-style-type: none"> • Population-specific needs including incontinence management, caregiver stress and burnout, and risk of falls • Screening tools for intake, institutional or facility risk, and family caregiver needs
Introduction to Iowa High Quality Healthcare Initiative (IHQHI)	
<ul style="list-style-type: none"> • Overview of Iowa DHS and HCBS waiver programs and LTSS facility-based services • Covered, case-by-case added, Valued-Added Services, and non-covered benefits (for example, through community-based organizations) • Consumer Choice Options 	<ul style="list-style-type: none"> • Health Homes and Integrated Health Homes, and Pharmacy services/processes, including DHS formulary and emergency supply • Iowa's Care for Kids program benefits, periodicity, best practices, and required elements of a checkup
IHQHI LTSS Population-specific	
<ul style="list-style-type: none"> • Child and adult abuse and neglect, including information specific to Iowa's Child Abuse and Dependent reporting requirements • Trauma-informed Care, Disability Literacy, Grief, Loss, and Bereavement • Medically Fragile population needs and services 	<ul style="list-style-type: none"> • HBCS waiver-specific — HIV, Elderly, Physical Disabilities, ID, Autism, SED, Health and Disability • Nursing facilities and ICF/IDs • State and federal — Integrated settings/HCBS definition of community, person-centered planning, and processes
Cultural Competency	
<ul style="list-style-type: none"> • Cultural competency program • People first language 	<ul style="list-style-type: none"> • Cultural competency plan • Language assistance line
Member Rights/Responsibilities	
<ul style="list-style-type: none"> • Member Advisory and Advocacy Group 	<ul style="list-style-type: none"> • Grievance, complaint, pre-appeal, appeal processes, including the role of the member advocate
Appointment Availability and Access Standards	
<ul style="list-style-type: none"> • In-network and out-of-network referrals • Provider and member satisfaction and surveys 	<ul style="list-style-type: none"> • Telehealth

Provider Information	
<ul style="list-style-type: none"> • Provider profiles that include contact information, specialty, and after-hours availability 	<ul style="list-style-type: none"> • Provider Manual, hotline, and portal/website
Operation Systems, Case Management, and Member 360	
<ul style="list-style-type: none"> • Documentation, information sharing, access, and security levels, documentation and forms, task/assignment tracking, progress notes, and completion dates • Core operating system training • General tasks, rules, and processes • Documentation process • Letter and fax generation • Check eligibility, identify plan and demographics, and look up authorizations 	<ul style="list-style-type: none"> • Member-specific information, scheduling the visit, using forms and historical forms and refresh as needed, appropriate completion of assessments • Care Compass and Care Compass Mobile • Careticker • Public Partnerships, LLC online tools • MySupport • Member 360
Hotlines	
<ul style="list-style-type: none"> • Member, Provider, and behavioral health services hotlines, 24-hour Nurse HelpLine, triage, crisis response 	<ul style="list-style-type: none"> • Regional case management team
Clinical Training for Case Managers	
<ul style="list-style-type: none"> • Member identification, screening, and grouping, including risk factor identification, stratification, and complex leveling • Use of Amerigroup Utilization and Medical Management criteria, Standards of Care, and authorizations, denials, reductions, and appeals processes 	<ul style="list-style-type: none"> • Chronic condition and behavioral health management and use of clinical practice guidelines and evidence-based practices • Crisis, transitions, and discharge planning; coordination of follow-along services, transfer action and evaluation
Case Management Peer Mentoring Program	
<ul style="list-style-type: none"> • New case managers will shadow current case managers and observe learned concepts 	<ul style="list-style-type: none"> • Certified Service Coordinators will be prioritized for Levels 1 and 2 Members

Classroom Training Provides Essential Knowledge

Amerigroup’s initial new hire classroom training provides employees with the essential information they need to serve our members as summarized in Table 4.3-3. This training gives them a strong base to assist our members in accessing the services they need when they need them. To fully engage employees in each training topic, we use a combination of techniques that includes didactic training, examples of member stories and videos, and practical application exercises. Upon completion of each classroom module, we confirm that our case managers demonstrate mastery of all covered modules.

Our initial classroom training provides a comprehensive overview of all aspects of the LTSS program and case management, including but not limited to member covered benefits and non-covered services, individual cost limits, managing care, and utilization management systems. Additionally, we educate employees on tools for engaging members and providing excellent customer service such as motivational interviewing, person-centered planning, tailoring services and supports based on member strengths, support needs and personal goals, development of person-centered service plans and ongoing monitoring. We teach employees to demonstrate our values through positive and trusting relationships with our members, their families and communities to optimize member experience, well-being, independence and full participation in their daily lives.

Question 4.3, #3

3. Describe your proposed staffing ratio for community-based case managers to members.

The provision of optimal case management support and coordination must take into account a number of case mix factors essential to nimble Community-Based Case Manager-to-member ratios such as intensity of involvement, acuity and complexity, geographic challenges and population distribution, contact frequency and modalities, and amount, scope and durations of service needs. Factors in our case mix structure will include a methodology that creates a weighting system to assist in determining average case manager-to-member ratios. Amerigroup has created a flexible caseload model that is responsive to our members evolving needs as they move through various life stages along with the ebb and flow of demands on their families and unpaid supports. Based on predictive modeling using claims data analysis, assessment results, and diagnostic classifications to stratify the LTSS population and projected needs, we are able to assign and adjust caseloads based on changes in member need.



Our person-centered approach to case management provides members and their families and natural supports with the intensity of case management needed based on each member's unique needs and living situation.

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Helping Assure Sufficient Staffing

Our staffing approach provides us with to flexibility to tailor case management support specifically to each member. Additionally, with support through ancillary staff, such as our multifunctional regional case management teams, member advocates and LTSS specialists, we are able to increase our level of interaction, coordination, and system navigation based on our members current medical, behavioral, or social support needs.

Through CareCompass Mobile Report Manager, our LTSS regional case management supervisors are able to view reports that monitor caseloads, contacts, frequency of contacts, changes in scope of coordination, and other relevant information impacting individual case managers' caseloads as well as population trends. Our LTSS regional supervisors use these reports, as well as case manager feedback, to continuously improve staffing models to meet changing members' needs.

We also work to adjust our hiring process based on case management staff projections using enrollment trends, claims data, and predictive modeling to maintain adequate staffing ratios. As we anticipate an increase in enrollment or changing member demographics, we immediately increase recruitment, hiring, and training processes to make sure sufficient staff are readily available to serve current and newly enrolled members. As needed, we assign temporary case managers from our pool of qualified regional staff to provide members with a main contact until they are assigned to a case manager or to provide interim support to our members while other employees are on paid time off.

In keeping with our systematic and thoughtful approach to maintaining staffing ratios, we will hire sufficient staff to have excess capacity during program implementation to facilitate efficient transition to Amerigroup and prevent any gaps in services. On an ongoing basis, we will monitor and review caseloads and will not hesitate to hire additional case managers and supporting staff to make sure that member needs are met in a timely manner. In our affiliates' experience managing LTSS programs, we have learned that providing members with ready, prompt access to a case manager is essential in continuity of care and service, positive health and life outcomes, and the achievement of personal and family goals.

External Communication and Coordination (4.3.2)

Question 4.3, #4

4. Describe how care coordination services will include ongoing communications with community and natural supports.

A foundational principle of Amerigroup's Community-Based Case Management model is coordination and collaboration across systems of care that intersect with our members day-to-day lives. We believe open communication with diverse stakeholders will foster the ability to bring to scale the expected practice that facilities-integrated services and supports with a holistic approach that recognizes the interdependence across medical, behavioral health, educational, employment, social, and functional supports will make sustainable strides in improved health status, safe community living, independence, and the overall well-being of our members and their families. We utilize this approach in all markets before, during, and after implementation

At a systems level, our engagement strategies across all markets include member and provider advisory committees, regular community forums, and participation in member-relevant local and statewide conferences to identify system of care gaps along with strategies to close those gaps, build consensus and innovative solutions related to issues and concerns, and facilitate continuous program improvements to better serve members.

Meaningful Engagement and Enhancing Communication and Coordination

Natural Supports

The fundamental role of Community-Based Case Managers is to serve as the main point of contact for the member and his or her family or representative as an advocate, navigator across systems of care, communicator, and coordinator of all activities. We have embraced person-centered principles and practices to facilitate member- and family-driven services and supports that are delivered to be responsive to what is important to our members and their families/representatives or unpaid natural supports to improve health, well-being, self-determination, and their ability to reside in the community. Members and those who know them best, typically their families, friends, and other natural supports, are key collaborators in our providing information on what is important to and for the member to shape person-centered services and supports that are meaningful not only to the members, but also to the family as a whole and unpaid supports that shoulder responsibility day-to-day for their loved ones. The fundamental role of Community-Based Case Managers is to serve as the main point of contact for the member and his or her family/representative or natural supports as an advocate and navigator across systems of care. Through our extensive experience, our members and, as appropriate, their families/representatives or unpaid supports develop trusting relationships with their case managers, often seeking guidance and support as service needs naturally ebb and flow with the changing schedules and demands of daily life.

To provide additional support, our members and their families or representatives are able to contact their Case Managers via our Member call center; members receive a warm transfer for a seamless connection to their Case Manager or the on-call case specialist to expedite resolving issues or concerns. Additionally, Amerigroup has partnered with Careticker, an innovative platform that



We recognize the interdependence across the medical, behavioral, and social needs of our members and coordinate between all stakeholders to serve our members.

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families and other natural supports are able to use as a resource together through a secure social engagement platform to improve member outcomes and experience, as well as the experience of families and other natural supports.

Interdisciplinary Team

Members and those closest to them such as family, other unpaid natural supports, and paid PCAs and/or provider agencies, typically form the interdisciplinary team identified by the member and/or family. We have significant experience across seven states supporting members and families to lead and direct their services and supports through informed decision-making and collaboration and partnership with their interdisciplinary team. The development of comprehensive person-centered plans involves all interdisciplinary team members and involves discussions about natural supports, community resources, Value-Added Services, Medicaid- and HCBS-covered and non-covered services, and other supports and programs to strategically get the right services and supports in place in the most cost-effective manner. Providers are identified and selected with service and support schedules determined prior to finalizing the service plan. After the service plan is completed, the Case Manager will then send the service plan along with all documentation to the Utilization Management (UM) nurse to review and obtain the authorization. All information is entered into our core operating system for electronic transmission into Member 360. The UM Nurse communicates and provides the authorization number and a written or electronic service authorization to the provider of the service and the Case Manager prior to the services being initiated. The member's Community-Based Case Manager will continuously assess the effectiveness of the service plan and works with the member and representative as applicable and other team members as appropriate to revise the service plan when desired outcomes are not achieved or when a member's needs or goals change.

Through open communication and exchange of information, we have found the interdisciplinary team is more effective in supporting members receiving HCBS waiver supports. For members residing in nursing facilities or ICF/IDs, we also facilitate open lines of communication and information-sharing with nursing facilities and ICF/IDs to enhance their care and services. Additionally through Member 360 and Careticker, described in Section 4.3, case managers and authorized providers are able to view in real-time member information and case notes to:

- Identify and mitigate risk factors and/or significant life changes negatively impacting the member's health, safety, and well-being
- Address issues quickly to avoid unnecessary emergency room visits, hospitalizations, and out-of-home placements
- Identify trends that signal that the service plans need to be revised, additional temporary services are needed to address gaps, and timely reassessments are needed due to a significant change in health or functional status

System of Care Providers

Amerigroup strongly believes in taking a fully integrated approach to members' physical health, behavioral health, oral health, social needs, and waiver-related needs. ***We believe this integrated approach is crucial to improving the member's quality of care and outcomes while proactively managing costs and emphasizing member choice, access, safety, independence, and responsibility through active engagement, communication, and coordination.***

Through our person-centered approach, Community-Based Case Managers are members' main point of contact from where all of their physical, psychosocial, and mental health needs can be addressed. Case Managers may have specialized expertise in medical, behavioral, social, LTSS, or waiver components of care in order to provide specific insight and knowledge aligned with member needs. Different specialists will stay involved with a given member so that no gaps in care occur.

We will engage with providers, including PCPs, hospitals and institutional providers, behavioral health providers, community mental health centers, federally qualified health centers, rural health clinics, LTSS providers, and health homes to facilitate the holistic integration process. Incentives to integrate care will be offered to providers, including incentives both in primary care settings and community mental health settings. We will share reporting with providers and encourage a continuous information feed to improve the quality of Medicaid data. We are willing to be the aggregation point/repository for data if providers are willing to provide requisite data.

As described in Section 4.3.1, our care and case management teams are equipped with innovative technology tools developed and refined over the years to further support integration of care and services.

- **CareCompass**, our internal care coordination and management system, provides information about Member conditions and medications. Chronological progress notes promote comprehensive care coordination for member needs/issues, regardless of whether the driver is physical health, behavioral health, social issues, or LTSS.
- **CareCompass Mobile** provides virtual office solutions to field-based case managers who are primarily working in the community and visiting members in their homes.
- **Member 360** provides case managers with a member dashboard that displays HEDIS care alerts; authorizations; prescriptions; lab results; and claims organized by type such as inpatient, emergency room, office visit, and behavioral health. *This dashboard is also available to authorized providers for members in their panels through our provider facing Member 360 program.*

Coordinating with other MCOs

For all members transitioning from another MCO to Amerigroup or from Amerigroup to another MCO, continuity of member care and services is our first priority.

Transferring from another MCO to Amerigroup

- We will contact the member's prior Community-Based Case Manager for information regarding the member's needs, current medical necessity determinations, authorized care and services, person-centered service plan and treatment plans.
- Community-Based Case Managers will also review available historical data to expedite the process. Our goal is to use every available resource to obtain information about members to avoid asking them, and their families or representation to repeat information already provided to a previous health plan.
- All previously authorized services will continue without authorization for at least the first 90 days or until a new person-centered service plan is developed.

Members Leaving Amerigroup and Transferring to Another MCO

- When a member is transferring to another MCO, our Community-Based Case Manager will contact the Case Management Department of the new MCO, with permission of the family or representative or the member if 18 years of age or older.
- We will provide the new case manager with the most recent InterRAI-HC or SIS assessment, the level of care determination, the person-centered service plan, the list of providers working with the member, and notice of any upcoming appointments.
- We will also offer to schedule a care conference to support transition of care and services with minimal interruption to members and their families.

Continuity of Care

Member 360 will be a vehicle to facilitate the transfer of health information to all providers involved in the new member's care. Authorized providers will have access to a single view that displays member data in an easy-to-navigate dashboard, including HEDIS care alerts, authorizations, prescriptions, lab results, and claims organized by type, such as inpatient, emergency room, and office visits. ***It will organize care coordination and case management information under a single tab, including information such as the member's service plan, assessments, goals, interventions and outcomes milestones, and a list of chronic conditions.***

Community-based Organizations

Occasionally, members have needs that may not be immediately met through our existing provider network or may not be a covered service. To support these members to remain in the community of their choice, Amerigroup engages all existing community resources to provide solutions. We know that healthcare providers and MCOs cannot operate in isolation from the community, and thus we have a rich history of actively engaging community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for members requiring a service that is not otherwise a covered benefit.

When building new relationships in our service areas, we identify community organizations that are integral to delivering non-covered services and that have the potential to address unmet needs of our members. We use a variety of strategies and actions to introduce Amerigroup to the community by engaging in outreach and awareness activities such as sponsoring and participating in health fairs, offering provider training, and giving back to the community through our national volunteer program. We strive to develop lasting relationships with local leaders and work to foster a common vision that promotes the well-being of the broader community and facilitates access to non-covered services for our members. Once we determine how best to work together, we invite organizations to contract with us or sign a statement of intent.

Amerigroup has already reached out to numerous community organizations and agencies in Iowa and is developing partnerships in anticipation of Contract award and implementation. Since March 2015, we have identified and met with dozens of community organizations to discuss how we could collaborate. For example, we have already begun to develop relationships with key community partners in Iowa as described in Section 4.1, including:

- Brain Injury Alliance of Iowa
- Coalition for Children's and Family Services
- Community Action Association
- Community Health Charities of Iowa
- Easter Seals
- Evangelical Lutheran Good Samaritan Society
- Iowa Association of People Supporting Employment First
- The Iowa Developmental Disabilities Council
- The University Center for Excellence on Developmental Disabilities
- The University of Iowa Center for Child Health Improvement
- Iowa's six Centers for Independent Living
- Iowa's six Area Agencies on Aging
- Iowa Counties Public Health Association
- Iowa Foster and Adoptive Parents Association
- NAMI Iowa

We will continuously establish strategic partnerships with agencies that serve our LTSS members in Iowa—agencies that members already trust and respect. Our goal is to leverage existing community supports to enhance their capabilities and provide members with choice and consistency in their service delivery and relationships.

Internal Contractor Communications (4.3.3)

Question 4.3, #5

5. Describe how internal operations support communication among departments to ensure community-based case managers are aware of issues related to their assigned membership.

Amerigroup takes an enterprise-wide approach to care coordination. We emphasize the importance of interdepartmental connectivity in all aspects of our operations to prevent gaps in care, as well as fragmentation or duplication of services. Our fully integrated regional case management teams help support interdepartmental connectivity by uniting all aspects of care coordination and case management, including clinical and non-clinical roles.

We further support interdepartmental connectivity by making sure that our case management team and assigned case manager are notified whenever any Amerigroup staff member uncovers member information that has substantial bearing on a member's holistic well-being. To support this level of interconnectivity, our case managers have access to our core operations system and CareCompass, which aggregates information from multiple Amerigroup departments to provide a whole-person view of our members. These systems will then feed information into Member 360, allowing a full view of the member's eligibility, claims, service plan, and other information to assist the staff with a quick and easy dashboard view of the member's care. Furthermore, we train all of our staff to direct any relevant information regarding our membership directly to our regional case management team, which is then able to direct this information to the member's case manager. In our experience, these processes best equip our case managers to exchange information and have a whole-person view of the member. This helps us improve case management and member outcomes.

Regional Case Management Teams

While case management depends on various departments such as clinical and non-clinical case management staff and utilization management, our regional case management teams are structured to facilitate ongoing and regular communication between departments. Our regional case management teams collectively assume responsibility for a population within a region and work closely with one another with a singular goal to support our members' interdisciplinary needs.

To help support communication between regional case management teams, we host weekly case rounds. All staff members within a regional case management team engage in case rounds at least once a week to strategize on ways to meet the needs of members with complex health care needs, including members receiving LTSS. Case rounds bring together a multifunctional team to facilitate a joint discussion of member needs. Due to their collaborative nature, case rounds can be used to discuss shared concerns relevant to all case managers' caseloads, as well as to share knowledge on issues associated with other team members' assigned cases. In addition, staff members within the regional case management team will initiate ad hoc discussions regarding members' needs so that they can quickly address issues or concerns that may arise.

Member 360

As part of our strategy to provide interdepartmental connectivity, our case managers have access to a proprietary information-sharing tool, Member 360. Member 360 integrates information across Amerigroup departments — updated daily — and includes information on eligibility, HEDIS care alerts, authorizations, prescriptions, lab results, and claims organized by type, such as inpatient, emergency room, office visit, and behavioral health. Use of Member 360 helps assure that case managers have access to enterprise-wide information regarding a member.

Member 360 enables fast access to key member information for all team members. Case managers can quickly find all critical information in a single view that displays all member data in an easy-to-navigate dashboard. The tool also alerts case managers and case managers to gaps in care or services for members. The tool's longitudinal patient record provides case managers with a clear view of care continuity for members enrolled in case management. In its first two months of testing, case managers reported a 30-percent reduction in the time required to locate key member information, enabling them to spend more time to focus on member needs.

“No Wrong Door” Approach

Amerigroup's “no wrong door” approach provides a single point of entry for all members to address requests, issues, and concerns end to end. This includes but is not limited to interactions with Member Services representatives, the Nurse HelpLine, member advocates, Provider Management, and Quality Management.

Calls and messages are routed to the appropriate employees. For member queries or issues, calls and messages are directed as appropriate to the member's assigned case manager, on-call case specialist, and an available regional case management team member.

If an Amerigroup employee, regardless of department, is notified of information that has substantial bearing on a member's whole-person care, he or she will take appropriate measures to inform the regional case management team. The staff member will first confirm the member's identity and service region and will then identify the regional case management team associated with the member. With member consent, the staff member documents the concern and will promptly call the Long Term Care/Care Coordination Manager or send a secure email regarding the issue. The Long Term Care/Care Coordination Manager will then direct the concern to the member's Community-Based Case Manager. As necessary, our staff members will prioritize urgent concerns to help assure speedy resolution. Through these processes, our enterprise is able to maintain connectivity and make sure that case managers are informed of all issues related to their membership.

Changes in Case Managers (4.3.4)

Question 4.3, #6

6. Describe strategies to minimize community-based case manager changes and processes to transition care when a member has a change in community-based case managers.

Through our experience we understand that it is critical to provide continuity of Community-Based Case Management services for our members. To this end, Amerigroup actively works to minimize case manager transitions, as well as helps assure seamless case manager transitions on an on-going basis and during Contract onset.

Minimizing Transitions

We recognize the importance of protecting long term relationships between case managers and members that promote open and honest discussions. To help achieve this goal, we deploy several strategies that promote continuity of care by minimizing case manager turnover, decreasing uncertainty during temporary case manager leaves, and matching member needs to case manager specialty. These strategies promote longevity of the member-case manager relationship while maintaining members' choice to adjust case managers as necessary. The interdisciplinary team and regional case management team structures also help assure that, should any unavoidable transition of case management team members arise, other team members who are familiar to the member will remain as a part of the member's team to promote consistency and continuity for the member.

Effective Retention Strategies

Based on our affiliates' experience and observations across markets, we know that poor case manager retention significantly contributes to avoidable case manager transitions. The North American average turnover for case managers is 25–30 percent, which results in frequent need to reassign case managers and hinders the member's continuity of care. However, from our affiliates' extensive experience serving members receiving LTSS across seven states, we have developed targeted strategies to improve case manager retention. ***Across our affiliates, we are proud to report a retention rate regularly exceeding 90 percent for our case managers.*** We will implement our proven retention strategies in Iowa to achieve superior results for our case management program.

Amerigroup has proactively identified systems for reducing turnover and increasing case managers' satisfaction with their jobs. We currently use these successful strategies and will continue to implement these moving forward:

- Hiring the “right employees”
- Frequent and ongoing communication
- Employee recognition programs that reward performance
- Engaging employees in ongoing communication
- Making sure that each employee is working at the top of his or her licensure and capabilities
- Ongoing training and support to equip staff for their roles and responsibilities

Hiring the “Right Employees” Increases Retention

Our affiliates' experiences have taught us that hiring employees who are a good fit for our case management program is an important retention indicator. Because our affiliate health plans have been coordinating LTSS for 17 years, we have a keen understanding of the qualities and competencies that are the most important for our case management team members. For example, we conducted a detailed analysis of our LTSS teams in multiple states to identify the competencies that most directly correlate with job performance for our case management teams. The analysis revealed that successful case manager attributes include thoroughness, flexibility, assertiveness, and self-structure. In response to these findings, ***our affiliates implemented consistent interview and screening processes to help assure appropriateness of fit for the case manager position.*** Our recruitment, interviewing, and hiring decisions focus on vetting candidates to be sure that they have the skills necessary to be successful. As part of the hiring process, applicants complete a job aptitude survey that helps us identify where they would best fit within the organization.

Engaging Employees through Ongoing Communication

Amerigroup has learned that communication is a key component of a healthy culture and employee engagement that encourage case managers to remain employed with Amerigroup. We know this is especially true for Community-Based Case Managers who may regularly be in the field and therefore are at risk for feeling disconnected from their colleagues and Amerigroup. Through weekly updates, team meetings, quarterly newsletters, and Town Hall meetings, we strive to keep employees informed and knowledgeable about our business. We send weekly updates to all employees to share state-specific information and to welcome new hires. We also recognize service anniversaries and celebrate promotions.

Our care coordination managers also provide our members with guidance throughout their employment to help assure that Case Managers feel supported and included as key members of our care coordination team. Our care coordination managers provide updates on program initiatives, assist case managers in resolving issues, and follow-up on performance goals. The managers create a personal connection with each case manager, increasing their satisfaction. Clinical leadership also provides targeted education, case

staffing, and open-forum question-and-answer sessions. This allows leadership to scan the landscape for specific issues or training opportunities and respond quickly.

To facilitate connectedness during visits in the community, we have also equipped our Case Managers with iPads to support their field work. Through the use of this innovative technology, Case Managers have access to communication tools such as email, our documentation system, and web-enabled applications. This allows case managers to stay connected while working in the field to serve our members and reduce duplication of their work efforts.

Employee Recognition Programs Reward Performance

We know that rewards and recognition are key to engaging employees in becoming high performers. In several of our states of operation, we have implemented rewards and recognition programs to acknowledge employees who perform above and beyond:

- ***Spot Bonus Programs.*** The Spot Bonus Program allows employees to be recognized for outstanding customer service by any stakeholder, including members, providers, the State, and others. The winning employee is recognized for going above and beyond.
- ***Values in Action Award.*** This is a quarterly award nominated and voted on by peers and leadership for going above and beyond. Multiple case managers have won this award. We reward winning employees with public recognition and a front-row parking spot.
- ***Service Recognition.*** Service Recognition recognizes our employees for years of service with the company. This program offers awards beginning with a five-year anniversary and then at each five-year service milestone going forward. It also offers retirement gifts for employees who retire with 20 or more years of service. Choices range from jewelry to silverware to clocks, depending on years of service.
- ***Informal Recognition.*** Informal Recognition includes timely and effective acknowledgements of an employee's contribution toward a department goal or objective. Rewards may be gift certificate/card; cash; occasional tickets for such events as movies, sporting events, and amusement parks; occasional team parties; and other appropriate gifts or outings.

Ongoing Training

We have also found that Case Managers are more fulfilled with their work experience and thus are more likely to stay with Amerigroup if they continue to feel professionally challenged and they find professional development opportunities. To this end, we offer staff ongoing training opportunities based on interest and need expressed by our Case Managers.

Anthem Learning Center is our one stop for all learning and development within the company. It includes all courses and systems we use to help employees become better at their jobs (Ace My Job). Our goal is to provide the resources employees need to do well in their job and prepare them for their next assignment (Own My Career). The center also provides managers with the tools to develop their teams (Develop My Team). This approach improves individual performance so that together we can transform healthcare with trusted and caring solutions.

Lunch and Learns are offered on a routine basis to team members to provide training and updates to team members. Topics covered are varied base on the needs of the team and can include but are not limited to cultural awareness, new services being offered by vendors or providers, best practices, time management, regulation updates, HEDIS, etc.

Innovative Strategies from Affiliate Plans



Our affiliate health plans coordinate LTSS for members in seven states, and we routinely share best practices, including those related to optimizing our care coordination employees' performance. For example, our affiliate health plan in New York identified the need to improve employee retention. This posed a challenge due to a highly competitive market with numerous LTSS plans and a limited candidate pool. In 2012, after careful analysis and planning, the health plan developed creative solutions to address retention, including:

- Offering all Case Managers the option for a four-day work week
- Rotating scheduled days off among team members

Since the program's launch, the New York health plan has seen significant improvements in retention; only one Case Manager left the plan, resulting in a **retention rate of 96 percent**. These successful approaches demonstrate our commitment to developing creative strategies for retaining employees. If appropriate, we will not hesitate to deploy these proven strategies in Iowa.

Case Manager Assignments

Amerigroup's quality improvement activities are geared toward enhancement of member experience; we continually refine our case management approach using person-centered practices and principles. Upon receipt of a new member's enrollment file, our regional case management team determines if additional discovery information is needed prior to the assignment of the Case Manager. **Community-Based Case Manager experience, knowledge, and skills are matched with our members based on diagnosis, complexity of medical and/or behavioral health conditions, and intensity of service and support needs.** Our regional case management teams serve as an additional resource to help Case Managers, members, and families identify and assess the needs and services tailored to the specific needs of the member; align resources for a specific condition or diagnosis; and respond to the member's preferences, strengths, and goals.

Facilitating Seamless Case Manager Transitions

Case Manager Transitions at Contract Onset

Amerigroup realizes the importance of member and family relationships with Case Managers, and we are committed to members keeping their State-assigned Case Managers for at least the first six months of Contract implementation. During this process we will work closely with existing State-assigned Case Managers and our members to develop individualized transition plans with a detailed transition strategy that is person-centered to promote continuity in recognition of the preferences and goals of the member and his or her family or representative to engage meaningfully and ease stressors related to transition. State-assigned Case Managers and newly assigned Amerigroup Case Managers will together provide a seamless experience for the members and their families or representatives, when appropriate, to make sure there are no disruptions in care or services during transition.

Upon receiving enrollment files from Iowa at Contract implementation, Amerigroup will reach out to the member through a welcome call to introduce the member to the plan and address any questions the member may have. During this conversation, we will inform members of their right to keep their existing State-assigned Case Manager for six months and will then ask members whether they would like keep their current Case Manager or immediately transition to an assigned Amerigroup Case Manager. Whether the member elects to transition to an Amerigroup Case Manager right away or wishes to remain with the existing State-assigned Case Manager for another six months, the Amerigroup regional case management team will match the member with a transitional or permanent Case Manager and will begin working to

develop the transition plan to make sure authorizations are in place and that there are no disruptions in care or services for the member.

If the member chooses to transition to a new Amerigroup Case Manager, we will inform DHS about this decision so that DHS can relay the decision to the outgoing Case Manager. The Amerigroup LTSS manager for the region will then work to promptly assign the member a new Amerigroup Case Manager, who will conduct an initial needs assessment in accordance with the timelines discussed in Section 4.2. With DHS permission, we would also seek to do a face-to-face visit between the outgoing and incoming Case Manager wherever possible to help assure the member is comfortable with the transition.

If the member chooses to keep his or her existing Case Manager during the six-month transition period, Amerigroup will respect the member's choice. The Amerigroup Case Manager will keep close and frequent contact with the existing Case Manager via phone, email, and in-person meetings throughout the transition period. In this situation, our Case Manager will work in collaboration with the outgoing Case Manager to conduct the State-adopted initial needs assessment in accordance with timelines discussed in 4.2 and with DHS permission will ask the outgoing Case Manager to be present during assessments and service planning. Upon completion of service planning, we will support the outgoing Case Manager in conducting follow-up calls and visits for the six-month period. We will facilitate the transfer of any medical information from Amerigroup to the outgoing Case Manager so that he or she can continue to be effective in his or her case management. Our Case Manager will seek to be informed and, wherever possible, involved in case rounds or interdisciplinary team communications facilitated by the outgoing Case Manager.

As the six-month transition period winds down, our Case Manager will conduct face-to-face transition visits with the outgoing Case Manager to help assure that the member feels secure in the transition. As needed, we will not hesitate to facilitate multiple joint face-to-face meetings to facilitate a smooth transition for the member, family, or representative. During the last weeks of the transition, Amerigroup will convene a final transition meeting with the member, family or representative, and, when appropriate, both Case Managers and the interdisciplinary team to make sure all documentation and information has transitioned from the outgoing Case Manager to the Amerigroup Case Manager to enhance a seamless transition.

Amerigroup will also be open to exploring the possibility of hiring the existing State-assigned Case Managers and fully integrating them into the team as Amerigroup staff based on qualifications and capabilities. Where possible and at the request of members, we will assign former State Case Managers to members within their previous caseload.

Ongoing Case Manager Transitions

We recognize that transitions will be necessary on an ongoing basis under certain circumstances. This includes circumstances in which the Case Manager is no longer employed by Amerigroup, has a conflict of interest and can no longer serve the member, or is on temporary leave from employment. Case Manager transitions may also occur if caseloads must be adjusted due to size or intensity of the Case Manager's caseload or if the member requests a new Case Manager. Anticipating these situations, we have developed several strategies to help facilitate seamless transitions between Case Managers when necessary. These strategies will help assure there are no interruptions in care for our members receiving LTSS in Iowa due to changes in Case Manager assignments.

Assigning Appropriate Replacement Case Managers

In the event of a necessary Case Manager transition, new Case Managers will be assigned in a timely fashion and will have the requisite qualifications. For long-term changes in Case Managers, the Regional Care Coordination supervisor will work expeditiously to assign a new Case Manager to promote continuity of care and services. The LTSS manager or case management team lead will match the Case

Managers and members ***based on diagnosis, complexity of medical and/or behavioral health conditions, and intensity of service and support need while assessing the Case Manager caseload capacity.***

Wherever possible, the outgoing Case Manager will contact the affected member telephonically to discuss the change and provide background about the Case Manager. During this process the Case Manager will explain reasons for the change and address any questions or concerns that the member may have. We will also inform the member of his or her right to request a new Case Manager if desired. Wherever possible, we will also schedule a face-to-face transition meeting involving both the former and new Case Manager. If the Case Manager is unable to telephonically inform the member of the change, our LTSS manager or case management team lead will inform the member and introduce the new Case Manager.

For short-term case assignment changes due to short-term leaves, we will facilitate smooth transitions with short-term assignment of Case Managers. Our LTSS managers and case management team leads understand the importance of making sure that every member has a Case Manager and will assign our members a temporary Case Manager in advance of a planned leave. Case Managers will be informed of their short-term assignment through their manager and through CareCompass system to help assure that they are aware of their responsibilities. For the duration of the transition, the temporary Case Manager will address any urgent concerns and will perform member outreach as necessary. Upon return of the original Case Manager, our LTSS managers will reassign the member to the original Case Manager to facilitate continuity of care.

Equipping Case Managers to Serve Members Effectively

To facilitate smooth transitions, we have implemented systems that prepare Case Managers to serve their new membership with relative ease. Once assigned, Case Managers will be able to view the member's complete records, including assessments, service plan, backup plans, and crisis plans through CareCompass. The Case Manager will also be able to view members' medical history through Member 360. By having this information easily available, Case Managers can get up to speed on member needs and circumstances very quickly.

In addition, our team-based approach to care coordination helps assure that Case Managers are well supported to service members. Our staffing model places Case Managers in regional case management teams that collaborate with one another to optimize care coordination. Case Managers with newly assigned membership are supported by their colleagues in the regional case management team if any questions should arise. Together, these processes minimize the risk of interruptions in care, as the Case Managers are effectively equipped to serve their newly assigned membership.

Discharge Planning (4.3.5)

Question 4.3, #7

7. Describe your proposed discharge planning process.

Planning and coordinating successful discharges for our members in LTSS programs are among our top priorities at Amerigroup. Our discharge planning approach integrates different components of the post-discharge transition by emphasizing the importance of working in close collaboration with clinicians located on-site at specified hospitals or providing this level of service directly through the assigned case management team.

By implementing policies that prepare members for successful discharge and support members upon discharge, we have achieved impressive results across our LTSS programs. For example, ***our Texas affiliate managing a Medicaid program for older adults with disabilities in Texas saw a 5–6 percent decrease in annual hospital readmissions after implementation of our comprehensive discharge planning program.*** Our organization's experience and success in coordinating hospital discharge for LTSS member populations makes us well equipped to support our members requiring LTSS in Iowa.

Comprehensive Discharge Planning Program

Through our Comprehensive Discharge Planning Program, we work to identify services and supports for our members and seek to support members as soon as they are admitted to the hospital. We provide our members with extensive support prior to discharge, during the discharge itself, and beyond discharge. If the hospitalization indicates a significant change in circumstance, our team also seeks to conduct a reassessment within seven days as described in Section 4.2. During this process, we seek to support our members' needs and preferences for transitions to mitigate risk of readmission and help improve our members' quality of life.

Engaging the Member upon Hospital Admission

We initiate our comprehensive discharge planning program immediately upon notification of hospital admission. Our Community-Based Case Managers are notified of hospital admission through Census Reports that are updated on a daily basis. Upon notification, the Case Manager seeks to meet with the member to discuss the conditions leading up to the admission, discuss the discharge planning process, and assess the member's risk for readmission.

Over the course of a member's admission, we also engage in ongoing conversations to help prepare the member for discharge. During ongoing conversations with the member and his or her family member or other natural supports, the Community-Based Case Manager will educate members and his or her natural supports about condition changes that may require immediate intervention. We also educate members about disease-specific interventions to boost their ability to take care of their health during discharge. Our conversations are supplemented with educational materials for reference.

Coordinating Discharge with Hospital Staff

We coordinate discharge with the hospital staff to help assure that members are fully equipped for success. Our Case Managers engage hospital staff upon admission to better understand the events leading up to the admission. Our Case Managers communicate with hospital staff on an ongoing basis during admission to understand how the member is progressing in his or her condition. Our Medical Director helps support these efforts and is available to Amerigroup Case Managers, providers, and other hospital staff for consultation.

The Case Manager also collaborates with the member, natural supports, and treating clinicians to identify potential gaps in care and work together to make critical decisions regarding the discharge plan and care setting. This team develops a comprehensive discharge plan to address each of the member's discharge needs such as the need for new equipment, follow-up appointments, and medications. The goal is to help assure that members receive the care they need and their personal objectives and preferences are safely addressed.

Prior to discharge our Community-Based Case Managers also engage with hospital staff to help support a medication reconciliation process. Members are often discharged without medications that were prescribed to them before their admission. To address this gap, we obtain the hospital discharge medication list from the hospital nurse, hospital discharge planner, or the member, family member or representative and compare prescriptions to the list of medications previously prescribed. We resolve any discrepancies by reviewing discharge medications with the outpatient provider.

Post-discharge Support

Upon member discharge, our Community-Based Case Managers work to support our members to prevent readmission. In the days following discharge, our case management team will follow-up with the member to confirm that the discharge plan is being followed and identify and address any needs that the member may have. We will also remind him or her of upcoming appointments and to offer assistance if barriers arise to following through with the plan. This is particularly important with regard to well-care

appointments that are scheduled for the member. If they have not had a regular checkup with their PCP or other preventive care services, we will facilitate scheduling and enabling member attendance at these appointments and will coordinate transportation as needed.

Should our conversations with members, natural supports, providers, or others indicate a significant change in circumstances that contributed to the hospitalization as described in Section 4.2, the Case Manager will seek to conduct a reassessment with the member upon discharge.

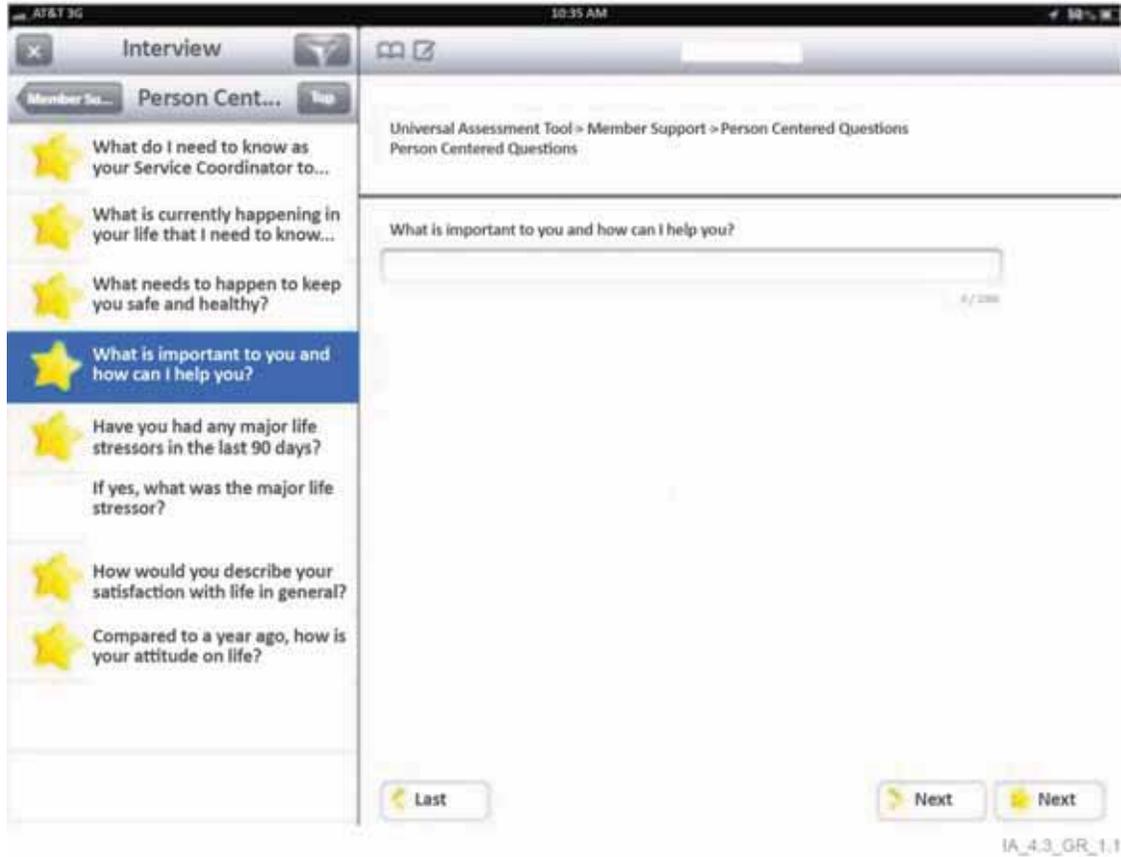
In-person Requirements (4.3.6)

Amerigroup understands the importance of standardized and consistent documentation of all in-person visits with members made by Community-Based Case Managers for the purposes of record keeping, as well as ongoing review and monitoring. We will utilize CareCompass Mobile, our innovative iPad technology used by Community-Based Case Managers, to facilitate documentation of all in-person interactions. Contact notes are then directly incorporated into members' case files on CareCompass as described in Figure 4.3-4. For each in-person visit, our Case Managers will be required to record and save case notes using a template that includes the following member information in accordance with SOW requirements 4.3.6:

- Physical condition, including observations of the member's skin, weight changes, and any visible injuries
- Physical environment
- Satisfaction with services and care
- Upcoming appointments
- Mood and emotional well-being
- Falls and any resulting injuries
- Member concerns or questions
- Statement from member's representative or natural support regarding any concerns or questions (when the representative/natural support is available)

By using CareCompass Mobile to electronically record contact notes, Amerigroup promotes efficiency, standardizes notes across all Case Managers, reduces risk of incomplete or lost case notes, and facilitates easy reference by the case management team.

Figure 4.3-4. CareCompass Mobile Facilitates Comprehensive Documentation of Member Contacts



Response to Problems and Issues (4.3.7)

As part of our member-centric approach, Amerigroup is committed to identifying, documenting, and responding to problems and issues, including service gaps and complaints regarding quality of care rendered by providers, workers, or Community-Based Case Management staff. We are LTSS experts, with affiliates serving more than 200,000 members eligible for our LTSS program in seven states. Our teams excel in meeting our contractual and state obligations while at the same time responding to problems and issues in a timely manner.

Service Gaps

Case Managers will continuously monitor gaps in care and resolve roadblocks by proactively engaging stakeholders, including the member, natural supports, providers, community-based organizations, and the interdisciplinary team. Case Managers will be able to monitor service provision through the CareCompass case management system, which tracks member progress with the service plan by incorporating the member’s medical records. If a Case Manager identifies regular gaps in care through medical records or through regular communication, the Case Manager will begin conversations with the member and appropriate stakeholders to identify potential causes and solutions. If warranted, the Case Manager will reach out to providers to address concerns and will not hesitate to change providers as necessary.

Member Concerns

Amerigroup adopts a “No Wrong Door” policy for grievances, whereby all verbal indications of discontent expressed about any matter or aspect of Amerigroup or its operation to any Amerigroup employee will be recorded as a grievance and processed. We will resolve grievances within 30 calendar days of the date we received the request or as expeditiously as the member’s health condition requires. We understand that we may request an extension for up to 14 additional calendar days to complete the grievance or appeal process if we feel it serves the best interest of the member. In cases where the member did not request the extension, we give the member written notice of the reason for the extension within two business days of the decision to extend the time frame. Amerigroup resolves clinically urgent quality of care concerns as expeditiously as the member’s medical condition requires but in no event greater than 72 hours after receipt. Further detail on the grievance and appeals process can be found in Section 8.15.

If a member in our LTSS program expresses a concern regarding service providers to any Amerigroup employee, the employee will document the concern, and the member’s Community-Based Case Manager will be informed. Once the Case Manager is informed about the concern by either the member or another Amerigroup employee, the Case Manager will work with the member to understand his or her concerns and collectively develop potential solutions. The Case Manager will proactively reach out to the all involved stakeholders to better understand the situation. The Case Manager will then propose a solution that helps meet member needs. This may include asking the provider to administer the services through different employees, modifying the way in which services are delivered, or switching providers. All our member-facing staff are thoroughly trained to record, report, and address member complaints. Through communication with providers, the member, and natural supports, the Case Manager will make best efforts to develop a solution that effectively resolves the member’s concern.

If a member in our LTSS program expresses a concern regarding care coordination staff, the employee receiving the complaint will inform his or her direct supervisor. The supervisor will review and investigate the claim through direct conversations with the member and Case Manager, as well as a review of the relevant records. If needed, the superior will assign a new Case Manager to the member and may develop a Corrective Action Plan for the Case Manager to improve performance.

Community-based Case Management Monitoring (4.3.8)

Question 4.3, #8

8. Describe your process for monitoring the effectiveness of the community-based case management process. Provide outcomes from similar contracts in other states, if available.

Amerigroup embraces ongoing monitoring and quality improvement as a workplace culture, not as a separate function within the health plan. Our culture of quality is embedded in every aspect of our organization. Every employee is a quality advocate, and all care coordination staff members take an active role in monitoring the effectiveness of the care coordination process and are assigned quality goals as part of their annual performance objectives.

Identifying and Remediating Individual Findings

As part of our process to monitor the effectiveness of care coordination processes, we will implement ongoing evaluations of the interactions between individual members and Case Managers to help assure that services are appropriately delivered and Case Managers are excelling in their level of care assessments, service plan development, and tracking of services.

We oversee the performance of our care coordination staff through regular reviews and audits. All care coordination staff have quality case reviews completed monthly on a random selection of open and closed case records from within the medical management system. Consistent implementation and documentation of the case management processes (that is, case initiation, assessment, planning, coordination, monitoring, and evaluation) are assessed through the quality case reviews process in accordance with SOW requirements 4.3.8.1 - 4.3.8.14.

The manager and/or designee and the individual employee review all case review results to assess the Case Manager's learning needs. The Case Manager is provided feedback on trends observed, confirmation that they are following their policies and procedures, and opportunities for improvement. An action plan for follow-up is developed, if necessary based on the review findings. Actions plans may include but are not limited to:

- Providing education and/or counseling to the employee until improvement is noted
- Conducting quality case reviews on a more focused basis (for example, weekly or biweekly) until achieving a consistent score at or above the designated minimum threshold
- Having managers conduct ride-alongs to observe Community-Based Case Manager technique, provide feedback, and address concerns

Tracking and Trending Data to Improve Effectiveness

We continuously track, trend, and analyze our quality-related data. This process encompasses grievances and appeals data, critical incidents and potential quality of care concern reports, provider/member satisfaction surveys, and utilization data. We then take action at the member, provider, and systems levels to improve safety, care, and service.

Continuously Developed Performance Reports

To support our efforts to be data driven, we have programmed our case management system, CareCompass, to produce daily reports that track key performance metrics. These robust tools allow are case management team to continuously monitor efficacy and help remediate individual and systemic issues as they arise.

These reports include metrics such as:

- Timeliness of annual assessments
- Timeliness of service plan development
- Timeliness of authorization or notice of adverse determination of services
- Rate of emergency room use
- Rate of inpatient admits and/or days/1000
- Rate of nursing facility days/1000
- Number of community re-integrations
- Number of diversion

Leveraging the Universal Assessment Tool to Drive Quality



To support the tools mentioned above, we also leverage assessment tools, including the Universal Assessment Tool (UAT), to track and trend data related to member experience. The UAT, used to compliment the InterRAI-HC and the SIS for initial member assessments and reassessments, is the primary method for assessing LTSS member satisfaction that includes, for example, participation in service planning, access to services, and support satisfaction with case management services. The member's Case Manager administers the UAT face-to-face with the member. The assessment responses are recorded in our care management system, CareCompass.

We then aggregate and analyze assessment data on a monthly basis, and we use a rolling three-month trend to identify opportunities for improvement, including in the following areas:

- Participation in service planning
- Ability to access services
- Receipt of new-member materials
- Satisfaction with services provided
- Satisfaction with case management program

Case managers will also ask questions regarding specific services the member receives, as appropriate. Responses will be recorded in our case management system and will be used at the health plan level to trend overall member satisfaction and quality of services being delivered across the plan.

Strategies to Improve Community-based Care Coordination

Annual and Quarterly Oversight

On an annual basis, the Quality Improvement Committee (QIC) will evaluate the care coordination program to evaluate whether the scope, goals, performance measurements, and planned activities are consistent with national and business strategic plans and the national case management standards of practice.

The QIC reviews all performance measure results in accordance with requirements in Scope of Work (SOW) Section 4.3.8.1–4.3.8.14. Quality performance measures for care coordination include but are not limited to:

- Case management quality case review outcomes
- Complaints with case management process
- Member satisfaction with case management services
- Documentation of member-identified issues and concerns in the case management plan as identified through reports and surveys
- Medication adherence assessment and follow-up in the service plan as an identified issue with interventions and targets

The QIC will also meet on a quarterly basis to provide oversight and guidance for all quality activities and has input into the case management process and quality measures. Quarterly reviews provide an additional checkpoint through which any issues or concerns with the LTSS care coordination program can be addressed in a timely manner.

Based on its findings, the QIC will identify key areas for improvement and will communicate these findings in performance results to regional and business unit staffs. When directed to do so by the QIC, the regional and business unit staff will be responsible for implementing action plans to improve or

correct identified problems. The annual QIC evaluation also results in a revision of the care coordination program to meet the upcoming year's needs.

Measuring Success of Strategies

Baseline Data Collection

Once we initiate a performance improvement project (PIP) related to Community-Based Care Coordination processes, we transform the design of the PIP into data collection processes that track interventions, incentive payments, encounters associated with the PIP, and other data points. The baseline data collection time frame is established, usually for a year. The Amerigroup quality team analyzes this information quarterly to obtain ongoing insight into the quality of care delivered to members.

Re-measurement

Subsequent data collection is compared to the baseline data to determine if the interventions are correct. Amerigroup quality management staff monitor all data results in comparison to the goals and benchmarks established by the health plan and identify areas exceeding or not meeting goals.

Adjusting Strategies

When we exceed targeted performance, we share interventions with other affiliate health plans to promote organization-wide adoption of best practices. When data points do not meet goals, we conduct root cause analysis and discuss results at the relevant workgroup meetings to identify barriers for members, providers, and the health plan. We implement new interventions and actions to address the identified barriers and then re-measure.

LTSS Results in Other Markets

Our affiliates' strategies to improve the Community-Based Care Coordination processes for our members receiving LTSS have yielded significant successes. Our affiliates regularly score over 90 percent on overall member satisfaction and satisfaction with care coordination in our LTSS program. They also achieve near 100 percent timely completion of reassessments in audits and successfully transitioned over 630 members from facility care to the community in 2014. Our overall success has been supported by successes in our individual markets as demonstrated in Table 4.3-4.

Table 4.3-4. Our LTSS Program Has Generated Positive Results for Members Across the Country

Affiliate Health Plan LTSS Program Results	
 <p>KANSAS</p>	<ul style="list-style-type: none"> • We were able to prevent 640 members at risk for institutionalization from entering the facility setting in 2014 • A 2014 survey of over 5,000 members in our LTSS program demonstrated that after one year of participation members were: <ul style="list-style-type: none"> ○ 17% less likely to use nursing facility services ○ 8% less likely to use an emergency room ○ 19% less likely to use inpatient hospital services
 <p>FLORIDA</p>	<ul style="list-style-type: none"> • In 2011, we achieved over 99% overall member satisfaction in our LTSS program • In 2011, we received consistent satisfaction ratings for case management, home services, and assisted living for our members receiving LTSS; more than 90% of members rated us an eight or higher on a scale of 0–10 • In 2013, 98% of members receiving LTSS surveyed rated Amerigroup's diversion program at an eight or higher on a scale of 0–10

Affiliate Health Plan LTSS Program Results

	<ul style="list-style-type: none"> • According to a member satisfaction survey done by the New York State Department of Health, 91% of respondents in the Amerigroup LTSS program said they would recommend their plan to others
	<ul style="list-style-type: none"> • In 2012, we achieved 99% member satisfaction with care coordination services for members receiving LTSS • We consistently achieved a 95-percent compliance rate for ongoing care coordination contacts • Between 2010 and 2013, we reduced the proportion of members receiving LTSS in nursing facilities from 82% to 60% • Analysis of UAT data has demonstrated consistent positive outcomes for more than 90% of members receiving LTSS in TN in the following areas: <ul style="list-style-type: none"> ○ Not experiencing social isolation ○ Participating in service planning ○ Accessing services ○ Receiving new-member materials ○ Services meeting member needs

Affiliate Health Plan Case Study: Strategies Implemented in Florida, 2010–11

As an example, the AHCA Nursing Facility Discharge Planning PIP experienced statistically significant decreases between measurement periods two and three, although all measures remained above the 80-percent goal. The team identified barriers related to institutional performance, which resulted in annual retraining of employees, revised data collection documents, increased number of medical records in the inter-rater reliability (IRR) process from one to 10, expanded audit function, and redistributed Case Manager responsibilities. The new interventions we implemented resulted in significant improvement. New prescription education increased to 93.9 percent in 2011, home health referral increased to 93.3 percent, and PCP notification increased to 86.2 percent.

In another example, we were faced with high caseloads as the result of a sudden program growth in 2010 and were unable to meet monthly member contact targets. We applied root-cause analysis, which guided us to add employees and reallocate Case Manager responsibilities. We met monthly targets throughout 2011 as demonstrated by re-measurement.

Admissions (4.3.9)

In accordance with requirements in Section 4.3.9, our team will support all members seeking nursing facility, ICF/ID, or community-based residential alternative setting. For members that are unable to be placed in facility-care based on the State's level of care determination or unavailable placement, our Community-Based Case Managers will meet in person with the member and/or his or her representative to discuss the reasons why placement was not possible and available alternatives and will work to identify a suitable alternative facility or community-based residential setting. Our Case Managers will also help assure that members have the option to receive HCBS in more than one residential setting appropriate to their needs and shall educate our members on all available settings. Our Case Managers retain detailed local knowledge of available facilities and providers and therefore are well equipped to help support our members in the LTSS program.

As discussed in Section 4.2, Amerigroup will also help assure that all PASRR requirements have been met prior to admission to the facility, including level I screening and level II evaluation as needed. Amerigroup is committed to making sure PASRR requirements have been met prior to the member's admission to a nursing facility.

Transitions between Facilities (4.3.10)

In the event that a member transitions between facilities, our care coordination staff will work to help provide a seamless transition. Our process for transitioning members between facilities allows members to be fully supported when they leave a facility, receive the services they need and desire, maintain continuity of care, and avoid an acute care episode. The Case Manager coordinates the planning and transition process with the member or his or her representative, family, advocate, legal guardian, PCP, and other providers and the discharge planning personnel at the facility to identify a new facility for the member and plan the transition.

Our Case Managers work closely with facility discharge planners, providers, and other staff to minimize disruption during the transition. This collaboration includes regular communication during face-to-face meetings, as appropriate, and through phone calls and emails. This communication increases as the transition date approaches, and the parties confirm that all pertinent healthcare information is transferred to the receiving facility.

Our Case Managers also engage with staff at the new nursing facility, ICF/ID, another facility, or residence to coordinate a smooth transition. Our Case Managers advocate on our members' behalf so their preferences and choices are respected. For example, they may work with the nursing facility to allow a member to bring his or her own bedding or to allow a modified schedule of activities. Our Case Manager arranges to meet the member at the nursing facility, ICF/ID, another facility, or residence on the date of admission to welcome the member, meet with facility staff (if applicable) to verify the services and support the member will receive, and begin developing action plans to deploy against member goals. For the duration of the member's stay, the Case Manager will conduct face-to-face visits, reassess the member's needs, as appropriate, involve natural supports, and communicate with facility staff. Our goal is to confirm that the member receives high-quality care that supports improved health outcomes.

Implementation (4.3.11)

Question 4.3, #9

9. Provide proposed strategies for ensuring a seamless transition of LTSS services during program implementation. Include a proposed strategy and timeline within which all members receiving LTSS will receive an in-person visit, an updated needs assessment and service plan. Describe how you will ensure services are not reduced, modified, or terminated in the absence of an up-to-date assessment.

Amerigroup understands the importance of coordinating seamless transition of LTSS services during program implementation to prevent any fragmentation or duplication of care and help assure member safety. ***Our affiliates have vast experience in working with over seven states transitioning from fee-for-service (FFS) to managed care within the last 17 years. Through each state's transition we have improved on our execution of implementations to bring our best practices to fruition.***

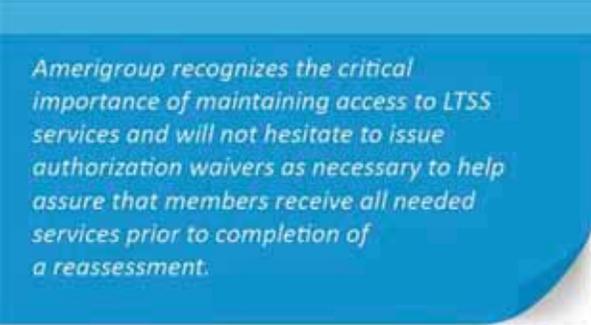
We know that LTSS services are critical to our members' ability to live safely in the community or facility setting and will help assure that members continue to receive their existing services without reduction, modification, or termination until an updated assessment is completed no later than 90 days from Contract implementation. To facilitate this process, we will communicate on an ongoing basis with both our members and providers.

As part of our comprehensive strategy to promote seamless transition for our members receiving LTSS we will also work to engage our members through ongoing communication and to address any concerns regarding provision of services and will seek to contract with existing providers to further help assure continuity of care. *Through early identification, assessment, and service plan development, we can successfully transition new members receiving LTSS to managed care.*

Providing Coverage of Necessary Services During Transition

Amerigroup will work with the State to help assure that services during periods of transition are not reduced, modified, or terminated in the absence of an updated service plan. To facilitate this process, we will work closely with DHS to obtain available information on members receiving LTSS, including medical records, service plans, and prior authorizations at the time of enrollment. We will enter this data into our core operating system. Prior authorizations and service levels will not be altered until the member has been successfully contacted and receives an updated assessment and service plan. This process will help promote continuity of care and minimize the possibility of gaps in care during Contract implementation.

The LTSS manager will then review all members' assessment expiration dates and will work to help assure that members receive a reassessment prior to their authorization expiration and no later than 90 days after Contract implementation. During this process the Long Term Care/Care Coordination Manager will identify any members who are at risk for authorization expiring prior to reassessment due to an abundance of members with imminent authorization expiry. If the LTSS manager identifies any risks associated with completing the reassessments prior to authorization expiration, he or she will immediately notify the CEO and COO, who will work in coordination with the Claims department to issue authorization waivers until a reassessment is completed. Amerigroup recognizes the critical importance of maintaining access to LTSS services and will not hesitate to issue authorization waivers as necessary to help assure that members receive all needed services prior to completion of a reassessment.



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Member Engagement and Communication

We realize members who have not previously participated in managed healthcare may experience a higher level of anxiety and stress associated with the transition. As a result, we provide detailed, accessible information about the member's right to receive services in accordance with his or her previous service plan until a new reassessment is completed. We also inform our members about our timeline for reassessment, seek to address any concerns that the member may have regarding the transition end, and encourage members to report if they observe any interruption of services.

Our processes for engaging and educating new members about our program, including their right to retain existing services, include:

- Informing new members of program benefits through DHS-approved welcome materials
- Conducting follow-up welcome calls to engage new members and identify immediate or existing healthcare needs — an opportunity to engage, build a relationship, and obtain health-related information

- Partnering with DHS and other MCOs in holding town hall meetings throughout Iowa communities to engage members and their families, giving them the opportunity to be introduced to Amerigroup, ask questions, or voice concerns
- Quarterly meetings with the Member Advisory Board

If any member reports an interruption in services to any Amerigroup employee, our LTSS manager will be informed and will work to resolve the concern with the appropriate departments immediately (for example, issuing an authorization and collaborating with Provider Relations and Internal Claims Resolution to have claims reprocessed if necessary). Any reports of interruption in service will be a top priority for the LTSS manager and our employees across Amerigroup.

Provider Engagement and Communication

During Contract implementation we also inform our providers of their right to receive compensation for services provided in accordance with current service plans until a reassessment is conducted. Similar to our communications with members, we will encourage providers to report any instances of service interruption for immediate resolution. Forums for communication with providers include but are not limited to:

- Ongoing communications and relationship-building activities with professional associations
- Communications between provider relations and provider entities during network development
- Partnering with DHS and other MCOs in holding Town Halls in which providers can openly ask any questions and voice any concerns.
- Quarterly meetings with the Provider Advisory Board
- Training sessions for providers

Amerigroup also recognizes the importance of existing relationships between members and their current providers and that those relationships have a distinct impact on the outcome of a member's care. This is particularly critical for our members receiving LTSS who often have special healthcare needs or multiple conditions that require coordination. To promote continuity of care, we will seek to contract with any providers that are currently offering services to our members. When situations arise, our Community-Based Case Managers will seek to keep members' existing providers. In our experience, this strategy helps promote seamless transition with minimal disruption in care for our members.

Nursing Facilities and ICF/IDs (4.3.12)

Case Management Requirements (4.3.12.1)

Question 4.3.12, #1

1. Describe proposed strategies for providing care coordination services for residents of nursing facilities and ICF/IDs, including the timelines and frequency of in-person visits.

Amerigroup's primary focus for residents of a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID) is to implement best practices for case management that provide members with excellent services in a supportive setting that prioritizes their desires and goals. Our approach to service planning emphasizes member choice, self-determination, and community integration. We accomplish this through focused member engagement. Our Case Managers partner with members, their families, and representatives to identify each member's unique needs, strengths, and preferences continuously through the member's care.

Person-centered Service Planning

Our Case Manager arranges to meet the member at the nursing facility or ICF/ID on the date of admission to welcome the member, meet with facility staff to verify the services and supports the member will receive, and begin developing action plans to deploy against member goals. For the duration of the member's stay, the Case Manager will conduct regular face-to-face visits; reassess the member's needs, as appropriate; involve natural supports; and communicate with facility staff. Our goal is to confirm that the member receives high-quality care that supports improved health outcomes.

For new members receiving LTSS, the LTSS manager will assign an appropriate Case Manager based on the member's location, coordinator capacity, and prior coordinator experience. New members will be assessed within 90 days of enrollment. During this in-person visit, the Case Manager will be responsible for:

- Explaining the assessment process and forms to the member and natural supports
- Evaluating the member's functional ability relative to performing activities of daily living
- Discussing the member's needs and whether those needs are currently being met by natural supports or the nursing facility
- Assessing member interest in transitioning to a home- or community-based setting
- Helping assure that the member is educated regarding services that are available through HCBS waivers if he or she wishes to leave the facility (including information on self-direction through the CCO)
- Identifying the key individuals involved in the member's care to comprise the interdisciplinary team; these members are the member, family members, representatives, other individuals of the member's choosing, and nursing facility or ICF/ID staff, including the member's social workers, nursing facility Case Managers, PCP, and other treating providers

Our Case Managers then prepare for the service planning process. Prior to service planning, our Case Managers work closely with the member and the member's interdisciplinary team, including facility staff, to identify the member's identified interests, goals, and support needs. Our Case Managers also work with the facility to review other relevant information, including medical records and prior service plans.

During the service planning process, our Case Managers meet with the member, interdisciplinary team lead, and any natural or legal supports whom the member requests to:

Use the CareCompass Mobile Device to complete the Universal Assessment Tool and service plan

Identify the member's needs and desired outcomes, including living arrangement, satisfaction with the facility, and any unmet needs

- Identify supports from all sources, including the nursing facility programs and offerings, as well as external paid and unpaid supports that together meet the member's needs
- Assess satisfaction with the member's existing nursing facility service plan
- Identify and address any gaps associated with the nursing facility service plan
- Incorporate the nursing facility service plan into our service plan once the plan is deemed appropriate
- Answer any questions from the member and leave their business card with the phone number to the care coordination phone queue

Ongoing Member Engagement and Monitoring

Regular Member Visits

Case Managers will continuously follow-up with our members in a nursing facility or ICF/ID on the effectiveness of the service plan through regular in-person and telephonic contact. Case Managers will be sure to contact members at least once monthly either in person or by telephone with an interval of at least 14 calendar days between contacts. Members will also be visited in their facility face-to-face by their Case Manager at least quarterly with an interval of at least 60 days between in-person visits.

Through ongoing monitoring, Case Managers will be able to gauge member progress with his or her service plan. To facilitate this process, case managers will record the member's physical condition, physical environment, satisfaction with services and care, upcoming appointments, emotional well-being, any injuries, and statements regarding any questions or concerns by the member or natural support. These responses will be recorded directly into CareCompass Mobile. Case Managers will then use member responses to follow-up as appropriate with nursing facility staff and the member's providers.

We will be cognizant of members with intellectual or developmental disabilities who are residing in nursing facilities or ICF/IDs due to lack of social supports or accessible resources in the community. We will work with these members and their families or representatives to help assure that their needs are fully addressed in the most appropriate manner and consistent with their preferences.

Collaboration with Facility Staff

A critical component of our care coordination strategy for facility staff involves coordinating with facility staff. We recognize that nursing facility staff interact with our members on a significantly more frequent basis and therefore see them as essential partners in care coordination for our members in facility care. To facilitate collaboration with nursing facility or ICF/ID staff, our Case Managers meet regularly with facility staff and hold quarterly meetings to discuss changes in our members' progress. We also seek to involve facility staff in Amerigroup case rounds and work collaboratively to address any issues that may arise.

Coordinating Facility Transitions

As part of our facility care strategy, we are committed to safe transitions to alternative settings for interested members. Our Case Managers continuously seek to identify members with an interest in transitioning to a home- or community-based setting in ongoing communications with the member, family members, and facility staff. In the transition planning process, we work with the member to identify all risks and identify all supports that can support the member from his or her first day in the community onwards. We also convene interdisciplinary transition conferences, including facility staff, to support the member in developing a transition plan and help address our member's diverse needs. Upon discharge, we support our members with post-transition monitoring in accordance with SOW requirements 4.3.12.6. Our Case Managers then work to quickly remediate any barriers or obstacles that the member may face to support maximal community integration.

Case Manager Specialization for Efficacy and Efficiency

Amerigroup recommends that Case Managers specialize in serving either facility members or HCBS members whenever possible. In our experience, this enables Case Managers to focus on the needs of a specific population rather than having to focus on both facility-based and community-based members. Specialization allows Case Managers to develop expertise in issues that predominantly occur only in facility care such as patient liability and dual-eligible payer strategy. Members benefit from their Case Manager's specialized knowledge about the processes and procedures governing the facility and their care.

Specialization increases Case Manager efficiency, builds relationships with facility staff, and increases member satisfaction. The Case Manager is able to develop strong working relationships with the staff of the facilities for which he or she is responsible. A strong relationship with the staff of the facility improves the channels of communication between the member, the facility, and Amerigroup. This close communication makes all parties aware of any unmet needs or adverse events, allowing them to respond quickly and appropriately. In addition, specialization allows the Case Manager to conduct face-to-face assessments for multiple members in the same location during the same day. This is a tremendous efficiency gain, minimizing travel time, simplifying scheduling, and allowing Case Managers to spend more time to focus on member needs.

Question 4.3.12, #2

2. Describe processes for working with nursing facilities and ICF/IDs to coordinate care.

At Amerigroup, we understand that care coordination and case management in the nursing facility and ICF/ID are unique and involve more interaction with and dependence on the providers who are providing a home for the member 24 hours a day, seven days a week. Given the importance of nursing facility and ICF/ID staff in coordinating care, we consider them to be critical members of a member's interdisciplinary care team. To promote coordination with nursing facilities and ICF/IDs, we have developed policies that help promote long-term relationships with nursing facilities and ICF/IDs and engage with staff members regularly to discuss member needs.

Our Staffing Model Fosters Communication

Our staffing model is designed to help Case Managers build relationships with nursing facilities and ICF/IDs that facilitate seamless communication to discuss members' needs and available services. We will make best attempts to assign Case Managers to specific nursing facilities and ICF/IDs to promote and foster the continuity and development of collaborative relationships with the facility's staff and encourage a coordinated process in providing members' services and supports. Our Case Managers will be on site routinely at the facilities where members reside to provide medical and social supports coordination and will thereby build relationships with staff members and develop familiarity with the specific facility's processes.

Because Case Managers are assigned to membership at specific facilities, our Case Managers will communicate very regularly with facility staff to coordinate based on member needs and seamlessly adapt to, complement, and collaborate with each facility's "norms" to provide effective coordination of care for our members residing in those facilities. Case Managers will meet weekly with facility staff to reconcile member census to stay abreast of any changes such as hospice enrollment or hospitalizations. This process allows us to react and respond quickly to changes in member status. Case Managers hold quarterly meetings with nursing facility and ICF/ID staff, members, and the members' supports, when appropriate, to discuss the members' goals, progress, and potential service gaps and to identify new needs or goals. Facility staff is also invited to attend Amerigroup case rounds that are pertinent to their

membership. Through this process, Case Managers are able to work collaboratively to resolve any potential issues by providing access to additional services or supports and offering creative solutions as an integral member of the treatment team.

We Work With Facility Staff to Coordinate Discharge

Case Managers work especially closely with nursing facility or ICF/ID staff during member transitions between facilities, from a facility back to the community, and vice versa. Our Case Managers collaborate with facility discharge planners and other staff to achieve a smooth transition. This collaboration includes regular communication during face-to-face meetings, as appropriate, and through phone calls and emails.

Communication increases as the transition date approaches, and the parties confirm transfer of all pertinent healthcare information to the Case Manager or receiving facility. During this process, the Case Managers collaborate with the facility social worker to convene a planning conference to identify all needs associated with the member's transition.

Our Case Managers also engage with staff at the new nursing facility or ICF/ID to coordinate a smooth transition. Our Case Managers advocate on our members' behalf so that their preferences and choices are respected. For example, they may work with the facility to allow a member to bring his or her own bedding or allow a modified schedule of activities. Based on our experience, we know that honoring the member's preferences leads to improved member outcomes.

Question 4.3.12, #3

3. Describe strategies for coordinating physical health, behavioral health and long-term care needs for residents and improving the health, functional and quality of life outcomes of members.

At Amerigroup, we know our care coordination efforts can have a significant impact on the quality of a member's nursing home or ICF/ID experience. We embrace our responsibility to establish strategies that meet members' diverse needs and improve outcomes for our members. To this end, we have structured our care coordination program for members in nursing facilities or ICF/IDs to promote and monitor high-quality care delivery, integrating a member's physical, behavioral, and LTSS needs while improving health, functional, and quality of life outcomes.

Interdisciplinary Case Management

Interdisciplinary case management across all members' needs is at the core of what we do. Central to our care coordination efforts is the interdisciplinary team, which includes the member's medical, functional, and quality of life supports. Our Case Managers communicate on a regular basis with all the individuals that comprise a member's interdisciplinary team to help assure that the member is progressing with his or her service plan and that his or her needs are being met. We also work to encourage communication between members of the interdisciplinary team as needed to help assure that members' care is not fragmented or duplicative.

To facilitate the Case Manager's ability to engage with all aspects of a member's care, we will implement regional case management teams (described further in Section 4.3.1). Each team is staffed with Case Managers that are physical health, behavioral health, HCBS, or facility experts. While our members receiving LTSS in nursing facilities or ICF/IDs will primarily interact with coordinators who have facility-based expertise, the other team members within the team provide critical support to help understand and address the full spectrum of member needs. In weekly case rounds, the team members have a standing forum to share experiences and best practices that help improve care coordination. Case Managers can initiate ad hoc discussions with their team members to address concerns or issues that may arise and need to be resolved prior to weekly case rounds.

Improving Outcomes for Our Members

Our Case Managers work to continuously monitor member's health, functional, and quality of life outcomes and deploy creative strategies to help improve outcomes for our members in facility care. During all our visits and telephonic conversations with members, we identify and document our members' reported physical health, behavioral health, and long-term care health outcomes in accordance with all requirements listed in 4.3.6. We also seek to identify any concerns related to our membership during ongoing conversations with nursing facility staff and natural supports, as well as by monitoring member progress with their service plan in CareCompass. We also continuously monitor the Long-term Care Minimal Data Set (MDS) data to monitor our members' health status.

Based on discussions with the member, family members, representatives, and facility staff, as well as review of the member's progress with his or her service plan and MDS data, our Case Manager will work with all stakeholders to identify solutions to the issue. These solutions may include but are not limited to:

- Resolving medical equipment, adaptive equipment, and other supply and service needs for members
- Addressing the need for specialty consultations and specialized services
- Addressing inappropriate use of psychoactive drugs for behavioral control
- Addressing inappropriate use of restraints

Once potential solutions have been identified, we will act as advocates on behalf of our members to help assure their needs are met. We will work in close collaboration with the member's interdisciplinary team to help assure timely resolution of the concern. If necessary, our Community-Based Case Managers will be empowered to seek help from other members of our Iowa-based team such as our LTSS manager or Medical Director to support our members.

In addition to coordinating between covered benefits, our Case Managers will make best efforts to identify and coordinate the provision of non-covered benefits for our nursing facility and ICF/ID members. For example, we will seek to coordinate with Iowa COMPASS to procure appropriate equipment to support safety and independence. We also plan to engage with State-funded programs, as appropriate, to optimize Iowa's investment in supporting seniors and people with disabilities. This would involve, for example, integration of service delivery with CMHCs and AAAs, as well as faith- and community-based organizations that deliver wraparound services not covered through Iowa Medicaid. Linking together the disparate, existing community services and agencies through a single service plan maximizes nursing facility outcomes and also makes the best use of available services throughout Iowa today.

Identifying and Reporting Concerns

Based on ongoing communications with the member and nursing facility or ICF/ID, our Case Managers are trained to monitor facility performance and report any concerns. In all telephonic and in-person conversations, our Case Managers ask members if they have any concerns related to the facility or their care provision. Case Managers will also rely on personal observation of both the member and the facility to identify and report issues. They will be monitoring for evidence of activities such as regular nursing rounds, coordination of laboratory and other required medical testing, and appropriate nutrition depending on each individual member's needs.

Our policies and procedures regarding reporting of concerns vary depending on the severity of the infraction. For relatively minor quality concerns that can be addressed quickly, our Case Managers will not hesitate to speak directly with nursing facility staff for resolution. These concerns could include:

- Level of lighting in the member's room
- Member concern regarding demeanor of specific staff members

- Member complaint that services are frequently scheduled during family/member visits

For more significant infractions that reflect general procedural or structural deficiencies in our nursing facilities, our Case Managers will escalate concerns to our Provider Relations team. Examples of such concerns could include:

- Suspicious odors
- Poor temperature regulation within the facility
- Verbally abusive staff members
- Poor quality services
- Regular infractions of members' service plans

Our Provider Relations team will then conduct an audit of the facility and will work with the facility to resolve any concerns. If the concerns persist, our Provider Relations team will implement a Corrective Action Plan that requires our nursing facilities partners to meet quality requirements.

In rare instances when the nursing facility fails to meet requirements stipulated in our Corrective Action Plan we will work to transition our members to another facility and will terminate our contract with the nursing facility. For very severe infractions that violate State licensure requirements, the Provider Relations team will report this to our Credentialing and Compliance managers so that the finding can be reported to the Health Facilities Division of the Iowa Department of Inspections and Appeals for State follow-up.

Client Participation Assistance (4.3.12.2)

Amerigroup recognizes that non-payment of patient liability can result in a member's discharge from nursing facility or ICF/ID care and therefore can disrupt the provision of services.

We also recognize that involuntary discharge from facility care often results in stress, confusion, and reduced quality of life for our members, and therefore we take several steps to avoid involuntary discharge. We ask our nursing facility partners to inform our Community-Based Case Manager if a member is in danger of discharge due to non-payment of the patient liability. Our Case Manager and nursing home staff then discuss the issue with the member and representative when appropriate, determine the barrier to payment, and seek to elicit cooperation. We also provide written notice to our members of their patient liability.

During our conversations, Amerigroup will screen for any misappropriation of funds that may have resulted in non-payment, and if concerns are identified we may:

- Refer the member to Adult Protective Services and/or law enforcement
- Submit request to the Social Security Administration to change the representative payee status to the person of the member's choosing or the nursing facility
- Engage additional family members
- Present evidence of payment to the facility if available

If patient liability continues to remain unmet, we will convene a formal meeting with facility leadership, the member and/or responsible party, LTSS Ombudsman, and any other representatives as applicable to review patient liability, potential consequences of non-payment, plan for payment, and available alternative facilities. Through these processes, we seek to give members the opportunity to address the patient liability and prevent discharge wherever possible.

In the event that Amerigroup, through the collaboration with the nursing facility and/or ICF/ID, is unsuccessful in resolving the payment of the patient liability by the member, then Amerigroup will work to find an alternate nursing facility or ICF/ID willing to serve the member.

Amerigroup Case Managers have comprehensive local knowledge of available institutional settings for our members and are therefore well equipped to support this transition.

In addition, our Case Managers will document all efforts made in the process of addressing patient liability and the steps and actions taken through such efforts in CareCompass.

State Resource Centers (4.3.12.3)

At Amerigroup, we understand the importance of coordinating care and administrating coverage for members in State Resource Centers (SRCs) as they provide intensive intermediate care facility services for individuals with intellectual disabilities. To help support these goals, we will support all members who have been deemed by the court not competent to stand trial (Iowa Code Chapter 812) or guilty by reason of insanity (Iowa Rule of Criminal Procedure 2.22) in entering an SRC. For all our members in SRCs, we will engage in member-centric care coordination as described in Section 4.3.12.1 that is compliant with the Conner Consent Decree.

We also understand Iowa's commitment to decreasing SRC beds in favor of alternative settings of care and will work to support this goal while avoiding gaps in care or duplication and fragmentation of care for our members. To support this goal, we will work to divert referrals from SRC placement to available services in the community and will fund transition activities, including staffing for overnight visits. Our proven strategies for facility diversion will help reduce SRC stays.

Compliance with Conner Consent Decree

Our Community Based Case Managers will work to help assure that members in SRC are served in a fashion that promotes compliance with all Conner Consent Decree Requirements relating to:

- Respect for individual dignity
- Member education regarding available services
- Right to choose settings of care
- Right to participate in service planning
- Continuous monitoring of the member's changing needs
- Involvement of the member's legal guardians or other designated representative

Our member-centric approach to care coordination, described in Sections 4.1 and 4.3.1, is founded on the principle of respect for our member's individual dignity, as well as a recognition that these preferences may change over time. To support members' right to self-determination we engage in comprehensive options counseling to educate members and their natural supports on all options available to them, including available services and their right to choose settings of care. We see the service plan as an extension of members' needs and wants and put members at the helm of their service planning process. After service plan development, we will continue to monitor members' changing preferences and will work to incorporate them into the service plan wherever resources permit.

Amerigroup also recognizes that members residing in SRC have intellectual disabilities and therefore may not be able to communicate all their needs or desires and/or may be unable to make informed choices. For these members, we will work very closely with the member's legal representative or other designated representative to coordinate services for the member. We will seek to involve the member and the member's representative in all decision-making, including choice of available services, settings of care, service planning, and ongoing monitoring. We will also support our members by helping assure that the representative is acting in the best interest of the member and will report any concerns to the appropriate authority, including the Adult Protective Services.

SRC Diversion

To help facilitate diversion and meet State goals for reducing SRC beds by 12 beds per year, we will implement a comprehensive diversion strategy that both keeps members from entering the SRC and works with members and their family or representatives who are interested in transitioning from SRC care to the community. Using processes described in Section 4.3.12.4 and 4.3.12.5, we will use predictive algorithms to identify members with ID at risk for facility admission and will engage in option

counseling. During this process we will provide members and their family or representatives with an array of options other than SRC care, including but not limited to ICF/ID, nursing facility, psychiatric medical institutes for children, and home- and community-based care. We will also provide the member with aggressive care coordination to maximize the degree to which member needs are met.

We will also continuously identify members who may be interested in transitioning members from SRC care to the community or alternative setting of care. Upon identification of a member interested in transition, we will work with the member, his or her family or representative, and his or her broader interdisciplinary team to coordinate a successful transition to the community. We will not hesitate to coordinate new placement, as well as post-discharge supports such as staffing overnight visits, and will work with the member, his or her family members, and representatives to identify additional community-based supports. As a Value-Added Service, we will help facilitate the process by providing financial assistance needed for the transition, easing the burden of purchasing household necessities.



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CONTAINS CONFIDENTIAL INFORMATION

Diversion Strategies (4.3.12.4)

Question 4.3.12, #4

4. Propose institutional diversion strategies and describe successes in other states.

Our comprehensive care coordination model and exceptional Case Management team implement a high-touch model that emphasizes member choice, thorough and coordinated service planning, proactive interventions, and continuous quality improvement.

Our approach has facilitated significant rebalancing of the LTSS system in our LTSS markets. *For example, our Tennessee affiliate was able to reduce the proportion of members receiving LTSS in nursing facilities from 82 percent to 60 percent between 2010 and 2013. Likewise, in Kansas, our affiliate health plan was able to prevent 640 members at risk for institutionalization from entering the facility setting in 2014 and achieved a 17-percent decrease in nursing facility use after one year of participation in our program.* Meanwhile our affiliate's members have been strongly supportive of our diversion strategies. In our Florida plan, 98 percent of members receiving LTSS surveyed rated our diversion program at an eight or higher on a scale of zero to 10. Based on our experience, we are confident we will be able to bring similar results to Iowa to prevent institutionalization and maintain member health, safety, and autonomy.

Early identification of members in need of LTSS is critical to diverting members from nursing facility placement. Individuals often enter the LTSS continuum in the nursing facility because of lack of knowledge, availability of housing options, or access to other resources. We focus a significant amount of effort on diversion, which is embedded in our comprehensive care coordination processes that include the following:

- Face-to-face administration of comprehensive member assessments that identify the member's needs and assess such factors as the member's capabilities, functional status, natural supports, and desired outcomes
- Collaboration with the member, his or her natural supports, and providers to develop a comprehensive service plan and manage needed changes and updates
- Informing each member about the option to participate in the Consumer Choices Option and that members who elect this option receive the support they need to manage a self-direction service provider such as consumer-directed attendant care
- Identification of all the member's physical health, behavioral health, and LTSS needs and the services and supports from all sources that will meet these needs and following up to confirm that all services are in place and satisfactory to the member
- Care coordination appropriate to the member's needs, which may include intensive management and frequent face-to-face contact for high-risk members or those who have complex care needs
- Periodic contact, as appropriate, with involved family and/or other natural supports and the member's physicians to solicit and provide feedback on the member's status and needs
- Identification of the member's gaps in care and action to help the member close these care gaps by providing interventions and coordinating preventive and other necessary care

Intervening to Prevent Institutionalization for High-risk Members

Amerigroup is also committed to identifying and preventing institutionalization for high-risk members, including members who are waiting placement in a nursing home, ICF/ID, or other institutional setting, members who may be on an HCBS waiver wait list, and members who have a change in circumstances or deteriorating health or functioning, have requested nursing facility or ICF/ID services, are admitted to a hospital or inpatient rehabilitation program, or are admitted to a nursing facility for short-term stay, in accordance with requirements in SOW 4.3.12.4. We will provide all members at risk of admission with additional options counseling and will provide aggressive care coordination to identify supports and services necessary to help the member remain within the community.

Identifying High-risk Members

Amerigroup will use a variety of means to identify members who may be at risk for institutionalization to help assure that all populations at risk for nursing facility or ICF/ID or other institutional setting admissions are identified.

Members with Deteriorating Health

To identify members who have deteriorating health, we have developed a proprietary predictive algorithm in partnership with the Duke Clinical Research Institute to complete an analysis of member assessment and healthcare utilization data to identify key risk factors for admission to an institutional setting from the community setting. Case Managers will be able to access this tool through our CareCompass Mobile application, where Case Managers will use the application to develop service plans targeted to the member's individual risks.



This initiative is led by our team of biostatisticians and epidemiologists who have more than 30 years of combined experience and have published 50 peer-reviewed papers and national presentations in academic healthcare research focusing on clinical outcomes, program evaluation, and predictive modeling. The Duke Clinical Research Institute also will complete a clinical research study that identifies optimal health pathways and services that can significantly improve quality of care and life for this population. As additional data from these studies becomes available, we will incorporate it into our proprietary tool to more effectively keep members in the community.

Other At-risk Members

Our Community-Based Case Managers will identify members who are on waiting lists for nursing facility care or an HCBS waiver through ongoing conversations with members, providers, and nursing facilities. We will also identify members who have been discharged from inpatient settings and rehabilitation or nursing facilities for short-term respite through our daily census, which is provided to Case Managers.

Intervening to Prevent Facility Admission

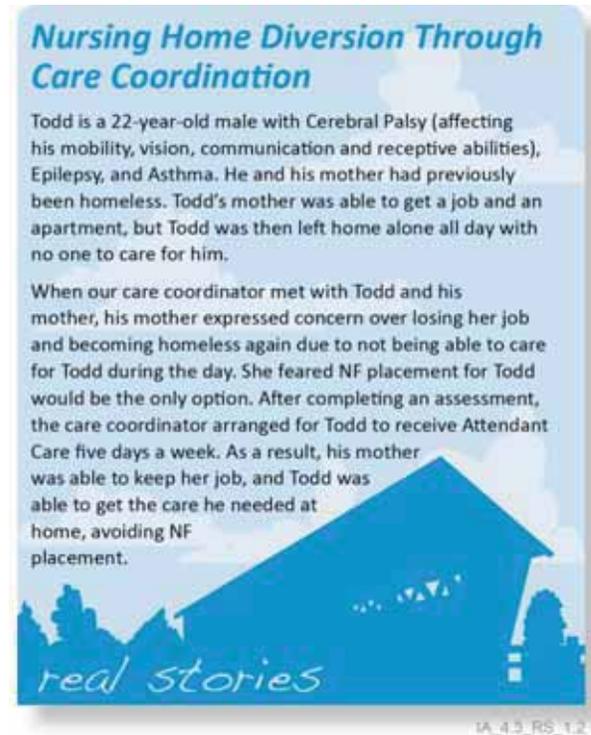
For all our members who are identified as being at high risk for facility admission, we will implement intensive care coordination and discharge planning processes as appropriate. In our experience, this process helps assure that members are aware of all their care options and are supported in the community of their choice.

As part of our care coordination strategy, we will provide options counseling to all our members to inform them of available resources to support them in a home- and community-based setting. As needed we will not hesitate to involve other members of our case management team, including our Medical Director, to provide additional information and context. Services that we may educate our members on may include but are not limited to:

- Adult day programs that may provide relief to natural supports
- Community programs providing services to members
- Value-Added Services benefits for members as described in Section 3.2.14
- HCBS waiver options
- Self-direction option (Consumer Choice Option)
- Option to be served in an alternative community setting

Our Community-Based Case Managers will then work to help assure that our members receive all available services and supports to prevent facility admission. We will also work to support members' decisions to be served in alternate settings or through the Consumer Choices Option.

For members who are awaiting discharge from inpatient, rehabilitation, or short-term facility care, we will also provide a comprehensive discharge plan as described in Section 4.3.5. During this process we will meet with members prior to discharge to understand members' needs and preferences associated with the transition and will educate the member on strategies for successful transition. We will also work in close collaboration with the hospital or nursing facility to help assure that the member has all necessary medications and devices needed for successful transition. As needed, we will complete a reassessment of member needs and will authorize additional services to help members remain within the community.



Community Transition Activities (4.3.12.5)

Question 4.3.12, #5

5. Propose strategies to identify members who have the ability or desire to transition from a nursing facility or ICF/ID setting to the community. Propose assessment tools, provide a sample transition and describe post-transition monitoring processes.

At Amerigroup, we are committed to supporting members living independently in the communities of their choice and engaging proactive efforts to identify members who have the desire and ability to transition from a nursing facility or ICF/ID. We recognize that members transitioning out of a facility are extremely vulnerable particularly in a more independent setting, given the complexity of their needs and the coordination of services required to meet these needs. To this end, Amerigroup has implemented an interdisciplinary transition process that proactively seeks to identify member needs and risks associated with transition and assists members in addressing those risks to facilitate safe and successful community re-integrations. *Amerigroup affiliates have successfully transitioned more than 630 members to the community in our seven states with LTSS programs during 2014. We have simultaneously achieved low facility readmission rates. For example, in our Texas affiliate, less than three percent of members who transitioned to the community in 2014 were readmitted within 90 days.* Given our organization's experience facilitating successful community integrations, we are confident we will be able to *facilitate successful transitions in Iowa.*

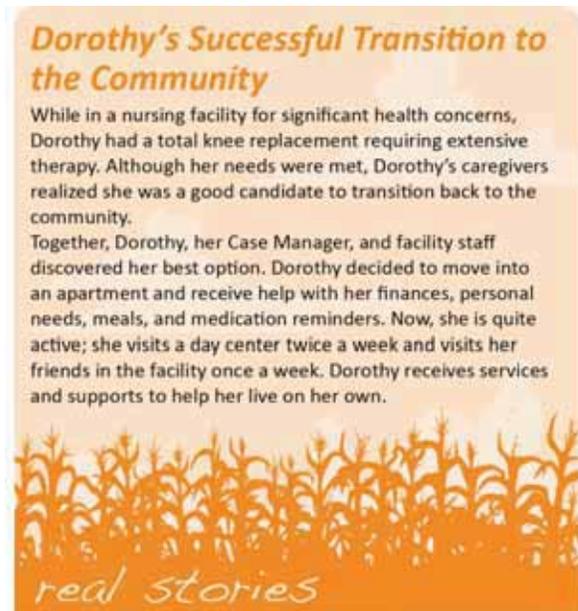
Transition Screening and Initial Assessment

Our Case Managers will conduct face-to-face transition screening assessments with each nursing facility and ICF/ID resident annually. In addition to annual screening assessments for all members in facility care, we will conduct a screening assessment for all members who express a desire to transition to the community during ongoing contact with a Case Manager and for members identified through MDS Section Q.

The screening is designed to:

- Confirm the member's desire and potential ability to transition
- Review the member's level of care to identify the appropriate waiver population for receipt of HCBS
- Educate the member about the transition process
- Inform the member about potential eligibility for participation in the Money Follows the Person (MFP) program

For members identified as potential candidates for transition, the Case Manager uses the UAT, a proprietary assessment designed specifically for our members in LTSS plans. The UAT assesses the member's physical, behavioral, functional, and psychosocial needs and also covers other factors important to transition planning such as access to natural supports and identification of housing needs and resources. The Case Manager then works with the member to understand his or her needs, goals, and preferences associated with the transition to help assure that all aspects of transition planning and



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transition maximally support the member. Through this conversation, the member and Case Manager develop an initial transition plan. A sample transition plan can be found at the end of this section in Attachment 4.3.12-1.

Supporting Members in Transition Planning

The Case Manager then works with the member to help assure the member is prepared for a successful transition. Once the Case Manager has completed the comprehensive assessment and developed an initial transition plan, our Case Manager engages an interdisciplinary team to support the member's transition called a Transition Case Conference. Transition Case Conferences include the member, member's PCP, other specialty providers, Centers for Independent Living (as applicable), Easter Seals, facility discharge planner, and social workers. This team works to help the member identify necessary steps to help assure the most successful transition to the community. To help develop an exhaustive transition plan, the Transition Case Conference addresses critical issues, including but not limited to:

- Summary of current medical, behavioral, and social needs
- Short-term and long-term care needs and goals
- List of services required and frequency
- Description of who will provide the services
- Name of PCP and natural supports
- Identification of potential challenges associated with transition that we will support the member in overcoming
- Housing options, training, employment, interests, and priorities
- Social Security or other benefits
- Review backup plan or set up a plan (if applicable)

During this process, the team thoroughly assesses the member's needs, gathering key information and documenting the required in-home services and related support. To help assure comprehensiveness, the transition case conference completes a transition checklist, including items such as deposits, furniture, appliance, and linens that help the team identify additional supports the member may require. Through continuous member engagement and support from the Transition Case Conferences, we are able to support successful transitions for our member.

The Case Manager supports the member in identifying all required services before discharge and coordinates with facility staff to arrange for the delivery of items or services that the member will require in the community. This includes arranging and confirming that appropriate home care, durable medical equipment, home modifications, and other services and resources are in place when the member leaves a facility. The Case Manager also helps our members secure any transportation assistance that is required and makes all necessary referrals for this service. Before discharge, Case Managers help schedule any follow-up and regular appointments with the PCP or specialist providers.

The Case Manager also supports the member in transferring medical records, medication information, and other pertinent member information to receiving PCPs and specialists upon discharge. The Case Manager coordinates medication reconciliation with pharmacy experts at the facility to compare the member's medications in the facility to the medication orders for the community. If there are discrepancies, the Case Manager contacts the member's PCP and/or treating provider to resolve the differences. He or she also confirms that the member has identified a community pharmacy to fill medication orders and that any required prior authorizations are completed prior to discharge. The Case Manager will then educate the member on the ability to establish with the pharmacy a monthly auto refill for his or her prescriptions as well.

Post-discharge Support

On the day of discharge and for the weeks following discharge, our Case Managers provide members who have recently transitioned with additional support to facilitate a successful transition. Our established practices, developed through our experience across seven LTSS markets, help minimize member readmissions and provide a positive experience for the member. On the day of the discharge, a member of the case management team will meet with a member at the facility. Here the Case Manager confirms that the member has all necessary medications, has arranged for all appropriate follow-up appointments, and has access to required transportation. Within 48 hours following the member's discharge from the facility, a member of the case management team confirms in person that all community-based services and supports are in place and satisfactory to the member and, as appropriate, his or her family or representative. We will also remind him or her of upcoming appointments and offer assistance if barriers arise that may prevent the member from following through with the plan. This is particularly important with regard to well-care appointments that are scheduled for the member. If he or she has not had a regular checkup with his or her PCP or other preventive care services, the Case Manager will facilitate the scheduling of and attendance at these appointments.

During the two months following transition, the Case Manager will continue to be in close communication with the member and natural supports to identify and address any roadblocks to successful transition. The Case Manager will make at least one in-person visit every two weeks to confirm that the member's home can support his or her needs. As the member adjusts to the new living arrangement after the second month, the Case Manager provides the intensity of care coordination needed to support the member in the community, making at least monthly face-to-face contact for the first year. Should it be determined that more frequent contact is required based on additional assessment of the member's needs and risk factors, then the Case Manager will document this in the initial transition plan or will update the transition plan as the follow-up visits occur.

Question 4.3.12, #6

6. Describe processes for interacting with the State's MFP designee and strategies to prevent duplication and fragmentation of care.

Amerigroup affiliates have significant experience administering MFP under a variety of models in several states (including California, Texas, Kansas, New Jersey, and Tennessee) that we will leverage to implement the MFP program in Iowa. We also have significant experience working closely with state MFP designees as partners in effectively coordinating the transition and delivery of services in the home- and community-based settings. During this process we will avoid duplication and fragmentation of care through clearly defined transition plans, communication with all stakeholders and providers regarding transition dates and services to be transitioned, and ongoing monitoring to help assure seamless continuity of service delivery.

Working as Partners with the MFP Designee

We will identify members for MFP using a multipronged approach. As described in response to Question 4.3.12, #5, we will conduct annual screenings for all members in nursing facilities and ICF/ID to determine their ability and interest in transitioning to a home- or community-based setting. We will also perform screenings for any members in facility care that express a desire to transition to the Case Manager or in response to MDS Section Q. If these members qualify as ID/DD or Brain Injury members receiving LTSS and have been in a nursing facility or ICF/ID for at least three months, we will proactively inform them and/or their representative, family members, and other natural supports about the MFP program and gauge interest.

If the member and/or representative express interest, we will refer him or her directly to the State for eligibility and enrollment determination. Once the State has verified enrollment of a member into the MFP program, we will work in close collaboration with the member, his or her representative, other natural supports, and the State MFP designee to create a transition plan and engage in the discharge planning. The State MFP designee will be invited to play a key role in the Transition Case Conferences to address critical issues such as medical follow-up, service plan appropriateness, risk identification, psychosocial needs, behavioral health issues, housing, and entitlement benefits as part of the member's transition plan. Case Managers will also provide regular updates to the State MFP designee as frequently as necessary regarding conversations with stakeholders, including providers and nursing home staff, as well as home assessments. We will inform the MFP designee about the transition planning progress and align on the transition plan prior to member discharge.

Preventing Duplication and Fragmentation of Care

We recognize that the simultaneous involvement of the MFP designee and Case Manager in administering the MFP program has the potential to result in duplication or fragmentation of care. To mitigate the risk of duplication or fragmentation, our transition plan for MFP designees will clearly outline responsibilities of the MFP designee relative to the Case Manager so that there is little room for misunderstanding. We will also work closely with the MFP designee to eliminate ambiguity in roles and responsibilities that could result in gaps in care. In addition to clearly defining responsibilities, we will make best efforts to assign MFP membership to Case Managers specializing in MFP so that they are familiar with the particular challenges associated with administering the MFP program and will therefore be best equipped to remediate any oversights. Staffing Case Managers based on MFP expertise will also minimize the number of Amerigroup contacts with whom the MFP designee must coordinate, further mitigating risk for duplication and fragmentation of care. Our designated MFP Case Managers will regularly communicate with the MFP designee to discuss member needs and collaboratively coordinate care.

Finally, our Case Managers will regularly monitor CareCompass and Member 360, our proprietary technology, to review the member service plan and medical history, including service utilization for members receiving LTSS. Through regular review of these systems, Case Managers will be able to flag in CareCompass and address any instances of duplication or fragmentation. In the event of duplication or fragmentation, the Case Manager will immediately connect with the MFP designee and appropriate stakeholders or providers to resolve any concerns and modify the member's service plan if necessary.

When MFP is No Longer Authorized by CMS

Amerigroup will collaborate with DHS, MCOs, and other stakeholders to assist with the development and implementation of a sustainability plan (subject to DHS approval) when the MFP grant is no longer authorized by CMS.

Post-transition Monitoring (4.3.12.6)

As discussed in Sections 4.3.5 and 4.3.12.5, Amerigroup is committed to supporting our members upon discharge from inpatient settings and facility care. Thus in accordance with SOW Section 4.3.12.6, Amerigroup will conduct in-person visits with members who have been reintegrated within two days of transition, every two weeks for the first two months following transition, and once per month for the first year following transition. While these requirements reflect minimum requirements, our Case Managers will not hesitate to make more frequent contact with members based on an assessment of the member's needs, preferences, and risk factors. Our Community-Based Case Managers will also monitor member admissions to hospital or facility settings through our daily Census Report and will work to support our members who have been readmitted. Our goal is to make sure we can assist with identifying issues and implementing strategies to improve outcomes for our members.

Utilization Review (4.3.12.7)

Amerigroup understands the importance of performing utilization review for our nursing facilities, nursing facilities for persons with mental illness, ICF/IDs, mental health institutes, and hospitals to help assure that services are being provided appropriately. In accordance with SOW requirements 4.3.12.7, Amerigroup will conduct on-site utilization review for facility settings at least annually and will conduct reviews of hospitals at least every three years. We will also arrange an exit interview in which providers will be informed of results at completion of the review and will provide providers with a written report. The written report will include evaluation of compliance, recommendations for enhancements, and corrective action as necessary. The report will be provided within 30 business days of completion. All members requiring specialized services will be included in the utilization review sample and reported to the State. The health plan will utilize the State reporting format should one be issued. In addition, the report will be reviewed and signed off by the health plan lead prior to submission to the State by the regulatory contract manager.

1915(c) HCBS Waivers (4.4)

Overview (4.4.1)

Amerigroup Iowa (Amerigroup) will draw upon the expertise of our affiliate health plans that cover HCBS waivers and our national LTSS experts to implement fully compliant and innovative home and community-based services to Iowans. Amerigroup's capabilities have been recognized by Julianne Beckett whose daughter Katie was the first Medicaid home and community-based waiver person in the country. Ms. Beckett believes Amerigroup will deliver needed innovations to improve the lives of those served by Iowa's Medicaid program, and her letter of support is provided as Attachment 1.1-1.

We will work with members, their families or representatives, DHS staff, and advocacy groups to continually evaluate and, when needed, refine our approach in Iowa to support the delivery of comprehensive and integrated services that improve members' health outcomes and functional capacity and support members to live, receive services, and participate in the community in the most integrated setting.

Service Plan Development (4.4.2)

Question 4.4, #1

1. Describe in detail how service plans meeting contractual requirements, state and federal regulations, and all applicable policies, will be developed for each member enrolled in a 1915(c) HCBS waiver.

Amerigroup Community-Based Case Managers hired from the local community and who have experience serving individuals enrolled in Iowa's HCBS waivers under the direction of Amerigroup Long Term Care Manager/Care Coordination Managers will help ensure service plans meet all State and federal requirements.

Service plan development will begin with completion of a comprehensive assessment:

- When a member is enrolled into an HCBS waiver following level of care determination and waiver enrollment authorization by the State or its designee
- For members newly enrolled into Amerigroup receiving HCBS waiver services at the time of enrollment, during the member's continuity of care period as described in Section 3.3
- Every 12 months thereafter when the Health Plan completes a level of care redetermination and the member's waiver eligibility is confirmed
- Whenever members request a revision to their service plan or when there is a significant change in members' needs or goals, at which time an assessment or reassessment will be completed

Amerigroup proposes to use our core LTSS assessment process, developed by our affiliates as a result over 17 years of delivering HCBS waivers services to managed care members. Our assessment identifies the member's individual goals, preferences, physical health, behavioral health, functional support, and social supports status and needs through a discovery process. An Amerigroup Community-Based Case Manager will complete the assessment, incorporating the results of the InterRAI HC or Supports Intensity Scale, as applicable, described in Section 4.2. Following completion of a comprehensive assessment and prior to authorization of waiver services, a service plan will be developed using a person-centered planning process led by or with the member, depending on the member's preference. This begins the process of ensuring that the member's social, school, work, and family goals and supports are included every step of the way.

The member's Community-Based Case Manager will work with the member and, as appropriate, the member's family or representative to identify ***a service planning team that includes professionals and non-professionals with adequate knowledge, training, and expertise surrounding community living and person-centered service delivery and who understand the personal needs and goals expressed by the member. Our approach for delivering CMH Waiver services is described in Section 3.2.11.***

The member and his or her Community-Based Case Manager will identify the team members, which may include the member's representative, family members, caregivers, service providers, health home staff for members enrolled in a health home, and others directly involved in the member's care. This can include input from the member's primary care provider (PCP) (if applicable), specialists, behavioral health providers, and Court Appointed Special Advocate Program volunteers (for children). We will obtain input from court-appointed mental health advocates, teachers, counselors, other case managers, and corrections officers as applicable. Additional clinical health plan staff such as nutritionists and a pharmacist will be available to the team to consult on specific issues as needed.

The member will select a team lead and the member's main point of contact from among the team members. If the member does not select a team lead, the service planning team makes the selection. If the team lead is not the member's Community-Based Case Manager, he or she will assist the team lead as needed with the person-centered service planning process.

The Community-Based Case Manager will be responsible for ensuring that service plan development is person-centered and timely and occurs at times and locations convenient to the member.

Preparation for Service Planning

Following identification of team members, the team lead and member will identify the preferred location, date, and time for service planning. In preparation for service plan development, the Community-Based Case Manager and team lead if not the member's Case Manager or care coordinator:

- Reviews the results of the member's assessment, including the member's identified interests, goals, and support needs
- Reviews other relevant information such as school Individual Educational Plans (IEPs), Vocational Rehabilitation Plans for Achieving Self-Support, previous waiver assessments and service plans, medical records, the member's current claims and encounter data, authorizations, and other health plan supports such as disease management and health education
- Consults with the member's PCP to help ensure the member's medical needs, including preventive health needs, are being met
- Reviews the member's HCBS waiver cost cap
- Identifies and arranges any accommodations needed by the member or other team members to participate in service planning such as interpreter services and visual cueing
- Notifies team members of the date/time and location of service planning and methods for participation (in-person, by phone conference, and through written input)

The Community-Based Case Manager, or team lead when not the Community-Based Case Manager, documents this review and findings in the care coordination and management system and in the Health Home electronic medical record (EMR) for members enrolled in health homes.

Frequency of Service Plan Development

The service plan must be completed and approved prior to the provision of waiver services and will be reviewed and revised: (i) at least every 12 months; or (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member. ***Members may request an update to the service plan at any time by contacting their Community-Based Case Manager.***

Person-centered Planning Process

The team lead will help the member drive the person-centered planning process *that emphasizes informed member choice, independence, and the principles of self-determination*. He or she will review the person-centered service planning process with the member, member's family, or representative to prepare for the service planning meeting and *provides the level of support and information needed throughout the meeting to help the member direct the process to the maximum extent possible and exercise informed choices and decisions*. The person-centered service planning process:

- Reflects cultural considerations, including the member's primary language or method of communication, cultural beliefs, and preferences
- Provides information in plain language that is transparent and easily understood by the member and member's representative and is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b)
- Addresses conflicts or disagreements, including divergent recommendations among team members, with priority given to the voice and choice of the member and family
- Assures informed choice and decision-making to the member regarding the services and supports they receive and from whom
- Adheres to guidelines addressing freedom from conflict of interest

The team lead will help the member and his or her representative, working with other team members as appropriate, to:

- Identify the member's desired outcomes and support needs, including the member's desired living arrangement, educational and/or employment goals and needs, and other community living goals and needs
- Identify services and supports from all sources, paid and unpaid, that together can meet the member's identified needs and support achievement of desired outcomes, considering the member's health and welfare needs, as well as the availability and appropriateness of services, including:
 - Medicaid State plan services
 - HCBS waiver services
 - Value-Added Services described in Section 3.2.14 such as assistive devices, additional hours of respite, and self-advocacy memberships
 - Services from other programs or agencies such as school-based services, vocational rehabilitation services, and workforce system services
 - Community-based resources, including housing, independent living, and social support services
 - Additional health plan benefits such as health education and disease management
 - Unpaid natural and caregiver supports
 - Family supports
 - Cost-effective supplemental services for members who would otherwise require a higher level of care
- Identify the amount, duration, and scope of needed HCBS waiver services in addition to State plan services and services available from other sources, including unpaid and family supports.
 - HCBS waiver services are reviewed to ensure these services do not duplicate other available services, which are to be accessed before waiver services.
 - Home and community-based settings options that comport with federal HCBS setting requirement regulations are reviewed with assistance from other team members. The Community-Based Case Manager may arrange a member's visit to a setting prior to a member selecting a setting. *We document each setting considered by the member in the service plan.*

- ***The service plan also records discussion and options provided for meaningful day activities, employment, and education opportunities*** including community supports like secondary education and other sources of coverage such as vocational rehabilitation options. ***Members choose from services that improve quality of life and community integration.***
- Calculate the service plan cost and compare the cost to the member's HCBS waiver cap; if the cost for requested services exceeds the cap, the team identifies ways to adjust the service plan while continuing to ensure the member's health and welfare
 - For members electing self-direction, calculate the amount of the budget available for self-directed services as described in Section 4.4.6.
 - Identify authorized and available HCBS waiver service providers, provide information about potential providers, and help the member select or change providers, as requested by the member
 - Develop an emergency plan that identifies the back-up providers and natural supports available to meet the member's needs when no approved service plan exists and which, if not addressed, may result in injury or harm to the member or other persons or in significant amounts of property damage; support services are interrupted or delayed or in the event of an emergency. The plan will include the member's risk assessment and the health and safety issues identified by the member's interdisciplinary team; the emergency back-up support and crisis response system identified by the interdisciplinary team; and emergency, back-up staff designated by providers for applicable services.
 - Determine if the member wishes to participate in the option to self-direct services described later in this section, and if so, identify which services will be self-directed in accordance with HCBS waiver policy and the amount available for the member's self-directed budget (see Section 4.4 – Consumer Choices Option).

Documentation

The member's Community-Based Case Manager will complete the service plan, which we will store in the care coordination and management system and, for members enrolled in Health Homes, also in the Health Home EMR. The Case Manager will include notes summarizing the meeting, including participants, method of participation, and any outstanding items that require follow-up. The member or his or her representative will be asked to indicate his or her agreement with the final service plan by signing the printed service plan. If the member or representative refuses to sign the service plan, we will work with the member to problem solve and, if no resolution is reached, implement the procedure described under ***Refusal to Sign the Service Plan***, later in this section, as approved by DHS.

We will provide a paper copy of the service plan to the member and representative as applicable and distribute it to other designated people involved in the plan. The care plan will also be available to Case Managers and providers in the member dashboard, Member 360.

Service Authorization and Initiation

The member's team will approve all HCBS waiver services included in the final service plan. The final approved service plan will then be sent to the prior authorization team to review and authorize the services and funding amount within the core operating system. If the team identifies additional benefits and includes them in the service plan, the Amerigroup Utilization Management Nurse or Utilization Management (UM) Manager will review and authorize them. The UM team will consult with the Medical Director when needed to confirm necessity of requested services and support.

The providers selected by the member will receive a service authorization number, a written or electronic service authorization, and a copy of the member's service plan. Waiver services may be initiated following receipt of the service authorization number.

Oversight

The member's Community-Based Case Manager will continuously assess the effectiveness of the service plan and works with the member and representative as applicable and other team members as appropriate to revise the service plan when desired outcomes are not achieved or when a member's needs or goals change. The service plan will be reviewed and revised: (i) at least every 12 months; (ii) when there is significant change in the member's circumstance or needs; or (iii) at the request of the member.

Service Plan Content (4.4.3)

Question 4.4, #2

2. Submit a sample service plan.

Sample Service Plan

A sample service plan is provided as Attachment 4.4-1 and includes each of the required elements specified in Section 4.4.3.

Emergency Plans (4.4.3.2)

Amerigroup will develop Emergency Plan policies and procedures, drawing upon the expertise of affiliate health plans that coordinate HCBS waiver services. Emergency plans will comply with Iowa Administrative Code and DHS policy for development and documentation of emergency plans for HCBS recipients. Policies and procedures will address the requirements in Scope of Work (SOW) Section 4.4.3.2 and will include such situations as personal emergencies and widespread public and natural emergencies.

Supported Community Living (4.4.3.3)

Amerigroup will develop Supported Community Living policies and procedures, drawing upon the expertise of our affiliate health plans that coordinate HCBS waiver services. These policies and procedures will comply with Iowa Administrative Code and DHS policy for supported community living. They will address such issues as how to accommodate housemate compatibility, shared staffing, and restrictions on member's rights. In addition, they will address characteristics of settings that comply with HCBS setting requirements and the method to identify settings determined compliant by the State. They will also address the procedure to be implemented if a setting appears to be or could be non-compliant with the HCBS setting requirements, including notification to DHS. The service plan will include the following for members in supported community living:

- The member's living environment at the time of 1915(c) HCBS waiver enrollment;
- The number of hours per day of on-site staff supervision needed by the member;
- The number of other waiver consumers who will live with the member in the living unit; and
- An identification and justification of any restriction of the member's rights, including but not limited to maintenance of personal funds or self-administration of medications.

CONTAINS CONFIDENTIAL INFORMATION

Refusal to Sign (4.4.3.4)

Amerigroup will develop and implement policies and procedures, subject to DHS review and approval, which describe the measures we will take to address instances when a member refuses to sign the service plan. Our proposed approach is described below:

If the member or representative declines to sign the service plan, the Community-Based Case Manager discusses alternative supports, services, or service settings that can meet the member's needs and assure the member's well-being, and, if agreeable to the member, the Community-Based Case Manager revises the service plan. If the member is unwilling to accept the alternatives offered, the community-based Case Manager will discuss the situation with his or her manager and develop a risk mitigation plan with the member. The risk mitigation plan will identify the services and supports available and the plan to mitigate any identified risks that could arise and documents the refusal to sign in the care coordination and management system. Amerigroup notifies DHS of the member's, or as applicable, representative's refusal to sign the service plan.

We will provide a paper copy of the service plan to the member and his or her representative as applicable and distribute it to other people involved in the plan. The care plan is also available to Case Managers and providers in the member dashboard, Member 360.

Compliance with Home and Community-Based Setting Requirements (4.4.4)

Amerigroup will confirm in accordance with 42 CFR 441.301 (b)(1) waiver services are not furnished to individuals who are inpatient in a hospital, nursing facility, institution for mental diseases, or ICF/ID.

As part of Amerigroup's education plan with HCBS providers, we will continue to educate and remind them that they cannot bill for services while a member is inpatient in a facility. In addition, we mine claims to identify instances when providers bill for delivery of HCBS waiver services while a member is in an institutional setting and recoup the payment when appropriate.

We will also ensure non-institutional LTSS are provided in settings that comport with the CMS home and community-based setting requirements as defined in regulations at 42 CFR 441.301(c)(4) and 42CFR 441.710(a) and as specified by DHS in rule or policy. We will cooperate fully with DHS in the assessment of an HCBS setting upon request of DHS.



Disenrollment (4.4.5)

Minimum Service Requirements (4.4.5.1)

Amerigroup will track and notify the State of any instance when a member enrolled in an HCBS waiver does not receive at least one billable unit of service under the waiver per calendar quarter. We will provide notification of such instances in the manner prescribed by DHS.

If the State determines a member is no longer eligible for 1915(c) waiver services, we will comply with the disenrollment determination.

Service Needs (4.4.5.2)

Question 4.4, #3

3. Describe how member's expenditures are tracked against any aggregate monthly cost caps.

Amerigroup will build upon the experience of our affiliate plans that cover HCBS waiver services subject to a cost cap and track expenditures against this cap. For example, in Tennessee, our affiliate health plan's care coordinators monitor cost neutrality by calculating the monthly cost neutrality amount based on three levels of institutional care and projecting expenditures for HCBS waiver services and other services included in the calculation as specified by the State, such as home health and private duty nursing services. We maintain the cost cap, HCBS projected expenditures, and monthly tracking in the care coordination and management system.

Our affiliates have been successful in other states, such as New Jersey, Tennessee, and Texas, using our proactive approach to intervene early to understand the reasons members may be approaching or exceeding their cost cap and to arrange or authorize alternative services when needed to maintain members in the community within the state's cost guidelines. We do not hesitate to authorize supplemental/additional services to prevent the need for higher cost care, including institutional placement, except when determined the only feasible service or the member's preferred service setting.

In Iowa, we will apply a similar process that meets the requirements specified in SOW Section 4.4.5.2 subject to DHS review and approval. Our proposed approach is described below.

The member's Community-Based Case Manager will continually monitor 1915(c) HCBS waiver member's expenditures against the aggregate monthly cost cap. The member's Community-Based Case Manager will review HCBS waiver claims, sum the cost of waiver services expenditures for the month, and compare the sum to the aggregate cost cap for the HCBS waiver recorded in the care coordination and management system in the member's service plan. The Community-Based Case Manager will use a *Cost Neutrality and Expenditure Determination* form to track and monitor each member's cost.

We take a proactive approach to monitoring the cost cap. If we find a member within 80 percent of the monthly cost cap amount or it appears that he or she will exceed the cap, the Community-Based Case Manager will contact the member and his or her representative as appropriate to complete a reassessment and determine if the member requires a higher level of care or if his or her needs can continue to be met through a combination of paid and unpaid supports. We will:

- Identify any non-waiver services available to meet the member's needs, including health plan supplemental services designed to help the member remain in a community setting and obtain authorization and/or coordinate access to these services
- If additional services are not available, advise the member of the exception process and assist the member with completion of an exception request for authorization of additional services or an additional amount of existing services
- If the exception request is denied, advise the member of his or her appeal rights, which will also be provided in writing through the standard grievance and appeals process
- Advise the member of alternative and appropriate care settings, which may include congregate care settings (for members not residing in a congregate care setting) when the cost of HCBS waiver services provided to the member in this setting is within the cost cap, or alternative institutional settings

- If the member refuses to transition to a more appropriate option, the Community-Based Case Manager will document this in the care coordination and management system and notify the Long Term Care Manager/Care Coordination Manager who will communicate this information to DHS.

It is also possible expenditures may be approaching or over the cost cap because services were used in excess of the amount authorized for the month, an error was made by the provider when submitting the claims, or for other reasons. In these types of situations, the Community-Based Case Manager will provide education and assistance to the member and/or provider as appropriate to avoid an overage going forward. If a provider is non-complaint with HCBS waiver service provision or billing requirements, the provider will be placed on a corrective action plan by provider relations staff, and the member will be given the option to select a new provider. Providers who continue to compromise the member's cost cap will be terminated. Our goal is to work with members and their community-based care manager and team of supports and service providers to assure they continue to receive the services and supports necessary to remain living in the least-restrictive and most integrated setting.

Receipt of Long-Term Care (4.4.5.3)

Amerigroup will notify the State if the member receives care in a hospital, nursing facility, or intermediate-care facility for individuals with intellectual disabilities for 30 days in one stay for purposes other than respite care. Amerigroup will require Long Term Care providers to notify us of a member's planned admission prior to admission and an unplanned admission within 24 hours of admission. An Amerigroup care coordinator or, if enrolled in a HCBS waiver at the time of admission, his or her Community-Based Case Manager, will contact members admitted to a hospital or long-term care institutional setting to begin discharge planning to support transition back to a community setting whenever feasible, with the concurrence of the member or his or her representative, and at the earliest date clinically indicated and agreed to by the member and treating providers.

Frequency of Community-based Case Manager Contact (4.4.6)

Amerigroup will develop policies and procedures, drawing upon the expertise of affiliate health plans that coordinate HCBS waiver services that comply with Iowa Administrative Code and DHS policy for frequency of Case Manager contact. Amerigroup Community-Based Case Managers will contact 1915(c) HCBS waiver members at least monthly, either in person or by telephone with an interval of at least 14 calendar days between contacts. Care coordinators will visit members in their residence face-to-face at least quarterly with an interval of at least 60 days between visits. Policies and procedures will include the scope and method of each contact, documentation of the contact, and the process to be followed when a member has experienced a change in need(s) or requests an update to his or her service plan. We will generate reports for case management teams identifying members who require a visit in the next 30, 60, 90, 120, or 180 days, to help make sure required visits are made timely.

Monitoring Receipt of Services (4.4.7)

Question 4.4, #4

4. Describe proposed methods for monitoring the provision of services identified on a member's service plan.

Amerigroup will adapt processes implemented successfully in other states where affiliates deliver HCBS waiver services to monitor the provision of services in Iowa. Our system is already configured to support oversight and monitoring and includes the capability to compare service delivery against authorized services and providers.

Amerigroup will maintain the member's service plan in the care coordination and management system and service authorizations in our core system. When services are authorized, a flag is set to be triggered on a specified date, in this case five days after scheduled service initiation, alerting the Community-Based Case Manager of a required activity. Each day, the Community-Based Case Manager reviews members flagged in the care coordination and management system. Community-Based Case Managers will call these members to confirm initiation of authorized services and that these services are meeting the member's needs.

If services have not been initiated or are not satisfactory to the member, the Community-Based Case Manager will identify the reason for this and the intervention needed to resolve the problem. We will also monitor HCBS waiver services claims monthly as part of the required monthly Community-Based Case Manager contact, which includes at least one face-to-face visit with the member in his or her residence quarterly as specified in SOW Section 4.4.6.

Prior to contact with the member, the Community-Based Case Manager reviews HCBS waiver claims submitted and claims paid, compares claims amounts to the member's cost cap as described previously in Section 4.4.5.2, and matches claims to the service plan to identify any apparent gaps in care. We also will program the care coordination and management system to notify Community-Based Case Managers if the following conditions, which must be reported to the State, are met:

- The member does not receive at least one billable unit of an HCBS waiver service a quarter
- The member has a stay in a hospital, nursing facility, or ICF/ID for 30 days for any purpose other than respite

During the monthly contact with the member, the Community-Based Case Manager will review any apparent service gaps to confirm them, review the member's service plan with the member to help assure authorized services are meeting the member's identified needs, and determine if the member has a change in needs, including caregiver availability that requires an adjustment to the service plan following a reassessment.

If there are service gaps, the Community-Based Case Manager will identify the cause and determine if intervention is needed. For example, claims may be missing if a member is sick and misses scheduled days of service that would have otherwise been provided, but these missed services might not constitute a care gap that requires intervention. Other reasons for service gaps that require specific intervention include:

- The provider failed to show up as scheduled, and the member did not notify the Community-Based Case Manager or the member declined authorized services.
- The provider is no longer available, and the member has not selected a new provider.

In these types of situations, the Community-Based Case Manager gathers information from the member and the provider to determine the cause of the problem and develop solutions, including ways to avoid the situation in the future.

We recommend that all health plans work together with DHS to select a single EVV vendor to monitor member receipt of HCBS waiver services and other services as noted in Section 13.1 of our response.

Self-Direction (4.4.8)

Question 4.4, #5

5. Describe in detail your proposed strategy for implementing the Consumer Choices Option, including how Support Broker and financial management services (FMS) will be implemented.

General Responsibilities (4.4.8.1)

Amerigroup fully supports self-directed care and services, and our affiliate health plans offer this option to HCBS waiver enrollees in Florida, New Jersey, Kansas, Tennessee, and Texas. In these states, our affiliates work closely with Financial Management Services (FMS) contractors, including with Public Partnerships, LLC (PPL) in Florida, Kansas, Tennessee, and Virginia. These affiliate plans have developed comprehensive policies and procedures that guide member election, the option to use a representative for self-direction, and implementation and support of self-direction. Best practices from existing, comprehensive, self-direction training programs and member education materials can be leveraged for Iowa.

Amerigroup will work with independent support brokers and with PPL for FMS services in Iowa. PPL provides FMS and/or support broker services in 26 states. PPL and our national self-directed care experts, with input from the Stakeholder Advisory Board and members electing self-direction, will work together to customize existing policies, procedures, training programs, and member materials for Iowa, developing additional and new content as needed to meet all requirements specified in SOW Section 4.4.8. In addition, we will develop and submit a Transition Plan to DHS for review and approval, describing how we will work with members, self-direction representatives, support brokers, DHS, other key stakeholders and the current FMS entity (Veridian) to support member's transition to PPL.

In addition, we will implement resources and supports to increase access to, and selection of, self-directed services, including peer supports for members to learn from others' experiences with self-direction.

The MySupport platform, described in Section 4.4.2, will also help members to connect with personal care attendants who have skills that match their individual needs, preferences, and values.

Support Broker Functions (4.4.8.5)

Amerigroup will work with current independent support brokers, assisting with enrollment and providing training and oversight, to make sure support brokers perform all of the support broker functions described in SOW Section 4.4.8.5 and IAC 441-78. Amerigroup affiliate plan self-direction experts and the FMS entity, working with DHS and with input from support brokers and the Stakeholder Advisory Board, will develop policies and procedures that build on our best practices helping members to successfully self-direct their services.

Enrollment

We will work with the support brokers and DHS to obtain each support broker's evidence of previous satisfactory completion of training and background screening and enroll them without delay upon receipt of this information. We will work with DHS to make sure experienced brokers may continue to provide services to their clients who transition to Amerigroup without interruption during the transition period to Amerigroup.

We will assist individuals wishing to become new support brokers to make sure they meet minimum requirements for age and education and have passed the required background checks (Child Abuse Registry, Dependent Adult Abuse Registry, Sexual Offender Registry checks, and DCI/FBI Criminal History Record checks) prior to working with Amerigroup.

Following enrollment, all support brokers (experienced brokers transitioning to Amerigroup and newly hired brokers) will complete training.

Amerigroup Training

Amerigroup training will consist of Amerigroup core training and Consumer Choices Option training.

Amerigroup core training will be designed to help support brokers understand our health plan operations, programs, and provider-specific procedures. Existing independent support brokers transitioning to Amerigroup will complete this training while they continue to provide support broker services to members.

The second part of training will be Consumer Choices Option and support broker-specific training and will cover all of the topics specified in SOW Section 4.4.8.5. Training will incorporate the DHS Independent Support Broker training content as applicable with additional content developed by Amerigroup as applicable. For example, we will develop training content and materials that describe Amerigroup's development of a member's service plan and self-directed budget and the roles of the Community-Based Case Manager and support broker. We will also develop, with our FMS entity PPL, Amerigroup's financial management services procedures, and PPL will participate in these trainings. We will develop training methods and content with DHS review and subject to DHS approval.

New support brokers (individuals not providing support broker services at the time managed care is implemented) may not provide support broker services to our members until they have completed and satisfied all training and background check requirements and are certified as a Mandatory Abuse Reporter.

Support brokers will have a variety of ways to complete training, including through webinars, online modules, and group trainings offered in key locations throughout the State. In addition, local health plan staff, including Provider Services Staff and Community-Based Case Managers, will be available to provide one-to-one assistance to support brokers with all aspects of training and service provision, including transition to Amerigroup.

All providers receive additional periodic training when changes occur that impact their responsibilities and may receive one-to-one training to address performance issues.

Oversight

Amerigroup will be responsible for completion of all required activities and will provide oversight of and technical assistance to support brokers and the FMS in the execution of their responsibilities as displayed in Table 4.4-1. Community-Based Case Managers will coordinate specific activities with support brokers but will not duplicate activities. ***Amerigroup will develop protocols clearly identifying responsibilities to help ensure non-duplication.***

Table 4.4-1. General Responsibilities of the Support Broker and FMS Will Be Carried out with Amerigroup Oversight

Activity	Support Broker	FMS
Identifying resources, including natural and informal supports that may assist in meeting the member’s needs	Y	
Developing a budget to address the needs of the member	Y	
Conducting employer-related activities such as assisting a member in identifying a designated representative if needed, finding and hiring employees and providers, and completing all documentation required to pay self-directed providers	Y	Y
Identifying and resolving issues related to the implementation of the budget	Y	Y
Assisting the member with quality assurance activities to ensure implementation of the member’s budget and utilization of the authorized budget	Y	Y
Recognizing and reporting critical incidents related to self-directed services as further described in Section 10.4	Y	Y
Facilitating resolution of any disputes regarding payment to providers for services rendered	Y	Y
Monitoring the quality of services provided	Y	Y

Community-Based Case Managers will, during the monthly contact with a member receiving HCBS waiver services, assess the member’s satisfaction with self-directed services, their support broker (if using a support broker), and the FMS. Any concerns raised at this time about any aspect of self-direction will be investigated by the Community-Based Case Manager and reported to the Provider Relations Manager and Long Term Care/Care Coordination Manager for assessment and resolution. In addition, we will address any complaints received from members or representatives concerning any aspect of self-directed services in accordance with the grievance process described in Section 8.15.

Oversight will also include monitoring of annual member satisfaction survey results as well as ongoing FMS monitoring of the member’s budget and expenditures. Any support broker issues that appear to be systemic (occur more than once with more than one member) will be addressed through both individual and systemic remediation, which may include changes to policies and procedures, additional support broker training, placing a support broker on a corrective action plan, or terminating the support broker from the network, as applicable.

Informing Members About the Consumer Choices Option

We will take every opportunity to inform Amerigroup HCBS waiver recipients of the Consumer Choices Option including the following ways:

- We will include a link to <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option> on our member website and information describing the option and how to obtain additional information in our member handbook.
- Every member enrolled in a waiver that includes self-direction will be offered the choice to self-direct during the service plan planning process, phone calls, reassessments, and other opportunities to describe the value of self-direction. The member’s Community-Based Case Manager will describe the option and explain which services may be self-directed, the option for a representative to direct services with the member or on the member’s behalf, the role of the support broker and FMS, and the responsibilities a member or representative will assume under the option.
- The service plan will include a statement that confirms the self-directed option has been offered to the member during service plan planning and will note the member’s decision (electing or declining the option).

- Members choosing to self-direct services will be asked to sign an informed consent form and risk agreement.

Question 4.4, #6

6. Provide a sample of the following tools and forms related to the Consumer Choices Option:
- a. Self-assessment tool for members seeking to self-direct service;
 - b. Informed consent contract; and
 - c. Risk agreement.

Self-Assessment (4.4.8.2)

Our affiliates have developed self-assessment tools and policies and procedures that specify how and when a member completes a self-assessment and the alternatives available to members when the self-assessment results indicate a member is unable to self-direct services. We propose to use the self-assessment tool submitted as Attachment 4.4-2 and will adapt our existing policies and procedures for Iowa.

Members determined unable to self-direct but who are still interested in this option may appoint a representative to assume self-direction responsibilities. We inform members that they may exercise their choice to self-direct at any time if they are not ready to participate after learning of their responsibilities.

Documentation (4.4.8.3)

In addition to the notation in the service plan (described previously in this section) indicating the member's decision whether or not to self-direct, we will obtain the member's informed consent using the *Informed Consent Contract and Risk Agreement* that will be signed by the member or their representative when applicable and the member's Community-Based Case Manager.

Community-Based Case Managers are responsible for ongoing assessment of risk for those members who self-direct their services, such as the member spending too much in one month from his or her self-directed budget and running out of funds the following month. At the time of the member's decision to participate in self-directed services, a risk assessment is completed or revised, and a *Risk Agreement* is initiated and signed by the member and his or her self-direction representative, legal representative as applicable, and Community-Based Case Manager. A new *Risk Agreement* is initiated and signed when a member experiences a change in needs and in authorized services. The member's Community-Based Case Manager reviews the contract and agreement and answers any questions the member or representative may have. The *Informed Consent Contract and Risk Agreement* are provided as Attachment 4.4-3.

Use of a Representative (4.4.8.4)

Amerigroup fully supports a member's option to select a self-directed representative such as a family member or friend to direct or help direct services. Amerigroup understands that representatives may be either a legal representative or non-legal representative freely chosen by an adult member. If a member selects a non-legal representative, Amerigroup acknowledges that they cannot be a paid provider of services and must be 18 years of age and will ensure consent forms are in place in these instances.

Our affiliate health plans that offer self-direction and PPL have extensive experience working with self-direction representatives. Both PPL and the member's independent support broker will work closely with the member and the self-direction representative, actively engaging the member during each contact. The independent support broker is responsible for making sure the self-direction representative is acting in the best interest of the member. If the independent support broker identifies a concern, this will be brought to the member's Community-Based Case Manager for investigation and resolution. We will adapt existing

member satisfaction surveys and service planning tools to help ensure self-direction representative (legal and non-legal) requirements specified in SOW Section 4.4.8.4 are met.

We will introduce the member to the support broker as soon as possible after his or her service plan is finalized and the member's desire to self-direct has been documented in the service plan. Support brokers will make telephonic contact within two business days, with an initial orientation and enrollment meeting set at the earliest opportunity. The support broker shepherds the member through each step of the enrollment process, helping the member and representative when applicable complete training and requisite paperwork as soon as possible.

The support broker provides the level of support the member and, when applicable, self-direction representative need to complete key tasks. Support broker responsibilities include:

- Educating members on how to use self-directed supports and services
- Assisting in managing budget expenditures and budget revisions
- Assisting with employer functions such as recruiting, hiring, and supervising providers
- Assisting with approving and processing job descriptions for direct supports
- Assisting with completing forms related to employees
- Assisting with timesheets, purchase orders, and invoices for goods
- Obtaining quotes for services and goods, as well as identifying and negotiating with vendors
- Assisting with problem-solving employee and vendor payment issues or concerns
- Assisting with back-up plan development
- Reviewing, monitoring, and documenting progress of the member's self-directed budget
- Completing critical incident reporting

Financial Management Services (4.4.8.6)

Amerigroup will contract with PPL, a *national leader in consumer direction for financial management services (FMS)*. PPL will coordinate and work with the independent support brokers who are approved by the State based on the requirements defined in IAC 441-78. PPL provides FMS to more than 26 states and routinely performs the following functions:

- Fiscal/Employer Agent Services in compliance with the IRS regulations
 - Payroll and timesheet processing
 - Tax filing and reporting
 - Criminal background checks and provider credentialing
 - Development of a provider registry
 - E-verification
 - OIG verification checks
- Financial Management
 - Budget planning, tracking, and accounting
 - Authorization management via business rules engine
 - Claims processing and payment
 - Banking and disbursing funds
- Support, Counseling, and Customer Service
 - Telephonic customer service during business hours in English and Spanish; a language line is also available
 - Provide training for support brokers and Case Managers/care coordinators
 - Provide training for other health plan staff

- Provide training for consumers and providers
- Offer peer trainer services
- Help individuals understand billing and documentation responsibilities, perform payroll and employer-related duties, purchase approved goods and services, track and monitor individual budget expenditures, and identify expenditures that are over or under the budget

PPL's experience and multi-state presence provides states, health plans, members, and their families with a high level of service and security. They offer a fully tested continuity of operations planning and have multiple operating locations that can be utilized in the event of an emergency, providing comprehensive back-up with uninterrupted service. PPL also operates a customer service call center with specially trained call center agents, interactive voice response options, and automated outbound call capabilities. They also provide email communication during standard business hours. Their information system capabilities include a multi-channel single repository time and attendance system to assure time entries are captured at the most convenient time and by the most convenient method, including an online timesheet and smartphone mobile application. Their systems are HIPAA compliant and secure and maintain security testing records.

PPL is proud of its reputation for providing high-quality support broker services, and this is reflected in performance data, audit findings, and the results of satisfaction surveys. ***For example, the 2013 audit of the West Virginia Intellectual and Developmental Disabilities Waiver Personal Options program achieved the highest score possible with zero deficiencies cited.***

Amerigroup is excited to offer an established partnership with PPL, a national leader in self direction for FMS. If selected as one of the Iowa High Quality Healthcare Initiative health plans, we are open to discussion with DHS on which FMS vendor may provide services to assure consistency between the plans and a smooth transition for Iowans.

Back-up Plan

Upon enrollment in self-direction, the support broker assists the member and/or representative in developing a back-up plan that documents how the member's needs will be met. *Identification of participant risks and the emergency plan are components of the service plan.*

The back-up plan addresses the three major risks:

- A worker is unable to provide services or fails to show up as scheduled
- The member experiences a personal emergency or change in condition
- There is a community catastrophe

The member and/or representative develop a written back-up plan. The back-up plan includes but is not limited to the following types of information:

- If a worker is unable to provide services, the back-up worker (who may be paid or unpaid) available to provide services is included along with the worker's contact information. Ideally, the back-up plan includes several paid and unpaid workers to help assure access at any time of the day or night.
- If there is a personal emergency, an emergency contact and other emergency-related information are included along with the member's PCP, hospital preferences, and advance directives. An emergency document suitable for prominent display in the member's home is completed and is to be posted where it is available for any responders.
- If there is a community catastrophe, a personal disaster preparedness plan that addresses who will respond to the participant, where they will go, and critical supplies and personal items they will take with them is included. Some participants prepare a suitcase with extra medications and items necessary for survival should a flood, fire, or other event occur. Members with special needs with the

help of the support broker identify the nearest special needs shelter and how and under what circumstances they will go to the shelter.

The back-up plan will be updated annually or when a member experiences a change in needs, provider, or living situation/circumstances and will be maintained in the member's file. The member will designate a location in the home where the back-up plan will be stored in addition to providing a copy to Amerigroup. The back-up plan is also maintained in the care coordination and management system and readily available in Member 360. This will help assure that all individuals who need access to the back-up plan can readily access it when needed.

Budget (4.4.8.8)

The member's self-directed budget is determined during service plan development. The services that may be self-directed are included in the service plan, and the member's Community-Based Case Manager calculates a budget based on the fee-for-service (FFS) rate for each service in the amount specified on the approved service plan. The budget is approved by the member's service plan team.

At the time of enrollment into the CCO, the support broker reviews the self-directed budget with the participant and/or self-direction representative and assists in the development of a spending plan, which specifies how budget funds will be utilized over the term of the budget. This includes helping the member identify the rate they want to pay their worker, comparable rates for the service when paid fee for service, and assistance with the negotiation process. In addition, the support broker helps make sure the member does not schedule a worker for more than 40 hours weekly. This helps assure the participant's service needs are met in the manner he or she chooses but within the limits of the assigned budget.

As services are provided and costs are applied to the participant's budget, PPL's web portal will identify and pend (not pay) any services in excess of the spending plan. These are researched, and the member, his or her self-direction representative and/or worker, support broker, and Amerigroup Community-Based Case Manager are notified of excess spending. The Community-Based Case Manager working with the member, support broker, and FMS, investigates and resolves these situations. The support broker monitors these occurrences to help assure timely resolution and also to provide feedback and training to the member and self-direction representative as needed. PPL will provide Amerigroup with budget utilization reports, which allow case-specific and program-wide monitoring of budget use.

Payment (4.4.8.9)

The member or his or her representative review and approve time sheets to determine accuracy and appropriateness, with the assistance of the support broker when needed. Members using the MySupport platform, as described in 4.4.2, will have access to an easy-to-use time sheet tracking system.

PPL has robust policies and procedures, as well as internal controls, for processing payroll and payment for goods and services. Prior to the program launch, PPL will document eligibility criteria, available services, start and end dates, unit and dollar limits, rates, and provider qualifications. These become the business rules and drive the process. In addition, they will configure their payroll system to correspond with all payment rules, including time sheet, budget caps, and invoice submission windows.

Members review the caregiver's time sheet and other invoices each week to confirm what has been submitted for payment to PPL. This can be accomplished via the PPL web application or mobile app, fax, or mail. In addition, PPL uses their web portal platform and other software to validate the provider credentials and expenditures against the authorized and approved itemized services and goods. All time sheets and invoices are reviewed and compared to the service plan and matched to the member's approval as a check and balance process. Any payment requests that exceed the authorization limits will be partially paid or pending for Case Manager review and approval or denied based on the established program rules.

PPL will recoup any unspent funds monthly for service accounts and annually for savings accounts. Amerigroup will work with PPL to establish the policies and procedures following DHS' rules for recouping unspent funds monthly for service accounts and annually for saving accounts. PPL typically runs biweekly or twice monthly payroll. PPL can run off-cycle or special payroll as needed to accommodate outliers in agreed-upon circumstances

Services Pending Implementation of Self-directed Services (4.4.8.10)

Amerigroup will provide all 1915(c) HCBS waiver services to members who elect the Community Choices Option with network providers until all necessary requirements are fulfilled to implement the self-direction of services. This includes, but is not limited to, verification of the provider's qualifications and completion and signature on all service agreements. If the member elects not to receive services using network providers, until all necessary requirements have been fulfilled to implement the self-direction of services, Amerigroup will document this decision and provide face-to-face visits with a Community-Based Case Manager or care coordinator at the frequency determined necessary to ensure the member's needs are met.

Provider Qualifications and Employment Agreement (4.4.8.11)

PPL will help assure provider qualifications are met and agreements are signed prior to enrollment and throughout the life of the employment relationship as specified in SOW Section 4.4.8.11. PPL ensures completion of criminal record checks and adult and child abuse registry check information. PPL's employer and employee profile logic defines the qualification to provide services and the services the employee is authorized to provide.

Member and Self-direction Representative Training (4.4.8.12)

The support broker will provide member and self-direction representative training that meets the requirements of SOW Section 4.4.8.12, including training in:

- The member's roles and responsibilities and those of a representative
 - Scheduling employees
 - Assisting with forms related to employees, including time sheets
 - Evaluating employees
 - Terminating employees
- Identifying resources to meet the member's self-directed service needs
- Developing a budget
- Managing and monitoring the budget
- Managing revisions to the budget
- Performing employer functions
 - Assisting with recruiting, hiring, training, and overseeing employees
 - Assisting with and approving job descriptions for employees
- Online tools training: BetterOnline™ Portal and Better@Work™ mobile app
- Critical incidents and how to report these
- Resolving disputes with employees
- Back-up planning

PPL has an extensive library of training materials developed for self-directed programs in other states that serve adults with physical disabilities, children with disabilities, individuals with intellectual and developmental disabilities, elders, and others that will be adapted for Iowa.

Monitoring (4.4.8.13)

Question 4.4, #7

7. Describe your approach for monitoring the quality of service delivery and the health, safety and welfare of members participating in the Consumer Choices Option.

In addition to the individual monitoring provided by support brokers and budget, expenditure, and provider qualifications monitoring provided by the FMS, Amerigroup will monitor the quality of service delivery and the health, safety, and welfare of members participating in the Consumer Choices Option through the following additional activities:

- We will hold weekly operational meetings and quarterly program meetings with PPL, an approach implemented successfully by our affiliate health plans, to discuss and develop ongoing improvements to internal processes resulting in a better experience for members enrolled in the Consumer Choices Option.
- We will also hold weekly calls to discuss members who have been referred for enrollment but have not initiated services. We will identify where in the process the member and his or her identified provider(s) are and if there are any barriers preventing the member or provider from completing the enrollment process. When barriers are identified, Amerigroup and PPL will discuss how to remove the barriers to complete enrollment. We will also maintain a dedicated employee to work with PPL in initiating consumer-directed services. This dedicated employee will serve as a liaison in the initiation process.
- In addition to our weekly calls, we will implement a consumer direction dashboard that enables us to track referral turnaround times. We will then use this information during our meetings with PPL to identify solutions to reduce turnaround times.
- Amerigroup will conduct interviews with members and representatives monthly and home inspections quarterly at a minimum to confirm that workers are acting in accordance with members' interests. We will develop interview and home inspection forms or checklists that must be completed by a member of our care coordination staff and entered into the care coordination and management system. Data from these activities will be reviewed to identify both individual issues that require follow-up with a member or his or her representative and program-level trends that require development of a quality improvement plan.
- Amerigroup can perform independent, real-time monitoring of support broker and FMS functions through PPL's web portal, which gives Amerigroup users administrative rights to review a member's self-directed activities and create reports reflecting the timeliness and accuracy of PPL's performance for specified functions.
- Amerigroup will conduct a participant satisfaction survey of program participants when a member elects to disenroll from the CCO or annually, whichever event occurs first. We will develop the survey tool with input from the Stakeholder Advisory Group and will produce and distribute an annual written report of findings to the Stakeholder Advisory Group, Quality Management and Improvement Committee, PPL, and LTSS team for review and identification of areas for improvement. We also will develop a performance improvement plan when indicated to be implemented by our Quality Management and Improvement program in conjunction with our Long Term Care/Care Coordination Manager.

Disenrollment from Self-direction (4.4.8.14)

Members may voluntarily disenroll from the CCO at any time. In addition, members may also be disenrolled when there is evidence of Medicaid fraud or misuse of funds or if continued self-direction poses a risk to the member's health or safety. Amerigroup will submit involuntary disenrollment requests to DHS for review and final determination. We will submit requests in the format required by DHS and include the information necessary for documentation of the rationale for termination to aid DHS' review and determination. In the event of disenrollment:

- Amerigroup will send a notice to the member regarding termination from the CCO following all policies and procedures established by DHS.
- The Community-Based Case Manager will facilitate a seamless transition from the CCO, helping assure that the member transitions to the standard HCBS waiver service model without interruption or gaps in service delivery.
- The member's Community-Based Case Manager will complete a reassessment and develop a new service plan with the member for traditional service delivery.

PPL will terminate the member in the PPL system, which will prevent any further payments (based on the Amerigroup notification of disenrollment from the CCO).

The Community-Based Case Manager may authorize interim HCBS waiver services to maintain the member in his or her community setting pending completion of a service plan, provider selection, and service authorization. This will reduce the potential for an interruption or gap in services for the member.

General Provisions (5.1)

Aggregate Cost-sharing Limit (5.1.1)

Question 5.1, #1

1. Describe your strategy for ensuring total cost sharing does not exceed five percent (5%) of quarterly household income.

Amerigroup Iowa (Amerigroup) agrees to comply with all cost-sharing provisions in accordance with 42 CFR 447.50 through 447.60, the State Plan, and the State's 1115 waiver for the Iowa Health and Wellness Plan. Amerigroup will track members' cost-sharing to make sure that in the event a member's five percent quarterly limit is reached, cost-sharing is no longer collected until the beginning of a new quarter, and the provider's reimbursement is adjusted accordingly. At that point, copayment amounts will no longer be deducted from claims reimbursement.

We will load income data that are provided to us by the State via daily 834 eligibility files to our claims processing system. Amerigroup tracks copayments through our Medicaid Management Information System (MMIS) on a quarterly basis. We track payments from both members and vendors that make payments on a member's behalf. If the five percent limit for the household is reached, all cost-sharing incurred by all household members is included in the calculation, as noted in Scope of Work (SOW) Section 5.1.1. Amerigroup will notify providers of members' financial participation or cost-sharing requirement and submit this methodology to DHS for review and approval.

We acknowledge that any cost-sharing imposed on Iowa Initiative Members must be in accordance with State and federal policy, as described in SOW Section 3.2.15.3 Cost Sharing and Patient Liability.

Conditional/Potential Members

All new members will be considered conditionally eligible for the first 60 days; new member information will be sent by the State on a Conditional Eligible 834 file. Upon receipt of the conditional 834 eligibility files, Amerigroup will mail fully eligible members a Welcome Packet that includes the following:

- Member Handbook
- Welcome Packet Insert — Please Read
- Welcome Packet Insert — Provider Directory Request
- Welcome Packet Insert — PCP Selection Form
- Employer Contribution Notice
- Non-profit Contribution Notice
- Welcome Letter content based on the member's Plan enrollment and Federal Poverty Level (FPL)

Experience with Cost-sharing, Billing, and Collections

Our affiliates' experience with the Healthy Indiana Plan (HIP) 2.0 and other states has paved the way for us to implement industry best practices for both cost-sharing and billing and premium collections.

For the past seven years, our Indiana affiliate has successfully administered cost-sharing and billing and collection services for the Healthy Indiana Plan. The plan's current enrollment is 25,800, with 16,500 caretaker members (families with children) and 9,300 members (individuals). An average of 15,600 members makes monthly contributions to their POWER accounts, similar to paying monthly Medically Needy premiums. Members are adults ages 18 to 64 and their dependents who are not eligible for employer coverage or Medicaid; have not had insurance coverage for the previous six months; and have a family income at or below 200 percent of the federal poverty level. The plan is responsible for billing and

collection, providing notices regarding member status including delinquent payments, and terminating members for non-payment. It accepts payments by mail, telephone, and online using electronic bank withdrawal, and has an arrangement with a large national chain of retail stores that will accept cash and debit card payments from members. Additionally, employers can pay up to 50 percent of a member’s premium, and the health plan can arrange an automatic payroll deduction for members.

Public Notice (5.1.2)

Question 5.1, #2

2. Describe processes for making information on premium and cost sharing available to both members and providers.

Making Cost-sharing Information Available

In accordance with SOW Section 5.1.2 and SOW Section 13.4.8 Member Financial Participation and Cost-Sharing, Amerigroup will provide the following information to both providers and members:

- The groups of individuals subject to cost-sharing charges
- The consequences for non-payment
- Cumulative cost-sharing maximums
- Mechanisms for making payments for required charges
- A list of preferred drugs or a mechanism to access such a list if drug copayments are applied by Amerigroup

Amerigroup currently has policies and procedures that guide us in identifying members who are exempt from cost-sharing provisions.

Amerigroup’s electronic member enrollment records include an indicator that reflects each member’s copayment status, which is updated with current information from DHS. Member identification cards are mailed within five days of receipt of the enrollment file from DHS.

New members with the no copayment indicator on the enrollment file automatically receive an identification card that indicates \$0 copayments, as illustrated in Figure 5.1-1. Existing members who reach their limits are noted through the inclusion of an indicator on the enrollment file that triggers an update to their electronic record and the automatic issuance of a new identification card indicating \$0 copayments.

Amerigroup will accumulate the cost share amounts for members. We will notify members in writing when their cost share maximum has been met for the quarter and provide instructions to call customer service if a member feels they have paid more than five percent of their family’s income for the quarter on healthcare. The letter will also include the effective date the cost share is met and inform the member they will have no further contributions or

Figure 5.1-1. ID Cards Will Clearly Identify Members with Cost-sharing Protections



copayments for the remainder of the quarter and that cost share will be reinstated at the beginning of the following quarter.

Our member and provider handbooks reference the cost-sharing and suspension processes. We inform providers cost-sharing is flexible and changes quarterly. The member handbook details how members may report their out-of-pocket expenses; what happens once we determine the cost share has been met for a quarter; what the member will receive; and how to access their information via the portal. We will continue to send the member an invoice but inform them that the actual premium amount due is suspended until the end of the quarter.

Amerigroup will also provide a cost-sharing calculator for our members via the member portal, which will allow members to login and view cost-sharing information as well as medical claims.

Provider Notification of Cost-sharing

Amerigroup will use several methods to make Network Providers aware of members' cost-sharing status. Our approach encourages optimal member service by offering providers several opportunities to confirm cost-sharing requirements when serving Iowa members, which results in reducing confusion and potential obstacles to care and services.

ID Card. As noted above, each member who is exempt from cost-sharing provisions is issued an ID card that indicates that copayments are not required. Amerigroup instructs providers to check member ID cards at each visit.

Monthly Summary Report. Each month, Amerigroup will deliver a listing of all members assigned to a PCP or medical home. Such rosters will include an indicator for members who are exempt from cost-sharing.

Provider Services. Provider Service Representatives can verify each member's cost-sharing status when checking eligibility by telephone.

Amerigroup continuously explores additional opportunities to share information with providers. We are currently developing other avenues for cost-sharing verification. For example, provider offices often verify a member's eligibility during an office visit through our voice portal. We are enhancing our provider voice portal to include automatic alerts for members who have no copayments. We are also upgrading our provider website tool to enable secure, real-time viewing of each member's copayments status when the provider office checks eligibility online.

Amerigroup will continue to identify and implement innovative tools to enhance the experience for both members and providers, including processes related to protecting members with no copayments.

We propose that providers use the State eligibility site, or the eligibility portal, to determine whether or not a cost-sharing amount should be collected. This approach has worked successfully for our Indiana health plan. The portals will show if there is a copayment required at the time of service. HP, our Web Interchange partner, will update copayment requirements according to the quarter the cost share is suspended in the Web Interchange.

Healthy Behaviors Program (5.2)

Tracking Compliance to Healthy Behaviors Program

Amerigroup Iowa (Amerigroup) is excited to aid in the administration of the Iowa Healthy Behaviors Program, which allows members to have their premium responsibility waived in the first year after a member's enrollment. Our care model encourages member responsibility in their health and incentives have been an effective way to encourage that responsibility. We understand that member premiums will continue to be waived in subsequent years if members complete the healthy behaviors described below in their prior annual period.

Amerigroup will comply with the requirements in Scope of Work Section 5.2 Healthy Behaviors Program. We understand that each year, the State will submit its proposed protocols and standards for the Healthy Behaviors Program to CMS for subsequent review and approval. As a steward of the State's program(s), we will judiciously implement policies and procedures in support of this Program.

For all Iowa Health and Wellness Plan members enrolled in the Healthy Behaviors Program, we will track completion of healthy behaviors in our Medicaid Management Information System and will educate members on both the benefits and importance of completing healthy behaviors. Amerigroup is aware that according to the current Program standards, to participate in the Healthy Behaviors Program and avoid paying a monthly contribution, Iowa Health and Wellness Plan members must:

- Get a **wellness exam** (annual physical) from a healthcare provider
- Complete a **health risk assessment**

Our healthcare analytics systems and care coordination processes enable us to track member completion of the healthy behaviors, tie premium collection in the subsequent enrollment year based on member's completion of healthy behaviors in the previous year, and educate members on the importance and benefits of healthy behavior completion.

We understand that members are granted a 30-day grace period after their enrollment year to complete their healthy behaviors and qualify for a contribution waiver.

Copayments (5.3)

Question 5.3, #1

1. Indicate if you propose to implement State Plan copayments on populations in addition to the Iowa Health and Wellness Plan and *hawk-i* members.

Amerigroup Iowa (Amerigroup) intends to impose copayments for Iowa Health and Wellness Plan participants in accordance with the State's 1115 waiver and *hawk-i* members in accordance with the State's CHIP Plan.

For all other enrolled populations, Amerigroup will impose copayments as outlined in the State Plan, *with the exception of the following three categories in which copayments will not be imposed:*

- Generic/Preferred Brand Rx
- Psychologists
- Physician Office Visits

The elimination of copayments for these services reinforces Iowa's health goals to provide coordinated care and high quality outcomes.

Amerigroup will comply with all benefit, copayment, and cost-sharing provisions as required by the Contract and statutory and regulatory requirements.

During implementation, benefit packages will be configured, and those populations that do not have copayments will be configured into a benefit package where they are not taken. This process begins when Amerigroup receives the 834 eligibility files from the State, which indicate the status of the member and then translates in the system to a benefit package that will not take copayments or will take copayments depending on the eligibility status of the member. We have the infrastructure necessary to support benefit and cost-sharing provisions, including systems configuration, training, and development of policies and procedures that promote compliance with Iowa's requirements. We also understand that some members are protected from copayments and cost-sharing provisions, as described later in this section.

Amerigroup affirms our understanding of cost-sharing prohibition for those members who are exempt from participating in cost-sharing provisions. Further, we acknowledge and understand that certain families may reach their cost-sharing maximum and should be protected from paying additional cost-sharing amounts.

Exempt Populations (5.3.1)

Question 5.3, #2

2. Describe how exempt populations and services as outlined in Section 5.3.1 and 5.3.2 will not be charged copayments.

Copayments will be determined in accordance with the State Plan and federal regulations, specifically in accordance with 42 CFR 447.56. Amerigroup has implemented similar population exemptions from copayments in other states, and we will determine the appropriate benefit package for each member using the information provided by the State and DHS. Copayment information will be included in the member's benefit package and printed on the member's ID card. Pursuant to federal regulations, ***Amerigroup will not collect contributions or impose any other cost-sharing, including copayments for:***

- Individuals between the ages of 1 and 18 years, eligible under 42 CFR 435.118
- Individuals under the age of 1 year, eligible under 42 CFR 435.118
- Disabled or blind individuals under the age of 18 years eligible under 42 CFR 435.120 or 42 CFR 435.130
- Children for whom child welfare services are made available under Part B of title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age
- Disabled children eligible for Medicaid under the Family Opportunity Act
- Pregnant women during pregnancy and through the postpartum period, which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, in accordance with 42 CFR 440.210(a)(2) and 440.250
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs
- An individual receiving hospice care, as defined in section 1905(o) of the Social Security Act
- Non-urgent use of hospital emergency rooms by members who are identified as an American Indian pursuant to 42 CFR 447.51; the State will identify all American Indian members through the eligibility determination process

- Individuals who are receiving Medicaid by virtue of their breast or cervical cancer diagnosis under 42 CFR 435.213

Exempt Services (5.3.2)

Amerigroup's affiliates have implemented similar service exemptions from copayments in others states, and we will make sure copayments are not imposed for the following exempt services:

- Preventive services provided to children under age 18 years
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p) and counseling for cessation of tobacco use
- Provider preventable services as defined at 42 CFR 447.26(b)
- Family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act

Nonemergency ER Use (5.3.4)

In accordance with SOW 5.3.4 Nonemergency Use of Emergency Room, Amerigroup will impose an \$8 copayment for Iowa Health and Wellness Plan members' nonemergency use of an emergency room (ER) and a \$25 copayment for *hawk-i* member's nonemergency use of an ER.

A copayment will *not* be imposed on *hawk-i* members whose family income is less than 150 percent of the federal poverty level (FPL). To impose cost-sharing for nonemergency use of the ER, the hospital providing the care must first conduct an appropriate medical screening pursuant to 42 CFR 489.24 to determine the individual does not need emergency services.

Amerigroup will inform our provider network of the emergency room services copayment policy and procedure such as the hospital's notification responsibilities outlined below and the circumstances under which the hospital must waive or return the copayment. We acknowledge that, before providing nonemergency treatment and imposing cost-sharing for such services on an individual, the hospital must:

- Inform the individual of the amount of his or her cost-sharing obligation for nonemergency services provided in the ER
- Provide the individual with the name and location of an available and accessible alternative nonemergency services provider; if geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed
- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost-sharing amount; the assessment of access to timely services must be based on the medical needs of the enrollee
- Provide a referral to coordinate scheduling for treatment by the alternative provider

Amerigroup will:

- Inform an individual of the amount of his or her cost-sharing obligation for nonemergency services provided in the ER
- Provide the individual with the name and location of an available and accessible alternative nonemergency services provider; if geographical or other circumstances prevent us from meeting this requirement, cost-sharing may not be imposed
- Determine that an alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost-sharing amount; the assessment of access to timely services must be based on the medical needs of the enrollee
- Provide a referral to coordinate scheduling for treatment by the alternative provider

Inability to Pay (5.3.5)

We understand that members may notify providers that they are unable to pay a copayment. As indicated in SOW Section 5.3.5 Inability to Pay, providers may not deny care or services to any member because of his or her inability to pay the copayment. To enforce this policy, Amerigroup will proactively engage and educate providers, provide documentation in the Provider Manual, and assist members who report they have been denied services based on an inability to pay.

Proactively Engage and Educate Providers

In addition to having the people, processes, and systems in place for determining cost-sharing and member contributions and informing members of their responsibility, we will proactively engage and educate our provider network. Providers will need to understand how the Iowa Initiative works and program eligibility requirements such as extending member enrollment to 12 months and providing a 90-day grace period to members for premium payments.

Our Provider Representatives will be working on the ground with providers, and will help educate them on changes to the program. We will also use our communication media, such as blast faxes, provider newsletters, and our provider website, to disseminate educational information to our network providers regarding the program.

We will also include Medically Needy training in our regularly scheduled twice-monthly provider orientation and training seminars. Our approach will foster a positive message regarding members enrolled in this program and will help members and their families find the primary care provider (PCP)/medical homes they need for quality healthcare.

Claims Payment (5.3.6)

Helping assure that provider payments are accurate and timely is an Amerigroup priority, as it is a key component of provider satisfaction. Payment and cost-sharing tracking is built into our claims payment systems and processes.

In accordance with SOW Section 5.3.6 Claims Payment, Amerigroup will reduce the payment it makes to a provider by the amount of the member's copayment obligation, regardless of whether the provider has collected the payment or waived the cost-sharing, except as provided under 42 CFR 447.56(c).

Please see Section 13.4 for a complete description of Amerigroup's Claims Payment and Processing best practices.

Patient Liability (5.4)

Question 5.4, #1

1. Describe your proposed methodology for notifying providers of the patient liability amount and paying providers net of the applicable patient liability amount.

Our affiliate health plans have a wealth of experience in administering benefits that include patient liability, and our team already has a solid understanding of the current patient liability requirements in Iowa. Each state has different requirements, and we tailor our operational processes for each one.

Our methodology for notifying providers is embedded in our established policies and procedures to make sure that members pay their patient liability. We understand that Iowa will notify us via the State's 834 files of any applicable patient liability amounts that are a member's responsibility.

In turn, Amerigroup Iowa (Amerigroup) will communicate the patient liability amount to our providers and delegate collection of patient liability to Network Providers, as appropriate. Amerigroup will pay our providers the net of the applicable patient liability amount.

Performing Required Tasks and Functions

Amerigroup will adapt our current protocols as necessary to reflect the process for collecting patient liability amounts that will be outlined in the contract. We will apply our best practices and standards that have been successfully deployed for similar programs. We fully anticipate that our current infrastructure and experience will enable compliance with Iowa's contract requirements.

For example, our provider agreements and provider manual will include a provision that acknowledges the member may have patient liability responsibilities and that the reimbursement from Amerigroup to the provider will automatically deduct any patient liability amount, as appropriate.

To illustrate our capabilities, in Tennessee, Amerigroup's affiliate is required to administer patient liability requirements for members who meet criteria and receive Long Term Services and Supports (LTSS), including those residing in a nursing facility and those receiving home and community-based services (HCBS) as an alternative. The State provides relevant patient liability data in its daily enrollment file, including the member's monthly liability amount. Amerigroup's Tennessee affiliate maintains discrete processes for nursing facility and HCBS providers, each of which we describe below to illustrate the depth of Amerigroup's capabilities for the Iowa Initiative.

As always, members who need additional assistance understanding their obligations or navigating the program can engage a Member Advocate from the health plan to assist them throughout this process.

Patient Liability for Nursing Facilities

We recognize that some members residing in a nursing facility or Intermediate Care Facility for people with Intellectual Disabilities (ICF/ID) have a patient liability that must be met prior to Medicaid services reimbursement. If a nursing facility or ICF/ID is considering discharging a member due to non-payment of the patient liability, Amerigroup will work with the nursing facility to remediate the issue and/or assist in locating an alternate nursing facility or ICF/ID willing to



Amerigroup will train our employees, including Case Managers, LTSS Service Coordinators, and Member Service Representatives, as well as our network providers on all requirements related to patient liability so that we can educate and support our members and providers.

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serve the member and document these efforts, in accordance with SOW Section 4.3.12.2 Client Participation Assistance.

Amerigroup's affiliates cover nursing facility services in several markets: California, Florida, Kansas, New Jersey, New York, Tennessee, Texas, and Virginia. Due to the unique nature and complexity of nursing facility claims, we maintain a specialized team to process and monitor claims and ensure that timeliness standards are met. Amerigroup has developed the experience, institutional knowledge, policies, and procedures necessary to meet the State's processing standards. Our knowledge will be leveraged in the Iowa program to ensure the prompt and accurate payment of nursing facility claims.

Amerigroup acknowledges understanding of the requirement to collect the member's portion of the rate for nursing facility care. We are successfully performing this function for our nursing facilities and maintain a process to deduct patient liability collected by providers. We work closely with our members and providers to help them understand the process.

Amerigroup works to ensure that no provider bills a member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost-sharing and patient liability.

Patient Liability for HCBS Providers

Amerigroup understands that HCBS providers who provide waiver services are also subject to patient liability requirements and that the primary provider is responsible for collecting the patient liability. For members with multiple providers, we will coordinate collection with those providers. Our affiliate in Tennessee has established a best practice for applying patient liability amounts that we may consider in Iowa. In any case, Amerigroup will comply with all State requirements.

HCBS providers are often small businesses that rely on a strong cash flow to thrive in their community. Amerigroup affiliates' best practices in other markets reinforce the financial viability of our HCBS providers by directly billing members receiving HCBS for their patient liability amounts. HCBS providers are paid in accordance with their contracts, and the affiliate bears the risk for member payment of their liability amount each month.

To illustrate how we may opt to conduct this for the Iowa Initiative, we look to our Tennessee affiliate experience. Community-Based Case Managers work with members to educate them as necessary about their patient liability requirements, including their monthly obligation, and support them in developing a payment plan. Each month, the health plan sends an invoice to the members for their patient liability amount and directly collects payments from members.

As with nursing facilities, the Community-Based Case Manager will work with members and their families or representative to resolve non-payment of patient liability amounts. In the process, the case manager will also verify that those members' finances are not being misappropriated by family or representative. The case manager supports the member to identify and try to resolve barriers to payment. For example, the case manager may refer the member to the local Center for Independent Living that offers budget and financial management training. Our staff will apply best practices and work with HCBS providers to address issues related to patient liability.

Balance Billing

Amerigroup will comply with all requirements addressed in SOW Section 5.4, Patient Liability and SOW 3.2.15.3 Cost Sharing and Patient Liability. In accordance with 42 CFR 438.106, Amerigroup and our contracted Network Providers will not hold members liable for any of the following:

- Covered services provided to the member for which DHS does not pay Amerigroup
- Covered services provided to the member for which DHS or Amerigroup does not pay the provider that furnishes the services under a contractual, referral, or other arrangement
- Amerigroup's debts or our subcontractor's debts, in the event of the entity's insolvency

Providers contracted with Amerigroup may not “balance bill” our members, which means that members cannot be charged for covered services above the amount Amerigroup pays to the provider.

We Educate Members and Providers

We communicate, educate, and remind providers on member payment issues in a variety of modes and methods, including:

- **Provider agreements** — As part of the provider agreement, Amerigroup Iowa will specify the nursing facility's responsibilities regarding patient liability. Our contracts with providers will explicitly state that members may not be billed for covered services.
- **New provider education** — We train new providers who join the Network, and balance billing is one of many topics that we address.
- **Existing provider education** — We train existing providers through group seminars throughout the year and during one-on-one office visits at least annually; if balance billing is an issue, we review our policy and federal and State laws and regulations.
- **Provider policy and procedure manual (Provider Manual)** — We address balance billing in our Provider Manual, which is an addendum to the provider agreement.
- **Provider bulletins and other general communications** — If balance billing occurs as an issue across the Network, we include this topic in general provider communications such as provider bulletins and newsletters; if it is specific to an individual provider or small set of providers, we address the issue in a personalized letter and outreach.

By signing our participating provider agreement, providers acknowledge acceptance of payment from us as payment in full as a condition of participation in the Iowa Health and Wellness Plan and in the Amerigroup Network.

Prior to authorizing services with out-of-network providers, we will assure that they fully understand and accept the prohibition against balance billing. Our Provider Relations employees educate providers on prohibited practices and continuously monitor their activity. Providers must report and maintain a central record of amounts charged to members and billing activity related to services provided to a member. In addition, we educate members about the resolution and the consequences of signing waivers for non-covered services. Amerigroup will help a member recover payments for inappropriate charges and will repay the member if the recovery is not successful.

Working with Members

We inform members that they may not be balance billed. Members may contact our Member Services call center for assistance with billing issues. Our Member Services call center and Grievance and Appeals Department work with members to promptly resolve balance billing issues. Further, in accordance with SOW Section 3.2.15.3 and all related State and federal regulations (such as 42 CFR 438.106), we and our subcontractors will not hold members liable for any covered service or for our debts. Should members have questions regarding cost-sharing and patient liability, our Member Services call center staff is prepared to respond to member concerns or issues, as required in SOW Section 8.3.2, Helpline Staff and Knowledge.

New and Innovative Approaches

Amerigroup will have Community-Based Case Managers who specialize in serving either members in nursing facilities or those living in the community with HCBS waiver services. This specialization fosters expertise in delivering services and cultivating relationships with providers who have very different needs. For addressing patient liability, this specialization helps our Community-Based Case Managers understand the impact of collecting patient liability amounts from members. For example, Community-Based Case Managers build a solid understanding of the billing and collection practices of the nursing

facilities in which they visit members and can collaborate with them to enhance them as necessary to maximize payment of patient liability amounts.

IDPH Sliding Scale (5.5)

Question 5.5 #1

1. Describe how your organization will ensure the IDPH approved sliding fee schedule is implemented among network providers.

- Amerigroup Iowa (Amerigroup) understands that substance use disorder services are available to Iowa Department of Public Health (IDPH) participants based on a sliding fee scale and that sliding fees are determined on the basis of income and family size and standardized for all IDPH-funded treatment service providers. Further, we acknowledge that for all IDPH-eligible transactions, IDPH funds shall be the payment of last resort for IDPH participants.
- Amerigroup understands that we will receive a per member per month capitation payment for all enrolled members, with the exception of IDPH-funded substance abuse services, which are funded by federal block grant and State appropriations under the authority of IDPH.
- Amerigroup acknowledges that we will not bear the risk for the delivery of IDPH substance abuse services and that we will receive separate funding from DHS and IDPH. In addition, we understand we must meet distinct funding and service requirements while assuring close coordination of all services and supports. In accordance with SOW Section 5.5, Amerigroup will make sure that the following practices are enforced:
 - IDPH-approved sliding fee schedule will be implemented among Network Providers.
 - IDPH participant billing and collection procedures will be consistent with those established and provided by the IDPH.
 - Services funded partially or completely by IDPH will not be denied to a person because of the inability of the person or group to pay a fee for the service.
 - There will be no charge for missed appointments, but a one-time no-show fee, not to exceed an amount established by IDPH, may be charged to IDPH participants.
 - Amerigroup will work to identify and implement innovative tools to enhance the experience for both members and providers, including educating providers about the IDPH sliding fee schedule.

General Provisions (6.1)

Amerigroup Iowa (Amerigroup), along with our affiliate plans, is an industry leader in providing culturally competent network solutions for our state partners: solutions that recognize and support the needs and preferences of some of the most vulnerable citizens. Our provider network development and management is based on the experience we gain by being on-the-ground in the markets we serve; collaborating with providers, community leaders and advocacy groups; and listening to our potential members and their families describe the challenges they face as they maneuver the healthcare system. Building our network strategies around this feedback creates a strong foundation for the repeatable and sustainable success of our networks. When it comes to provider network development and maintenance, our results are strong:

Amerigroup appreciates how to build provider networks. In our organization’s last three significant builds, our affiliate health plans contracted more than 72,000 providers, as shown in Table 6.1-1.

Table 6.1-1. Amerigroup Affiliates’ Extensive Experience in Building Networks

Provider Type	Amerigroup Affiliates’ Recent Network Builds		
	Kentucky*	Tennessee*	Virginia*
Primary Care	5,672	2,167	7,765
Behavioral Health	2,452	1,348	5,783
Specialist	23,176	5,068	14,202
FQHC/RHC	207	101	87
Urgent Care	482	246	51
Hospital (including CAH)	113	52	74
Nursing Facility	10	166	159
LTSS/Ancillary	985	763	1,352
Totals	33,097	9,911	29,473

* Products in Kentucky were TANF/CHIP/BH; in Tennessee for east and west territory expansion products were TANF/CHIP/LTSS/BH/DSNP; in Virginia the product was MMP.

- **Providers count on Amerigroup for prompt payment.** Knowing that many of our providers are very reliant on payments they receive from us, we process payments at least twice per week and streamline our processes to support prompt claims payment. As an example from our affiliate health plans, for the first two months of 2015:

 - 96.7 percent of electronic claims from Florida Nursing Facilities were paid in 10 days
 - 99.9 percent of clean claims from Kansas Nursing Facilities were paid in 14 days
 - 99.9 percent of clean claims from Tennessee Home- and Community-Based Services (HCBS) providers were paid in 14 days.
- **Amerigroup members have high satisfaction with their health plan.** What our members think about us, as reported through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, represents the final measure of our success in building and maintaining strong provider networks. As illustrated in Table 6.1-2, the 2014 CAHPS survey shows that the average results across all of our affiliate health plans were meaningfully **above the NCQA 75th percentile target in all eight categories** for children and six out of eight categories for adults.

Table 6.1-2. Amerigroup Affiliates' 2014 CAHPS Scores Indicate Excellent Member Satisfaction

CAHPS Scores by Percentile (2014)		
Category	Adult	Child
Getting needed care	80.90	85.81
Getting care quickly	81.57	90.98
How well Doctors communicate	89.08	93.15
Customer Service	86.66	89.04
Rating of Healthcare	71.30	85.74
Rating of Personal Doctor	77.61	86.61
Rating of Specialist	79.84	86.76
Rating of Health Plan	73.80	86.80

As explained through our detailed answers in the remainder of this section, and as proven in the statistics above, Amerigroup stands ready to deliver a robust provider network that will meet the established January 2016 go-live date and will meet the needs of our assigned members throughout the life of our contract.

Provider Network (6.1.1)

Question 6.1.1#1

1. Describe how you plan to meet all network composition requirements.

Meeting Network Composition Requirements

Amerigroup will meet the Iowa network requirements by drawing upon the knowledge and experience our affiliates have gained over the past 24 years working in Medicaid and other state-sponsored programs across 19 states. Although simple sounding, we successfully build and maintain networks because we build care systems that serve members in their local communities.



An example of Amerigroup's focus on local solutions is the consultative relationship we developed with Wellmark, Inc.—which has served Iowans since 1939 when it was known as Blue Cross of Iowa—to help us improve our working knowledge of Iowa and its providers. Wellmark is assisting us in partnering with their Accountable Care Organizations (ACOs). Wellmark's intimate knowledge of the Iowa market has allowed us to gain an understanding of Iowa providers and programs and how they interact with members who will be covered under the Iowa Initiative. This has included brokering a discussion with 3M regarding their Value Index Score (VIS) product. Wellmark has assisted in identifying providers that are already in value-based purchasing arrangements so that we know how best to approach the

provider regarding similar arrangements with Amerigroup.

Building upon our Wellmark relationship, Amerigroup is fully engaged with Iowa-based providers, community groups, advocacy organizations, and professional associations. With an overarching commitment to driving improved health outcomes and quality of life for each member, these engagements allow us to better identify network opportunities so that we have the right providers available for our

members. Additionally, by having the right providers in our networks, we can fully integrate the member's physical health, behavioral health, and social services and supports across the spectrum of providers.

We appreciate the relationship the State has built with the University of Iowa. We understand the University of Iowa has been awarded a grant to ensure peer support specialists throughout Iowa are appropriately trained. Further, we recognize that the University of Iowa Health Alliance is a crucial provider of health care services to all Iowans. With that as the background, Amerigroup has engaged with the University of Iowa to establish a partnership that will bring the full array of the University's services and programs to our membership. In addition to acute and behavioral health services linkages, we look to collaborate on items such as:

- Disease prevention, early detection, and intervention
- Supporting transitions for children, youth, and young adults
- Living Well with a Disability training
- Applied Behavioral Analysis and autism services
- Improved health outcomes
- Improved quality scores
- Financial incentive models to incentivize better access to care, decreased medical costs, and improve quality scores
- Telehealth programs
- ACT (SAMHSA) pilot for people with intellectual and/or development disabilities with co-occurring behavioral conditions

As this partnership develops, we will work to realize the benefit of the expanse of department- based initiatives the University has already deployed within Iowa. While not meant to be an exhaustive list, we have interest in the departmental programs of the:

- Child Health Specialty Clinics
- Center for Disabilities & Development
- Center for Child Health Improvement & Innovation
- University Center for Excellence on Developmental Disabilities
- Department of Pediatrics
- Department of Psychology

To signify our commitment to work together, Amerigroup and the University of Iowa have executed a letter of intent and we have agreed to formal contract discussions in May. We are excited about this relationship and anticipate that partnering with the University of Iowa will allow for continued development and implementation of innovative real solutions that improve health and the quality of life for Iowa's most vulnerable citizens, while saving taxpayers money. We believe the efficiencies created and the increase in quality of care and services will be the measurement of success for this partnership.

Our network will include acute care providers, federally qualified health centers, rural health clinics, local health departments, and individual providers that may be strategically located in areas with high or scant concentrations of Medicaid recipients. Our successful network will include community mental health centers, substance use disorder providers, nursing facilities, assisted living facilities, centers for independent living, area agencies on aging, and providers who supply home improvements. Once contracted, our local teams will work closely with all providers—especially those less familiar with being part of a managed care system—so that they are successful within our network and for our members.

As part of our behavioral health network, we have adopted a strategy to develop robust capabilities in behavioral health telehealth and to reimburse services delivered via telehealth at the same rate as office-based services.

To fill in any remaining opportunities for provider types that we may need to consider, we will continue to obtain information about Iowa's providers who currently serve fee-for-service Medicaid members. Reviewing this group of providers will help us continue to identify potential gaps in our network, as well as allow us to cross-walk our membership with providers who may already be caring for our potential members. Once identified, we will work to pursue contracts with those providers.

With 24 years of experience in other markets, our Provider Services team has a great deal of success in helping fee-for-service providers and stakeholders understand and accept the benefits of managed care for members.

Network Development in Iowa to Date

Amerigroup will offer a high-quality, culturally-competent statewide network of providers for the January 2016 start date. Through the avenues described above, and use of GeoAccess® tools, we will demonstrate that our network composition will meet all of the requirements in Exhibit B of the Scope of Work.

Our provider network will have the capacity to enroll a membership of 250,000 members or more. As of April 15, 2015, our network development efforts have yielded Letters of Intent (LOIs) from an array of provider types, summarized in Table 6.1-3.



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Table 6.1-3. Amerigroup has Actively Engaged with Providers in Iowa

Provider Types	# of Provider Outreach	# of LOIs/Letters of Support	Approximate # of Locations Represented
Family Planning	17	6	35
Independent Rural Health Centers + Hospital Rural Health Center Affiliates	4	5	20
Federally Qualified Health Centers	40	13	40
Hospitals	123	12	21
Multispecialty Clinics	34	6	739
Health Departments/Public Health	101	26	30
Community Mental Health Centers	36	16	85
Behavioral Health Regional Centers	15	2	2
Home Care & Assisted Living	45	30	52
Skilled Nursing/Nursing Facility	25	26	53
Home Health	7	10	13
Centers for Independent Living	6	7	20

Although not referenced by name in the table, we have secured LOIs with **Broadlawns Medical Center**, **The Iowa Clinic**, **the University of Iowa Health Alliance**, and **Paramount Health Options**. We have also received a letter of support from **IowaHealth+**, who has also assisted in collecting letters of intent from

its member FQHCs. These provider organizations are significant for our network because of the depth and breadth of the services they will provide Iowa Initiative members.

By securing LOIs with these providers, we have established a valuable relationship that forms the foundation for completing a provider contract. With the reception Amerigroup has received during the plethora of provider conversations, we have full confidence in our ability to deliver a robust provider network to Iowa.

To date, we have had discussions with many key Iowa providers, including:

- **Catholic Health Initiatives**, where we are working with a number of providers
- **Unity Point**, which includes 873 providers statewide
- **Mercy Health Network** (including Trinity Health), which includes 1,330 providers statewide
- **University of Iowa Health Alliance** (Mercy Cedar Rapids, Genesis Health Systems, University of Iowa Health Care, Wheaton Franciscan Healthcare)

Furthermore, we have met with the **Iowa Health Care Association** and **Iowa Center for Assisted Living**, and joined them at their 2015 Spring Conference as a Conference Sponsor. More than 400 people representing nursing facilities, assisted living facilities and home health providers attended this conference.

Network Development Goals and Plans

Amerigroup's provider network development goal is grounded in the requirement that we are responsible for providing or arranging for the provision of any medically necessary covered service required by our members, whether specified by the Iowa Initiative documents or not. To that end, our focus is on understanding the provider network that currently serves Medicaid, hawk-i and the aged, blind and disabled populations, as well as assuring appropriate access to Long Term Services and Supports (LTSS) and pharmacies.

Amerigroup's network development plans have and will include:

- Review of our expected membership and its relation to the overall population distribution of the State
- Finalization of the number of providers, by type and location, which will be needed to properly support the depth and breadth of benefits we will administer with a focus on preventive and primary care services
- Refinement of the number of providers when consideration is given to access standards and travel distances that may currently be experienced by Medicaid members
- Engagement with providers who are currently serving Iowa Medicaid members through a combination of reviewing the current Medicaid network, reviewing Wellmark's existing network, and outreaching to providers in the community to understand their referral and use patterns
- Proactive communications with potential providers regarding our strengths and experience in all aspects of Medicaid, including our hands-on approach to provider services in a post go-live era and emphasis on our focused support of those providers who work extensively with waiver populations and LTSS
- Contract terms and conditions that clearly define Amerigroup's expectations of performance and hold all parties accountable to the success of the program
- Continuous monitoring and adjusting of our recruitment focus to confirm that the needs of all member populations and provider types are part of Amerigroup Iowa's network
- Proactive education that addresses provider needs including review of:
 - Member benefits associated with all population
 - Reimbursement practices, including prompt and accurate claims payment

- Technical assistance to help providers succeed, such as one-on-one training to minimize claim submission errors
- Practices aimed at simplifying operations and the provider's administrative burden, such as availability of electronic claims submission, electronic remittances, and electronic fund transfers

We view success as building and maintaining a provider network that addresses the entire continuum of care our members need and receive—from primary care to specialized healthcare services—reflecting our company-wide, member-centered, and family-focused mode of care and service delivery.

Providing Covered Services

We will be ready to assume responsibility for all preventive and primary care services, physical health, behavioral health, and LTSS, including HCBS waiver programs, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDs) services and supports for the Medicaid, hawk-i, and IDPH participant populations and as required by 42 CFR 438.206. Our approach includes establishing partnerships with existing providers and support systems across Iowa, providing a variety of proven and innovative healthcare programs that will improve outcomes for Iowa Initiative members, and building a close relationship with DHS to promote program success. We create a stable environment through our focus on continuing care delivery by recruiting existing providers, which will allow activities in progress at transition to continue uninterrupted and rapidly bring members receiving ongoing services under our Care Coordination practices. We attribute much of our success to the respect providers have for Amerigroup and our focus on partnership to deliver quality care to our members.

Amerigroup maintains a singular focus on managing publicly-funded health and social support programs. Through our affiliates, we serve more than 5.2 million members in Medicaid other state-sponsored health programs, including nursing facility residents, HCBS program participants, and individual dually eligible for Medicaid-Medicare benefits. The scope of our proposed efforts for the Iowa Initiative reflects our *depth of affiliates' experience across similar populations and benefits*, including a wealth of programs and protocols tailored to the distinct needs of each population we serve.

Experience with Iowa Initiative Covered Services

Amerigroup brings to Iowa extensive experience coordinating and delivering a wide range of integrated benefits and services to diverse Medicaid populations. Table 6.1-4 summarizes our affiliates' membership by population and service to illustrate the depth of our expertise working with individuals, benefits, and providers similar to those in Iowa. *As Table 6.1-4 illustrates, through our affiliates, we are currently serving every population defined in the Iowa Initiative.*

Table 6.1-4. Amerigroup Affiliates Deliver Integrated Benefits to More than 5.2 Million Members*

Amerigroup Health Plans and Programs they Serve, by State											
	Medicaid	CHIP	Foster	Dual Demos	ABD	SMI	ID/DD	AIDS/HIV	TBI	ACA Expansion	LTSS
CA	✓	✓		✓	✓		✓	✓		✓	✓
FL	✓	✓	✓		✓		✓	✓	✓		✓
GA	✓	✓	✓								
IN	✓	✓	✓		✓						
KS	✓	✓	✓		✓	✓	✓		✓		✓
KY	✓	✓	✓		✓					✓	
LA	✓	✓	✓		✓						
MA		✓									
MD	✓	✓	✓		✓					✓	
NV	✓	✓				✓				✓	
NJ	✓	✓	✓		✓		✓	✓	✓	✓	✓
NY	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
SC	✓				✓			✓			
TN	✓				✓		✓	✓			✓
TX	✓	✓		✓	✓		✓				✓
VA	✓	✓	✓	✓	✓	✓	✓				
WA	✓	✓	✓		✓					✓	
WV	✓				✓		✓				
WI	✓				✓						
Total	4.1 million	334,000	41,000	15,000	470,000	250	23,000	10,000	2,100	461,000	202,000

* Membership numbers presented above are inclusive of membership as of December 31, 2014 for our parent company Anthem, Inc. and its state sponsored health plans. Members may be counted in more than one category and numbers are rounded. In addition, in February 2015, our parent company completed the acquisition of two Florida managed care organizations, Simply Healthcare Plans, Inc. (Simply) and Better Health, Inc. (Better).

Our affiliates have a long history in designing and implementing state-specific programs, including those covering populations such as Iowa's HCBS waiver program. We design each program to reflect the local community and state goals and objectives. Our core strengths in benefit and service integration across all populations include:

- **Physical and behavioral health integration** offering member-centered physical and behavioral health programs that holistically coordinate a tailored array of care and services for each individual member, including social and community supports
- **Dedicated and integrated Pharmacy Department** that brings together prescription drug management with Care Coordination, and offers members convenient access to pharmacy benefits that maximize quality and health outcomes in the most cost effective manner
- **Long term services and supports** that are integrated and coordinated with physical and behavioral health services while incorporating highly specialized assessment and service coordination tools with member involvement and direction—supporting members to remain in control of their health
- **Management of nursing facility care** that focuses on diversion and reintegration as well as care and service planning for the nursing facility stay

- **Clinical and data systems** that support efficiency and precision in coordinating benefits across multiple settings

Capacity to Meet the Needs of Covered Populations Network Development and Contracting

Our Provider Services Department has primary responsibility for developing, managing, and monitoring our provider network. Our network development and contracting approach complies with all DHS guidelines and requirements for Iowa Initiative members. In developing, administering, and monitoring the network, we will not discriminate with respect to participation, reimbursement, or indemnification against any provider who is acting within the scope of his or her license or certification under applicable state law solely on the basis of that license or certification. We do not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Recognizing our responsibility to provide members with accessible services and a choice of providers, we strive to be proactive in network development and management – carefully identifying and planning for potential network gaps before they become an issue. We regularly review our provider network design and distribution to determine if there are opportunities for improvement. In addition, we monitor member complaints around access and review requests for authorizations from non-participating providers to identify gaps. Most network gaps are the result of providers ceasing to do business, leaving the service area, closing their panel to additional members, or losing their credentials. ***Across our affiliate plans, voluntary turnover rate for providers disenrolling from the network is less than one percent.*** When we identify network gaps or the potential of a network gap, Amerigroup uses a variety of integrated and comprehensive intervention strategies to quickly fill these gaps. For example, our Iowa Provider Solutions team will provide outreach to targeted providers or provider types to discuss network participation.

We developed a five-step process for network development and contracting, presented in Table 6.1-5.

Table 6.1-5. Amerigroup’s Proven Network Development and Contracting Process

Step	Activity	Methodology
1	Identify providers in the coverage area	We identify potential providers through input from our internal staff (including member outreach, provider services, and medical management); existing network providers; our members and their families; community-based organizations; advocates; and listings from applicable regulatory boards of licensed providers. We will also identify providers who are not enrolled in the Iowa Initiative and encourage their participation. In addition, our website provides contact information for providers who may be interested in joining our network.
2	Contract with providers	Our Provider Engagement and Contracting Representatives contact providers, often in-person, to explain the program to them, answer any questions, and obtain signed agreements.
3	Credential providers	We then verify the credentials of providers through our NCQA-approved credentialing process. (Section 6.1.3 for additional details regarding our credentialing and recredentialing process.)
4	Approve providers	Once credentialing is completed and the provider has been approved by the Credentials Committee, we continue with the administrative process of contracting. We verify the W-9 and state-mandated Professional or Facility Applications for completion and accuracy. Once we verify all documents, the Provider Engagement and Contracting Specialist receives the packet and applies an effective date of 30 days in the future. The specialist is required to submit all necessary documents (contracting checklist, rate sheet, provider contract and any amendments, state-mandated professional or facility application form for each participating provider, and W-9) through the tracking database within 10 calendar days of receipt. We load the provider’s contract information into our network database. This sets the provider up for inclusion in our Provider Directory and identifies the provider for future provider communications.

Step	Activity	Methodology
5	Educate providers	We invite all newly contracted providers and their office staff to participate in orientation training. The orientation sessions will be extensive and will include in-service, face-to-face training to communicate all applicable DHS and Amerigroup policies, procedures, rules, regulations, and expectations. We also identify available resources and appropriate methods of communication with Amerigroup. We will offer various times and locations as well as webinar opportunities to attend presentations as part of our initial provider orientation activities and also on an ongoing basis throughout the year. As part of the orientation, our staff provides an overview of the Provider Manual, which will incorporate all DHS and Amerigroup policies and procedures relevant to the operations of the provider office in the delivery of covered services to our members. More information on our education and training procedures can be found in Section 6.1.6.

Serving Expected Enrollment

Amerigroup’s fully scalable operations will enable us to effectively identify and contract with providers who can serve Iowa Initiative members across all enrollment categories. Our experience with diverse populations and comprehensive benefit packages through our affiliates in other states have led us to anticipate Medicaid enrollment, evaluate member preferences, and thoroughly develop and refine our unique capabilities required to efficiently deliver covered services, including primary and preventive services, while improving health outcomes. Our local, community-based managed care model is based on national program knowledge and expertise developed throughout our organization’s 24-year history. Our health plans share best practices to support and further improve innovation and program development for our customers.

For example, we have implemented and thoroughly tested the necessary solutions to promote independent living for seniors and people with disabilities. Our employees use our iPad®-based CareCompass Mobile tool to support field-based assessment and management of individuals who need LTSS, enabling them to personally connect with and engage members who have the most extensive care coordination needs. A more complete description of CareCompass Mobile can be found in Section 3.2.4.

Another example of our expertise with diverse populations and benefits is our fully integrated care coordination model. Our model facilitates greater member engagement and self-management of varying and often inter-related medical, behavioral, social, and functional conditions resulting in overall improvements in health status and well-being.

For members with serious mental illness (SMI), HIV, or traumatic brain injury that also have two or more identified chronic conditions, or who have one chronic condition and are at-risk for a second; we will provide Health Homes to integrate services around the member, as outlined in Table 6.1-6.

Table 6.1-6. Amerigroup Services that Support Health Homes

Amerigroup Services Supporting Health Homes	
The Amerigroup Health Home Coach	Specialty Care Providers
Community-based Providers	Social Support

In addition, we are experienced in coordinating acute care services for individuals with intellectual and/or developmental disabilities, especially collaborating with various state agencies and community organizations to address the diverse needs and preferences of this population. Amerigroup will leverage our affiliates’ extensive LTSS experience and capabilities to address the unique needs our members, such as tailored health risk and care management assessment. While the specific care pathways for these members will differ somewhat from other populations, our proven approach and infrastructure to identify, assess, and coordinate care and services for this population is well established and fully replicable in Iowa.

Question 6.1.1, #2

2. Describe any counties or areas of the state and any provider types in those areas where you anticipate facing network development challenges. Discuss your mitigation strategies.

Network Development Opportunities

Through our extensive analysis and discussions with Iowa providers and stakeholders in the Iowa Initiative, we understand the challenges that exist for members when they attempt to seek services in a State where 36 percent of the population lives in rural areas. Additionally, as mentioned previously, we know from discussions with advocacy groups and provider groups there are areas of the State that are challenged in providing members a robust array of services, particularly in primary care, behavioral health, certain specialties, and transportation.

Health Professional Shortage Areas exist across Iowa. For instance, for primary care providers, there is a shortage in 40 counties according to the Iowa Department of Public Health (2014 data), and a shortage of rural health clinics in 47 counties according to the Iowa State Office of Rural Health (2014 data). For behavioral health services, 89 of all 99 counties in Iowa have a shortage of behavioral health providers according to the Iowa Department of Public Health (2014).

In addition, several Iowa counties are considered Medically Underserved Areas, including but not limited to Franklin, Tama, Audubon, Palo Alto, Fremont, Lucas, Monroe, Decatur, Wayne, Van Buren, and Appanoose counties, according to the Iowa Department of Public Health (2012 data).

Mitigation Strategies

Members who are a part of the Iowa Initiative will require appropriate and timely access to the broad range of services covered under the program. When access may pose an obstacle to service delivery, we will use several tactics to mitigate these challenges, including:

- Speaking with existing network providers regarding the potential of them expanding their services and/or locations
- Using our LTSS Community-Based Case Managers/Care Coordinators to help identify potential providers to contract with to assist in meeting the needs of our members
- Having our Provider Services staff personally visit locations around Iowa to make sure we are getting real time, real situation information and not simply relying on a list of providers
- Reviewing any provider list that DHS maintains for the fee-for-service program to make sure that we have contacted all providers who currently provide services within the Medicaid program
- Encouraging the use of telemedicine in rural or underserved areas to connect members to care (in compliance with Iowa rules and regulations)
- Contracting with nurse practitioners
- Establishing single case agreements with providers, when necessary, to augment services

Closing Network Gaps – Specialty Services

When we encounter barriers or gaps in our Iowa network, we will take specific action so that no member is without adequate coverage. Options include:

- Transporting the member to a surrounding county for care
- Encouraging geographic expansion of existing network providers
- Facilitating the use of mobile services
- Adopting telehealth monitoring programs

- Contracting with additional available providers, using single case agreements if necessary to expedite delivery of critical care

Provider Services will monitor our network through GeoAccess mapping. If a Care Coordinator has difficulty obtaining services from a network provider, he or she will notify Provider Services and often will offer names of providers for consideration. Our priority is to obtain immediate services for our members, usually through a single case agreement. After we resolve the urgent need, the Provider Services team will initiate contract discussions.

Mitigating Primary Care Challenges

Given the current shortage of PCPs in Iowa, as well as the number of PCPs who are age 55 and older, Amerigroup will work closely with DHS to offer solutions. Solutions may include:

- **Working with medical schools to educate students on primary care shortages** and advantages of working in rural areas (including the assistance they can gain in paying back student loans)
- **Partnering with rural health centers, hospitals, and public health departments** to collaborate on solutions for health care services, such as rotating provider clinics for both primary and specialty care
- **Considering higher reimbursement rates** for providers who would rotate in specialty/mobile clinics in a critical access hospital
- **Strengthening skills of PCPs and OB/GYNs related to behavioral health.** We will work to strengthen the skills of our PCPs and OB/GYNs in identifying and treating behavioral health and substance use disorders. These are often the first providers to recognize a behavioral health or substance use disorder issue. In areas with few behavioral health providers, PCPs and OB/GYNs may often be the treating provider for such conditions. Amerigroup gives these providers guidelines for depression screening and sample screening tools to facilitate the process. Our affiliate health plans launched annual webinar training to further strengthen PCP skills related to screening, treatment, and referral to specialists for members with behavioral health conditions. The training educates PCPs on:
 - Behavioral health conditions typically treated in a primary care setting
 - Screening of mental health conditions for substance use disorders
 - Communication with behavioral health providers
 - Referral to behavioral health specialists, including when to refer and how to identify appropriate behavioral health providers
- **Paying PCPs** who extend office hours to provide primary care to our members outside of normal operating hours

CareMore Model



By introducing CareMore, an Anthem affiliate, Amerigroup will offer the State a breakthrough model of care delivery that combines wellness, medical supervision, and a revolutionary approach to member engagement and participation. CareMore's PCPs, acting as primary care team leaders, and their extensivists, guide members through every step of an integrated health care journey, regardless of the setting—facility-based, within the home, or outpatient—thereby managing acute and chronic events from beginning to end to assure continuity of care. CareMore uses the expertise of physicians, nurse practitioners, behavioral health and other specialty clinicians, and social support experts who are adept at managing the experience of our members in body, mind, and spirit.

The CareMore experience will include at least one physical location, starting with a facility centrally located in the Des Moines market. It will be a central part of the community it serves. The location will be equipped to provide highly responsive care and provide an opportunity for members to connect with their

health care team and participate in individualized support, preventive care, disease management, and health education. More information about CareMore can be found in Section 3.2.4.

Mitigating Behavioral Health Challenges

Amerigroup will offer telemedicine services for behavioral health services throughout the State to address the potential gaps within the network. This will include identifying partners to become originating sites for telemedicine, such as hospitals, rural clinics, and health departments.

Mitigating Transportation Challenges

Amerigroup will work with our transportation vendor, Logisticare, to develop solutions that address potential gaps that we have learned are an issue in Iowa. This includes identifying local transportation choices where we could reimburse for non-emergent transportation, which includes working with providers, senior centers, or emergency medical service companies to assist with expanding transportation. Additionally, as a Value-Added Service, we will cover up to 10 round trips to transport eligible members and their families to therapeutic appointments.

Single Case Agreements

Providing our members with appropriate and timely access to care is vital. In some instances our members may need to seek treatment from a provider that is out of the area or State, or not participating in our provider network. We use a defined process for handling these types of cases to assure the member is receiving needed treatment in a timely manner. When we become aware of a request for a member to see a non-participating provider, our clinical employees follow strict protocols to confirm continuity of care and medical necessity. They also check for sanctions against the requesting provider. Our local Provider Services staff works directly with the practitioner to complete any necessary paperwork (single case agreement) to document the authorization and reimbursement details. Should a member need an evaluation for transplant services, we have a team of clinicians that work to locate centers of excellence to assure members have access to quality healthcare.

Provider Agreements (6.1.2)

Question 6.1.2 #1

1. Describe your process for reviewing and authorizing all network provider contracts.

Reviewing and Authorizing Provider Agreements

Amerigroup has an established process for reviewing and authorizing all network provider agreements. Our provider agreements will be reviewed and approved by DHS. We will use a standard Medicaid contract for all providers, in compliance with requirements set forth in Scope of Work (SOW) Section 6.1.2 Provider Agreements.

Our provider agreements will meet all State of Iowa (including RFP requirements) and federal language requirements, as well as accrediting agencies' contract requirements. Our provider agreements state the terms and conditions of the agreement, including effective date, the responsibilities of Amerigroup and the participating provider, as well as specified healthcare services for which the provider will be responsible, including any restrictions or limitations. We describe our comprehensive credentialing process in Section 6.1.3 Provider Credentialing.

Our legal department prepares any changes required in provider agreement templates, and we will submit all changes for approval by DHS before they are used with providers. Across many functional areas—Regulatory Services, Compliance, Legal Services, Provider Services, Provider Solutions, Network Management, and Utilization Management—our employees identify any new state or federal requirements, requests by providers, or other pertinent updates that would affect the provider agreement

template. These subject matter experts will be a major part of managing projects, implementing benefits, and understanding accreditation, clinical, and business requirements under the Iowa Initiative.

We will submit any changes to the sample provider agreement to DHS for approval. Depending on the change, the following may occur with existing contracted providers:

- Amendments sent to impacted providers via unilateral amendment notification procedures identified in the provider's agreement
- Notice in a provider bulletin outlining the changes and faxed to providers as well as placed on our provider website
- New agreements sent to providers for signature
- Amendments sent to the providers for signature
- Necessary modifications made to the Provider Manual

Provider Agreement Requirements

Amerigroup provider agreements meet all requirements set forth in SOW Section 6.1.2 Provider Agreements. Our agreements also specify that the provider will be required to:

- Assure continuation of member benefits
- Cooperate with Quality Management and Improvement activities
- Permit access to medical records to the extent permitted by state and federal law
- Maintain the confidentiality of member information and records
- Comply with the affirmation statement indicating that the provider may freely communicate with patients about available treatment options, including medication treatment options, regardless of benefit coverage limitations
- Provide timely notification to members affected by termination of a provider or an entire provider group
- Comply with provider non-discrimination statements and meet all regulatory requirements so that members are not discriminated against in the delivery of healthcare services
- Comply with administrative policies and procedures, including payment systems, utilization review, quality assurance and improvement, credentialing, confidentiality, medical management, sanctions, member grievance, and other specified programs

Amerigroup's agreements contain a provision that includes definitions for all terms used in the agreement that have specific client, managed care, member payment, and provider payment meanings. Contracts used with nursing facilities and HCBS providers will contain the specific language that has been outlined within the Scope of Work.

We will notify DHS of any risk sharing agreements we enter into with providers. If providers receive a capitation payment, their contracts will state that all encounter data must be submitted to Amerigroup within 90 days of the date of service. When negotiations with a provider result in changes to the standard pre-approved contract, those changes are reviewed by different levels of management within the company to assure the suggested change is appropriate. If negotiation with a provider results in substantive changes to the base contract, that contract will be filed and approved by DHS before it is executed by Amerigroup.

Nursing Facility Provider Agreements (6.1.2.1)

Amerigroup's provider agreements include the following requirements for nursing facilities:

- Promptly notify Amerigroup of a member's admission or request for admission to the nursing facility as soon as the facility has knowledge of such admission or request for admission
- Notify Amerigroup immediately if the nursing facility is considering discharging a member and consult with the member's Care Coordinator
- Notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with State and federal requirements
- Comply with responsibilities regarding patient liability as described in Section 5.4 and acknowledge that the State has sole responsibility for determining patient liability amount
- Notify the Contractor of any change in a member's medical or functional condition that could impact the member's level of care eligibility for the currently authorized level of nursing facility services
- Comply with federal Preadmission Screening and Resident Review requirements to provide or arrange to provide specialized services and all applicable Iowa Law governing admission, transfer, and discharge policies

In addition, our provider agreement includes language that allows for automatic termination of the agreement if the nursing facility is involuntarily decertified by the State or CMS.

HCBS Providers (6.1.2.2)

Amerigroup's provider agreements include the following requirements for HCBS providers:

- Provide at least 30 days advance notice to Amerigroup when the provider is no longer willing or able to provide services to a member and to cooperate with the member's Care Coordinator to facilitate a seamless transition to alternate providers
- Continue to provide services to the member in the event that a HCBS provider change is initiated for a member, regardless of any other provision in the provider agreement, in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by Amerigroup, or as otherwise directed by Amerigroup, which may exceed 30 days from the date of notice to Amerigroup
- Immediately report any deviations from a member's service schedule to the member's Care Coordinator
- Comply with the critical incident reporting requirements as described in SOW Section 10.4.2
- Comply with all child and dependent adult abuse reporting requirements

Question 6.1.2 #2

2. Provide sample provider agreements.

Amerigroup Iowa has developed its Provider Agreement for the Iowa Initiative in accordance with all RFP, DHS and other State and federal requirements and includes a sample provider agreement in Tab 6 as Attachment 3.2.7.5-4.

Question 6.1.2, #3

3. Indicate if you propose to impose any requirements for exclusivity agreements for quality or payment purposes.

At this time, Amerigroup does not intend to introduce exclusivity agreements for quality or payment purposes into the Iowa market, as we believe these can ultimately limit our ability to create integrated care models. With that said, Amerigroup will develop and implement value-based purchasing arrangements and incentive programs that assist in improving the quality of care rendered to our members.

Question 6.1.2, #4

4. Propose the percentage of provider contracts that will be consistent with value-based purchasing by January 1, 2018 and specify the percentage annually for each year thereafter. Will you move into value-based purchasing before 2018?

Value-based purchasing (VPB) and incentive programs that link provider payment to improved performance are a cornerstone in our work with our provider network. As described more fully in our response to Section 10.3, our value-based purchasing programs cover a wide range of provider types, from primary care to attendant care and from small providers to ACOs. We propose implementing several different provider incentive programs, including:

- ACO Shared Savings / Shared Risk
- PCP Quality and Access to Care
- Behavioral Health – Community Mental Health Centers
- Personal Attendant Care
- PCP Quality and Population Management
- OB/GYN - Birth Outcomes
- Nursing Home Facilities

Amerigroup's affiliates have extensive experience in developing and administering value-based purchasing programs, such as our PCP Quality and Population Management Incentive Program which drives improvements in quality and service delivery while appropriately managing costs. It began as a pilot program in our Georgia and Tennessee health plans in 2010 with positive results. This program works to:

- Improve targeted clinical quality results
- Promote quality, safe, and effective patient care across the healthcare delivery system
- Improve provider operational efficiency
- Improve medical cost management by providing incentives for improving quality care and tools for providers to reduce medically unnecessary utilization and costs

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Our VBP arrangement will recognize population health outcome improvement as measured through the VIS, combined with a decrease in total cost of care for the population in the VBP arrangement. As measured by a percentage of members covered by such an arrangement, *Amerigroup commits to the following percentages for the Iowa Initiative:*

- By January 1, 2017 – 30 percent of our total assigned population (members) will be assigned to provider in VBP **contracts.**

- By January 1, 2018 – 40 percent of our total assigned population (members) will be assigned to providers in VBP contracts.
- Each year after 2018, the goal will be to increase the number of members covered by VBP arrangements by 5 percent per year through year 2020.

We support DHS' position that driving population health through delivery system reform under VBP requires that providers have a clear understanding of the specific lives for which they are accountable. As such, Amerigroup members who are part of a VBP will be assigned to a designated primary care provider (PCP). In support of VBP arrangements, Amerigroup will provide PCPs with a listing of assigned members on at least a monthly basis. This PCP information will be immediately reported for use in system wide coordination enhancements as specified by DHS, such as provider alerts through the Iowa Health Information Network (IHIN), or if possible, the provider member rosters.

Provider Credentialing (6.1.3)

We have successfully credentialed over 118,000 practitioners, ancillary providers, and facilities across our affiliates. We have the systems, staff, and policies and procedures in place to accurately and timely credential the full spectrum of physical, behavioral health, and LTSS providers required for the Iowa Initiative. We will use our robust process that meets all of the requirements of the RFP, as well as federal and State laws and regulations related to the credentialing of healthcare providers. We have successfully credentialed practitioners, facilities, and ancillary providers, plus all of the physical health, behavioral health, and LTSS provider types needed for the Iowa Initiative. Our robust credentialing and re-credentialing process meets National Committee for Quality Assurance (NCQA) accreditation requirements as evidenced in our successful NCQA surveys.

Credentialing Policies and Procedures (6.1.3.1)

Question 6.1.3, #1

1. Describe your credentialing process.

Our processes help facilitate the thorough and timely completion of credentialing applications. We closely monitor timeliness of the credentialing process, including the number of:

- Applications received
- Applications processed
- Age and turn-around time specific to credentialing applications
- Status of applications, including requests for additional information
- Applications received, administratively closed, and approved
- Credentialing and re-credentialing applications denied

We will credential providers within the timeframes outlined in Exhibit F of the Scope of Work. In 2014, across our affiliates, we averaged less than a 30-day credentialing turnaround time upon receipt of a complete and clean application for 14,000 providers.

Our current credentialing and recredentialing processes meet DHS requirements and NCQA guidelines. In our most recent health plan reviews, our credentialing program was found to be in full compliance. We regularly review our credentialing policies and procedures and update them in accordance with new NCQA standards, and when new federal or State requirements are issued.

Amerigroup's credentialing process verifies that all network providers are qualified by training and experience to deliver healthcare services to our members. The credentialing of network providers is an

important component of our contracting and quality management process, assuring that quality of care is maintained or improved and verifying that providers hold current State licensure and enrollment in the Iowa Initiative. We will incorporate ongoing assessments of the quality of care delivered by providers as they participate in our network. Our written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and recredentialing of providers and facilities, as well as the training to be delivered for Amerigroup staff on the policies and requirements for credentialing Iowa providers. Our Iowa Credentials Committee and Quality Management and Improvement Committee will review and approve these policies annually.

Credentials Committee. Our national Credentials Committee is a policy-making body responsible for all credentialing policies and procedures across our organization. The Amerigroup Iowa Medical Director will be a voting member of this committee and will be responsible for setting clinical competence and conduct criteria for the entire Amerigroup provider network via this policy making body. Locally, we will have a Credentials Committee, including no less than two participating licensed Iowa physicians, one of whom will practice in the specialty type most frequently used by Amerigroup members. These physicians will also operate within the scope of the credentialing program and have no other role in Amerigroup’s network management. The Chair of the Credentials Committee may appoint additional participating practitioners of other specialty types, as deemed appropriate. The committee also consults specialists as needed to complete the review of a provider’s credentials.



Credentialing Practitioners. Amerigroup credentials the following contracted healthcare practitioners:

- Physicians (includes Medical Doctors, Doctors of Osteopathy, and Doctors of Podiatric Medicine)
- Nurse Practitioners wishing to include their name in provider directory publications
- Certified Nurse Midwives
- Chiropractors
- Licensed Clinical Social Workers
- Licensed Mental Health Counselors
- Licensed Marriage and Family Therapists
- Psychologists

For the Iowa Initiative, we will delegate and oversee credentialing of vision providers by our subcontractor, Superior Vision.

Employee Training on Credentialing and Recredentialing

All of our employees are continuously trained in all areas of credentialing, which include review of all policies and procedures, systems, and checklists with required information as well as introduction to all verification sources and how to identify issues and concerns. We also train staff on quality audit processes that review the credentialing and recredentialing operations, including standard reports that identify gaps, and check for any incomplete or missing required evidence. Additionally, we offer training for departments involved in the credentialing program, such as medical leadership and provider services. We make training materials available on intranet sites and offer monthly trainings for new staff.

Initial Professional Provider Credentialing

We will use DHS' standard provider credentialing form during the credentialing process. As part of the participating provider agreement, providers must agree to all DHS and Amerigroup standards for credentialing and maintain standards of the Iowa Initiative, including compliance with DHS record-keeping requirements, access and availability standards, and Quality Management and Improvement Program standards.

We also use the industry standard Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource to capture provider credentialing applications, thereby reducing the administrative burden placed on practitioners. This proven approach includes verification that qualifications and credentials are accurate, thorough, and efficient, while also easing provider burden.

To initiate a new credentialing application via the CAQH system, providers may contact CAQH or Amerigroup directly. Basic provider demographic information is collected via the system, and the provider will grant permission for Amerigroup to access the common credentialing application. Applicants must complete and attest to the correctness of the credentialing application information submitted into CAQH's Universal Credentialing DataSource. Amerigroup will access and accept the provider credentialing applications submitted and maintained in the Universal Credentialing DataSource.

We extract completed credentialing applications from CAQH for primary source verification in accordance with State and NCQA requirements. Elements included in the credentialing verification process include, but are not limited to, the following NCQA-required elements:

- Valid license to practice in the state in which the practitioner will be treating covered members
- Current enrollment in the Iowa Initiative
- Hospital admitting privileges
- Current valid Drug Enforcement Administration (DEA), Chemical Database Service (CDS), and state-controlled substance certificates
- Education and completion of residency
- Board certification, as applicable
- Medicare/Medicaid sanctions or Federal Employee Health Benefit (FEHB) program sanctions or limitations
- Malpractice insurance
- Malpractice claims history
- National Practitioner Data Bank/Health Care Integrity and Protection Database query
- Disclosure by providers and fiscal agents; information on ownership and control
- Work history
- State or federal license sanctions or limitations
- Excluded Providers: Searches will be conducted on the names of parties disclosed during the credentialing process against the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) list of Excluded individuals/Entities, and the General Services Administration System for Award Management. Parties appearing on any of these databases will not be contracted with or employed by Amerigroup.
- Disclosure by providers: information on persons convicted of crimes

Process for Recredentialing

All participating providers included in our credentialing program are re-credentialed at least once every three years, consistent with NCQA standards. During the recredentialing period, we re-verify the provider's data from the initial credentialing process to confirm that all elements are active and in good standing. The recredentialing process incorporates re-verification and the identification of changes in the provider's licensure, sanctions, certification, health status, and/or performance information (including malpractice experience, hospital privilege, or other actions) that may reflect on the provider's professional conduct and competence. Amerigroup reviews this information to assess whether network practitioners and health delivery organizations continue to meet our credentialing standards.

We review all information collected and stored in the provider's file. The provider's file includes evidence of education, sanctions, licensing, updated disclosure statements, and quality of care or quality for service complaints/grievances as well as outcomes of investigations. We query the excluded provider's database on all re-credentialed providers. We review and consider additional information such as the following:

- Member(s) grievances that resulted in a sanction, restriction, or other action and/or four or more grievances in 12 months (as applicable)
- Administrative issues, utilization management issues, and quality of care information pertaining to educational interventions and sanctions imposed on the provider (as applicable)

The following performance indicators are also incorporated into the recredentialing process for PCPs:

- Information from quality improvement activities (as applicable)
- Member grievances (as applicable)
- Other plan-specific data as available and applicable

Credentialing HDOs

Health Delivery Organizations (HDOs) include acute care hospitals, home health agencies, skilled nursing facilities, nursing homes, LTSS providers, freestanding surgical centers, lithotripsy centers treating kidney stones, free-standing cardiac catheterization labs, and behavioral health facilities providing mental health and/or substance use disorder treatment in an inpatient, residential, or ambulatory setting.

To assess whether an HDO participating in our network meets appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing. In addition to State licensure and other eligibility criteria, all participating HDOs are required to maintain accreditation by a relevant, recognized accrediting body or, in the absence of such accreditation, we may evaluate the HDO's most recent site survey by pertinent federal or State oversight agencies.

Amerigroup considers accreditation from the following oversight organizations. We note acceptable accrediting agencies after each provider type in Tables 6.1-7 and 6.1-8.

Table 6.1-7. Medical Facilities – Acceptable Accrediting Agencies

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), National Integrated Accreditation for Healthcare Organizations (NIAHO), and Center for Improvement in Healthcare Quality (CIQH)
Ambulatory Surgical Centers	TJC, HFAP, Accreditation Association for Podiatric Surgical Facilities (AAPSF), Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), and Institute for Medical Quality (IMQ)
Home Healthcare Agencies	TJC, CHAP, ACHC
Skilled Nursing Facilities	TJC, Commission on Accreditation of Rehabilitation Facilities (CARF), Board of Certification (BOC) International
Nursing Homes	TJC, BOC Int’l
Free-standing Cardiac Catheterization Facilities	TJC, HFAP (may be covered under parent institution)
Lithotripsy Centers (kidney stones)	TJC

Table 6.1-8. Behavioral Health – Acceptable Accrediting Agencies

Facility Type (Behavioral Health)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	TJC, HFAP, NIAHO
Residential Care—Psychiatric Disorders	TJC, HFAP, NIAHO, CARF, Council on Accreditation (COA)
Partial Hospitalization/Day Treatment—Psychiatric Disorders	TJC, HFAP, NIAHO, CARF for programs associated with an acute care facility or Residential Treatment Facilities
Intensive Structured Outpatient Program—Psychiatric Disorders	TJC, HFAP, NIAHO, COA for programs affiliated with an acute care hospital or healthcare organization that provides psychiatric services to adults or adolescents, CARF if program is a residential treatment center providing psychiatric services
Acute Inpatient Hospital—Chemical Dependency/Detoxification and Rehabilitation	TJC, HFAP, NIAHO
Acute Inpatient Hospital—Detoxification Only Facilities	TJC, HFAP, NIAHO
Residential Care—Chemical Dependency	TJC, HFAP, NIAHO, CARF, COA
Partial Hospitalization/Day Treatment—Chemical Dependency	TJC, NIAHO for programs affiliated with a hospital or healthcare organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents, TRICARE or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents
Intensive Structured Outpatient Program—Chemical Dependency	TJC, NIAHO, COA for programs affiliated with a hospital or healthcare organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents

New HDO applicants will submit a standardized application to Amerigroup for review. If the candidate meets our screening criteria, the credentialing process will begin. During the credentialing process, we will conduct searches on new HDO applications against the HHS-OIG List of Excluded Individuals/Entities and the General Services Administration System for Award Management. Parties appearing on any of these databases will not be contracted by Amerigroup.

Delegation of Credentialing/Recredentialing

At times, we may elect to delegate credentialing and recredentialing activities to another entity. A description of our delegation oversight responsibilities and an overview of the delegation process are detailed in our quality improvement program as well as our policies and procedures. All delegates will undergo an initial predelegation audit, complete with file audit and policy and procedures review, followed by a committee review and recommendation. Once delegated, each entity is required to submit regular updates and undergo annual re-assessments. Activities and responsibilities associated with delegated activities are documented within the written agreement between Amerigroup and the subcontractor. The agreement requires the subcontractor and medical groups to provide reports related to the performance of their delegated activities and other obligations under the agreement. Amerigroup complies with NCQA standards for delegation oversight.

Verification of Credentialing Assertions

Upon receipt of completed credentialing applications and during the recredentialing process, we cross-reference providers' information with the OIG's List of Excluded Individuals/Entities and any available State databases to identify excluded providers. These lists are also cross-referenced during our credentialing team's monthly sanctions monitoring process described above. As we identify excluded providers from the List of Excluded Individuals/Entities or any other State sources, the provider is given an adverse credentialing determination when identified during credentialing or is terminated from our network when identified during the recredentialing or monitoring process.

In accordance with the federal and State regulations, we will obtain certain information from contracted providers, and any individuals and/or entities having a five percent or more direct or indirect ownership or a controlling interest in the entity, to verify if the person or persons have any federal sanctions that would prohibit us from reimbursing the provider for services furnished to a member.

Providers excluded from participation under federal regulations for either Medicare or Medicaid will not be eligible to contract with Amerigroup or any of our subcontractors.

Newly contracted providers, re-contracted providers, providers requiring credentialing, and delegated groups must complete a Disclosure of Ownership and Control Interest Statement (Survey) to be considered for participation in our network. Our national Sanction Monitoring Unit reviews extracted specific data monthly.

The Sanction Monitoring Unit is responsible for identifying participating medical providers loaded in Amerigroup provider databases that have been sanctioned by any of the State licensing boards or agencies. Based on information disclosed in the survey and notification of any positive match against a participating provider, we will review and determine appropriate corrective action, which may include termination of the provider agreement.

If the provider agreement requires termination due to the information disclosed or an identified sanction, we will follow its established termination procedures.

Nondiscrimination Policy

Amerigroup does not discriminate against any potential provider on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein, or against healthcare providers who serve high-risk populations or who specialize in the treatment of costly conditions. Amerigroup's credentialing processes do not discriminate against (1) a healthcare professional solely on the basis of license or certification, or (2) a healthcare professional who serves high-risk populations or who specializes in the treatment of costly conditions.

Other than gender and language capabilities, which are provided to members to meet their needs and preferences, we do not require this information in the credentialing or recredentialing process. The Credentials Committee bases its decisions on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process. Amerigroup will notify DHS of any credentialing applications that are denied due to program integrity–related issues.

Adverse Actions Taken on Provider Applications for Program Integrity Reasons (6.1.3.2)

As part of our provider enrollment and credentialing process, Amerigroup will require that providers disclose whether they have been convicted of a criminal offense, have had civil or money penalties or assessments imposed under Section 1128A of the Act, or have been excluded.

We do not contract with providers who have been excluded from participating in federal healthcare programs under Section 1128 or Section 1128A of the Social Security Act.

Ongoing Sanction Monitoring

To support credentialing standards during credentialing and between recredentialing cycles, Amerigroup has an ongoing monitoring program to verify continued compliance with credentialing standards and to assess and address any issues of substandard professional conduct and competence, including fraud and abuse issues, for providers and HDOs. The credentialing staff reviews reports from various sources, including the following:

- Office of the Inspector General
- Federal Medicare/Medicaid Reports
- Office of Personnel Management
- State Licensing Boards/Agencies
- Member Services Department
- Clinical Quality Management Department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data)
- Other health plan functional areas, as appropriate

We also consider any other verified information received from appropriate sources.

When a participating provider or HDO has been identified by these sources, we use formal criteria to assess the appropriate response, which may include review by the Chair of the Credentials Committee, review by the Medical Director, referral to the Credentials Committee, or termination. We will report practitioners and HDOs to the appropriate authorities as required by law.

Timeliness (6.1.3.3)

Amerigroup will follow established policies and procedures that will support the credentialing of providers according to the following performance requirements as outlined in Section 6.1.3.3 and Exhibit F of the Scope of Work: (i) 90 percent within 30 calendar days, and (ii) 100 percent within 45 calendar days.

LTSS Providers (6.1.3.4)

Amerigroup conducts criminal history background checks on all LTSS providers in all of our affiliate plans. Amerigroup has pursued access to the FACT Clearinghouse for our affiliate plans through appropriate State departments charged with public safety. We will automatically bar a provider who has a finding of physical or sexual abuse of a child or adult from participating in our Iowa Network based on information we receive from a DHS-approved entity, such as the FACT Clearinghouse.

For all other finding types, we will collaborate with the State of Iowa to review the findings and decide whether participation in the network will be allowed. We will consider the following prior to issuing a decision to include or bar a provider from our Iowa provider network:

- The severity of the finding
- The length of time that has passed since the finding occurred
- Any pattern of abuse or neglect
- The age of the victim(s)
- Any other relevant risk factor

We are committed to protecting the safety and well-being of our members. Once participating in our network, we will check the FACT Clearinghouse and sex offender registry at least annually.

Facility Requirements (6.1.3.5)

All facilities, including but not limited to hospitals, in the Amerigroup Iowa network will be licensed as required by the State.

Substance Use Disorder Providers (6.1.3.6)

Amerigroup will require that all substance use disorder services provided to members are provided by programs licensed by the Iowa Department of Public Health, in accordance with Iowa Code chapter 125 or by hospital-based substance use disorder treatment programs licensed and accredited in accordance with Iowa Code Section 125.13.2(a). We will consider counselor certification as specified in Iowa Administrative Rules 641—155.21(8) as an acceptable credential for practitioners employed by a licensed substance use disorder treatment program.

Question 6.1.3, #2

2. Describe methods to streamline the provider credentialing process.

Streamlining Provider Credentialing

Amerigroup fully supports the use of standardized credentialing applications, and we will adopt the Iowa Standardized Credentialing Application for all Iowa practitioners. We can accept electronic versions of the Iowa Standardized Credentialing Application via CAQH and paper copies. Our affiliates have been participating with the CAQH Universal Credentialing DataSource for several years in order to reduce the administrative burden placed on practitioners when multiple versions of credentialing applications are used. We are also familiar with state-specific credentialing applications used outside of the CAQH DataSource and already use these credentialing applications in several of the states we currently serve. This proven approach includes verification that qualifications and credentials are accurate, thorough, and efficient, while also easing provider burden. Upon identification of a potential provider to be added to our Iowa network, we will solicit the applicant to complete the Iowa Standardized Credentialing Application, which is available from CAQH. The provider must provide a minimum of five years of work history, evidence of current malpractice coverage, a history of malpractice claims paid, and copies of all current, unrestricted licenses and registrations, including the DEA or CDS certification information.

Once we receive a clean application, we log the application based upon receipt date and then forward it to our national Credentialing Department, where all verifications and credential file preparation is conducted. We create and maintain an electronic credential file for each provider applicant. This file contains all copies of documentation received, as well as verifications, in accordance with NCQA and state-specific requirements. Upon completion of all verifications, the Credentialing Department will screen the credentialing applicant for



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completeness and will send to the Amerigroup Iowa Credentialing Committee for approval. Our Iowa Health Plan Credentialing Committee will include practicing physicians and providers as well as our Iowa Plan Medical Director. We screen all credentialing applications upon receipt to identify any deficiencies or missing information. Credentialing Specialists contact applicants whose applications are incomplete and request the missing or needed items. Applicants are given one week from the date of request to submit the missing information. Typically, we make three attempts directly to the applicant to retrieve the missing or expired information. If the information is not received within this time period, we return the application to the provider with a request to reapply with all required documentation.

In addition to using the CAQH Universal Credentialing DataSource process, Amerigroup has implemented several innovations that help streamline the provider credentialing process. For example, we use Cactus software system to support reporting, tracking, and trending. We track disclosure of ownership electronically and include the results in our monthly monitoring/screening and use Bridger to perform monthly program integrity checks, which includes an enhanced matching process for quicker identification and review of sanctioned/excluded individuals. We have also worked closely with our state partners to implement new workflows, forms, and tools to streamline the credentialing process for all Medicaid managed care organizations.

Question 6.1.3, #3

3. Describe your plans for performing criminal history and abuse checks and assuring all network providers hold current licensure as applicable.

Member safety is an Amerigroup priority. We use tested policies and procedures to ensure our network providers meet our standards. Prior to contracting with a provider or supplier, our Provider Credentialing Department screens each prospective health plan provider against the HHS-OIG List of Excluded Individuals/Entities (LEIE) and the General Services Administration's System for Award Management. We also screen current network providers against the LEIE monthly as required by applicable state regulations.

We conduct primary source verification in accordance with NCQA standards. This verification process includes verification of licensure and DEA, education and training, board certification, sanctions (federal and state), malpractice history, and malpractice coverage. We also assess the applicants training and education against training requirements established by the Credentialing Committee. If a practitioner fails to meet these training requirements, we close the application and return to the provider.

As part of the credentialing and recredentialing process, we will perform the criminal history check and abuse checks through sites made available by the State of Iowa for all providers including LTSS (as required). Otherwise, we will include an internal attestation to the requirements in the standard process in accordance with DHS standards.

Question 6.1.3, #4

4. Describe your plans for ensuring non-licensed providers are appropriately educated, trained, qualified and competent.

Non-Licensed Providers (6.1.3.7)

Amerigroup understands the critical role that non-licensed providers, including HCBS, independent support brokers, and transportation vendors, play in delivering comprehensive and timely healthcare to members in Iowa. Therefore, we help our non-licensed providers adapt to State and federal requirements for healthcare delivery with onsite training and technical assistance while assuring quality healthcare for our members. Such training and assistance is particularly valuable to organizations in rural areas where the organization might be the only source of services, yet does not have access to the business resources typically available in urban areas. We provide training to all of our providers. Where assistance with in-depth training on specific functions or supports by a non-licensed provider is necessary, we collaborate and contract with subject matter experts to assist us in delivering this training so that providers can deliver the care our members need. As an example, we would partner with our Financial Management Services vendor to provide training in conjunction with Amerigroup to independent support brokers.

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To the extent possible, we model our standards for credentialing non-licensed providers in accordance with NCQA and CMS requirements, with exceptions made for some elements where the standard may not be applicable. Since there is no standardized data exchange method for credentialing information on non-licensed providers, Amerigroup conducts the following activities:

- Determine which provider types must have a State-issued provider ID
- Understand the current requirements, such as those posted on the State's website for provider enrollment and licensing of the provider's specialty
- Require that providers complete an Amerigroup ancillary application and submit a W-9, evidence of liability insurance, and a business license in addition to any other specific requirements that the State may have for that provider type
- Help providers obtain licenses, most recent compliance survey, and corrective action plan, as applicable, and potentially include a site visit by Amerigroup personnel
- Validate the provider's good standing with the HHS-OIG and the General Services Administration's Excluded Parties List System websites as well as other data sources as directed by DHS

Cultural Competence (6.1.4)

Question 6.1.4 #1

1. Describe your plans for ensuring the delivery of services in a culturally competent manner.

For 24 years, our affiliate plans have provided culturally competent services to diverse populations in state-sponsored programs across 19 states. We know that cultural competence requires a deep understanding of how culture and heritage impact member care, health, and access to services. To provide culturally competent services to members in Iowa, we will take what we know and continue to learn about the State, its communities, and its resources and combine it with Amerigroup's tradition of providing culturally competent services and the best practices shared by our affiliates nationwide.

We adhere to all 15 National Culturally and Linguistically Appropriate Services (CLAS) Standards in healthcare and our policies and procedures fully support these standards. Additionally, we embrace a "Three R" approach to delivering culturally competent services—recognition of, respect for, and response to the culture, ethnicity, values, religions, beliefs, gender identities, and desires of members—while preserving their dignity.

Delivering Culturally Competent Services to All Members

Many distinct cultures are represented in Iowa communities, such as African American, Latino/ Hispanic, and American Indians/Alaskan Native populations. In addition, cultural competence encompasses more than just racial and ethnic differences; it includes any marginalized population group who may be ethnically and racially similar, but who are at risk for stigmatization or discrimination, different in other identities, or who have different care needs that result in health disparities.

We strive to identify and bridge gaps to make sure *all* of our members receive equitable and effective care. We provide access to members with special health needs (such as video relay for the hearing impaired) and we work with State agencies and community partners to meet the needs of members with disabilities. We build our networks and local community health plans mindful of the diversity of our members and the potential impact on their access to healthcare services. Showing the true diversity of our members is very important – it tells the story of who our members are and who we are.

Cultural Competency Starts With Us

At Amerigroup, cultural competence is a leadership principle and an integral part of our tradition. We know that proactively embracing and honoring the differences among our membership is vitally important to address members' health needs successfully. We will strive to promote culturally- and linguistically-responsive services for all of our Iowa Initiative members by:

- Recruiting and hiring a culturally diverse workforce, including local Iowa staff as well national and call center staff who mirror our membership
- Conducting orientation and ongoing cultural competency training for every Amerigroup employee
- Building and maintaining a culturally competent network of providers who are attuned to cross-cultural issues, respect cultural differences, communicate effectively, and provide the same level of quality care to every member
- Providing comprehensive, linguistically-appropriate, and culturally-sensitive communication materials for members and their families



Amerigroup defines cultural competency as the delivery of integrated health care services within the context of members' cultural beliefs, behaviors, practices, disabilities, and language preferences.

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- Partnering with local, community-based organizations and advocacy groups to help us identify, better understand, and address the needs of members
- Providing methods for communication in alternative formats, such as our video relay line for those who are deaf or hard of hearing, large print and Braille for those who have low vision or are blind
- Offering language assistance and interpreter services for those with limited English proficiency. For example, we know that in Iowa nearly seven percent of the population over age five speaks a language other than English in the home, and we can provide oral translation/interpretation services for over 200 languages at no cost to members through our language line. See Section 8.2 for full descriptions of our communication services.
- Conducting ongoing organizational assessments of culturally- and linguistically-appropriate capabilities as part of our Quality Management and Improvement Program and making adjustments as our membership evolves to assure cultural competency across all our functional areas
- We develop cultural competency strategic plans for the specific programs we manage. This integrates knowledge, attitudes, and skills reflective of a culturally competent organization, and serves as the blueprint for our overall cultural competency program and practices. Plans are descriptive, organized around objectives and strategies, and designed to provide a measurable approach to assure cultural competency across Amerigroup, our providers, and our subcontractors.

We make sure that cultural competency practices – such as the value of honoring members' beliefs, being sensitive to cultural diversity, and adopting attitudes and interpersonal communication styles that respect members' cultural backgrounds – are incorporated across every part of our delivery system. For example, we include relevant questions asked during initial and comprehensive member assessments, develop cultural supports in the member's care plan, recruit qualified, multi-cultural practitioners, and partner with local, community-based organizations and cultural groups to provide additional support for our members.

In addition, all Amerigroup employees participate in our cultural competency computer-based training course upon hire and must complete an annual refresher course thereafter. Training defines cultural competency and presents examples of it in action. Our cultural competency training efforts help make sure that our employees understand that delivering services to people of all cultures, races, ethnic backgrounds, sexual orientations, abilities, and religions must occur in a manner that recognizes, values, affirms, and respects the worth and dignity of all members. Our curriculum includes definitions, benefits of cultural competency, government regulations, values, language resources, health-related beliefs, cultural-specific health disparities, and variations in social comfort factors. Learning objectives include the ability to:

- Describe laws and regulations concerning cultural competence
- Identify and appreciate the cultural groups we serve, including but not limited to those with disabilities and advanced age, through specialized modules
- Assess cultural beliefs and preferences that impact a member's world view and how these beliefs impact their choice in care
- Identify how culture influences members' approaches to health care and social services as well as their attitudes toward aging, disability, and illness
- Understand and apply approaches that promote self-awareness and acceptance
- Describe the ways Amerigroup accommodates our diverse membership
- Describe and apply techniques to overcome language barriers and communication disabilities

We also require all newly hired employees to participate in diversity training during their orientation. In addition to our core training, our Member Service Representatives will receive additional training on local Iowa geography and other Iowa Initiative-specific training. See Section 2 for a full description of our Staff Training Plan.

Addressing the Specialized Health Needs of Diverse Groups through Community Collaborations and Partnerships

We are committed to driving improved health outcomes and quality of life one member at a time—by doing the right thing for every member, every time. We work to address any geographical, cultural/linguistic challenges, or any other barriers our members may face. We develop comprehensive grassroots and community outreach programs, and collaborate with community partners who work with diverse populations on various cultural and health issues and disparities. Our members' lives focus on their homes and neighborhoods. By reaching out to them where they live in a culturally responsive way, we can increase participation in health promotion and illness prevention activities. To promote culturally competent care in local communities, we do the following:

- Host health fairs and participate in others through partner organizations
- Hold classes in the communities we serve to make it easier for members to attend and get the benefit of information we share
- Employ local, community-based outreach teams to locate and engage members in a culturally competent manner (For example: our Texas affiliate developed best practices for using “promotores”, locally-based individuals who promote health education and prevention in a culturally- and linguistically-appropriate manner, particularly for underserved populations)
- Offer the Value-Added Service of Amerigroup Community Resource Link, a searchable online resource for all local Iowa community-based programs, benefits, and services displayed in an easy-to-read format and searchable with GPS technology to provide members a holistic view of community resources they may not otherwise be aware of
- Partner with organizations, such as community centers, shelters, senior centers, clinics, housing authorities, and food banks to help locate and engage members (For example: our affiliate health plans partner with 189 public health departments across the country to break down barriers and connect members who are homeless to meaningful access to care and services. With an estimated 16,000 Iowans experiencing homelessness, many of which will have Medicaid coverage, enhanced outreach will be critical to helping these members access care and fully coordinating their care across systems.)

Amerigroup Continuously Identifies Ways to be Culturally Competent

Cultural competence is not static. It is a dynamic process that involves continually learning and responding as our membership evolves. We routinely analyze member utilization and demographic information to identify the cultural groups and unique characteristics of the communities we serve, determine any communities or cultural groups that are not being reached or served, and identify solutions for reaching these communities or cultural groups.

For example, our Louisiana affiliate identified dialect differences within the American North and South Vietnamese communities that were part of its membership. Their experience working with Vietnamese community partners helped make them aware that there was a disconnect between Vietnamese translated material and the southern Vietnamese dialect. As part of our affiliate's standard process, all translations are handled by a national marketing services translation vendor. Our affiliate resolved the situation by forwarding the translated materials to the Vietnamese Initiative in Economic Training (VIET) translation services. VIET made translation and dialect changes to the member materials, which were then sent back

to the national marketing services translation vendor to verify for compliance. The materials were then submitted to the State of Louisiana for final approval.

Through lessons learned, such as the example above, we know to pay close attention to our members' distinct needs that may not be covered in our standard processes and to make immediate adjustments as needed. For example, we may find these changes necessary for Iowa's Native American and Alaskan Native populations, who also use many different dialects.

Amerigroup's Associate Resource Groups Celebrate Diversity

As part of emphasizing the importance of collaborative community partnerships, our parent company, Anthem, established Associate Resource Groups that operate within all Amerigroup affiliates to encourage employees to join groups within the company that celebrate and support diversity in all its aspects such as ethnicity, gender, sexual orientation, and disability. These groups represent diversity and inclusion, and have allowed our affiliates to achieve major strides in our employees' partnerships with the communities we serve. Associate Resource Groups bring together employees across our lines of business. They not only assure attention to diversity, but also actively participate in community programs designed to address health disparities for the specific groups represented. Current groups formed in other affiliates include African American Professional Exchange to address diversity in the African American community; and SOMOS, a Latino and Hispanic diversity group. In Iowa, we will continue these efforts with the same level of commitment and involvement from our employees.

Culturally Appropriate Care (6.1.4.1)

The quality of the patient-provider interaction has a profound impact on members' ability to communicate symptoms to their provider and adhere to recommended treatment. When developing our provider networks we consider language, thoughts, communications, actions, customs, and cultural beliefs, and values of our members because we are aware that:

- The health, healing, and wellness belief systems of our members affect how they engage in their health care and with their care providers
- Illness, disease, and causes can be perceived differently by the member and the provider, which affects how care is perceived and given
- The behaviors of our members seeking health care and their attitudes toward our health care providers can affect how often they seek health care support
- Providers who are informed about cultural competency are able to deliver services through a wider set of values, which can open a broader range of access, including members with disabilities, those of varying sexual orientation, or those from other cultures

We expect our providers to demonstrate cultural awareness and to have appropriate skills, such as the ability to understand another's values, beliefs, and culture. Our network strategy and performance measures are designed to incorporate NCQA standards, most notably: ***The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.***

Cultural competence, multi-lingual support, accessibility to the provider's premises, and any special communication abilities are an integral part of our provider network development efforts. These requirements are detailed in the Provider Manual and online directory, as well as ongoing communications with network providers. We consistently recruit and retain providers who can best meet the cultural, ethnic, and linguistic needs and preferences of members. This helps promote choice among providers, so that ***members can select from a diverse array of network providers (and change when needed) based on their cultural preferences and unique healthcare needs.***

We have learned that many health care professionals are committed to providing culturally competent care, but lack the awareness, knowledge, or skills to do so. Through our provider training, we furnish information that providers and their staffs can use to remove cultural barriers between them and members. We strive to make sure that our providers are not only culturally sensitive, but also reflect the culture and languages of our members.

We encourage members to contact us to report all grievances, including the inability to obtain culturally competent care. To determine the impact of our cultural competency program, we closely monitor member grievances and satisfaction surveys. We also make special effort to assure that our processes are culturally sensitive and train grievance and appeals staff be sensitive to member needs throughout the grievance and appeals process. Detailed information regarding our Member Appeals and Grievance process can be found in Section 8.15 of this response.

Identifying Providers to Serve Members with Disabilities

While provider language proficiency and translation are essential to communicating with members, we believe this barely touches the surface of culturally competent service delivery for members with disabilities. Members with disabilities often face challenges when accessing care, such as the need for accessible exam tables or other adaptive aids in order to receive care or testing. Our Provider Services Staff will work to identify providers equipped to provide services to members with disabilities, or with expertise in treating members with special needs. We will also implement a local approach to identify PCPs and specialists located near members who are knowledgeable about the experiences members with disabilities frequently encounter. We will ask caregivers, community-based providers, Case Managers, and organizations working with members with disabilities such as Centers for Independent Living to help identify providers to recruit.

Provider-Patient Relationship (6.1.5)

Amerigroup values the provider-patient relationship and understands that the patient's health and well-being depends on this collaborative relationship. We know that health care professionals contribute to this partnership by serving as their patient's advocate regarding their health and rights. Therefore, we do not and will not prohibit or restrict a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is their patient regarding the member's health status, medical, behavioral health, or long-term care options. This includes any alternative treatment that may be self-administered; any information the member needs to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or non-treatment; or the member's right to participate in decisions regarding his or her health care and to express preferences about future treatment decisions.

Provider Relations and Communications (6.1.6)

Question 6.1.6, #1

1. Describe your provider relations and communications strategy.

Providers are our valued partners in helping members lead healthy lives. Every day across our markets, our affiliate health plans work with Network Providers to transform care delivery and improve health outcomes. We emphasize communication and collaboration with all our providers across the care continuum, including medical homes, primary care providers (PCPs), behavioral health, LTSS and other specialty providers, and hospitals. We will maintain local, field-based Provider Services staff in Iowa who will work with providers face-to-face as well as other channels to engage and support providers in the important work they do.

Amerigroup's provider relations and communications strategy reflects the needs of the Iowa Initiative and complies with all relevant Scope of Work requirements. Our strategies include:

- **Locally based Provider Services staff** to inform and support providers by building strong relationships on the ground, locally in Iowa.
- **Provider Manual** to communicate important program information.
- **Provider training and education** to inform providers on the Iowa Initiative and our policies and procedures through individual and group provider training and education programs.
- **Provider website** to give providers comprehensive, online access to actionable, informational and streamlined information.
- **Provider newsletters** to provide relevant and helpful information to providers on a quarterly basis, including up-to-date health information and any relevant program changes (newsletters are conveniently available on our website).
- **Provider mailings and blast faxes** to provide key updates or reminders to providers (billing reminders or updates, regulation changes, EDI, ERA/EFT, program changes, etc. (information would be available on our website as well).
- **Quick reference guide** to offer providers summarized critical process information from the Provider Manual, including eligibility verification and reference information.

Our communication strategies will address topics of importance to providing and delivering quality care and services to Iowa members including Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), lead testing, children with special healthcare needs, asthma, prenatal care, behavioral health, LTSS, inappropriate utilization of emergent services, and reduction of racial and ethnic healthcare disparities to improve health status. Various quality and utilization reports also serve as communication vehicles for providers. For example, providers will receive a gaps-in-care/missed opportunity report to remind them of EPSDT services due while provider profiles benchmark individual provider performance for identified metrics against plan performance, available State benchmarks, or the NCQA Quality Compass percentile.

Amerigroup's locally based Provider Services staff work in the field, connecting and meeting one-on-one with providers, associations and community-based organizations. Provider Services staff members are recruited from the communities they serve and understand the health beliefs and practices of the population and the needs of the providers they serve. Through their one-on-one meetings and via training sessions held in person or via telecommunication tools such as WebEx, our Provider Services staff help bridge any gaps that may develop between program requirements and the realities of local healthcare delivery systems, services and supports. They supply information that supports successful operating procedures and an understanding of the Iowa Initiative, as well as program policies and requirements, billing procedures, and electronic billing, answering questions and resolving issues for providers. In Georgia, a state of comparable geographic size and rural nature to Iowa, our affiliate health plan's Provider Services staff made 7,500 face-to-face visits in 2014 to provider offices.



Amerigroup develops profiles that are used in partnership by Provider Services staff and local providers to customize training and education sessions for individual providers and their office staff. Our profiles benchmark and rank individual provider performance against plan performance goals, available State benchmarks, and the NCQA Quality Compass percentile. The profile is available to providers to track their own performance and identify areas where they might require the assistance of Provider Services staff.

Located throughout Iowa, Provider Services staff will be visible in the provider community and enhance their relationship with our providers by attending professional events and associations of practice

management leaders, professionals and other administrators. For example, our representatives speak at the American Association of Professional Coders conference where we provide valuable information regarding claims and billing.

Evaluating our Provider Communication Strategy

Amerigroup embraces a multipronged approach to evaluating the effectiveness of our provider communication strategy. We design our education and communication programs to comply with all State and contractual requirements, and we monitor adherence through our robust Quality Management and Improvement (QM/QI) infrastructure. Some of the ways we monitor effectiveness include:

- Post-training surveys
- Annual provider satisfaction surveys
- QM/QI program outcomes

We incorporate data from these sources, along with feedback from the Medical Advisory Committee, into our communication strategy.

Post Training Surveys

Following each formal training activity, providers complete a survey on their training experience to evaluate the content shared and the presentation of information. Amerigroup also conducts random audits of Provider Services visits to determine whether on-site training met the desired objectives. We incorporate this feedback to improve the performance of our Provider Services staff.

Provider Satisfaction Surveys

Nationally, less than one percent of providers voluntarily terminate from Amerigroup's affiliates' Networks. We continually strive to improve the provider experience by collection and analysis of satisfaction surveys. Annually, the survey process assesses provider satisfaction with training and education, communications, provider enrollment, complaints resolution, claims processing and reimbursement, and Utilization Management processes. Survey information helps us better understand our Provider Network—its needs, its challenges, and the opportunities it presents for member-centered, cost-saving innovations.

Quality Management and Improvement Program Outcomes

Our QM/QM Program monitors and measures the outcomes of clinical care and services by analyzing clinical and service performance indicators and healthcare outcomes to identify and act on opportunities for improvement. This information is also used to identify performance improvement and compliance rates and to identify and act on opportunities for improvement, such as provider training and education strategies. The QM/QI team compares findings to results from previous years and to national and State value-based performance goals. We understand that provider training contributes to overall outcomes, and we include a provider training component in all our performance improvement plans. Our quality assessment and improvement programs for the Iowa Initiative will track measures, including:

- Access to Care and services
- Reduction of inappropriate utilization of emergent services
- EPSDT
- Asthma
- Maternal/child health
- Wellness
- Behavioral health

Question 6.1.6, #2

2. Describe your policies and procedures to maintain communication with and provide information to providers.

We design provider communication policies and procedures to give providers easy access to the information they need to help better serve members. Communication policies and procedures meet or exceed regulatory compliance considerations such as HIPAA. In addition, they are designed to simplify program and service navigation for both providers and their patients.

We identify topics to communicate to providers weekly, monthly, quarterly, and annually. Topics are derived from State and federal regulations pertaining to Medicaid and/or Medicare, State contracts, NCQA standards, the health plan policies and procedures, balance billing, provider requests, and other relevant sources.

For the Iowa Initiative, Amerigroup Provider Relations staff will work with our national Provider Services Organization and operational areas to prepare detailed provider education materials that meet changing business needs and to make sure providers have access to pertinent information. Changes to federal and State requirements and company policy are carefully monitored and communicated to providers.

Communication Channels

Our communication policies and procedures are in place for multiple media channels. As a result, we can communicate with and support providers in ways that fit into their individual work flow and preference. We use:

- **Provider Services staff** – Amerigroup Iowa Provider Services staff will be present daily in the communities they serve to build long-standing, trusted relationships. They will meet regularly with Network Providers, administrators, billing and clinic managers to make sure they have up-to-date program information.
- **Online resources and training** – The provider website gives providers immediate access to prior authorization services, claims tools, reimbursement policies, communications, other resources and tools to support them in delivering the best possible care to our members.
- **In-person training** – All Network Providers participate in an orientation session. Please see the response to Question 6.1.6.5 for a description of information offered during these sessions.
- **On-demand training for new technology and program changes** – When we introduce new tools and technology or there is a program change, local and national Provider Relations resources collaborate to create and deliver training strategies, materials, and schedules to make sure providers are up to date.
- **Print resources** – We offer the Provider Manual in hard copy upon request at no cost and post it online. Provider newsletters offer up-to-date information on policies and procedures, program changes, and enhancements. We fax and/or mail updated program information to physician offices, clinics, facilities, LTSS and other providers. Quarterly Reimbursement Policy Bulletins summarize policy changes.

We request feedback from Network Providers to determine what is working well and how to improve policies and procedures whenever possible. We also monitor data from provider and member services helplines as well as grievance and appeals filings to identify opportunities to revise policies and to develop new communication approaches.

Provider Manual (6.1.6.1)

Amerigroup will develop and maintain a Provider Manual that is created specifically to meet the needs of the Iowa Initiative and serve as a comprehensive document designed to inform Network physicians, hospitals, clinics, facilities, LTSS and other providers of Amerigroup guidelines and requirements.

Topics include but are not limited to:

- Program benefits, limitations, and State waivers
- Claims filing instructions and balance billing
- Prior authorization criteria and processes
- Cost-sharing requirements
- Definition and requirements pertaining to urgent and emergent care
- Participant's rights and responsibilities
- Providers' rights for advising or advocating on behalf of their patients
- Provider non-discrimination information
- Policies and procedures for grievances and appeals in accordance with 42 CFR 438.414
- Contractor and DHS contact information, such as addresses and phone numbers

The manual is available on our provider website and as a downloadable PDF. A hard copy of the manual is available upon request by the provider.

Provider Website (6.1.6.2)

Question 6.1.6, #3

3. Describe your plan to develop a provider website and describe the kinds of information you will make available to providers in this format.

Amerigroup maintains a comprehensive, secure, provider website that maximizes usability and administrative simplicity. Our provider website offers a variety of tools and resources, including an online copy of our Provider Manual along with a variety of provider training and education resources from the latest provider communications to toolkits (such as our EPSDT Toolkit), all designed to make the provider's job easier. We showcase basic information and tools such as our Provider Manual, prior authorization procedures, formularies, and reimbursement policies, and we use the website to deliver information to providers, including announcements, alerts, and forms. Our provider website includes a search engine with advanced options for finding information. The latest forms and training materials are always available on the provider website. We have staff available to support provider queries about website information, ranging from our Provider Services staff who can help find data on our websites to staff who can help providers register and access information.

We understand the value a well-designed website offers to providers. Our provider website will be designed to simplify practice management, enable site users to navigate easily to the information they need, and support provision of excellent care to the Iowa Initiative program members. The site simplifies practice management by giving providers the ability to review billing and claims payment information.

They can access:

- Important billing news and administrative updates
- Claims submission and status
- Prior authorization requirements and request status

Amerigroup web technology offers the following benefits:

- Providers can use a single sign-on process instead of logging in to multiple payer systems.
- Providers can submit claims, determine member eligibility, view claims status, and access payment information for Amerigroup and multiple other payers in one place.

Table 6.1-9 identifies provider website functions.

Table 6.1-9. Amerigroup Provider Website Functions

Function	Description
Before Login	
New User Registration	Allows Network and out-of-network providers to register for access to our site
Login Assistance	<ul style="list-style-type: none"> • Recover user name • Reset password • Recover account activation code
Application Request	Allows providers interested in joining the Amerigroup Network to submit a request for more information
After Login	
Eligibility Tool	Allows user to verify a patient’s enrollment status and assigned PCP
Panel Listing Tool	Allows user to see panel listings for a provider, group, or independent practice association over a specified date range
Claims Tools	Claims submission <ul style="list-style-type: none"> • Claims status look-up • McKesson’s Clear Claim Connection to verify code combinations • Instructions to submit claims using electronic data interchange • Notification receipts for 837 batch uploads via the site’s Message Center
Account Management Tools	Allows user to manage: <ul style="list-style-type: none"> • Demographic information (practice info, profile information, updated rosters) • Provider accounts (add new Tax ID numbers and manage Tax ID numbers) • User profile information (user name, password, contact info)
Delegated Administration Tools	Permits delegated administration, enabling a provider or practice administrator to assign/revoke user rights; features include: <ul style="list-style-type: none"> • Managing user roles • Activating accounts • Adding and activating new TINs
Help and Reference Library	Repository of forms and documents available for download: <ul style="list-style-type: none"> • Provider manual and quick reference card • Medical and office support forms • Claims forms • Links to our State and vendor partner websites
Provider Announcements	Ongoing Amerigroup and DHS news and bulletins, including those related to billing

Function	Description
Before and After login	
Ongoing Amerigroup and DHS News and Bulletins, including those related to billing	Local office and toll-free Provider Helpline phone numbers and email addresses
Prior Authorization Tools	The authorization/precertification tools allow: <ul style="list-style-type: none"> • Determination of service precertification or notification requirements • Submission of authorization requests • View of authorization status • Download of special authorization request documents
Clinical Policy Guidelines	Assists in providing quality care by reducing inappropriate use of medical resources
Reimbursement Policies	Allows access to our reimbursement policies, including information on electronic data interchange and electronic funds transfer; helps providers submit accurate claims by outlining the basis for reimbursement if the service is covered by a member’s benefit design
Online Tutorials and User Guides	Flash tutorials and downloadable user guides to assist users with the site’s functionality; upcoming training opportunities and tutorials on other topics, such as cultural competency

Enhanced Website Resources—Member 360

To advance providers’ access to member health information, Member 360 combines member data and information from various sources into a single record to deliver a holistic picture of the individual’s utilization, care management services, and gaps in care. It includes information such as member health risk assessments, care plans, longitudinal health records, and clinical data. Through the *provider facing* Member 360, providers can see their members’ records via the Amerigroup self-service website, giving them simple, easy-to-access data and information to help *engage members in their own health and well-being*. The integrated data are displayed to make it easy for providers to act, assuring their patients of the services they need. This view enables providers who treat our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve quality of care. The physician view will enable providers to understand from a population health perspective how members are doing and, more importantly, to get information to help them achieve better results.

Provider Services Helpline (6.1.6.3)

Question 6.1.6, #4

4. Describe your plans for the provider services helpline, including the process you will utilize to answer, route, track and report calls and inquiries.

Timely and accurate responses to our providers are essential to building a relationship with them. Complementing our local Provider Services staff, our national Provider Helpline offers convenient access to specifically trained, seasoned representatives who address questions through a single point of contact. We offer providers who telephone our Provider Helpline a menu of both automated and live agent services. We will staff the Provider Helpline daily between 7:30 a.m. and 6:00 p.m. central time. During business hours, providers can opt out of the voice portal and connect with a Provider Services Representative. After business hours, providers can use the provider website to access practice guidelines, frequently asked questions, Provider Manual, and other information. Providers will use a toll-free number to speak with someone about billing questions, access prior authorization for services, and receive assistance with member eligibility questions.

We train our Provider Services Representatives to consistently and accurately respond to provider requests and questions. Our integrated desktop technology enables rapid access to information and displays all data related to a member's benefit design, assigned PCP, service utilization and claims history, authorizations, and other health insurance coverage. Combined, the provider services helpline and provider website offer providers support 24 hours a day every day.

Answer, Route, Track, and Report Processes

Calls received from our Network Providers automatically will be identified by their area codes and routed to the Provider Services Representative who is trained and equipped to address information, processes, benefits, and services that are part of the Iowa Initiative.

We track reasons for provider calls, including:

- Benefits
- Billing claims
- Eligibility
- Network
- Prior Authorization

We report the following metrics for provider calls:

- Total provider calls logged as complaint or appeal
- Total provider calls referred
- Total provider calls resolved

We are committed to meeting DHS performance standards and reporting requirements, as specified in Scope of Work Section 6.1.6.3. Amerigroup will use the information received from tracking provider calls to improve how we can enhance our communications, training and relationships with providers in Iowa thus improving provider satisfaction.

Provider Training (6.1.6.4)

Question 6.1.6, #5

5. Describe your provider training plans.

Amerigroup will provide annual and ongoing education and training to Provider Network participants. We agree to have all training materials reviewed and understand that they are subject to approval by DHS. In addition, we will develop training plans that support traditional LTSS providers who transition to offering services. We will assist with services such as information technology, billing, and systems operations. Provider training will address the topics identified in Scope of Work Sections 6.1.6.4.1 through 6.1.6.4.10. In addition, as we build relationships and contract with providers Amerigroup will identify additional training topics that would be included in our training and orientations. For example, in California our affiliate health plan worked with the Nursing Home Association to solicit input on our training materials prior to conducting our training sessions. This approach allowed us to ensure that we were addressing all their key questions as they transitioned from fee for service to managed care for LTSS.

Network Providers represent the foundation of how our members access care that supports health and well-being and how members experience our organization. From the beginning, we will work collaboratively with our Network Providers and make sure they have the training and resources needed to serve our members and other patients well. Our training plans are designed to inform and support providers using:

- An in-person, group and webinar orientation sessions
- Ongoing training
- Dedicated Provider Services staffs
- Online tools and resources

Using monthly provider training meetings and webinars, we will tailor information to give providers personalized assistance, which helps make sure providers have the information and tools needed to support Amerigroup members. Using the methods listed above, we will introduce and reinforce information on the important topics listed in Scope of Work Section 6.1.6.4, including:

- The role of the Care Coordinator and the importance of notifying a member's Care Coordinator
- Abuse and neglect training including procedures and requirements
- Critical incident training
- Provider requirements and responsibilities
- Prior authorization policies and procedures
- Medicaid policies including updates and changes
- Member Centered Planning Process
- HCBS settings per CMS regulations

Orientation

Amerigroup will invite newly contracted providers and their office staff to participate in an orientation session, which will take place within 30 days of contract execution or anytime at the request of the provider. We will provide training to 100 percent of our Iowa Network PCPs within the first 30 days of contract execution. We design our in-service, face-to-face and webinar orientation sessions to:

- Communicate DHS and Amerigroup policies, procedures, regulations, and expectations
- Identify resources made available by Amerigroup, such as online tools and the Provider Helpline
- Introduce the roles of Provider Services staff and how they can assist each clinic or office
- Define how to communicate with Amerigroup quickly and easily for each given circumstance or need (for example, patient referrals and administrative questions)

At initial training, we provide copies of our Provider Manual, prior authorization quick reference guide, and member benefit collaterals. We also include a Q & A session to address provider questions and provide clarifications.

Ongoing Training

Amerigroup will provide educational sessions for Network Providers several times a year. We will develop and offer educational sessions for Network Providers. Training will be tailored to meet the particular needs of local providers. The sessions will give providers:

- Program and regulation updates
- Information on industry and care trends
- New information that can improve member outcomes
- Recommendations on reducing administrative burden
- Information and steps that can impact performance goals
- Introduction to enhancements to our Iowa services and programs

In addition, we will offer quarterly group training sessions as refreshers and to enable providers to train new office or billing staff on the Iowa Initiative and our specific programs and services. Amerigroup Provider Services staff support individual trainings and on-site sessions anytime we identify a need or providers make a request. Session location options include group presentation settings, webinars, the providers' offices/facilities, and during the quarterly State-led workshops.

We cover meaningful topics in several ways, including online tutorials, in-person, and live web seminars. Topics include.

- **The Iowa Initiative program overview:** populations served by the program, eligibility, covered services, waivers, value-added services, Medicaid policies and procedures, and our local contact information
- **Provider responsibilities:** cultural competency and assisting members with special needs; appointment access, after-hours availability and wait time standards; reporting communicable disease; preventive health service standards; grievances, appeals, and claims dispute processes; medical record standards and reviews, and other policies or procedures; working with our pharmacy benefits administrator; and emergency service responsibilities
- **Amerigroup programs:** Provider Incentive Programs and Patient-Centered Medical Homes
- **Amerigroup services:** our role and responsibilities; Quality, Chronic Care, and Case Management Programs and referral processes; behavioral health services and the whole-person treatment model; electronic service records; language and interpreter services; and telemedicine and Amerigroup On Call programs
- **Member services:** enrollment process; rights and responsibilities; PCP selection, assignment, and change processes; ID cards; advance medical directives; compliance with State EPSDT and immunization schedules; and grievance and appeals processes

Certain high-volume providers receive training via monthly, quarterly, and annual education visits or via operational meetings with Provider Services staff. Provider Services staff will meet one-on-one with hospitals quarterly and with PCPs at least annually.

Communication Review and Approval (6.1.6.5)

Amerigroup will submit provider communications to DHS for pre-approval at least 30 calendar days prior to expected use and distribution, unless otherwise requested by DHS. We will submit substantive changes to previously approved communications to DHS for review and approval at least 30 calendar days prior to use. We will comply with DHS processes that facilitate submission and approval of materials. We will also submit information that includes the State's name and correspondence that may be sent to providers on behalf of DHS to DHS for review and approval. Approval given for DHS or other State agency name or logo is specific to the use requested and shall not be interpreted as blanket approval. Upon DHS request, we will include State program logos in its provider communication materials. We understand DHS reserves the right to mandate that specific language be included in provider communication materials.

At least 30 calendar days prior to use and distribution, Amerigroup will submit new and previously approved communications to DHS. Following DHS approval, we will post each provider communication piece to our Iowa provider website.

To facilitate version control and communication integrity, we will assign unique document control numbers to each provider communication. The document control information includes a date that identifies when we finish a document originally or when we finish an update or revision.

Contractor Developed Materials (6.1.7)

All materials developed by Amerigroup will be made available to DHS and archived in an electronic library. The materials will be available to DHS throughout the contract term and transitioned to DHS after the contract term.

Notification of Provider Disenrollment (6.1.8)

Question 6.1.8, #1

1. Describe procedures for ensuring continuity of care and communication with members when a provider disenrolls.

Our primary concern is the well-being of our members. Assuring seamless transitions and continuity of care is an integral part of assisting members when a provider disenrolls from the Network. We manage our care coordination services and processes so that each member receives uninterrupted care. As the national annual voluntary termination rate for our PCPs is less than 1 percent across our affiliates, we seldom need to transition care for a member due to provider disenrollment. However, Amerigroup does have policies and procedures in place to accommodate members in those rare instances when a provider becomes unavailable.

Member Notification of Provider Termination

When a PCP or other provider serving as the primary source of care for a member voluntarily or involuntarily disenrolls from our Network, we will send notification letters to affected members in accordance with Agency and federal requirements.

When termination involves a PCP:

- The letter will explain the member's need to choose a new PCP within 30 days.
- We will encourage members having difficulty choosing a new PCP to contact the Member Services Helpline for assistance.
- We reach out to members in active care or who have not selected a new PCP within 30 days to see if they require assistance selecting a new PCP.

When members do not select a new PCP, Amerigroup assigns them to a PCP in our Network who best meets their needs within their geographic area. If a provider disenrolls from our Network but remains a provider part of the Iowa Initiative, we will monitor the provider to make sure he or she continues to care for program members at least 30 calendar days or until the member has a new provider. If a provider disenrolls from the Iowa Initiative, we will help the member locate a new provider that meets his or her needs.

Provider Disenrollment Information Submission

Using web interchange, we will notify the State fiscal agent's provider enrollment unit of the intent to disenroll a provider. When advance notice of disenrollment is available, notification will occur within five business days prior to the effective disenrollment date. When advance notice is not feasible, we will submit the disenrollment within five business days of the provider's termination effective date.

We reassess our Network when a PCP terminates to verify that PCP access and network composition are not impacted by the termination. We will notify the proper regulatory agencies within 15 business days if there is a determination that the Provider Network could materially reduce access to care. We will submit any required reporting of provider enrollments and disenrollments by email, fax, or mail, as requested by

the Agency. We will report Network status of PCPs, specialists, hospitals, ancillaries and other providers annually or when there are significant changes in the Network.

Provider Notice of Termination and Continuity of Care Requirement

A contracted provider terminating his or her contract with us must submit written notification at least 90 days prior to the termination date. As stipulated in their agreements, when providers terminate their contract, they must provide continuation of care for members for at least 30 calendar days or until the member's assignment to another provider becomes effective. We also help our members on a one-on-one basis to receive continuity of care when their specialist has terminated from the Network.

Medical Records (6.1.9)

Question 6.1.9, #1

1. Describe your process for transmitting and storing medical data, including the use of technology and controls to ensure confidentiality of, and access to, medical records.

To comply with Iowa Administrative Code 441, Chapter 79.3, Amerigroup Iowa will draw upon our affiliates' more than two decades of experience developing and implementing policies and procedures to meet and exceed contractual requirements for participating provider medical records content and documentation. As a partner with numerous State and federal government agencies, our affiliates have established extensive processes to verify the consistent protection of the confidentiality of member information. Amerigroup's participating providers contractually agree to follow all federal and State laws and regulations regarding medical records, specifically 42 CFR 456 with regard to utilization control requirements, related policies, and procedures. Amerigroup will comply with all requirements addressed in SOW Section 6.1.9 Medical Records and SOW Section 2.15 Confidentiality of Member Medical Records and Other Information.

Transmitting and Storing Medical Data

Amerigroup requests medical records from providers by confidential mail or fax request. When requesting by fax, we use cover sheets to protect the names of our members, sending the request to a private fax machine in the provider's office. We verify private fax numbers with our providers on an ongoing basis. The majority of our providers return requested medical records to us by mail or fax. Some provide copies when we visit their offices during medical records reviews. In all cases, we store the medical record using one of two methods, depending on the intended use and receiving department:

- We receive electronic data as an image through a secure portal. We store the image in a secure database repository such as FILENET or Ultera. Once we secure the image within the repository, originals are destroyed.
- We receive hard-copy medical records or other protected information and store them in a secure, locked filing cabinet accessible only to those clinical employees requiring use of the data.

When receiving electronic data that need to be stored as a hard copy, the file arrives through a secure portal, and we maintain the file(s) in a locked filing cabinet. Then, we destroy the electronic originals. Amerigroup adheres to all standards set forth in our records retention policy.

Access to RightFax (a secure facsimile process available on computers) and electronic database repositories is limited to those with network security and authorization to access the information. Users of either software program can enter and access the information only with a unique user ID and password.

Technology and Controls to Secure Medical Records

On the rare occasion we send or receive protected health information (PHI), medical records, and other confidential information by email, our company uses the ZIXCorp® software program Secure eMail, a program that automatically encrypts emails and attachments identified as potentially containing PHI.

Secure eMail

Secure eMail requires setting up a user ID and password to retrieve information sent to recipients outside our email system. Here is how it works:

- If we send a provider an email or attachment containing PHI, the provider is notified that he or she has a Secure eMail message
- By clicking on a link in the email notification, the provider is directed to the Secure eMail website
- Providers can forward the email, but the recipient cannot access the content of the email
- Providers using Secure eMail for the first time must register to create a password-protected account
- The provider logs into the Secure eMail Message Center to retrieve the email and attachment

Secure eMail also enables the provider to encrypt and send us secure emails. The Secure eMail program has a help desk to answer technical questions. The service is available to Amerigroup network providers at no charge.

Provider Medical Record Standards

Medical records will be maintained in a manner that supports effective and confidential member care and quality review. Providers must comply with HIPAA security requirements. Amerigroup performs medical record reviews upon signing a provider contract and, at a minimum, every three years thereafter to verify that providers comply with these standards. Policies, procedures, and expectations will be documented in the Provider Manual. We require providers to store

and retrieve medical records in a manner that protects patient information according to the Confidentiality of Medical Information Act. This act prohibits a provider of healthcare from disclosing any individually identifiable information regarding a patient's medical history, treatment, or behavioral and physical condition without the patient's or his or her legal representative's consent or specific legal authority. Records required through a legal instrument may be released without patient or patient representative consent.

We perform random medical record reviews of all primary care providers (PCPs), including General Practice, Family Practice, Internal Medicine, Pediatrics, select OB/GYNs, and other specialists who may be serving as a member's PCP, to verify that providers comply with these standards.

Medical Record Documentation Standards

In accordance with State and federal laws, Amerigroup makes sure that medical records contain documentation that supports all medical services a member receives. Our standards for medical records comply with IAC 441-79.3 and 79.4. Every medical record, at a minimum, must be legible; dated; and signed by the physician, physician assistant, nurse practitioner, or nurse midwife providing patient care and include the following:

- **Identification.** Each page or separate electronic document of the medical record must contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the



medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

- **Basis for service — general rule.** The medical record must reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record will include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:
 - The member's complaint, symptoms, and diagnosis
 - The member's medical or social history
 - Examination findings
 - Diagnostic test reports, laboratory test results, or X-ray reports
 - Goals or needs identified in the member's plan of care
 - Physician orders and any prior authorizations required for Medicaid payment
 - Medication records, pharmacy records for prescriptions, or providers' orders
 - Related professional consultation reports
 - Progress or status notes for the services or activities provided
 - All forms required by the department as a condition of payment for the services provided
 - Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program
 - The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative
- Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment

Service Documentation

The record for each service provided will also include information necessary to substantiate that the service was provided:

- The specific procedures or treatments performed
- The complete date of the service, including the beginning and ending date if the service is rendered over more than one day
- The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis; for those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service will be recorded, rather than the beginning and ending time
- The location where the service was provided if otherwise required on the billing form
- The name, dosage, and route of administration of any medication dispensed or administered as part of the service
- Any supplies dispensed as part of the service
- The first and last name and professional credentials, if any, of the person providing the service
- The signature of the person providing the service or the initials of the person providing the service if a signature log indicates the person's identity
- For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services

Security of Medical Records

Medical records will be secure and inaccessible to unauthorized access to prevent loss, tampering, disclosure of information, alteration, or destruction of the record. Information will be accessible only to authorized personnel within the provider's office, Amerigroup, and DHS representatives or to persons authorized through a legal instrument. Records will be available to Amerigroup for purposes of quality review, HEDIS®, and other studies.

Internal Safeguards to Maintain Data Integrity

To support the Iowa Initiative, we will maintain appropriate administrative, physical, and technical safeguards to maintain data security, including the following:

- Enforcing administrative procedures for execution of security measures
- Maintaining physical safeguards such as protection of computers, equipment, locks, and keys
- Implementing and maintaining adequate measures to control access to computer systems
- Instituting processes to prevent unauthorized access to data that are transmitted electronically

All employees receive thorough training on the overall requirements of HIPAA Privacy and Security Rules, as well as how these rules apply to specific job functions, as described in Section 2.15.

Maintenance and Retention (6.1.9.1)

Active medical records will be secured and inaccessible to unauthorized persons. Amerigroup has electronic record-keeping system procedures in place to help verify patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of our computer systems. Security systems are in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to make sure that recorded input is unalterable. To that end, Amerigroup makes sure that our retention practices align with the requirements outlined in SOW Section 6.1.9.1 Medical Records Retention, including:

- Identifying each medical record by State identification number
- Identifying the location of every medical record
- Placing medical records in a given order and location
- Maintaining the confidentiality of medical records information and releasing the information only in accordance with SOW Section 6.1.9.4 Confidentiality of Medical Records
- Maintaining inactive medical records in a specific place
- Permitting effective professional review in medical audit processes
- Facilitating an adequate system for follow-up treatment, including monitoring and follow-up of off-site referrals and inpatient stays

Amerigroup will maintain records during the time the member is receiving services from the provider, for a minimum of seven years from the date when a claim for the service was submitted to the medical assistance program for payment, and as may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

Corrections to Medical Records

In compliance with DHS rules, we understand that a provider may correct a medical record before submitting a claim for reimbursement and that DHS allows for corrections to medical records as follows:

- Corrections must be made or authorized by the person who provided the service or by a person who has firsthand knowledge of the service.

- A correction to a medical record must not write over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
- Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.
- If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

Member Rights (6.1.9.2)

In accordance with SOW Section 8.10.6 Copy of Medical Records and 42 CFR 438.100(b)(2)(vi), Amerigroup maintains procedures that guarantee members have the right to request and receive a copy of his or her medical records and to request that they be amended or corrected. Providers are required to offer a copy of a member's medical record upon reasonable request by the member at no charge, and they must facilitate the transfer of the member's medical record to another provider at the member's request.

Consent and Availability of Medical Records

A provider's medical records system must allow for prompt retrieval of each record when a member comes in for a visit. Providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, facilitates an accurate system for follow-up treatment, and permits effective professional medical review and medical audit processes. Medical records must be legible, signed, dated, and maintained for at least seven years as required by State and federal regulations or for the duration of contested case proceedings, whichever is longer, in accordance with SOW Section 2.4.2 Medical Records.

Access to Medical and Financial Records (6.1.9.3)

Providers must permit Amerigroup and DHS representatives to review members' medical records for the purposes of monitoring provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality, or any other reason. Our contracts include the necessity to share information for oversight and better member outcomes. Providers will be encouraged to use technology, including the Iowa Health Information Network (IHIN), to transmit and store medical record data.

Confidentiality of Medical Records (6.1.9.4)

All members' medical records will be stored in a confidential manner and will not be released without written consent of the member or responsible party. Written consent is not required for transmission of medical record information to physicians, other practitioners, or facilities providing services to members under contract with Amerigroup or for transmission of medical record information to physicians or facilities providing emergency care. However, written consent is required for the transmission of medical record information of a former member to any physician not connected with Amerigroup. The extent of medical record information to be released in each instance will be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All releases of medical records will be compliant with the HIPAA Privacy Rule.

Availability of Services (6.1.10)

Question 6.1.10 #1

1. Describe your plans to ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members.

Appointment Availability and After-hours Access

Amerigroup affiliates have extensive experience managing networks to help assure providers adhere to all requirements of the health plans we develop and manage. For the Iowa Initiative, we will establish an in-depth, cross-functional process to monitor the current status of our network, project future needs, readily identify any network deficiencies or gaps, and replicate this successful process to make sure our network is able to meet and exceed the needs of Initiative beneficiaries. In accordance with 42 CFR 438.206, we will consider multiple elements when developing and maintaining our provider network. Our network providers will maintain hours of operation that are no less than the hours of operation offered to commercial members. We will also make covered services available twenty-four hours a day, seven days a week (24/7), when medically necessary. We are uniquely positioned to anticipate Medicaid enrollment; evaluate member needs, preferences, and utilization patterns; and demonstrate our ongoing commitment to a robust and responsive provider network. We will routinely review the overall member enrollment to gauge our network against the total eligible population. This allows us to understand the scope of eligible individuals and anticipate and meet the needs of any increase in enrollment. We will also conduct ongoing analysis of clinical data to make sure the network contains the appropriate mix of providers to serve Iowans.

We inform providers about appointment availability and after-hours access standards in their provider agreements, orientations, and Provider Manual. Through the orientation and training, we emphasize that hours of operation for our Medicaid members can be no less than those offered all other patients in their practice. We routinely monitor provider adherence to these standards through:

- Annual audit of a random, statistically valid sampling of primary care providers (PCPs) and designated specialists to assess appointment availability and after-hours coverage
- Review of member grievances, critical incidents, and advisory committee feedback
- Feedback from Care Coordinators and Case Managers

After-hours Services

Our members must have access to healthcare 24/7. Providers are required to have a system for members to call after hours with medical questions or concerns. We regularly monitor provider compliance with after-hours access standards by randomly sampling providers and conducting calls to their offices after hours. Failure to comply with after-hours access requirements may result in corrective action, including termination from our network.

Providers must adhere to the following after-hours protocols:

- Answering service or after-hours personnel must:
 - Forward calls directly to the PCP or on-call provider or inform members that the PCP will contact them within 30 minutes



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- Ask if the call is an emergency; if so, they must immediately direct the member to dial 911 or proceed directly to the nearest hospital emergency room
- Have the ability to contact a telephone interpreter for members with language barriers
- Return all calls
- Answering machine messages:
 - May be used when staff or an answering service is not immediately available
 - Must instruct members with emergency healthcare needs to dial 911 or proceed directly to the nearest hospital emergency room
 - Must provide instructions on contacting the PCP or on-call provider in a nonemergency situation
 - Must provide instructions in English, Spanish, and any other language appropriate to the PCP's practice

We require providers to use an Amerigroup-contracted network provider for on-call services. When that is not possible, the provider must use his or her best efforts to make sure that the on-call provider abides by the terms of our provider contract and standards.

When we identify a provider who is out of compliance with appointment standards, our employees visit the provider and present a letter requesting a Corrective Action Plan. We continue to monitor compliance and re-survey the provider after 90 days to verify compliance. Ultimately, we remove any provider who fails to meet access standards from our network.

Provider Compliance (6.1.11)

Question 6.1.11 #1

1. Describe procedures for ensuring network providers comply with all access requirements and for monitoring providers for compliance.

Policies and Procedures for Network Provider Accessibility

Amerigroup has established policies and procedures that outline our standards for timely, appropriate access to quality healthcare. Following guidelines set by DHS, NCQA, and the American College of Obstetricians and Gynecologists (ACOG), these standards promote fair, reasonable, timely medical appointments, emergency services, and continuity of care for new and transferring members. They establish timeliness standards based on provider type and urgency of member needs, as well as maximum in-office wait times. We closely monitor provider compliance with access to care standards and take corrective action to address noncompliance. We will comply with all requirements specified in Attachment 1, Scope of Work.

Amerigroup is committed to maintaining an Iowa Initiative provider network that not only meets geographic access standards, but also our members' racial, cultural, and linguistic needs. We recognize that there can be cultural and linguistic barriers that affect our members' ability to understand or comply with certain instructions or procedures. In addition to recruiting a diverse network, we offer various tools and resources to help providers deliver culturally competent services. For example, we regularly educate providers around cultural competency and include this topic in our provider orientation. We also provide internal training around cultural competency and developed our Caring for Diverse Populations Toolkit that we post to the Provider Resources page on our website. We developed the toolkit to address very specific operational needs that often arise in a busy practice because of changing service requirements and legal mandates. Toolkit topics include:

- Resources to assist with a diverse patient population base
- Resources to communicate across language barriers

- Resources to increase awareness of cultural background and its impact on healthcare delivery
- Regulations and standards for cultural and linguistic services
- Resources for cultural and linguistic services

Amerigroup outlines our internal appointment waiting time standards in Table 6.1-10. We educate providers on these requirements during initial orientation and reinforce them through ongoing training and our Provider Manual.

Table 6.1-10. Appointment Waiting Time Standards

Service/Provider Type	Assessment and/or Treatment
Emergency examinations	Immediate access during office hours
Urgent examinations	Within 24 hours of request
Non-urgent “sick visits”	Within 72 hours of request
Non-urgent routine exams	Within 21 days of request
Specialty care examinations	Within 3 weeks of request
Outpatient behavioral health examinations	Within 14 days of request
Routine behavioral health visits	Within 10 days of request
Outpatient treatment following discharge from an inpatient hospital	Within 7 days of discharge
Post-psychiatric inpatient care	Within 7 days of discharge

Medical Appointment Standards

Through provider education, our Provider Manual, and provider visits, we encourage PCPs to perform an Initial Health Assessment (IHA) and Preventive Care Assessment for newly assigned members. An IHA is not needed if the member is an existing patient of the PCP group (but new to Amerigroup Iowa). In addition, follow-up is not needed if there is an established medical record that shows baseline health status. The medical record should include sufficient information for the PCP to understand the member’s health history and to recommend treatment as needed. Transferred medical records meet standards for an IHA if a completed health history is included. Medical appointment standards for members under the age of 21, those 21 and older, and prenatal and postpartum visits are shown in Tables 6.1-11 through 6.1-13.

Table 6.1-11. Medical Appointment Standards: Services or Members Under the Age of 21

Nature of Visit	Appointment Standards
Initial Health Assessments	<ul style="list-style-type: none"> • Newborns: within 14 days of enrollment • Children: within 60 days of enrollment • Adults (18–21): within 8 weeks of enrollment

Table 6.1-12. Medical Appointment Standards: Services for Members 21 or Older

Nature of Visit	Appointment Standards
Initial Health Assessments	Within 90 days of enrollment

Table 6.1-13. Medical Appointment Standards: Prenatal and Postpartum Visits

Nature of Visit	Appointment Standards
First trimester	Within 14 days of request
Second trimester	Within 7 days of request
Third trimester	Within 3 business days of request or immediately if an emergency
High-risk pregnancy	Within 3 business days of request or immediately if an emergency
Postpartum exam	Between 3 to 8 weeks after delivery

Question 6.1.11 #2**2. Describe emergency/contingency plans in the event a large provider is unable to provide needed services.**

In the event a large provider is unable to provide needed services, Amerigroup will implement contingency plans. We will submit these plans to DHS for approval and will include the following elements:

- If a large provider is unable to provide a specific service, the Healthcare Services team in concert with the Provider Services team will find an appropriate alternative for the member's care. The member will be engaged in care with the identified provider as quickly as medically necessary.
- If a large provider is not available to render any services, we recognize that many members are likely to be affected. In this instance, care of the members will be quickly triaged to determine how rapidly medically necessary care is needed, and appropriate arrangements will be made with surrounding area providers to get the member the care within the defined time frame. This can include arranging for transportation, if necessary, and making sure members' care is managed to help assure continuity of care. In addition, we will incorporate the use of telemedicine as part of the plan.
- If a natural disaster is the cause of significant providers becoming unavailable, we maintain a Disaster Recovery Program that not only addresses our business needs but also encompasses member services.

In August 2012, Hurricane Isaac devastated portions of Louisiana as its slow-moving trajectory, far-flung storm surge, and torrential rains impacted portions of the State.

Following the Disaster Recovery and Business Continuity Plan, our Louisiana affiliate collaborated with the State agency to support our members, including staffing the State's Emergency Operations Center 24 hours a day during the worst part of the disaster. Daily calls between health plan leadership and national support resources focused on member access to services, employee safety, and continued business operations. Before, during, and after Hurricane Isaac, our affiliate initiated a number of activities, including:

- **Member Outreach** — The affiliate plan provided members useful information on its website and through automated calls:
 - Health plan employees personally called more than 500 active members in Case Management to confirm that they had a disaster plan
 - They initiated automated calls to members in the Tangipahoa Parish to warn them of impending flood waters in the aftermath of Hurricane Isaac
 - The ongoing Emergency Procedures homepage and Community Resources link on its website delivered useful information that helped members stay prepared
- **Managing our Members' Care** — Our affiliate successfully transitioned all members' services activities to the national call center during the worst of the storm. Once it abated and employees were able to return to the New Orleans offices, member services were transferred back to the local plan. To meet member care needs, the health plan:
 - Waived authorization requirements from the start of the storm through September 2, 2012
 - Worked with the call center clinical team to manage authorizations and inpatient admissions, complete discharge planning, and align members with special healthcare needs to PCPs and available community resources to avoid duplication of effort
- **Partnering with our Subcontractors** — Our affiliate worked with subcontractors to enable members to get the support they needed. This specifically included:
 - Relaxing pharmacy rules for medical injectibles so members were able to get medications without authorizations

- Working with durable medical equipment and transportation vendors before the storm to support members (for example, getting to shelters, having evacuation plans, having proper medical supplies)
- **Maintaining Quality Management** — The health plan collaborated with national Quality Management partners to prevent disruption of quality of care and appeals.

As part of our organization-wide culture of continuous improvement, our Louisiana health plan conducted a detailed review of its response to Hurricane Isaac to identify what went well and opportunities for improvement. The health plan provided recommendations to the State, including suggesting briefings with all Louisiana MCOs to promote timely and accurate exchange of information and provide uniform communication of crisis-related information to members and providers.

Network Development and Adequacy (6.2)

Member Choice (6.2.1)

Amerigroup Iowa (Amerigroup) is committed to offering quality care in the least restrictive manner possible. Part of that is offering members choice with respect to providers. We have already started building relationships with key Iowa providers and provider organizations that will be the foundation of a sufficient provider network that includes an array of primary, acute, long-term support services, behavioral health, and ancillary providers for members covered under the Iowa Initiative. This provider network will offer members choice in providers and sufficient access to covered services without regard to variations in provider reimbursement. From our list of participating providers, members can choose a primary care provider (PCP) that best meets their needs. They can choose to have a second opinion rendered by providers within the system, and if there is not a reasonable alternative, we will work with the member to find an acceptable non-participating provider for that opinion. Additionally, if a member needs the services of a specialist, he or she can work with his or her primary care provider to select a specialist that best meets his or her needs. We provide a listing of LTSS services and supports that are available to members in their area so that they can choose an LTSS provider of their choice



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Amerigroup’s programs are built upon a member-centric focus with emphasis on improved health outcomes and quality of life one member at a time – by doing the right thing for every member every time.

Members can view our provider network via our member website. The website includes a searchable online directory to select a PCP based on the member’s preferences and location. The tool always contains the most accurate information on our provider network. We update the web-based provider listing every night from our core operating system. Prospective members can also view our provider directory from our

website. If a member enrolls and has an established relationship with a provider who is not part of our network, Amerigroup will contact that provider with the intent to contract him or her into the network.

Network Development and Maintenance (6.2.2)

Question 6.2, #1

1. Describe in detail your plans to develop and maintain a comprehensive provider network, including goals and tasks and the qualifications and experience of the staff members who will be responsible for meeting network development goals.

Amerigroup's affiliate health plans have a strong record of developing and maintaining provider networks that meet and often exceed adequacy and sufficiency standards in the 19 states where we manage state-sponsored health programs. We diligently monitor access to and the availability of our provider network. We continually generate and evaluate GeoAccess reports for physical and geographic access to make sure members have ample choice of providers. We also regularly monitor information obtained through our Network Strategy Workgroup and Health Education Advisory Committee, as well as Provider Services, Medical Management, Quality Management, and Member Services departments to identify opportunities to improve the network and address any deficiencies. When we identify a deficiency in meeting access standards, our Provider Services staff promptly develops a detailed action plan—including staffing, responsibilities, resources, and a timeline—to correct the situation. Strategies may include:

- Identifying and recruiting additional providers
- Identifying out-of-network providers for single-case agreements
- Working with existing providers with closed panels to meet requirements for re-opening the panels or asking them to accept the member on an exception basis
- Expanding or facilitating transportation services.

We monitor the plan's progress until we attain compliance. Amerigroup has created a Provider Network Development and Management Plan to meet the requirements contained in SOW Section 6.2 Network Development and Adequacy. We use the plan to develop, maintain, and monitor an adequate provider network and will be maintained by our Iowa-based Provider Services Department. Our Provider Services team developed and will refine, evaluate, and manage the Plan with ongoing input from our Network Strategy Workgroup. This cross-functional workgroup includes representatives from Provider Services, Medical Management, Quality Management, Compliance, Community Outreach, Government Relations, and Finance. The workgroup provides valuable insight and feedback to make sure that our network has the right number, mix, and geographic distribution of quality providers to meet the needs of our members and to comply with Amerigroup standards and Contract requirements. The workgroup is led by the Provider Services Manager and meets quarterly. Our Iowa Health Plan CEO, Medical Director, and Chief Operating Officer also serve on the workgroup.

Our provider network development and maintenance tasks incorporate the following:

- Establish rapport with the provider community
- Educate providers regarding services that Amerigroup provides
- Discuss partnerships with provider population to meet the membership needs
- Secure agreements to form network
- Credential providers
- Provide ongoing provider support through Amerigroup's Provider Services Department

As mentioned earlier in Section 6.1.1, through a close partnership with Wellmark, Inc., and engagement with existing Iowa State resources for valuable feedback, we have gained an understanding of Iowa's provider community and the health care needs of its Medicaid, hawk-i and other members who will be served under the Iowa Initiative.

We will build trust and develop collaborative working relationships with Iowa providers through our on-the-ground approach. We will assure that providers are well-versed in our programs, processes, or procedures. Our goal is to forge successful relationships with Iowa's providers that will position us at the forefront of the contracting process and assure compliance with network requirements. We will continually seek to improve our network by listening and responding to our members, providers, stakeholders, and community partners. Our collaborative approach to developing, assessing, and updating our network will foster an adequate and accessible network for our members.

Excluded Providers (6.2.2.1)

Amerigroup will comply with all requirements in Section 6.2.2.1 and will not execute provider agreements with providers who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs per Sections 128 or 1156 of the Social Security Act or who are otherwise not in good standing with a State's Medicaid or Medicare program. We have proven processes in place so that excluded providers are not included in our network. This includes checking the lists of providers currently excluded by state and federal governments every 30 days.

Network Development Considerations (6.2.2.2)

Our network adequacy and capacity model considers all of the requirements in the RFP for establishing and maintaining a provider network that offers members adequate access to covered services, including those found in RFP Exhibit D – Covered Benefits. Our intent is to develop a network that meets and/or exceeds access and capacity standards to foster member access and choice of providers based on:

- Expected utilization of services required by the populations served by the Iowa Initiative
- Anticipated enrollment of all populations included in the program, including Medicaid, CHIP, SSI, and waiver populations
- Numbers and types of providers required to furnish the contracted services, including training, experience, and specialization
- Provider capacity (including the effect of providers who are not accepting new Medicaid/CHIP patients)
- Geographic location of providers and Medicaid enrollees (including distance, travel time, means of transportation, and physical access for members with disabilities)

In our considerations of access for members with disabilities, we capture physical access for each provider location and use this to map access for members with disabilities and expand contracting as indicated. All network providers will execute a written agreement to participate in our network. Our network capacity modeling incorporates the following steps and considerations.

Anticipated Enrollment (6.2.2.2(i))

Our anticipated enrollment determines the composition and capacity needs of our provider network, including PCPs, specialists, hospitals, ancillary providers, and long-term care providers. We start by identifying and counting the available providers by type and specialty that we will target for participation in our network based on the needs of our expected members. We target all available providers for contracting, including but not limited to providers with whom we have already obtained LOIs.

In determining our initial network capacity, we estimate the projected number of enrollees we expect to receive. For modeling purposes, we adjust our initial network capacity target to accommodate twice the

anticipated enrollment, allowing for sufficient excess capacity in our network projections. For Iowa, which intends to award two to four Contracts, we estimated three Contract awards, which would mean that one-third of the number of beneficiaries will be enrolled with Amerigroup; we then double that number to obtain the baseline enrollment from which we determine the needed provider network capacity.

Expected Utilization of Services, Numbers and Type of Providers Required, Providers not Accepting New Medicaid Patients (6.2.2.2(ii) – 6.2.2.2(iv))

We analyze the expected populations and the services they need. To account for expected utilization of services, we establish target ratios of members to providers by provider type. *We use conservative member-to-provider ratios, assuring appropriate access for services.* For example, we model our PCP capacity using a ratio of 1,500 members to a PCP and 750 to a physician extender. We also recognize that advanced registered nurse practitioners serve as PCPs in Iowa and are considered independent practitioners. We use a ratio of 10,000 members per provider for specialists, while also assuring that we include the subspecialists experienced at working with our members with various special needs.

We also examine travel time for specialists, particularly higher volume specialists such as OB/GYNs, cardiologists, psychiatrists, allergists, dermatologists, gastroenterologists, general surgery, ophthalmologists, and orthopedic surgeons. This allows us to assure we have adequate capacity to absorb variations in utilization caused by variations in populations and other variables.

Amerigroup's Participating Provider Agreements require providers to accept members up to the specified capacity limits. During the contracting and credentialing process, providers may designate when they are open to accept new members or are limiting enrollment to current patients. Amerigroup maintains an expectation that if a provider closes his or her practice, he or she is taking that action for all populations and payer. We adjust our capacity estimates to account for providers who are accepting current patients only or are not open to new Medicaid members. For example, if we have 350 PCPs in a given service area but only 300 have open panels, our adjusted number of available PCPs for new member enrollment would be 300. Providers with closed panels that have actual Amerigroup members are considered when determining overall network capacity.

Geographic Location of Providers and Members (6.2.2.2(v))

We target all available providers within the travel distance requirements established in the RFP, including providers in contiguous states that also fulfill the travel and distance requirements. Travel time and distance standards vary between urban and rural areas to account for the different means of transportation available in those areas, such as availability of public transportation. We use GeoAccess software to measure both the average distance of members to a provider and the percentage of members who have access to a provider of each type within the defined travel distance standard. This method allows us to assess the adequacy of our network for each provider type against the time, distance, and capacity standards and assists in identifying any gaps in coverage that we need to target for continued ongoing contracting.

Throughout our initial network development period, we evaluate our provider network against the time and distance and capacity measurements. To determine capacity, we multiply the provider counts for each provider type by the applicable capacity ratio to determine network capacity. For example, if we have 200 age-appropriate PCPs and 35 physician extenders in a given area with open panels, we multiply 200 by 1,500 and 35 by 750 to obtain a maximum PCP network capacity of 326,250 members within the area.

We test the capacity result obtained from the network adequacy model against our anticipated enrollment. We couple geographical adequacy with the capacity standards in GeoAccess software to allow us to take both elements into consideration when evaluating the capacity and adequacy of our network.

Amerigroup uses data to support our on-the-ground, local approach to network development. Iowa is the 14th least densely populated state, which presents a challenge in network development. Amerigroup's affiliates have built strong provider networks in states with challenges similar to Iowa—including Kansas, Nevada, and New Mexico, which are the 11th, 9th, and 6th least densely populated states. In Iowa, we will use census data, enrollment files, and various State/federal agency reports to identify members' language, race, and ethnicity. This information helps assure that our network meets the cultural and linguistic needs of members. In developing our initial network, we will target all available Iowa providers to serve the needs of the populations served under the Iowa Initiative

Using available data, we also perform analyses to identify population centers and high-volume Medicaid providers. Our goal is to maximize continuity of services for members so we can focus our efforts on those providers who are currently providing the most services to the covered population. Conversely, this analysis also identifies areas where both the population and availability of providers are sparse. This helps us develop our strategies for contracting with the available providers in those areas and developing our approaches to outreach strategies in underserved areas.

Upon development of a provider network, we monitor it to assure it continues to meet the needs of our members. As part of our efforts, we use actual data collected from various internal and external sources, including:

- Utilization and claims data, encounter data, laboratory data, and pharmacy data
- Results from health risk assessments
- Information on State agency eligibility categories
- Demographic information
- Health Department epidemiology reports
- Member complaints
- Quality of services
- Volume of out-of-network authorizations

We use this information to evaluate and adjust our provider network, as needed, to meet the needs of our members and future members.

We also use data to learn about provider availability. For example, Amerigroup studied Iowa's provider availability and learned about the State's historic shortage of physicians using data from sources such as the U.S. Department of Health and Human Services report on Health Professional Shortage Areas and Medically Underserved Areas/Populations. This data supported our development of solutions to enhance access, such as the use and promotion of physician extenders and telemedicine.

Policies and Procedures for Selection, Credentialing and Retention of Providers (6.2.2.3-6.2.2.5)

Amerigroup understands the complexities surrounding Medicaid provider network development and expansion. We have the knowledge, tools, and experience necessary to develop and maintain statewide networks that offer members a selection of providers. Our systems, employees, and policies and procedures allow us to select, accurately credential, train, and re-credential the full spectrum of providers in a timely and efficient manner.

We maintain policies and procedures that prohibit discrimination with respect to participation in the program, reimbursement, or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, Amerigroup does not discriminate against providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR

438.214(c)]. Amerigroup will not refuse to credential and contract with a qualified provider on the sole basis of the network already meeting the contractual distance accessibility standard if there is a subset of enrollees in the proposed service area that must travel beyond the average standard to access care.

Current DHS Providers (6.2.2.6)

Our network development activities for the Iowa Initiative will include giving specific provider, who are currently enrolled as DHS providers, the opportunity to participate in the Iowa network for the first two years of the Contract: (i) community mental health centers (CMHCs), (ii) 1915(i) HCBS Habilitation Services providers, (iii) nursing facilities, (iv) ICF/IDs, (v) health homes, and (vi) 1915(c) HCBS waiver providers, with the exception of Case Managers and Care Coordinators. Our plan also addresses the DHS performance standards that will be required of providers, and during the first two years of the Contract, Amerigroup will recommend to DHS disenrollment of providers who do not meet the performance measures. After this two year time period, we will continue to reimburse these provider types at a rate equal to or higher than the current Iowa Medicaid fee-for-service rate.

Provider Reimbursement Rates, Provider Notification, and IDPH Network (6.2.2.7-6.2.2.9)

Amerigroup will extend contract offers at Medicaid fee-for-service rates to all provider types not identified in Section 6.2.2.6 of the SOW during the first six months of the Contract. We will continue to reimburse these provider types at a rate that is greater than or equal to the current Iowa Medicaid fee-for-service rate after this six month time period. Amerigroup will provide written notice to individual providers or groups of providers who we have elected not to include in our network, as well as the reason for the decision. Amerigroup understands that IDPH will procure the provider network for IDPH-funded substance abuse treatment services and will contract with the IDPH network for inclusion in our provider network.

Qualification and Experience of the Provider Services Staff

Amerigroup is committed to staffing the Iowa health plan's Provider Services department in a manner that complies with all DHS requirements and that positions us to deliver high quality services to Iowans from Day One. Since Amerigroup is new to the IHQI program, we do not currently have individuals fulfilling all roles. However, in preparing to implement operations in Iowa, Amerigroup has identified a seasoned Transition Team of leaders with extensive Medicaid experience and a deep understanding of the needs of the Medicaid members. The Transition Team will be responsible not only for overseeing the initial operations of the IHQI Contract—which includes hiring highly-qualified Iowa-based staff—but these individuals will have accountability and responsibility for the success of the Iowa health plan on an ongoing basis.

The Provider Services staff, led by its Manager, will have responsibility for the continued development and maintenance of the provider network and in monitoring the network's adequacy. On the Transition Team, Julie Skaggs is the Provider Services Manager. Within our national organization, Julie serves as a Director of Health Plan Support and National Provider Relations. A seasoned professional with over 20 years of health care experience, she has experience in building and enhancing provider networks, managing network operations, exceeding financial targets, formulating health plan policy, the development of health plan accreditation programs, and extensive leadership experience in managed care. With this depth of knowledge and experience in managed care, Julie will work diligently to build a successful team in Iowa.

The staff Amerigroup assembles will work to build lasting and trusting relationships with providers to offer our members the right size, the right composition, best quality, and the most efficient network. An integral part of our plan is to hire the staff necessary to provide the highest level of quality service to Iowa providers and thereby create a path that enables quality care for our members.

We look to hire locally based staff that understands the intricacies of the State and its health care delivery system. At a minimum, staff will be expected to have a high school diploma with one to three years of experience in customer service or any combination of education and experience that provide an equivalent background. In a management position, we look to recruit staff that has a BA/BS degree with seven years of experience in managed health care or hospital environment, provider relations or network management and three years leadership/management experience or any combination of education and experience that would provide an equivalent background. For staff that will be engaged in contracting activity, we do require that they have one to three years of contracting experience.

Furthermore, Amerigroup will seek to hire staff that has experience in working with the wide variety of provider types that are part of our network. Our affiliates' 24 years of experience in state-sponsored health programs has proven that by hiring staff with such experience, we develop a level of trust with our providers because we have staff working with them that understands their business, their concerns, and their challenges.

Network Adequacy (6.2.3)

Amerigroup will deliver a statewide network of high quality providers to meet network adequacy standards for a January 2016 start date. Amerigroup will document adequate network capacity—which addresses time and distance standards and the provider number, mix, and geographic distribution as outlined in Exhibit B of the SOW—at the time we enter into a contract with DHS, at any time there is a significant change in our operation, or the program changes in services, benefits, payments, enrollment of new populations, or as directed by the State. Amerigroup's CEO will sign all documentation of network adequacy before submission to DHS. In addition, Amerigroup will provide written notification to DHS at least 90 days in advance of any anticipated inability to maintain a sufficient network in any county. We diligently monitor access to and the availability of our provider network. We generate and evaluate GeoAccess reports continuously for physical and geographic access to make sure members have ample choice of providers. We also continuously monitor information obtained through our national Network Strategy Workgroup and Health Education Advisory Committee, as well as Provider Services, Medical Management, Quality Management, and Member Services units, to identify opportunities to improve the network and address any deficiencies.

When we identify a deficiency in meeting access standards, our Provider Services staff promptly develops a detailed action plan—including staffing, responsibilities, resources, and a timeline—to correct the situation. Once launched, we monitor the progress and effectiveness of the plan until we meet or exceed standards.

Provider Outreach / Contracting in Rural Areas (6.2.3.1)

Question 6.2, #2 (6.2.3)

2. Describe your strategies for provider outreach and contracting in rural areas.

Our affiliates' experience in building provider networks extends to some of the most geographically challenging areas in the United States. We will employ a proactive outreach and contracting plan to build our target provider network that incorporates the approach we have used in our affiliate plans with a high concentration of rural populations. We understand the extra attention that is needed to build and maintain a successful network in the rural areas of Iowa, where providers may be unaccustomed to managed care and need additional support through face-to-face interactions or similar outreach. Our knowledge allows us to fully leverage our experience and collaborate with providers to improve the delivery of services covered under the Iowa Initiative.

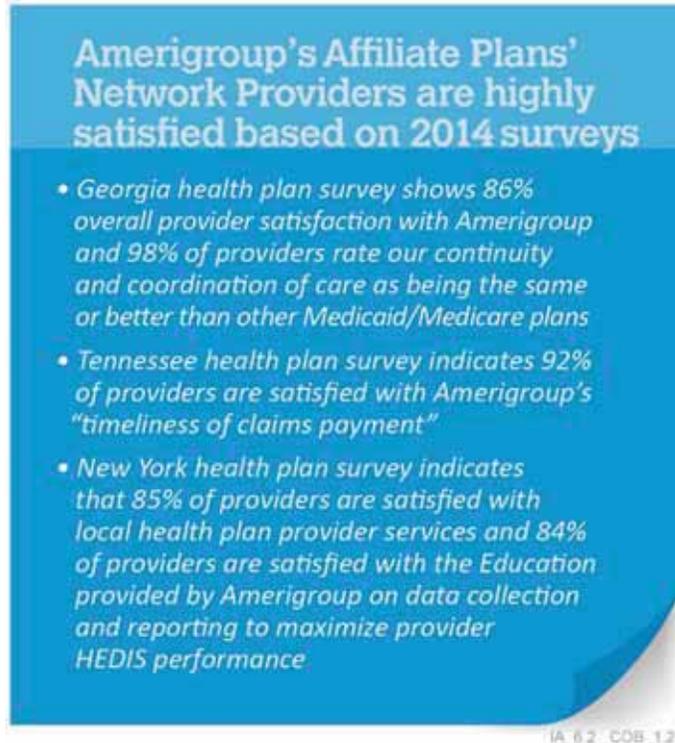
We strive to maintain a comprehensive network of providers that meets the needs of the members we serve, and we make every attempt to retain our network providers. We continually seek to identify opportunities to improve the experience for our providers from annual provider satisfaction surveys to one-on-one interactions. We provide more detail in SOW Section 6.3 on Amerigroup's support, training and active engagement with providers that maintains a high level of provider satisfaction and retention.

Amerigroup has been steadily working on building relationships with Iowa providers. To ensure we provide the best possible statewide network, we engaged with provider associations and other organizations that represent providers throughout Iowa to introduce Amerigroup and gain their support. Our results and summary of LOIs were presented earlier in Section 6.1.1.

We are working with our strategic partner, Wellmark, to develop a robust statewide database of all Iowa Medicaid, non-Medicaid and safety net providers incorporating the listings and information provided by the State.

Amerigroup recognizes that access to specialty care is limited in several areas in Iowa, particularly in rural counties. Together with our affiliate health plans in numerous rural markets across the nation, we leverage and employ an array of proven strategies for provider outreach and contracting, including:

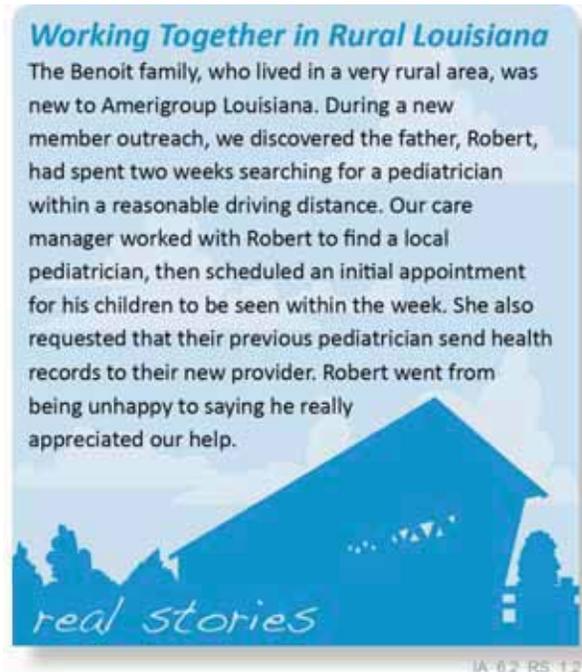
- Monitoring of our current provider network through GeoAccess to identify network gaps in access and inform provider network development efforts
- Ongoing partnering with strong network providers to open offices in rural areas, offer additional needed services, and provide after-hours and weekend appointments
- Co-locating of clinical health plan and provider staff in FQHCs, CMHCs, RHCs, and School-based Health Clinics (SBHCs)
- Developing innovative programs that provide supportive, in-home case management and identifying available community-based resources, such as our Nurse and Family Partnership for at-risk pregnant women and mothers
- Creating awareness and use of existing telemedicine opportunities, as well as identifying and funding additional opportunities through partnerships with providers and community-based organizations
- Providing in-home and telephonic pregnancy monitoring for members with high-risk pregnancies through home injections, hyperemesis treatment, and pre-term labor management
- Providing a prenatal packet to all pregnant members upon identification that provides important information to support healthy mom choices, including early and ongoing prenatal care, nutrition, and choosing a pediatrician prior to childbirth



Amerigroup will also synchronize efforts with DHS' Bureau of Primary Care and Rural Health Iowa Primary Care Association and the Iowa Hospital Association to identify and assess opportunities for boosting access to specialty services throughout Iowa's rural counties and make sure we build upon and do not duplicate existing initiatives within the State.

Although our focus has primarily been in-state, we have reached out to providers in border areas up to 50 miles outside of the Iowa State line to facilitate access to services for recipients who may not have them readily available within their area of the State. We also identified providers that provide outreach and linkages to address access challenges in rural areas of Iowa, such as the University of Iowa.

Our strategies for increasing access to care in rural and hard-to-reach areas include expanding the use of technology in rural areas, contracting with community health centers, and authorizing services provided by out-of-network providers. We will also implement targeted strategies for connecting members with developmental disabilities to services, such as specific outreach events and educational programs directed toward informing members with disabilities, their caregivers, and providers about how to access available services.



Enhancing Services Through FQHCs, CMHCs, RHCs and SBHCs

Amerigroup and our affiliates cultivate deep roots in the communities we serve, and we seek long-term solutions to health care challenges, including the lack of access to specialty care in rural areas. A strategy that has been effective in other states is our collaboration with FQHCs, CMHCs, RHCs, and SBHCs to expand their scope of specialty services. These providers have established operations in rural communities, including relationships with recipients, community agencies, and other stakeholders.

In other states, our affiliates have worked with FQHCs and RHCs to add specialty services not currently available locally. For example, in one rural area, access to behavioral health services was restricted, so our affiliate health plan worked with the local PCPs to add a behavioral health specialist to the practice, enabling access to specialty services that had been severely limited, to improve health outcomes in the community. Amerigroup actively explores similar options for other specialty services that can be built into the existing infrastructure of safety net providers.

Many health plans struggle to address access issues for their members with behavioral health conditions due to a lack of providers in certain market territories. We have developed several innovative approaches to address provider shortage and access issues.

To provide behavioral health services in rural areas, we employ various network development strategies. We extensively outreach to all behavioral health providers within rural areas to encourage them to join our network. We outreach to providers willing to do home visits for members who lack transportation. Amerigroup also reaches out to PCPs practicing in rural areas to determine each clinician's ability and willingness to provide basic behavioral health assessments and treatment. Amerigroup may adjust credentialing standards to accept PCPs who are trained and experienced in psychopharmacology. We support PCPs in screening and treating members for behavioral health conditions through our PC-INSITE program and Screening, Brief Intervention, Referrals and Treatment (SBIRT), both described in detail below. We also offer PCPs telephonic consultative services with Amerigroup's Physician Advisors.

Finally, we identify rural hospitals and determine their capabilities to provide behavioral health services, including brief inpatient or substance use detoxification services, for members who are unable to travel to larger or more specialized facilities.

Telehealth Services

Given Iowa’s shortage of behavioral health professionals in rural service areas, telehealth services can play an important role in providing a network with ready access to services. Telehealth is used to support health care when the provider and member are physically separated. Amerigroup offers innovative behavioral health services via telehealth, including outpatient consultation services, outpatient psychotherapy, and medication evaluation and monitoring. These behavioral health services are delivered via special secure webcams that providers have installed in their offices. Teleconferencing has been shown to be a highly economical, convenient, and effective services delivery method. In addition, Amerigroup will use the services of Breakthrough Behavioral, Inc., described earlier in Section 6.1.1, that will enable a member to receive behavioral health therapy via an Internet connection.

PC-INSITE

Amerigroup understands that many members with behavioral health conditions may not seek assistance from a behavioral health provider, and as such, we are working to make sure the members get the services they need in the primary care setting. Our PC-INSITE is a program we developed for PCPs that will enhance and support the identification and treatment of behavioral health conditions in the primary care office where Amerigroup has Health Coaches.

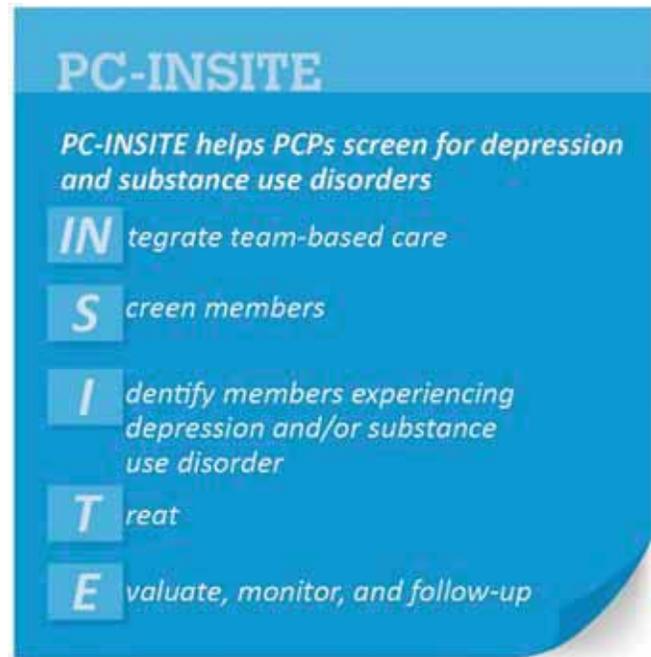
PC-INSITE is an approach that works to screen members in primary care settings for depression and/or substance use disorders and diagnose, treat, and manage these conditions to reduce a negative impact or complications of their medical conditions. PC-INSITE is based on well-documented evidence that depression and substance use disorder are correlated with higher total health care costs and the fact that PCPs are more likely to prescribe

antidepressants than psychiatrists. In our experience with primary care practices, we have learned that roughly 10 percent of members were diagnosed with depression, while various studies have reported that the general population prevalence is 15 to 40 percent. We decided that our objectives would be to bolster the information and resources in the primary care setting to enhance the prompt diagnosis and treatment of behavioral health conditions. PC-INSITE is described in more detail in Section 3.2.4.

By improving the management of a member’s depression or substance use disorder, overall health is improved, the member’s health service experience is enhanced, the practice improves quality scores (HEDIS), and health care costs are reduced.

SBIRT - Screening, Brief Intervention, Referrals and Treatment

We will work closely with PCPs to share evidence-based practices such as screening tools that will enable them to assess their members’ needs and provide targeted treatment or referrals. One such best practice



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that we will promote to our PCPs is SBIRT, a covered service for our members. SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and screening for individuals with risky substance use and referral to treatment for those members who meet criteria for a substance use disorder. SBIRT has been demonstrated to reduce both alcohol abuse and health care treatment for the abuse. We are committed to increasing the use of this covered service through provider education and partnerships. Through provider education, we will support PCPs in screening our members for behavioral health conditions, and on the web portal we provide them the tools and trainings to complete such screenings. We reimburse all PCPs for all SBIRT services.

Monitoring Utilization to Assure Equality of Service Areas and Availability

Amerigroup will monitor utilization to assure that all members covered through the Iowa Initiative have equal service access and availability, a full network of providers located within the applicable mileage standards established by the State, and reasonable wait times and appointment access. Additionally, throughout the care management process, we monitor access to care and collaborate with our network development team should we identify trends that suggest restricted access in parts of Iowa. In all cases, we focus on facilitating member access to the full array of services available to them.

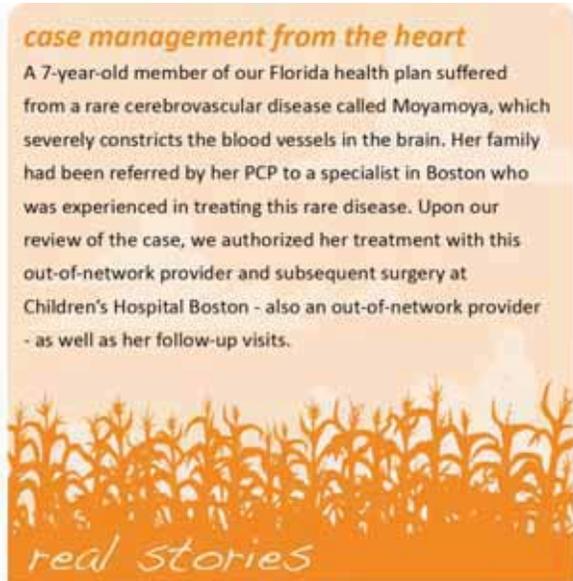
Question 6.2, #3

3. Detail any way in which you propose to limit members to in-network providers.

Out of Network Providers (6.2.4)

Amerigroup will establish a network that provides all covered services and access standards to our members as required by DHS and Exhibit B of the RFP, and, with the exception of family planning, emergency services, and services to maintain continuity of care, we will require members to use in-network providers. We encourage participation of all qualified providers and will seek DHS approval before closing the network. Amerigroup is developing a robust statewide network in Iowa. However, our experience validates that accessing out-of-network services to deliver care in accordance with DHS requirements and local member needs is required even in mature markets. This is especially true for members with special health care needs residing in rural areas. To assure that these services are appropriately provided and paid for, we will adopt an authorization process that has proven successful in our other health plans. When an in-network provider is not available to meet a member’s non-emergency needs, Amerigroup refers the member to an out-of-network provider. In this instance, the Nurse Medical Management clinician or nurse case manager monitors the case from the point of a request for an out-of-network authorization, verifying that treatment is available and delivered.

Upon receipt of an authorization request from the PCP, our medical management clinician verifies member eligibility and then ascertains the reason



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the service is requested of an out-of-network practitioner or facility. The prior authorization Utilization Management Nurse performing the assessment of the member's health needs forwards requiring continuity of care coordination to our Chief Medical Officer or Behavioral Health Medical Director for further discussion and review determination. If the Chief Medical Officer deems providing services by the out-of-network practitioner is medically necessary, we then execute a single-case agreement, following the steps below:

- We check to verify provider licensure and no licensure sanctions, including confirmation that the provider does not appear on any exclusion lists, at a minimum, when we authorize care to an out-of-network provider. We will not enter into single case agreements with any provider who has sanctions.
- Our Utilization Management Nurse approves the authorization for services by an out-of-network provider.
- Our Provider Services Department negotiates a single-case agreement with the provider which sets forth provider payment (a comparable in-state/network rate, the State Medicaid fee-for-service rate, State-approved out-of-network provider payment methodology, or a negotiated fee schedule that assures the cost to the member will not be greater than the in-network cost), as well as prior authorization and care management requirements.
- During initial contact with an out-of-network provider, our Provider Relations Department develops a relationship with the provider to encourage contracting with Amerigroup and to establish open, two-way communication to support information sharing and coordination of care.
- Our Utilization Management Nurse develops a strategy to coordinate a member's transition to an in-plan provider once the member is stable or the care requires long-term treatment that is available from a participating practitioner.

To assure timeliness, each day our Utilization Management team reviews reports that track aging of open cases to set priorities and focuses on those that require immediate action. The team also reviews system-generated logs to identify and resolve potential barriers to timely case closure. Finally, they monitor data in weekly or monthly reports to identify trends that might indicate problems with current processes or workload distribution.

Out-of Network-Care for Duals (6.2.4.1.1 – 6.2.4.1.3)

Our model emphasizes individualized care and service coordination, which are vital for the Iowa dual eligible population that typically includes members with the most severe chronic, complex, and disabling conditions. Amerigroup's affiliates currently serves 231,000 dual eligibles through both Medicare Advantage Special Needs Plans (SNPs) and Medicaid programs. For services where we are not the primary carrier, an authorization will not be required. If we are the primary carrier, Amerigroup will require authorization for services (for example, LTSS). We will pay the coinsurance or deductible, but no more than the Iowa Medicaid rate.

Question 6.2, #4

4. Describe your plans to ensure providers do not balance bill its members and plans to work with members to help resolve billing issues.

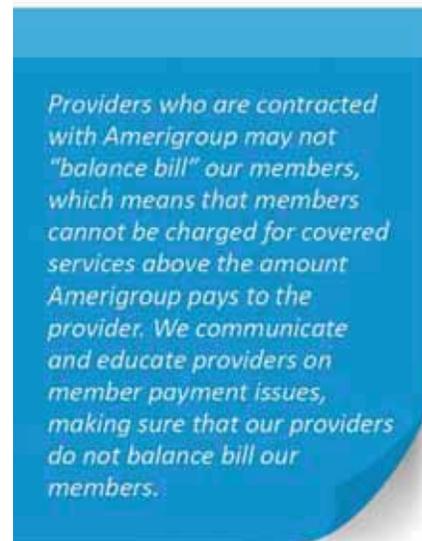
Making Sure Providers do not Balance Bill Members

Amerigroup will comply with all requirements addressed in Scope of Work Section 6.2.4 Out-of-Network Providers and Section 5 Billing and Collections. In accordance with 42 CFR 438.106, Amerigroup and our contracted network will not hold members liable for any of the following:

- Any payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if Amerigroup provided the services
- Covered services provided to the member for which DHS does not pay Amerigroup
- Covered services Amerigroup provided to the member for whom DHS or Amerigroup does not pay the provider that furnishes the services under a contractual, referral, or other arrangement
- Amerigroup’s debts or our subcontractor’s debts, in the event of the entity’s insolvency

Providers contracted with Amerigroup may not “balance bill” our members, which means that members cannot be charged for covered services above the amount Amerigroup pays to the provider. We communicate and educate providers on member payment issues, making sure that our providers do not balance bill our members. We remind providers in a variety of modes and methods. For example, we inform providers regarding balance billing requirements through the following methods:

- **Provider agreements**—our contracts with providers explicitly explain that members may not be billed for covered services.
- **Education for new providers**—we train new providers who join the network, and balance billing is one of many topics that we address.
- **Education for existing providers**—we train existing providers through group seminars throughout the year and during one-on-one office visits at least annually; if balance billing is an issue, we review our policy and federal and State laws and regulations.
- **Provider policy and procedure manual (Provider Manual)**—we address balance billing in our Provider Manual, which is an addendum to the provider agreement.
- **Provider bulletins and other general communications**—if balance billing occurs as an issue across the network, we include this topic in general provider communications, such as provider bulletins and newsletters. If it is specific to an individual provider or small set of providers, we address the issue in a custom, personal letter and outreach.



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By signing our participating provider agreement, providers acknowledge acceptance of payment from us as payment in full as a condition of participation in our network.

A provider can bill a member only when the following conditions have been met:

- The member receives a non-covered service
- The member has exceeded the program limitations for a particular service
- The member chooses to receive a non-covered service, knows the service is non-covered prior to receiving, and knows he or she is responsible for the charges associated with the non-covered service. In this case, the provider must maintain appropriate documentation and communicate and monitor compliance with these billing procedures to substantiate that the member voluntarily chose to receive and take responsibility to pay for a non-covered service.

Payment to Out-of-Network Providers

Our single case agreements outline payment terms, billing instructions, and member cost sharing, as applicable. Our single case agreement will specify that member cost sharing will not be greater than it would be if the services were provided by a network provider and that provider reimbursement will not be less than 100 percent of State fees. Prior to authorizing services with out-of-network providers, we will assure that they fully understand and accept the prohibition against balance billing.

Working for our Members Regarding Payment Liability

We inform members that they may not be balance billed. Members may contact our Member Services Helpline for assistance with billing issues. Our Member Services and Grievance and Appeals Departments work with members to promptly resolve balance billing issues.

Further, in accordance with SOW Section 6.2.4 and all related State and federal regulations (such as 42 CFR 438.106), we and our subcontractors will not hold members liable for any covered service or for our debts.

We continually encourage non-participating providers to become enrolled with Amerigroup so they can participate in our provider network. In some cases, our members may access covered Medicaid services from a provider who is not enrolled in the network and then receive a bill from that provider (that is, an Amerigroup member inadvertently seeks covered services from an out-of-network provider). If a member notifies Amerigroup he or she is receiving a bill, we will contact the out-of-network provider and assist him or her with becoming enrolled so he or she can receive reimbursement for covered services. Amerigroup will also educate the provider so he or she can submit a clean claim to Amerigroup for reimbursement and he or she will cease billing our member. If appropriate, Amerigroup will also consider this provider for contracting and inclusion in our provider network.

Requirements by Provider Type (6.3)

Question 6.3, #1

1. Indicate if you will use a primary care provider (PCP) model of care delivery.

Amerigroup understands the value of a strong member-provider relationship and will institute a primary care provider (PCP) model for members of the Iowa Initiative. In this model, members are assigned to a single PCP who is responsible for coordinating their care and making referrals to specialists.

Amerigroup's PCP approach has proven to be a valuable resource for enhancing the member care experience, improving member health outcomes, and controlling medical costs. To meet the needs of individuals enrolled in the Iowa Initiative, we will build a comprehensive, accessible PCP Network. We understand that all policies and procedures related to our PCP model will be reviewed and approved by DHS prior to implementation.

Primary Care Providers (6.3.1)

Amerigroup's PCPs will serve as the primary point of contact for members of the Iowa Initiative. Amerigroup will not impose restrictions on a member's freedom to change between PCPs. PCPs provide members with a health home, their first stop in the healthcare process and a centralized hub for a wide variety of ongoing healthcare needs. Specific PCP designations are required for members under a value-based purchasing arrangement. We make monthly panel listings available to each PCP, which includes a current list of enrolled members assigned to them. The PCP's role is to:

- Coordinate a member's healthcare twenty-four hours a day, seven days a week (24/7)
- Develop the member's care and treatment plan, including preventive care
- Maintain the member's current medical record, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times as outlined within the provider agreement and Provider Manual
- Refer members for specialty care
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognoses for recovery to members or the representatives
- Facilitate interpreter services by presenting information in a language that members or their representatives can understand
- Keep members' medical and personal information confidential as required by State and federal laws

The PCP's scope of responsibilities includes providing or arranging for:

- Routine and preventive healthcare services
- Emergency care services
- Hospital services
- Ancillary services
- Specialty referrals
- Interpreter services
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative, or palliative services

PCPs coordinate and make referrals to specialists, ancillary providers, and community services. PCPs are expected to:

- Help members schedule appointments with other healthcare providers, including specialists and ancillary providers
- Track and document appointments, clinical findings, treatment plans, and care received by members referred to specialists or other healthcare providers to provide continuity of care
- Refer members to health education programs and community resource agencies, when appropriate
- Coordinate with the Women, Infants, and Children (WIC) program to provide medical information necessary for WIC eligibility determinations such as height, weight, hematocrit, or hemoglobin
- Coordinate with the local tuberculosis (TB) control program to make sure that members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy
- Report to DHS or the local TB control program any member who is noncompliant or drug resistant or who is or may be posing a public health threat
- Screen and evaluate for detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders

Question 6.3, #2

2. If a PCP model will be utilized, describe the following:

- a. Physician types eligible to serve as a PCP.
- b. Any panel size limits or requirements.
- c. Proposed policies and procedures to link members to PCPs.

Types of Physicians Eligible to Serve as a PCP

For the Iowa Initiative, Amerigroup will use the following standard provider types that can serve as a PCP: family practice, general practice, internist, pediatrician, obstetrician/gynecologist (OB/GYN), certified nurse midwife (in rural areas only), nurse practitioners, Advanced Registered Nurse Practitioners (ARNPs) and tribal providers. In addition, Aged, Blind, or Disabled (ABD) beneficiaries often need a level of service that is best met by a specialist who assumes the PCP role; in these instances. Members may request a specialist as a PCP, or their Case Manager may arrange for a specialist as a PCP in consultation with the member. All requests must be approved by our Medical Director, who verifies that the specialist understands and agrees to provide all services required by PCPs and agrees to adhere to PCP access standards.

Panel Size Limits or Requirements

In terms of panel size, Amerigroup holds the view of maximum capacity is the important measure rather than a minimum panel size. We review provider panel sizes on a regular basis to confirm access and availability are not an issue. Additionally, we generally limit the panel size for an individual PCP to 1,500 and 750 for physician extenders.

Policies to Link Members to a PCP

Members' relationships with their PCPs have a significant impact on their health. Members will select a contracted PCP as their primary provider of healthcare services. If the member does not select a PCP, Amerigroup will assign a PCP to the member.

We keep providers up-to-date with detailed information. Amerigroup makes available to each PCP a current list of assigned members and, from time to time, provides medical information about the member's potential healthcare needs. That way, providers can more effectively provide care and coordinate services.

Amerigroup works with members and providers to establish and maintain strong relationships from initial enrollment through ongoing preventive care and treatment. In helping members identify, voluntarily select, and connect with PCPs who best meet their needs, we focus on choice, convenience, and member comfort. Our outreach is both high tech and high touch and employs an ongoing, layered communications approach to reinforce the importance of the member/PCP connection.

We engage members and providers through a variety of means with messages that foster close relationships between members and providers, including:

- One-to-one contact
- Phone calls and messages
- Member incentives such as Healthy Reward credits that can be used to buy health-related products
- Member and community events
- Clinic Days (designated days at a provider's office to schedule members with gaps in care)
- Mass media such as print ads and billboard notices
- Emails, printed material, text messages
- Amerigroup Mobile 2.0
- Sharing reports with providers such as missed opportunities, recent emergency room visits by their attributed member
- Online resources and tools
- Provider Quality and Population Management program that encourages providers to promote members to receive preventive health care

Initial PCP Selection/Auto-assignment/Notification

Members have an opportunity to make an initial connection with their PCP during enrollment when they select a PCP. If the member does not select a PCP, Amerigroup will assign a PCP to the member. We will continuously work with members to assist them in making appropriate PCP selections. Amerigroup examines member data, factoring member preference/familiarity with providers into each auto-assignment based on the following algorithm:

1. Assign the member to the most recent valid PCP the member had an historical relationship with
2. Assign the member to an active family member's (closest in age) PCP
3. Assign the member to the PCP of a family member found in the claims history file
4. Automatically assign the member to a PCP based on quality and efficiency ratings as well as geographic proximity, language, specialty, and other relevant factors.

Members may change their PCP selection at any time without restriction. Amerigroup makes available to each PCP a current list of assigned members and, from time to time, provides medical information about the member's potential healthcare needs. That way, providers can more effectively provide care and coordinate services.

Question 6.3, #3

3. If a PCP model is not proposed, describe methods to ensure compliance with 42 CFR 438.208 as described in Section 6.3.1.

As explained in our response to Questions 6.3, #1 and 6.3, #2, Amerigroup proposes a PCP model.

Question 6.3, #4

4. Describe your plan for providing a sufficient network of all provider types outlined in Section 6.3, including timelines and tasks.

Plan for Providing a Sufficient Network

Our approach to building a strong Provider Network is based on collaboration, mutual respect, and trust. To that end, Amerigroup makes a significant commitment to our providers because we understand that managed care for low-income and underserved individuals requires the development of customized, community-based systems of care with specialized knowledge and capabilities. We will use our resources to strengthen our Network Provider practices by supporting their needs, assisting quickly with issues as they arise, and, most importantly, providing the tools and resources providers need to successfully serve Iowa Initiative members. Our approach emphasizes access and quality of care for our members by helping us achieve a fully integrated and accountable system of care that provides and promotes member-centered, family-centered, community-based, coordinated, culturally competent, and accessible care and services for our members.

As part of creating a sufficient network, it is important to have a plan that allows for the network build to be completed on a timely basis. To that end, Table 6.3-1 contains a high-level summary of the tasks and timelines that will be followed to accomplish the build of the network, including all provider types in SOW Section 6.3. These tasks will be detailed further within Amerigroup’s overall implementation plan that is subject to DHS approval.

Table 6.3-1. Amerigroup’s Plan to Provide Sufficient Network across All Provider Types in SOW 6.3

TASK	Pre-Award Period	Award to Contract Effective Date
Document key providers for each of the populations that will be served under the IHDS program	✓	
Engage with the provider community, associations, and community groups to begin to foster and develop trust and understanding	✓	✓
Educate providers regarding Amerigroup, its history, and its dedication to building networks	✓	✓
Obtain Letter of Interest (LOIs) where possible	✓	
Obtain DHS approval of Amerigroup’s provider contract		✓
Begin process of obtaining contracts and credentialing information for all providers that will allow for a sufficient network to be available to members		✓
Within 90 days of Contract effective date, have a network that is 50% compliant		✓
Within 60 days of Contract effective date, have a network that is 70% compliant		✓
Within 30 days of Contract effective date, have a network that is 90% compliant		✓

Physician Extenders (6.3.2)

Amerigroup values the services that physician extenders, including Nurse Practitioners, ARNPs, and Physician Assistants, can provide to our members. In Iowa, we understand Nurse Practitioners can work without the supervision of a physician, and we will contract accordingly. Other physician extenders are healthcare professionals who are licensed to practice medicine under the supervision of a physician. Our experience with physician extenders has resulted in enhanced provider accessibility—especially in more rural, underserved areas; improved quality of care for our members; and reduced costs. Amerigroup has extensive experience working with physician extenders in our affiliate plans, and we have developed a physician extender fee schedule. Amerigroup will comply with all requirements of Section 6.2.12 of the SOW.

Amerigroup will work with our PCPs and specialty providers to help them understand and support the use of physician extenders. Our Provider Education program will include benefits and policies of using and reimbursing physician extenders, including allowing for better use of physician expertise and providing career advancement for nurses. We will work with DHS to expand our training programs, including internships, for physician extenders.

Our approach to expanding physician extender acceptance and use includes the following key elements:

- Demonstrating the clear and compelling value, especially to physicians, of the benefits of physician extenders
- Communicating our goal of increasing the number and quality of physician extenders to all stakeholders
- Educating providers about our reimbursement policies for physician extenders

As part of the Amerigroup Network and in accordance with 42 CFR 441.22, we will make sure that Nurse Practitioner services are available to our members, including out-of-network Nurse Practitioners if no Nurse Practitioners are available in our Network. We will inform members about available Nurse Practitioner services.

In addition, our Provider Services Staff's fieldwork in Iowa will include the topic of physician extenders in their contact lists, mailings, and outreach activities. We will include this topic in our discussions with providers and in our initial provider orientation.

Behavioral Health Providers (6.3.3)

Amerigroup's Network of behavioral health providers will be appropriately credentialed and meet or exceed DHS requirements for access, availability, and network composition.

Through continued discussions and research with our provider partners in the Iowa community, we are engaging the behavioral health liaisons to identify this medically underserved population. Through engagement with the University of Iowa Health Alliance, the Regional Health Centers, and the Community Mental Health Centers, we will develop outreach to rural areas of Iowa with plans to engage in telemedicine opportunities in the Rural Health Clinics, Health Departments, and Federally Qualified Health Centers (FQHCs) and peer specialists, where we commit to support training of peer specialists, and also commit to paying for initial credentialing fees for 100 new peer specialists (peer support is a covered mental health benefit).

Essential Hospital Services (6.3.4)

We will develop and maintain our Network to ensure sufficient access to essential hospital services to Iowa Initiative members. Using GeoAccess software, we will continually monitor and regularly analyze hospital access for our members to confirm ongoing compliance with the standards of accessibility set forth in Exhibit B of the RFP. If any member(s) does not have access to a hospital within program time and distance standards, our Access to Care Unit will authorize and arrange for member access to an out-of-network hospital.

Amerigroup has outreached to all hospitals in the State of Iowa and contiguous bordering markets in South Dakota, Nebraska, Illinois, and Wisconsin. Large systems encompass roughly 71 percent of the hospitals in Iowa and perform close to 90 percent of the current Iowa Medicaid hospital usage. They have verbally agreed to begin negotiating agreements or returned Letters of Intent (LOIs) or Letters of Recommendation on behalf of Amerigroup.

Physician Specialists (6.3.5)

Amerigroup's Network of specialist providers will be appropriately adequate and reasonable in number by specialty and geographic distribution to meet or exceed DHS requirements for access, availability, and network composition to medical and behavioral health needs without excessive travel. We will have signed provider agreements for all specialty types listed in Exhibit B of the SOW.

Amerigroup is working with several physician specialty groups to bring specialized services to members through discussions with various health systems, primary care associations, and established relationships. We have received Letters of Intent and Letters of Recommendation from The University of Iowa Health Alliance, The Iowa Clinic and Paramount as well as verbal commitments from several large health systems that work directly with specialty provider groups. We are collaborating with specialty providers regarding our tools and expertise to make sure we work together to help manage this member population.

Health Homes (6.3.6)

Health Homes are an emerging best practice to address members with chronic health conditions or a serious mental illness or serious emotional disturbance (SMI/SED). Drawing upon our affiliates' experiences and expertise in Health Homes, we are prepared to continue Iowa's work in evolving health homes for members with two or more chronic conditions (chronic condition health homes) and integrated health homes for members with SMI/SED conditions. In Section 3.2.10 of our response, we provide a detailed review of our approach to Integrated Health Homes and Health Homes. Additionally, in developing the Integrated Health Homes and Health Homes network, we will help assure all providers meet the minimum requirements for participation as defined in the State plan and DHS policy.

FQHCs and RHCs (6.3.7)

We understand the value that local health agencies and community-based organizations have in the delivery of healthcare to the Medicaid population. FQHCs and Rural Health Clinics (RHCs) are essential to provide the medical, behavioral, and additional support services needed for this population. These provider types are also more influential in the rural areas of Iowa and provide services in the medically underserved areas of the State. We strive to maximize the inclusion of these agencies and



Amerigroup understands the value that local agencies and community-based organizations have in the delivery of healthcare to the Medicaid population. FQHCs and RHCs are essential safety net providers, and we will contract with those organizations that are willing to join the Amerigroup network and that meet all of our requirements that confirm the ability of these providers to deliver quality services.

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organizations in our Network and collaborate to provide better services for our members. We have conducted ongoing outreach to 100 percent of the FQHCs and RHCs, with many LOIs and verbal support for contractual engagement. Additionally, we have received a letter of support from Iowa Health+ as well as their assistance in soliciting and collecting LOIs from their FQHCs.

We understand the value that local health agencies and community-based organizations have in the delivery of healthcare to the Medicaid population. Amerigroup and our affiliates have a strong history of working with FQHCs and RHCs, many of which are part of our quality improvement and member-centered medical home programs in many states. Our collaboration with these agencies helps to provide better outcomes for our members.

Family Planning Clinics (6.3.8)

Amerigroup has developed relationships with various providers of Family Planning services in Iowa, including but not limited to the Family Planning Council of Iowa, RHCs, Departments of Public Health, and FQHCs. Reaching out to 100 percent of these clinics, many of whom participate in Family Planning Waivers, we have defined opportunities of collaboration between our organizations that can promote the health and well-being of the members and to encourage their participation in the Iowa Initiative.

Maternal and Child Health Centers (6.3.9)

Amerigroup has identified, contacted, and begun discussions with 76 percent of the defined Maternal and Child Health Centers in Iowa. Many of the services provided take place in Family Planning Clinics and Public Health Departments across the State. In working with the Family Planning Council of Iowa and other Public Health Departments, we are sharing various programs and enhanced services to meet the needs of this population. We will continue to work collaboratively to help assure that all Maternal and Child Health Centers are participating in the Amerigroup Iowa Network.

Urgent Care Clinics (6.3.10)

Amerigroup understands that urgent care centers play an important role in providing an option to more expensive emergency room care and that the clinics also provide convenient access for members. Amerigroup will continue to seek opportunities for independent and health systems who have established urgent care clinics to contract additional urgent care centers throughout Iowa. Amerigroup will include urgent care clinics for members enrolled in the Iowa Initiative. These facilities meet the State's accessibility requirements for urgent care facility participation as they are open at least 11 hours Monday through Friday and at least five hours on the weekends. Amerigroup understands that upon execution of the Contract, agency approval will be required regarding our approach to the use of urgent care clinics in our network. In addition, Amerigroup will implement and adhere to agency approval of the approach, and any changes to the approach will be submitted to the agency for prior approval as outlined in the executed State Contract.

Other Safety Net Providers and Community Partners (6.3.11)

Amerigroup intends to use and partner with community entities and advocates, such as the Area Agencies on Aging, to:

- Enhance our understanding of services that are available in Iowa
- Expand our knowledge of where gaps in the delivery system may exist
- Collaborate on solution designs that will address such gaps in care
- Understand their abilities to provide the needed services

- Contract with them to provide services to our members

Amerigroup understands that upon execution of the Contract, agency approval will be required regarding our approach to the use of other safety net providers and community partners in our network. In addition, Amerigroup will implement and adhere to agency approval of the approach, and any changes to the approach will be submitted to the agency for prior approval as outlined in the executed State Contract.

Community-Based Residential Alternatives (6.3.12)

Amerigroup understands the important role that community-based residential services may play for members under the age of 18 with needs that require services and treatment outside of the family home. Amerigroup will work diligently with providers and Community-Based Case Management team to identify community-based residential alternatives that are close to the member's natural home, or the place they consider home, to foster greater family involvement and reunification whenever possible.

Indian Healthcare Providers (6.3.13)

Question 6.3, #5

5. Describe your plans for meeting the requirements regarding Indian Healthcare Providers.

Amerigroup will comply with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA) and the requirements as outlined in the SOW Sections 6.3.13.1 through 6.3.13.6 and enumerated below:

- Amerigroup will permit any Native American (Indian) member who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the Network as a PCP (if applicable), to choose that Indian healthcare provider as his or her PCP, as long as that Indian healthcare provider has the capacity to provide the service.
- Our Provider Services staff will be responsible for demonstrating that there are sufficient Indian healthcare providers in Amerigroup's Iowa Network who will provide timely access to services available under the Contract for Indian members who are eligible to receive services from such providers.
- We will reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to Indian members who are eligible to receive services from such providers either at: (i) a rate negotiated between Amerigroup and the Indian healthcare provider; or (ii) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by a Network Provider who is not an Indian healthcare provider.
- Amerigroup will make prompt payment to all Indian healthcare Network Providers as set forth in Section 13.4.6 of the Scope of Work (SOW).
- Amerigroup will provide DHS—in the timeframe and manner required by DHS—utilization and/or reimbursement data that are needed to make any applicable supplemental payment to a Indian healthcare provider
- Amerigroup will not reduce payments to Indian healthcare providers or other providers of contract health services under referral by an Indian healthcare provider for covered services provided to a Indian member by the amount of a copayment or other cost-sharing that would be due from the Indian member if not otherwise prohibited under Section 5006(a) of American Recovery and Reinvestment Act of 2009 ARRA.

- Amerigroup has contacted the Meskwaki Health Center, which is the only Indian Health Service clinic in Iowa, to begin discussions and seek assistance in outreach opportunities to potential Indian healthcare providers in states bordering Iowa. Our affiliate health plans and Tribal Liaison managers have existing relationships with Indian Health Services and Tribal 638 providers in other states, which will allow Amerigroup to bring our best practices to Iowa. Additionally, as part of our outreach efforts, we will provide healthcare information to Native Americans residing in Iowa. Amerigroup will closely monitor the inclusion of Indian healthcare providers in Iowa and comply with Section 6.2.3 of the SOW in the event an Indian healthcare provider enters the market.

Eligibility (7.1)

In accordance with Section 7.1 of the Scope of Work (SOW), Amerigroup Iowa (Amerigroup) acknowledges that the State has the exclusive right to determine an individual's eligibility for the Iowa Initiative and that Amerigroup cannot review or appeal the individual's eligibility once it has been determined by the State. Subsequently, we can provide the State with information indicating the member's eligibility has changed.

Our affiliate health plans have a combined 24 years' experience in receiving eligibility and enrollment information from state entities and in enrolling members into our plans. Together, we have more than 5.2 million members enrolled in state-sponsored healthcare programs in 19 states across the nation. Our affiliates have managed member enrollment and disenrollment for our healthcare programs that are new, covered under waiver programs, and transitioning from another plan into our plan. We analyze state-delivered information to determine eligibility changes. This includes out-of-area members, data issues that are in conflict with business edits, and enrollment in products that do not coincide with members' demographic information. We also identify members who may be issued multiple state-identified numbers (Medicaid IDs) through enrollment load edits and robust duplicate member reporting.

When we determine that a member's eligibility has changed to the extent that he or she should not be eligible, we provide this information to the state, through secure email, for review. We will update the member's eligibility status based on feedback and guidance received from the state.

MCO Selection and Assignment (7.2)

In accordance with the Scope of Work Section 7.2, Amerigroup Iowa (Amerigroup) understands the enrollment of members by DHS may be the result of the enrollee's selection of a plan or through the assignment by DHS. Through our parent company and affiliate health plans, we bring years of experience working with state Medicaid Management Information Systems (MMIS) and enrollment brokers to share member information. We are well accustomed to these processes—our dedicated national Enrollment Department currently receives transaction-based and full-roster files from 19 state agencies and/or their enrollment brokers. We can receive data through electronic media and will support transmission of enrollment data utilizing the HIPAA-compliant ASC X12N 834 transaction format. With our extensive enrollment experience, we are well positioned to work with DHS and its enrollment broker.

Current Enrollees (7.2.1)

Amerigroup understands that enrollees will be eligible for enrollment in our health plan at the start date of operations and will be assigned by DHS in accordance with the auto-assignment process. Once the auto-assignment process has occurred, DHS will notify the member that they have 90 days to choose another contractor and that the Enrollment Broker will accept the members' requests for a plan change. Through our affiliate health plans experience managing eligibility, enrollment, and disenrollment across other state-sponsored programs, we have experienced employees, robust technology, and established processes, policies, and procedures for receiving the eligibility file from the Enrollment Broker, as well as managing the enrollment of all Amerigroup-assigned members according to DHS requirements. Our national Enrollment Department manages enrollment files and uses the enrollment data received to properly map the members to the correct benefit packages, including those members who may have copays.

1915(c) HCBS Waiver Enrollees and Institutional Populations (7.2.1.1)

In accordance with SOW Section 7.2.1-2, Amerigroup will enroll all members into our health plan, including members under the Home and Community-Based Services (HCBS) waiver and those in institutions, nursing facilities, or ICF/ID who select or are auto-assigned to Amerigroup. We are committed to assuring all our members receive quality healthcare without discrimination or delay. Our enrollment process ensures any mandatory or voluntary member who selects or is assigned to Amerigroup Iowa will be enrolled and that all potential enrollees will be accepted in the order in which they are assigned without restriction.

New Enrollees (7.2.2)

In accordance with SOW 7.2.2, Amerigroup understands that applicants will select a contractor at the time of application and that new enrollees who do not select a contractor at the time of application will be auto-assigned in accordance with the auto-assigned process.

New Enrollee Plan Selection Information (7.2.2.1)

Amerigroup will support the State in its efforts to assist members and their families in making informed decisions regarding their health. Amerigroup will provide the State with plan information, within the appropriate timeframe, to assist the State in developing informational materials for potential enrollees.

We believe that health plan selection is paramount to initiating or continuing healthcare for members, and we support the State's process of automatic assignment to a health plan to promote timely member outreach and engagement. Upon notification of a member's automatic assignment or selected health plan enrollment with Amerigroup, we will conduct member engagement activities, including providing education and information on members' rights and responsibilities, benefits, services, how to engage in their own healthcare decisions, and how/who to contact for assistance for reassignment to another health plan. We accomplish this through:

- Member handbook
- Our website
- Network Providers
- Our Member Services helpline
- New member welcome call

All reachable new members will receive a welcome call within the first 30 days of enrollment. In addition, to personally introducing Amerigroup, orienting the member to our services and identifying any member-specific issues during the welcome call, we will:

- Welcome new members to Amerigroup, as well as verify and update member information
- Verify a member's PCP selection; or if a member has been auto-assigned to a PCP, the member may change PCPs
- Explain the member's benefits, including behavioral health and substance abuse services
- Conduct a screening survey for any special health needs

By using this approach, and providing the State with the required plan information, we are able to efficiently assist potential members in understanding Amerigroup benefits and how to access care.

We will also provide education and training to our Network Providers and health plan employees on State and health plan requirements for member eligibility, enrollment, and disenrollment, including but not limited to the following:

- Receiving eligibility and enrollment information from the State
- Assisting members in applying for Iowa Initiative benefits
- Enrolling members in our health plan following their selection of or auto-assignment to our health plan

Auto Assignment (7.2.3)

In accordance with SOW Section 7.2.3, Amerigroup acknowledges the State's algorithm for automatic assignment into the Iowa Initiative. We acknowledge that the members auto-assigned to Amerigroup may not understand why they were auto-assigned and/or may have the desire to change health plans for a variety of reasons. We believe that individuals want and have the right to be informed and involved in the decisions about the care they receive and through whom they receive that care. We will assist these members by answering any questions they may have, attempt to resolve any concerns, and/or will refer them to the Enrollment Broker to change health plans if warranted.

Enrollment Discrimination (7.3)

In accordance with SOW Section 7.2, Amerigroup Iowa (Amerigroup) will enroll all members into our plan in the order they are listed on the 834 within 48 hours of receiving the file. We will not discriminate against individuals eligible to enroll in the Iowa Initiative on the basis of their health status or their need for special healthcare services. In addition, we will not discriminate against eligible enrollees based on race, color, or national origin.

Immediately upon enrollment, members will be eligible for the full scope of the Iowa Initiative's program benefits. Amerigroup has no policy or practice in place that has the effect of discriminating against enrollees. To help assure adherence to our policies against discrimination, we train employees annually on our Compliance Program. The local Iowa Compliance Officer (PCO) monitors all employees training results and supplies them to management for follow-up if required. The Compliance Officer is responsible for the overall compliance with State, federal, and company policies.

Amerigroup has policies and procedures to assure that Network Providers do not engage in unlawful discrimination against any eligible or prospective health plan member. We prohibit providers from using discriminatory practices against Amerigroup members such as preference to other insured or private pay patients or separate waiting rooms or appointment days. We require that services always be provided without regard to race, creed, gender, color, ancestry/national origin, marital status, sexual orientation, income status, age, program membership, or physical/behavioral health status. We currently meet all State and federal requirements across our affiliate Medicaid health plans and will do the same in Iowa. Network Providers must accept members for treatment and not intentionally segregate members in any way from other persons receiving services.

Our provider contract and provider manuals specifically prohibit unlawful discrimination. The provider contract contains a nondiscrimination clause that prohibits providers from denying any member "... aid, care, service, or other benefit on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion." The clause cites the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Federal Rehabilitation Act of 1973, in addition to other State and federal statutes. All providers are legally obligated to abide by the terms of the contract, and Amerigroup is legally, ethically, and morally bound by the same State and federal statutes. We review these requirements with providers during orientation, and our Provider Services Staff reinforce these requirements during their ongoing interactions with providers. Providers found to engage in unlawful discrimination will be subject to disciplinary action up to and including suspension or termination of Network status.

Member Disenrollment (7.4)

Question 7.4, #1

1. Describe your grievance process for addressing member quality of care concerns and member disenrollment after the first ninety (90) days of enrollment.

Amerigroup Iowa (Amerigroup) acknowledges, understands, and will comply with the requirements in Section 7.4 Member Disenrollment understanding that members may disenroll without cause either during the first 90 days of enrollment and/or every 12 months thereafter. We take member disenrollment very seriously and understand that members will disenroll from our health plan for a variety of different reasons. Through our affiliate health plans operating state-sponsored programs, we have 24 years of experience identifying and managing situations in which members may choose to disenroll from our health plan or demonstrate behavior that may lead to disenrollment.

Whether based on member request or Amerigroup's internal policies, we look at potential disenrollment as an opportunity to develop new, innovative programs that meet our members' needs. Consequently, we review, adjust, or eliminate our processes or policies that create barriers to our members engaging in their own healthcare. Our primary goal is to support our members' voice and choice in their healthcare decisions, which includes honoring their requests for disenrollment from Amerigroup's Iowa Initiative program.

Where possible, we make every attempt to resolve a member's concerns. We have a variety of tools, resources, and supports that are effective in connecting members to the benefits and services they need. We strive to inform and empower members and their families on how to use Amerigroup benefits, how to access services, and the importance of preventive care. Our goal in supporting members is always to improve healthy behavior and avoid unnecessary disenrollment that can disrupt continuity of care for those who need it most.

Member Disenrollment for Cause (7.4.1)

Cause (7.4.1.1)

Amerigroup acknowledges the for "cause" reasons that a member may disenroll from a plan as listed in the SOW Section 7.4.1.1. Amerigroup prides itself on educating all members assigned to our plan. Amerigroup is committed to delivering quality healthcare to all its members, including those members who may be better served by disenrolling from our program. Amerigroup proactively informs members, from the beginning of enrollment, via the welcome call and the member handbook, of their member rights. We reach out to new members via welcome calls in the first 30 days of their enrollment and member retention calls prior to the end of the 12-month consecutive enrollment period. During these calls, we:

- Orient members to the health plan
- Verify member information
- Assist with primary care provider (PCP) assignments or adjustments
- Address any other issues related to their eligibility

It is our experience that the majority of members' issues relate to the PCP. These PCP issues are often easily and quickly resolved at this first level of intervention. If a member expresses any concerns about enrolling or remaining with Amerigroup, we will make every attempt to resolve the issue.

Members may choose to change their documented preferred language or PCP at any time and as many times as they desire. Members may request a change in their PCP in writing or verbally through our Member Services, Nurse HelpLine, their Case or Disease Manager, or Member Advocate. Should the member have prior healthcare services upon enrollment, we will honor all existing authorizations with the member's current provider, including authorizations for services provided by out-of-network providers, and frequency of service identified in the member's care plan for up to 90 days following enrollment or until Amerigroup completes a comprehensive assessment with the member. Consequently, we design our Case Management programs to provide members with high-risk or specialized healthcare needs additional supports to foster their engagement resulting in improved member satisfaction.

Amerigroup and our affiliate health plans promote the appropriate use of services and maintain our position as a steward of precious healthcare resources. We are committed to serving our members and work closely with members and all providers involved in their care to address inappropriate utilization or behavior. Our proactive approach in addressing the most common reasons members disenroll shows in the success rate of our affiliate Louisiana health plan, where we effectively reduced disenrollment to less than 1 percent.

Process (7.4.1.2)

Amerigroup understands and acknowledges the process of disenrolling a member for cause as outlined in the SOW Section 7.4.1.2.

Amerigroup's grievance and appeals resolution process identifies and addresses quality-of-care matters and issues occurring for members who disenroll within the first 90 days of enrollment. We will encourage members to contact the plan to report all grievances regardless of the subject matter. The member can report a grievance telephonically to our Member Services Department. We document all issues in a common database to enable appropriate classification, timely investigation, and accurate reporting to the appropriate quality committee with an escalation process in place for grievances of a critical nature. Trended data will be reviewed on a periodic basis. Should the member be dissatisfied with the outcome, we will direct the member to the Enrollment Broker, as well as provide the Enrollment Broker with a copy of the member's grievance record.

Amerigroup has a highly structured grievance resolution process, in accordance with all applicable contracts and federal and State laws and regulations, that affords several levels of recourse to our members for addressing their issues in a professional, respectful, and timely manner. The health plan's Quality Management Department investigates and resolves all grievances. Amerigroup has a record of resolving complaints, grievances, and appeals in timeframes below state limits in the states where we operate today. ***For example, in Texas—our largest affiliate health plan—the average time for resolving member complaints was 16.2 days from date of receipt to date of notification of disposition.***

In all cases, we support the member throughout these processes. It is our experience that designating specially trained staff to work closely and advocate on the member's behalf throughout this process results in greater member satisfaction and prompt resolution of grievances.

Contractor-initiated Disenrollment (7.4.2)

In compliance with SOW Section 7.4.2, Amerigroup will neither terminate the enrollment of nor encourage a member to disenroll because of his or her healthcare needs or a change in healthcare status. We acknowledge all State-initiated disenrollments and the circumstances under which they may occur.

Amerigroup's goal is to maintain continuity of quality care for its members. Therefore, a Call Center Representative or Case Manager will attempt at least three interventions with a member before requesting disenrollment when we identify noncompliant behavior. Our multi-step intervention process includes:

1. At least three verbal attempts over a period of 90 calendar days by a Case Manager to consult with the member and reconcile the situation with counseling
2. At least one verbal caution issued to the member
3. At least one written warning sent to the member, certified return receipt requested
4. At least one notification of acceptable reason for disenrollment to DHS

The Case Manager conducts the first step in our disenrollment intervention process by consulting the member and documenting the identified concern. If the concern is identified by another Case Manager or a provider, the consulting Case Manager obtains documentation from the identifying party. If it is determined from the discussion with the member that an adjustment in, or addition to, treatment (for example, mental health counseling) is needed, the Case Manager will facilitate the change to the treatment plan. If the member continues to be non-compliant, we issue a verbal caution and subsequent written warning.

Before requesting adverse enrollment, our Case Manager will work with the PCP and any other treating professionals involved in the member's care, including behavioral health and home and community-based providers, to develop an individualized care plan that will help the member address his or her behaviors. The care plan will also include all supportive services and resources required to meet the member's needs. The care plan is aimed at achieving treatment goals and addressing any barriers to the improvement of the member's quality of life. Ultimately, the goal is to define and address all medical, behavioral, and social service needs, including educating the member about compliant behavior.

Notification of Member Death or Incarceration (7.4.3)

In accordance with SOW Section 7.4.3, Amerigroup will notify the State, in the manner prescribed, of the death or incarceration of any Amerigroup member within 30 days of our becoming aware of the member's death or incarceration. Upon notification, Amerigroup will provide the State with the member's full demographic information including any and all incarceration or date of death. Furthermore, Amerigroup will not pursue recovery against the estate of any deceased member.

Marketing (8.1)

Marketing Activities (8.1.1)

Question 8.1, #1

1. Describe in detail your marketing and outreach plans.

Leveraging Affiliate Experience for Iowa

Amerigroup Iowa (Amerigroup) will leverage the experience of our parent corporation and our established programs to forge relationships with community, social and supportive services, and faith-based organizations in Iowa as a foundation to build a marketing and outreach program tailored to meet the needs of Iowa's children, adults, seniors, and individuals of all ages with disabilities on Medicaid and other state programs.

Nationally, our affiliates currently serves more than 5.2 million members in state-sponsored programs, and have designed marketing plans that recognize the unique needs for the diverse populations in each of those 19 states. Before members can effectively engage in improving their health status, they must first be informed of the programs available to them, how these programs can improve the quality of their lives, and how to enroll and stay enrolled in our member-centric plan.

Our Amerigroup Iowa marketing and outreach efforts will include a geographically balanced plan, a multi-level media campaign, and collaboration with stakeholders and community organizations and directly informing members, their families and guardians about covered services, our Provider Network, and the programs we will offer to help members maintain or improve their health, emphasizing member choice, access, independence, and responsibility. The goals of this plan are to:

- Create program awareness to engage and retain individuals eligible for the Iowa Initiative
- Introduce Iowa members to the superior education, access, quality, and service experiences available to Amerigroup enrollees
- Maintain an Amerigroup presence in both urban and rural communities in which we live and work
- Increase accessibility to our programs and employees
- Provide clear and easy-to-understand materials to members young and old, those in recovery from mental health or substance abuse challenges, children, foster children, parents, and single adults
- Extend services to all members and communities by promoting alliances with community-based organizations and events

We will also use marketing activities and materials to promote the use of Amerigroup's member incentive program and Value-Added Services, such as:

- **Healthy Rewards**, our easy-to-use member incentives program, which allows members to earn rewards for achieving health goals and receiving checkups and preventive screenings
- **Financial Training and Skills Development** including education, coaching and access to self-assessment tool.
- **Self-Advocacy Memberships** to help members develop the skills to advocate for themselves through training, resources and participation in advocacy
- **Taking Care of Baby and Me**, our prenatal care program for pregnant members

- **SafeLink**, extra cell phone minutes through our association with a national firm that provides cell phones and text messaging services to our members so they can establish and maintain contacts with our Care Management staff
- **Tobacco Cessation Program** including coaching to support members in their decision to quit smoking in addition to pharmacological therapies

Geographically Balanced Marketing and Outreach

Amerigroup will deploy regional, field-based marketing and outreach teams assigned to six distinct geographic areas in the State, targeting urban centers like the Des Moines area and the Cedar Rapids-Iowa City corridor, as well as reaching all the rural areas where 36 percent of Iowans reside, to inform potential members about the Iowa



Exemplifying our investment in the communities we serve, Amerigroup affiliates participated in over 74,000 community events and activities.

IA_8.1_COB_1.1

Initiative and to introduce Amerigroup. These six areas correspond to the DHS behavioral health regions.

Our teams will conduct marketing and outreach events across the State such as health fairs, Back to School Days, and a range of other events and presentations with local organizations, social and supportive services, and faith-based groups. Our teams work on a day-to-day basis with organizations such as:

- Centers for Independent Living, Meals on Wheels, Area Agencies on Aging, senior centers, and statewide aging and disability organizations
- Churches, synagogues, and mosques, with which we collaborate to conduct outreach and host health fairs
- Public health departments and community organizations with whom we conduct joint outreach

Our community-level marketing includes attending local events, distributing brochures, and talking with the staff and members of these community organizations to provide information about Amerigroup, share important health messages, describe available services and benefits, and provide information on how Amerigroup Iowa can help them address their healthcare needs. In 2014, Amerigroup affiliates participated in over 74,000 community events and activities in the 19 states in which we operate.

Additionally, we will leverage technological solutions, such as social media, that have proven effective in reaching across geographical boundaries to allow us to connect with members and potential members no matter where they live.

Multi-level Media Campaign

Amerigroup seeks to meet members and potential members where they are by offering multiple means for them to learn about the services and benefits available to them and how to access them. We will engage in a multi-level campaign to raise awareness of our program as a premier healthcare solution for children and their families, foster children, adults, seniors, and individuals of all ages with physical, intellectual, and developmental disabilities—a solution that will include benefits and services specifically designed to address needs related to the unique needs of our specialized populations. We will leverage communication channels such as mail, phone, mass media, and customized brochures, as well as newer techniques such as conversational automated calls and social media sites with DHS authorization—which have demonstrated effectiveness in the states where we employ these methods. Our multi-level campaign will incorporate personal, high-touch campaigns and traditional marketing and educational materials.

Personal, High-touch Media Campaigns

In our affiliates' 24 years of experience administering state-sponsored health programs, frequent and personal communication is most effective when conducting marketing and outreach activities. Therefore, we will employ several personal, high-touch methods for communicating with potential members, which include:

- Grassroots outreach
- Sponsorships
- Social media

Grassroots outreach

In our experience, grassroots outreach is the most effective way for us to communicate our message to members and potential members when and where they are most likely thinking about their health. To that end, we regularly participate in health fairs and other health-related community events. Our geographically distributed core teams will travel throughout Iowa to conduct grassroots marketing, talk to people in the community, and provide information about important health messages and the benefits we offer. We will customize our outreach information based on identified needs and preferences for Iowa members, including for children and families and those who have physical health, behavioral health, and/or participating in LTSS.

Sponsorships

Amerigroup affiliates sponsor health-related events and exhibits geared toward specific ethnicities within the community. Our goal is to connect with members and potential members where they are in a culturally and linguistically competent way.

Amerigroup will join with local organizations to sponsor community-wide events that serve as a forum for marketing activities. These partnerships will enable us to engage with community-based organizations to co-deliver key health messages targeted to the local populations and to provide them with resources to meet their diverse needs. These organizations will include advocacy groups for Iowa Medicaid populations, including foster children, individuals with behavioral health needs, individuals with physical, and intellectual and/or developmental disabilities.

Social media

Amerigroup will leverage the Internet and other technology to break down barriers that traditional communications often face, including geographic barriers. Examples include using Facebook and Twitter to promote health and wellness efforts. An innovative approach that uses a very familiar social media format is introducing Disabled Sports USA to members through YouTube. For our members who are blind or have vision loss or other disabilities, we work with and help support Disabled Sports USA. Highly accessible through the Internet and YouTube, Disabled Sports USA serves more than 60,000 youth, wounded warriors, and adults annually through a network of approximately 100 community-based chapters in 37 states, including Adaptive Sports Iowa, a chapter in Ames, Iowa, offering the following activities: beep baseball, cycling, guide running clinic, National Junior Disability Championships, skiing, track and field, and wheelchair basketball.

Stakeholder and Community Organization Collaboration

Amerigroup affiliates in 19 states have forged strong bonds with stakeholders and community organizations, providing us an in-depth knowledge and understanding about the needs of our many diverse communities. We will leverage this experience and the collaborative relationships we have built over time with community organizations to educate members and potential members about the Iowa Initiative program.

We will use this approach in Iowa and have already identified key organizations with whom we intend to partner, such as:

- Community Health Charities of Iowa
- March of Dimes Iowa
- The Arc of Iowa
- Vera French Foundation
- Healthy Birth Day
- Rick's House of Hope
- Child and Family Policy Center
- Iowa Library Association
- Statewide Independent Living Council
- Caregivers Association
- Community Action Association
- Epilepsy Foundation
- Boys and Girls Clubs of Central Iowa
- Johnson County Case Management
- Child Advocacy Board
- Public Health Association
- IOWAHEALTH+ and its member Federally Qualified Health Centers
- Area Agencies on Aging
- NAMI Iowa
- Disability Rights Iowa
- Iowa Foster and Adoptive Parents Association
- Iowa Disability and Aging Advocates
- Easter Seals
- Youth Homes of Mid America
- Centers for Independent Living

Additionally, as a Value-Added Service to help ensure our members are aware of all local Iowa community-based services, *we will provide members access to our Amerigroup Community Resource Link*. This Link is a searchable online resource for community-based programs, benefits, and services in an easy-to-use format and searchable with GPS technology. The Amerigroup Community Resource Link will be a reliable source for members and valuable tool regarding the wide range of programs and services available throughout Iowa.

Permissible Marketing Activities (8.1.1.1)

Traditional Marketing Strategies

We have found that traditional marketing strategies are effective in connecting with a large number of members and potential members. These strategies include:

- General media campaigns
- Written materials
- Public relations initiatives

General Media Campaigns

Media messages will inform the public about Amerigroup participation in Iowa Initiative programs and benefits and the importance of preventive care and establishing a medical home. To penetrate urban areas, we will use outdoor media, such as billboards, combined with radio. For rural areas, we will look to a combination of radio and advertising in free local and regional publications. Our strategy will be formulated at the county, township, and ZIP code levels, with additional resources committed to difficult-to-reach rural pockets and medically underserved areas.

In addition, we will continue to advertise in the most effective ways to reach our members and prospective members. We typically invest in such approaches as online banner advertisements tied to print advertising with statewide publications. We will also consider online and mobile contacts that are able to reach members and their families. Because time is precious to these multi-tasking individuals who often use mobile devices, we are investing in digital advertising as a new way to reach this population.

All material described in this section will be submitted to DHS in draft for approval at least 30 days prior to distribution.

Written Materials

Amerigroup's marketing team will create a comprehensive offering of materials, including the welcome packet, reminder postcards, flyers, surveys, and other materials, to support broad and specific healthcare education in Iowa. We will distribute these on a regular basis as our marketing and outreach staff participates in health fairs and community events and interacts with enrollment brokers. Written materials will be available in alternative formats, such as large print and Braille upon request.

Public Relations Initiatives

Amerigroup will provide editorial content to publications statewide, and our Medical Director and other clinical leaders will participate in on-air radio and television interviews about key health topics, such as prenatal care, well-woman visits, immunizations, smoking cessation, exercise, diabetes, heart disease, and other topics, when opportunities are available for them to do so. These key personnel will also be made available to health and lifestyle reporters covering Medicaid issues and healthcare in Iowa.

Prohibitions on Marketing to Potential Members (8.1.1.2)

Amerigroup values the trust it must earn from its members as foundational to a lasting relationship. Accordingly, our Compliance Program and Marketing Oversight Program have controls in place to monitor and oversee our marketing team to prohibit direct or indirect door-to-door, telephone or other "cold call" marketing activities. Amerigroup will assure that a potential member makes his or her decision whether or not to enroll in our plan free from inappropriate enticements, such as offering other types of insurance as a bonus for enrolling.

General Marketing Prohibitions (8.1.1.3)

Marketing Monitoring and Oversight

Tracking our activities is important to us because it helps us see how well we are meeting or exceeding our marketing goals in all areas of the State, both urban and rural. It also lets us know if we need to re-evaluate an approach. Amerigroup outreach teams will use *Salesforce.com*, a tool that allows us to systematically track our activities to make sure that we are geographically balanced and that our activities are effective.

Evaluating the Effectiveness of Marketing Strategies

We will measure the success and continually improve our marketing plan based upon the following indicators:

- Market-leading plan preference rates tracked through membership enrollment data. This will be an indication of how well we execute the program overall.
- Member satisfaction tracked through customer surveys. This will indicate how well we meet our members' needs.
- Member retention rates tracked through disenrollment data. This will also indicate the level of member satisfaction with their healthcare experience. We will use these data and information to adjust our marketing and outreach strategies to maximize our efforts to engage and educate members and potential members.

Monitoring for Compliance with State and Federal Requirements

Amerigroup's marketing oversight program is designed to verify that all marketing activities are performed by employees (including vendor employees) who are trained to understand their responsibilities and who display a continued commitment to carry out their obligations with the utmost

care, accuracy, and integrity. Amerigroup will submit all marketing materials to DHS for approval at least 30 days prior to distribution.

To monitor compliance with marketing requirements, Amerigroup has a Compliance Program and a corresponding marketing oversight program, both of which have proven effective with our affiliate plans in other state-sponsored programs.

Our Compliance Program has as its cornerstone in our parent company's Code of Business Conduct and Ethics (Code). The Code establishes standards of behavior for all Amerigroup employees. It is supported by specific Compliance Program Policies and Procedures.

All Amerigroup employees will receive compliance program training covering the Code; employee responsibilities for reporting violations of law, regulations, the Code, or Amerigroup policies; the use of our hotline as a reporting mechanism and other compliance issues. Marketing and other Amerigroup employees must comply with the Code and all relevant laws, regulations, and contractual integrity program documents that pertain to their offices. Failure to comply with the Code, the marketing integrity program, the Compliance Program policies and procedures, or the marketing policies and procedures will lead to disciplinary action that may include termination of employment.

Member Communications (8.2)

General (8.2.1)

Question 8.2, #1

1. Describe your overall strategy for communicating with members.

Member Communications

Our affiliate health plans have a proven track record of informing and helping potential and current enrollees across many specialized populations understand the requirements and benefits of new, expanded managed care programs and migrating those populations from years of fee-for-service delivery system experience to the new managed care program. Our organization's modalities, in-person communications, written materials, web-based content, social media, and call center supports have been so successful that our state partners have used them in their own campaigns to educate citizens on new program advances.

We appreciate and respect the unique aspects of the specialized populations enrolled, their clinical needs, and their cultures. We understand that trauma-informed care is as essential to a foster child as self-directed home care is to an adult with a physical disability or a recovery- and hope-oriented philosophy of care to an individual with a severe and persistent mental illness. We will use every opportunity to deliver important information about benefits, preventive care, and the value of our member-centric programs as we engage our members and their families. Amerigroup will provide written notice to members about any actions that might impact their benefits or how they access care. Our member education, outreach, and engagement strategies are informed by our routine analysis of member information and how members respond to our engagement efforts. We analyze member utilization and demographic data to:

- Identify the cultural groups or unique characteristics of the communities we serve
- Determine communities or cultural groups that are not being reached or served
- Understand the reasons why those communities or groups are not being reached or served

Amerigroup Iowa (Amerigroup) will comply with the information requirements at 42 CFR 438.10, making certain that all information is accurate in content and easily understood.

Language Requirements (8.2.2)

Question 8.2, #2

2. Describe your plans to provide oral interpretation services and translated written information and how you intend to notify members of the availability of these services and how to obtain these services.

Member Communications to Members with Non-English Language Preferences

Through our affiliate health plans, Amerigroup has significant national experience producing culturally responsive materials to our members. In Iowa, where nearly seven percent of the population over the age of five speaks a language other than English in the home, we will distribute all printed member materials in English and Spanish. We will also distribute printed materials in other prevalent languages as identified by DHS and as determined to be the language spoken by at least five percent of the general population in our service area at no additional cost to DHS. We will use the primary language indicator in the enrollment file to most cost-effectively deliver communications to members in the appropriate language. Members who speak non-prevalent languages or want a communication in a language other than that indicated on their enrollment record may request a written, oral, or alternate format translation of materials they receive. We provide oral translation/interpretation services for over 200 languages at no cost to our members.

We inform our members of our written and oral translation/interpretation services and how to access them in the member handbook, on the member ID card, during the welcome call, on our member website, and via taglines in prevalent languages on all written materials. In addition, members are notified of the oral interpretation services that are available each time they call us.

Interpreter Services

Amerigroup understands and will comply with Section 8.2.2 requirements around interpreter services. We continuously assess the communication needs of our members and design solutions to best meet their needs. Our Iowa staff will include employees who reflect the cultural and linguistic backgrounds of the members we serve. We will hire sufficient Spanish-speaking employees to meet the needs of our Spanish-speaking Iowa members. We will also hire employees that speak other languages as determined by our member population and/or as directed by DHS.

To meet members' cultural and linguistic needs, we offer phone menus in English and Spanish, as well as access to bilingual Member Services Representatives. We provide free, immediate translation services in more than 200 languages 24 hours a day, seven days a week (24/7) whenever a member calls us. Our employees are trained to quickly identify situations requiring interpreter services and can usually arrange for a representative who speaks the language or an over-the-phone interpreter to join a call to speak to the member in his or her native language within an estimated 45 seconds. The interpreters understand medical and benefit terminology. This interpretation service is also available to members during visits with Amerigroup providers. When a member needs language interpretation to communicate with a provider, the provider contacts us, and a Member Services Representative creates a conference call between the provider, member, and interpreter.

In some parts of Iowa, Amerigroup may use locally contracted interpreter vendors or on-site interpreters. In these situations, an Amerigroup Care Manager can make arrangements for an interpreter to accompany the non-English-speaking member on a medical appointment so he or she can communicate with the provider. Our Care Management department can also make arrangements for a sign language interpreter

to accompany a deaf or hard-of-hearing member on a medical appointment to offer signing services. After hours, such arrangements can be made by the Nurse HelpLine.

Members with hearing or speech disabilities can contact us through either Relay Iowa’s 711 TTY number or Video Relay Service to communicate with our Member Services Representatives in the same efficient and effective manner as those calling directly.

Relay Iowa may be used by our members who are deaf, hard-of-hearing, or deaf-blind or are having difficulty speaking to call us just like any other standard telephone user. The member calls 711, and the operator assists the caller in communicating with the Amerigroup employee.

Video Relay Service (VRS) allows those who are deaf or hard-of-hearing to communicate over the phone. The caller, using a television or a computer with a video camera device, contacts a communications assistant at their vendor of choice. The communications assistant then calls Amerigroup and relays the conversation back and forth between the parties – in sign language with the caller and by voice with Amerigroup. Because the conversation flows more naturally back and forth between the parties, the conversation can take place much more quickly and effectively than with TTY. Since individuals using VRS communicate in sign language, they are able to more fully express themselves through facial expressions and body language, which cannot be expressed in text. We train our staff to identify and respond to TTY operators and VRS communications assistants as if the employees were talking directly to our members.

Alternative Formats (8.2.3)

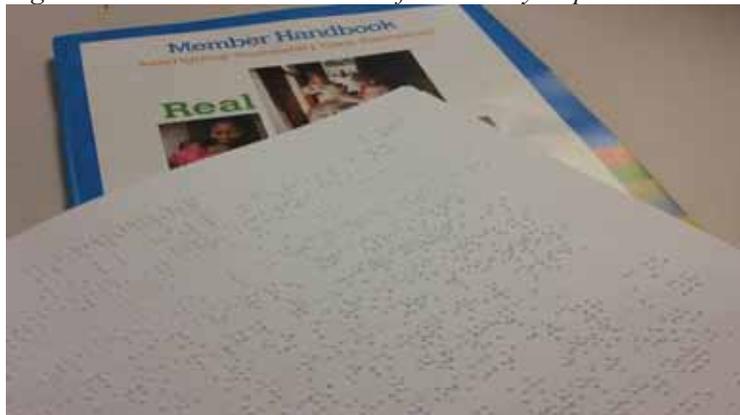
Question 8.2, #3

3. Describe your plans to provide all written materials in alternative formats and how you will identify members needing alternative formats.

Through our affiliates, Amerigroup has extensive experience addressing the communication needs of members who speak non-written language; are blind, deaf, or hard-of-hearing; or have other disabilities that make traditional communication difficult. We will leverage this experience in Iowa as follows:

- Our websites are fully 508 compliant and available in Spanish; members may use Google Translate on any page to access it in over 90 languages. In addition, the U.S. Access Board has released a proposed rule updating accessibility requirements for information and communication technology (ICT) under Sec. 508 of the Rehabilitation Act (“508 compliance” standards). We are tracking this emerging regulatory guidance closely and look forward to responding in our member- and provider-facing ICTs
- Upon request, we will provide a Braille, large-print, or audiotope/CD version of any printed communication a member receives. Figure 8.2-1 shows an alternative format for visually impaired members

Figure 8.2-1. Alternative Format for Visually Impaired Members



- Members may call us and have us read written materials to them over the phone (may also be used with TTY and VRS services)
- Our provider directory information includes languages spoken by certain providers

We inform our members about these no-cost services and how to access them in the member handbook, on the member ID card, during the welcome call, on our member website, and via taglines in prevalent languages on all written materials.

Review of Member Communications (8.2.4)

Amerigroup will submit all new marketing and member materials, as well as any substantive changes to previously approved materials, to DHS at least 30 calendar days prior to expected use and distribution or within the time frame requested by DHS. We will comply with all DHS-specified processes for such review and approval. Amerigroup will also submit for State approval any information that includes the State's name or logo and any correspondence that we may send to participants on behalf of DHS. We understand that approvals given are specific to the use requested and shall not be interpreted as blanket approval. We will include the State program logo(s) in our marketing/member communications upon DHS request and include any and all DHS-specified language in our communications as mandated.

Policies and Procedures for Ensuring Accuracy (8.2.5)

Question 8.2, #4

4. Describe your policies and procedures for ensuring materials are accurate in content and translation.

We develop member materials collaboratively across departments and with our state partners to help assure we deliver clear, concise, accurate, consistent, relevant, and culturally appropriate messages to our members. Across our affiliates, member materials for more than 5.2 million members have been developed through our national Member Communication, Brand and Marketing Departments using specifically tailored messages, benefits, services, and languages; policies, processes, and procedures; compliance and regulatory requirements as well as community and member event programs.

We take seriously our adherence to state guidelines and requirements around member materials. We use a Collateral Materials Approval Process (CMAP) to review all proposed member materials for accuracy, readability, and language/alternate format translation and to assure materials do not defraud, mislead, or confuse members. During CMAP, a multi-disciplinary team of subject matter experts, regulatory and compliance staff, and legal counsel will review the materials for cultural sensitivity, accuracy, and compliance with all relevant federal and State of Iowa requirements. In addition, we also incorporate guidance from CMS's *Toolkit for Making Written Material Clear and Effective* in creating written materials that are easier to read, understand, and use. We use an online tracking tool that promotes consistency in routing all materials for review and that thoroughly documents each reviewer's approval and/or changes. Once member materials has been approved internally, we will submit the finalized material to the State for review and approval prior to printing or distributing.

As part of our process, we translate State-approved new or revised materials in English to Spanish, or other identified primary language. We send materials in English to our translation vendor, who will create a Spanish version (or other language version, as requested). This vendor produces the translation, which we will also submit to the State for approval. Only then do we consider the document complete and ready to disseminate. Amerigroup reviews member materials at least annually. We will provide copies to the State of all policies and procedures related to member materials upon request.

New Member Communications (8.2.6)

Question 8.2, #5

5. Provide sample member enrollment materials as described in Section 8.2.6.

We know that our members lead busy lives, and new programs or changes to existing programs can be an adjustment. Once members are assigned to our health plan, we execute a multi-modal outreach campaign to help assure they feel welcome and supported and they understand their benefits. This campaign may include welcome mailers or automated welcome calls to connect with members as soon as we can after receipt of the enrollment file. We also mail members the required new member packet and inform them each year that they may request a new member handbook, provider directory, or any other information related to their benefits and care. We use these materials to engage and encourage members to invest in themselves by effectively using the benefits, services, programs, and community resources available to support positive health outcomes.

New Member Communications — Enrollment Materials Pre-enrollment Welcome Flyer

Provided enrollment data is available in time, we will send a mailer to welcome members in advance of the ID card and new member packet. This flyer describes what the member will experience over the next one to two months, reassures them that we are dedicated to providing good service, and provides contact information.

Welcome Calls

We use automated welcome calls as a cost-effective and timely way to welcome members and provide information. Members have the option to speak with a live agent to ask questions or learn more. This call may also include some of the initial health screener questions.

Member ID Card

Within five days of notice of enrollment from DHS, Amerigroup sends each member an ID card via first-class mail. Member ID cards are sent separately from the welcome packet to help assure that the member has access to and knowledge of his or her PCP as soon as possible. The member ID card will include the benefit plan, effective date, PCP name and contact number, and Amerigroup contact information. A mocked up ID card for a member served by Amerigroup Iowa is shown in Figure 8.2-2.

Figure 8.2-2. Sample Member ID Card



New Member Packet

We mail new member packets within five business days of receipt of enrollment files. All information will meet the requirements set forth in Section 8.2 and will be submitted for DHS review and approval prior to distribution in accordance with Section 8.2.4. These packets will include:

- A welcome letter designed to provide a warm and welcoming start to each member’s experience with us. We thank members for joining us and reiterate that they can change their PCP by calling the Member Services helpline. We also direct members to our website and encourage them to register to

access our convenient online tools. Finally, the letter provides key contact information such as phone numbers for the Member Services helpline and our 24-hour Nurse HelpLine.

- A notice telling the member how to find a network provider nearby by using our online provider directory or calling our Member Helpline; the directory will include all information detailed in 42 CFR 438.10(e)
- A member handbook
- Recognizing the differences in the types of members we will enroll and the variety of unique benefits and services they are eligible for and need, Amerigroup may customize our new member packets through the following ways that we have found effective in making members feel welcome and helping them understand the program:
 - **Member handbook supplements** that detail specific benefits, services, and operations involved in supporting certain subsets of members. To streamline communications, make them as easy to read as possible, and reduce costs, we may develop an all-member handbook that covers the benefits, services, and operations that are consistent among all populations and then add unique supplements for different populations whose benefits, services, and needs are unique.
 - A **member packet contents flyer** that explains everything in the packet so that members don't get overwhelmed by the contents and know how to use them. We develop a flyer for each type of packet, considering the information needs of different populations such as standard Medicaid vs. Waiver groups.
 - **Benefit-specific flyers** if something needs to be called to a member's attention, such as how to use transportation or take advantage of incentive programs.
 - **Population-specific flyers** to highlight services for certain populations, such as service coordination.
 - **Value-Added Services booklets** that highlight extra benefits we provide and explain how to use them. Again, we tailor these booklets to the member population.

Right to Request and Obtain Information (8.2.7)

Each year, either on the member's anniversary or the anniversary of the Contract effective date, Amerigroup will notify members of their right to request information in accordance with 42 CFR 438.10. We will mail a postcard with information about how to request a new member handbook or provider directory and reminders that they must recertify their eligibility to continue to receive benefits. Such notification includes reminders that members may receive information in the language and format of their choice upon request.

Notification of Significant Change (8.2.8)

Question 8.2, #6

6. Describe your processes for identifying significant changes as described in Section 8.2.8 and notifying members of such changes.

Amerigroup has a robust system in place that enables us to quickly identify, respond to, and communicate material changes to members. We take a similar approach as described in Section 2.16 (Material Change to Operations) by assessing any significant change in our health care delivery that impacts our members' accessibility to services and benefits, and then developing and disseminating responsive communication materials to notify members of that change as quickly as possible.

Our experienced Iowa management team will make sure that significant changes are minimized, but when necessary, implemented effectively. To that end, our Iowa leadership will engage and work directly with the State to communicate these changes.

To identify significant changes, the Amerigroup Regulatory Oversight Manager monitors events, such as contract amendments and policy notices, and works with business owners to evaluate the impact of the event on operations. The Regulatory Oversight Manager uses our Compliance 360 tracking tool, which will notify all impacted departments of material or significant changes in health plan contracts and operations, and impacted departments must immediately respond. Business owners must acknowledge receipt and document steps to implement the change.

Communicating Change to Members

Amerigroup recognizes that every change is different in the manner and extent to which it may affect our members. Depending on the nature of the change and its impact to members, we determine the most effective ways to communicate.

To communicate significant changes to members, our Iowa health plan team will work in conjunction with our national Communications Department to develop member communications/notifications and to update/change member materials, such as the handbook or any other materials, where significant changes affect the accuracy of content. All communication materials will go through our CMAP process, as described in Question 4.

We will notify members of significant changes within the State's prescribed timeframes. Such notification will be via first-class mail and may be augmented by website postings, automated outbound calls, or live-agent outreach. For example, when a provider leaves the network, a letter to all impacted members is automatically generated and mailed. If there are few nearby providers to replace that provider, a Member Services Representative may telephone members assigned to him or her to help them find a new provider.

When material changes require updates to the member handbook, we work to revise the handbook as quickly as possible. While the handbook undergoes updates and approvals, we include the original member notification of the change in new member packets until the revised member handbook is ready.

Certain changes have significant impacts on members' choice and benefits, and Amerigroup is prepared to address them quickly:

- **Restrictions on the member's freedom of choice among network providers:** Amerigroup takes pride in our ability to build effective, collaborative relationships with providers. If a contracted provider is terminated from the network, we will notify each affected member who received primary care from or was seen on a regular basis by the terminated provider within 15 days of receipt or issuance of the termination notice. If there are significant changes to the ways members access

providers (for example, if a referral will be required to see a certain provider type), we will notify members 30 days in advance of that change.

- **Member rights and protections:** If member rights and protections change, we will notify them of the specific changes and the impacts thereof by mail. A revised rights and responsibilities document will be inserted into the member packet until the handbook is revised, approved by the State, and made ready for distribution. We will also post a notification of the change and the revised rights and responsibilities document on the member website.
- We will notify members 30 days in advance of any changes to the following operations. If a member handbook revision is needed, we will include an insert to accompany the handbook in new member packages until the handbook can be revised.
 - Grievance and fair hearing procedures
 - Amount, duration, and scope of benefits available
 - Procedures for obtaining benefits, including authorization requirements
 - The extent to which, and how, enrollees may obtain benefits from out-of-network providers
 - The extent to which and how after-hours and emergency coverage are provided
 - Policy on referrals for specialty care and for other benefits not furnished by the member's PCP
 - Cost-sharing

Notice of Action (8.2.9)

Amerigroup will give members written notice of any action, not just services authorization actions, within the timeframes for each type of action as described in State and federal rules, regulations and policies and according to our response in Section 11.2.7 Notice of Actions for Services.

Member Services Helpline (8.3)

Question 8.3, #1

1. Describe your plans for the member services helpline, including the days and hours of operation.

Amerigroup Iowa (Amerigroup) will offer comprehensive, personalized customer service to our members using a fully-integrated call center technology platform. In 2014, our Member Services Call Center answered more than 5.5 million calls from members across all of our health plan affiliates with a call abandonment rate of less than one percent. We make it easy for members to reach us to get the assistance they need, their questions answered, and their concerns resolved. We believe in quality over quantity as evidenced by our 2014 member services average quality score of 96.8 percent.

Members who call our toll-free number can select from a menu that directs calls to our Member Service Representatives (MSRs), Behavioral Health (BH) associates, Nurse HelpLine or points of self-service, depending on the caller's needs and preferences. Our Member Services Helpline offers:

- A single point-of-contact for members to simplify services
- Menus in English and Spanish
- 24/7 automated self-service for checking enrollment status, changing PCP, updating address and phone number, and requesting an ID card, Member Handbook, or provider directory
- Advanced technology that enables us to flow calls among multiple call centers if needed to respond to spikes in call volume or business disruption due to a natural disaster, such as a hurricane
- MSRs specifically trained to serve Iowa Initiative members
- Clinical assistance through our Nurse HelpLine 24 hours a day, seven days a week (24/7)

Member Services Helpline Operations

MSRs will be available from 7:30 a.m. to 6:00 p.m. Central time, Monday through Friday, excluding State Holidays, to meet the needs of Iowa Initiative members. We understand that good customer service drives overall satisfaction. We continually evaluate and adjust staffing levels to adapt to evolving call trends and help assure adequate staffing during peak call periods.

Our call routing and monitoring technology maximizes efficiency and productivity by assuring real-time access to the full range of call data, including trends for call volume, average handle time, average hold time, average speed of answer, call blockage rate and call abandonment rate. Such capability allows us to be nimble in responding to spikes in call volume – such as during implementation phases – or business interruptions due to a natural disaster at any one location. Our call center technology enables us to seamlessly route calls to different sites to continue serving members. Our call centers have continuously maintained high call efficiency without delay to members during these critical times. Our platform is scalable, replicable, and already operational.

In addition, we recognize the importance of being available to members beyond normal business hours. Through Interactive Voice Response (IVR) technology – described in Question #2 below – we assist members 24/7 through self-service options as well as the option to speak with a registered nurse through the Nurse HelpLine.

We know that members expect and deserve customer service that gets them the information or assistance they need quickly. The strategic design of our call center enables MSRs to provide callers the accurate information they need. Our call center system design features:

- Professional, courteous, and knowledgeable staff who will efficiently and effectively address a variety of member inquiries
- An integrated desktop and online tools that enable consistently accurate responses
- Ongoing feedback to MSRs designed to support and enhance high performance levels
- An up-to-date, online Knowledge Management system

Question 8.3, #2

2. Describe the process you will utilize to answer, route, track and report calls and inquiries. Indicate if an Interactive Voice Response (IVR) system is proposed.

Answering and Routing Calls

Amerigroup uses call routing technology that recognizes the area code of the caller and routes members to our English- or Spanish-language Interactive Voice Response (IVR) menus where, once the member's ID number is authenticated, they can access our self-service menu. Members who either do not have or do not know their Member ID number are asked the reason for their call and are immediately routed to the most appropriate resource to meet their need. At any point during a call a member can opt to speak to a MSR, a BH associate, or a HelpLine Nurse.

The IVR enables us to quickly identify a caller's need and rapidly direct him or her to the most appropriate resources with a minimum of prompts. Based on the member's selection, our automated call distribution system routes the call to an employee who is most appropriate to meet the caller's needs (for example, a Nurse or an MSR with particular expertise in Pharmacy benefits). The IVR also offers self-service options for select functions, including checking eligibility status, changing contact information, selecting a new PCP, or requesting a new ID card, Member Handbook, or Provider Directory.

Routing to Member Service Representative

When members choose to speak with a MSR, IVR technology connects them with someone who can help. Our IVR enables members to reach the right MSR using a minimal number of prompts. For example, if a caller needs to speak with someone related to behavioral health, we route the call directly to the most appropriate, trained, and knowledgeable staff. MSRs provide their names when greeting callers.

Across our affiliate health plans, more than 90 percent of member inquiries are resolved during the initial call. Often, calls that are not resolved during the initial conversation require follow-up work with external entities. For example, a caller has a plan effective date that requires follow-up with the state. When members need to speak with an external entity, such as DHS representatives, MSRs will warm-transfer (if warranted) members to make sure they are connected to the assistance they need.

After Hours Automated System Provides Members with Clear Options and Instructions

We recognize the importance of being available for our members. Through our IVR, we can assist members 24/7 by offering self-service options as well as access to clinical staff through the Nurse HelpLine. The automated system instructs members to call 911 in case of an emergency or connects them to the Nurse HelpLine if they are unsure whether they are experiencing an emergency or if they need non-emergency clinical assistance. The Nurse HelpLine is described in Section 8.4.

Automated Self-service Options for Members

Amerigroup recognizes the importance of being available to members beyond normal business hours. We assist members 24/7, including holidays, through our Interactive Voice Response (IVR), offering Members self-service options. Amerigroup's automated self-service options will allow Members to retrieve information commonly requested during after-hours calls to the Member Services Call Center. We find this is an increasingly popular option for Members along with the Member website for 24/7 access to information. Members can access our voice-controlled automated system in English and Spanish. The prompts provide self-service options for such functions as checking eligibility status, changing the member's contact information, changing the member's PCP, requesting a new member ID card, Member Handbook, and provider directory. The option to leave an after-hours voicemail message informs callers about how to obtain urgent/emergent assistance and instructs them on how to leave a message for non-urgent/non-emergent services. Designated employees retrieve voicemail messages the next business day. The associate will contact the member within one business day following receipt of the message. Our Voice Mailbox provides ample capacity to handle message volume.



Tracking and Reporting Calls

Amerigroup uses multiple call status reports at a variety of frequencies, ranging from every 15 minutes to quarterly, that detail our compliance with performance standards. Our reports show trends for call volume, average speed of answer, and abandonment rate. We evaluate existing processes for our Call Center and make necessary adjustments to meet or exceed all service levels and requirements to improve the quality of service offered by our MSRs. Amerigroup maintains established processes that allow leadership to monitor adherence to established performance standards for delegated services.

We maintain operating protocols that promote consistent achievement of our service standards. Our Workforce Management team conducts real-time monitoring of the Call Center's telephony metrics using a variety of technology tools and custom reports. When call volume increases beyond the capacity of our scheduled MSRs, we expand the call answering queue to include designated backup MSRs who may be located in any of our six national Call Centers. This approach enables us to optimize staff efficiency while capably meeting performance standards. Additionally, our workload balancing application helps assure that our scheduled staff can meet the forecasted needs. An added benefit of being able to move calls between our multiple Call Centers is that we react quickly during natural disasters. For example, inclement weather during the winter of 2015 forced the closure of Amerigroup Call Centers in New York, Virginia, Kansas, and Tennessee. We were able to immediately shift calls to our other Call Center sites and maintain service.

In accordance with Scope of Work (SOW) Section 8.3.6, Amerigroup will report service level performance and will work with DHS to provide this information in DHS's preferred timeframes and specifications.

Availability for All Callers (8.3.1)

Question 8.3, #3

3. Describe your plans to provide services for the hearing impaired and non-English speaking population.

Amerigroup strives to assure that all members have meaningful, timely, and convenient access to care. Our MSRs include employees who reflect the cultural and linguistic background of our members.

Other interpretive services that are provided:

- Professional over-the-phone interpreter (OPI) service vendor
- TRS line for those who are deaf or hearing impaired
- Iowa-based interpreter service vendors

Services for Members with Limited English Proficiency

Amerigroup provides access to linguistic services for all members. This is not only a regulatory and contractual requirement; it is a core element of our Cultural Competency program and philosophy. To meet members' cultural and linguistic support needs, we offer phone menus in English and Spanish, as well as access to Spanish/English bilingual MSRs. We train all of our employees on how to identify the need for and initiate interpretation services. Our call center is able to accommodate members of various languages through our OPI vendor. Through our OPI vendor, **we serve our members in more than 200 languages**. When a member who does not speak English or Spanish contacts us, the Member Service MSRs will place the caller on a brief hold to bring in an OPI. Generally, within an average of 45 seconds, the interpreter, the member, and the MSRs will be connected in a three-way conversation.

Services for Members With Hearing and/or Language Disabilities

We train all MSRs to interact with members and parents or guardians who contact Amerigroup using Telecommunications Relay Service (TRS). The Federal Communications Commission adopted use of the 711 dialing code for access to TRS. To further assist members and potential members in understanding the requirements and benefits of their plan, and to meet their customer service needs, Video Relay Service (VRS) allows those who are deaf or hard of hearing to communicate over the phone. Using a television or a computer with a video camera device, the caller contacts a communications assistant at their vendor of choice. The communications assistant then calls Amerigroup and relays the conversation between the parties, using sign language with the caller and by voice with the Amerigroup MSRs. Individuals using VRS communicate in American sign language and so can express themselves using facial expression and body language, which are important components of American Sign Language.

Additional Language Assistance Options for Members

To further assist members and potential members in understanding the requirements and benefits of the Iowa Initiative, and to meet their service and care needs, we will also provide the following, free of charge to members:

- Oral interpretive services will be available either in provider offices or telephonically
- In-office sign language assistance at the provider's office
- Written materials in English and Spanish or any additional prevalent language identified
- Member Handbook including information on accessing linguistic services to members
- Provider directory will include a listing of the languages spoken by providers

Helpline Staff Knowledge (8.3.2)

Question 8.3, #4

4. Describe your training program curriculum and training process for call center staff.

Amerigroup understands that employees who directly interact with members and providers are critical to building and maintaining trusting relationships in each community that we serve. We make training a priority for our MSRs and will offer all employees serving Iowa members an extensive customer service training program that will include curriculum specific to the Iowa Initiative. We will maintain a diverse team of thoroughly trained employees who cultivate respectful and supportive relationships with Iowa members and their families and with our providers. Our training curriculum employs several educational strategies designed to accommodate different learning styles, including written materials, interactive class discussions, and computer-based tutorials and supports MSRs to build the skills necessary to deliver knowledgeable and accessible assistance and services to our providers and to members of all cultures and abilities.

As part of our extensive training program, all Amerigroup employees serving Iowa members will attend a one-day orientation about Amerigroup, HIPAA privacy compliance requirements, and our customer and membership base. MSRs then participate in an intensive 18-day training course before they begin answering live calls from members in the Nesting environment. The full training continues for a total of 43 days and is delivered in segments in which a MSR learns certain processes and applies those processes for a short period of time. The MSR then returns to the classroom and learns additional skills that build on the first segment. Our training process will be broken into the following components:

- Classroom training: multi-week program will be facilitated by an experienced trainer who has in-depth knowledge of the Iowa Initiative services and benefits
- Nesting: live calls are received in the production environment to acclimate to system tools and resources
- Huddles during the nesting period: MSRs meet for an hour daily to discuss situational events for clarification or resolution
- Quality Review: during the nesting period, increased call monitoring is performed to ensure MSRs are performing to expectation.

Beginning with new hire training, we educate employees on our member-centered approach to care, best practices, and strategies for engaging customers. Throughout their employment, we provide continuous training, coaching, and supervision to support employees in consistently applying these principles when serving our customers. We teach employees to demonstrate our values through the choices they make in daily interactions with each customer and that a single action by any one employee has a ripple effect that ultimately impacts the customer experience. We conduct our training in a controlled environment with supervision and coaching, followed by an evaluation period. The curriculum covers a variety of topics, including but not limited to Member Services core training, Provider Services training, and training specific to the Iowa Initiative.

MSRs are also trained to use our Knowledge Management system and Integrated Desktop application for real-time access to program requirements, covered services, eligibility, and claims data. MSRs will be instructed and be proficient on all Iowa Initiative program details and update alerts so when members and providers call, they will receive up-to-date program information and changes.

Member Services Helpline Staff Training Curriculum

Our structured classroom-based curriculum includes modules that will educate MSRs on:

- Covered Programs and Services, including behavioral health, LTSS, and community-based services
- Eligibility Policy for the Iowa Initiative
- Structure of the Iowa Initiative, Covered Services, and Program Requirements
- Iowa Contract Requirements
- Positive Behavior Supports; Person-Centered Practices
- Community Inclusion and the Importance of Maintaining Independence in the Community
- Cultural Competency Program, including Assisting Members with Limited English Proficiency
- Hearing Disabilities, and Responding to Members with Communication Difficulties or Challenging Behaviors
- Amerigroup Managed Care Principles, including Coordination of Care and the Importance of Consumer Directed Services
- Medicaid, Medicare and Managed Care
- Value-Added Service offerings
- Compliance/Amerigroup Fraud and Abuse Program and Member Rights and Responsibilities
- Systems Training/Online Resource Tools
- Non-Capitated Services and Community and Social Services
- Providing Training to Members Regarding Protections Related to Abuse, Neglect, or Exploitation
- Identifying and Reporting Critical Events or Incidents such as Abuse, Neglect, or Exploitation
- Systems Training/Online Resource Tools
- Triaging Calls, Caller Verification Process
- Locating a Provider/Disseminating Information about a Provider
- Call Monitoring and Quality Management
- Processes for Submitting a Complaint/Grievances and Appeals
- Appointment Availability/Access Standards
- Handling Crisis Calls
- Incentive Programs
- Balance billing issues and cost-sharing and liability inquiries

Nesting Period

During the nesting period, recorded and live calls are monitored to ensure employees are performing according to expectations. This allows new staff to practice the skills they learn during training and receive real-time feedback on the quality of their interactions with callers.

Ongoing Training

After MSRs receive initial training and begin taking member calls, they benefit from ongoing training initiatives to make sure that their skills remain fresh and they are continually engaged in professional development. For example, when we introduce a new product or system, we make certain each MSR receives training and fully understands. We offer courses to enhance service skills and professional development, such as the following:

- Identifying and Responding to Customer Styles
- Providing Customer Service Over the Phone vs. Face-to-face
- Shaping the Direction of Customer Service in Your Organization
- Understanding the Defining Moment in a Customer Interaction
- Implementing Standards to Stay In Tune to Your Customer Needs and Expectations
- How to Uniquely Serve Each Customer

Other training topics will include quality, best practices and opportunities, Iowa bulletins, advance review of member and provider communications, and program and/or benefit changes. All training documentation, lists of attendees, and staff agendas are retained for tracking and review purposes.

Helpline Performance Metrics (8.3.3)

Question 8.3, #5

5. Describe your call center monitoring process to ensure helpline performance metrics are achieved.

Amerigroup will meet or exceed a service level of 80 percent of calls answered within 30 seconds or less using the equation identified in SOW Section 8.3.3. In fact, *over the last year, our performance across all our affiliate health plans administering state-sponsored programs was 90 percent of member calls answered in 30 seconds or less.* We continuously monitors call metrics (e.g., number and percentage of calls answered during a defined timeframe, average speed of answer, call abandonment rate) to manage Member Services Helpline (call center) performance.

A Workforce Management team conducts real-time monitoring of the call center's telephony metrics, using a variety of technology tools and custom reports. When call volume increases beyond the capacity of our scheduled MSRs, we expand the call answering queue to include designated back-up MSRs who may be located in any of our six national call centers. This approach enables us to optimize staff efficiency while capably meeting performance standards. Additionally, our workload balancing application helps to assure that our scheduled staff can meet the forecasted needs.

Backup System (8.3.4)

Question 8.3, #6

6. Describe your plans for a backup solution for phone service in the event of a power failure or outage or other interruption in service.

Amerigroup is committed to maintaining member access to information and services in any emergency. We will use our Member Services Helpline, our member website, and IVR to provide information – and our Business Continuity and Disaster Recovery Plan contains processes to maintain availability of these services before, during, and after an emergency or business disruption. Through this Plan, we will maintain call center operations in the event of a disaster or emergency. The Plan enables both systems and services during power failure, outage, or other interruption using a combination of resources, including network redirection of work, national-owned worksite recovery capacity, mobile recovery resources, and secure satellite connectivity for voice and data.

Nationwide, Amerigroup and our affiliates employ a proven backup plan and system to assure that in event of a power failure or outage, our members continue to have easy access to MSRs. Amerigroup's Medicaid Service Organization maintains call centers in Houston, Overland Park, Tampa, Nashville, New York, and Virginia Beach. Our telephone technology enables these national call centers to flow calls among each other as necessary, creating one virtual call center. When call volume exceeds forecasted levels and the capacity of scheduled MSRs, we quickly expand call answering queues across the country. Cross-trained MSRs in several national call center sites can immediately start to take calls for a site impacted by power failure, outage or other service interruption. All of our call centers maintain the same high standards concerning abandonment rate, service levels, and other key call center metrics. We also provide the same cultural and language services to meet the needs and preferences of members.

We maintain a nimble call center plan that goes beyond staffing ratios. Because using these ratios as a means to assure appropriate call response for members is too rigid to respond in a timely fashion to any kind of spike in call volume, we instead forecast our staffing needs. This allows us to predict staffing levels down to 15-minute increments. Forecasting, based on many factors, including call arrival patterns, seasonality, and contractual obligations, gives us the dexterity to respond to unexpected call volumes, such as service interruptions at any call center due to natural disasters or other business continuity events, or simply an increase in call volume without risking our members' timely access to a MSR.

Our Business Continuity and Disaster Recovery Plan aligns the business requirements of the operating units and the deliverables of support areas to meet stakeholder commitments following an unplanned event. Given the importance of open communication in our continuity activities, we will work and coordinate with DHS and appropriate contractors to help assure a continuous delivery of services at all times. This plan is detailed further in Section 13.2. Further, as part of our business continuity and disaster recovery processes, we will immediately notify DHS in the unlikely event our phone system becomes inoperable or a back-up system is being used.

Integration of Service Lines (3.5)

Question 8.3, #7

7. Describe if any separate member services lines or staff will be used to address member needs by service type (i.e., physical health, behavioral health and long-term care services).

Through our single, fully-integrated call center platform, members can use our toll-free number for assistance with any and all of their benefits under the Iowa Initiative. Our six national call centers are managed as one virtual call center served by employees trained and qualified to respond to callers with questions or issues across physical and behavioral health, and long-term care services and supports.

If the call is outside a MSRs' skill set, they may direct callers to employees with more in-depth expertise. Calls can be routed to specialized call teams within the organization such as:

- Member Pharmacy MSRs
- Website technical support
- Nurse HelpLine RNs
- BH and Physical Health Case Managers
- Community-Based Case Managers

Question 8.3, #8

8. Describe proposed entities to which you will be capable of warm transferring member calls.

On occasion, callers request or require assistance with being connected to an external entity. Amerigroup supports warm transfers to select entities as appropriate for a given caller and circumstance. Such entities include:

- Transportation services
- Dental services
- The health crisis line
- The Case Manager and Case Management team

Nurse HelpLine (8.4)

Question 8.4, #1

1. Describe how the Nurse HelpLine will be publicized to members.

Our 24/7 Nurse HelpLine is part of our Amerigroup On Call Program that provides medical and behavioral health advice based on approved protocols to guide members to the most appropriate point of care, such as an urgent care center, the emergency room, or self-care at home for non-urgent conditions. We take every opportunity to inform members so they know how to contact our Nurse HelpLine any time day or night. We use multiple communication channels and methods to publicize the helpline to members such as:

- Publishing the direct toll-free Amerigroup On Call telephone number on on Member ID cards
- Including information in our Member Welcome Letters, and Member Handbook
- Featuring contact information on our website
- Promoting information in our automated welcome calls to each member during program implementation and to new enrollees going forward
- Providing focused outreach that includes information to members who are identified (through our utilization data analysis) as visiting the Emergency Room (ER) frequently

The Nurse Helpline enhances member access to physical and behavioral health care while also encouraging appropriate use of health care services and avoiding unnecessary hospitalization and ER visits. Members can contact the Nurse HelpLine for non-emergency medical questions and concerns by calling the single toll-free Member Services call center number and choosing the Nurse HelpLine option.

Question 8.4, #2

2. Describe the credentials Nurse HelpLine staff must possess.

All of our AOC staff are licensed registered nurses with the clinical experience and skills necessary to meet the needs of Iowa Initiative members. They will receive extensive training that will assure their ability to guide callers and deliver knowledgeable assistance to members.

Question 8.4, #3

3. Describe processes and protocols for when a physician must be consulted.

The processes and protocols for when a physician must be consulted are incorporated into sophisticated clinical algorithms software used by our Nurse HelpLine registered nurses to assess a caller's health condition and provide recommendations for seeking treatment, which may include self-care, an appointment with the caller's PCP, instruction to call 911, or referral to the emergency room or urgent care services – all based on the nature and severity of the symptoms.

The algorithms used by the program are very meticulous in their design and allow the nurse to quickly and efficiently guide the conversation with the member to ensure appropriate recommendations are brought forth. When a situation arises where the registered nurse believes he or she needs additional support in rendering a final recommendation to the member, the registered nurse will have access to a physician, who will respond to the inquiry within 30 minutes.

In addition, Amerigroup may offer Iowa members our virtual physician telemedicine program made available through our innovative solution, LiveHealth Online. LiveHealth Online provides access via a secure website that enables members with a video-enabled computer, tablet, or smart phone to receive a live audio/video consultation with an Iowa licensed, board-certified physician who can diagnose, make

medical recommendations, and prescribe medications when necessary. In implementing LiveHealth Online, Amerigroup will fully comply with all Iowa statutes, regulations, and rules regarding virtual health care services.

Electronic Communications (8.5)

Question 8.5, #1

1. Describe how technology will be leveraged to communicate with members.

Technology Informs and Educates Members and Families

Amerigroup's member education strategy will continually evolve to support our members and families through access to information to promote better health outcomes. We will employ a variety of technological solutions to improve communication and provide our members with a diverse selection of communication choices, including.

- Email communication
- Smart Phone mobile applications
- Text messaging
- Social Media

We provide additional detail on each of these programs later in this section. We pride ourselves on having a member-centric engagement strategy and strive to communicate with our diverse membership through means that individuals find comfortable and familiar. Amerigroup has the ability to collect member preferences through a variety of contact points during and after the orientation process. We will make it as easy as possible for members to opt in or out of electronic communication modes at their convenience.

Question 8.5, #2

2. Describe how information on member's preferred mode of receipt of communications will be collected and how information will be sent in accordance with such selection.

Upon enrollment into Amerigroup Iowa, members will be given an orientation to our program and be offered a choice of receiving communications from us via regular mail or electronically. Members will receive an orientation through a welcome call apprising them of their options. Member Handbooks will contain information needed to choose and change their preference for receiving communications, and prompts will be included in the registration process for the secure member website. Members receiving Long-Term Services and Supports will be informed by their Community Based Case Managers as to their communications options. Members may alert us at any time to a change in their preference simply by contacting the Member Services Helpline.

Members choosing to receive communications from us electronically will receive e-mail alerts letting them know that materials are available on the secure member website for their review. The e-mail alerts will never contain Protected Health Information. If Amerigroup receives a notice of failed delivery, we will send a follow-up notification via regular mail within three business days with directions to contact the Member Services Helpline for assistance to restore electronic communications or opt back into paper

communications with material delivered by regular mail. Upon receipt of the request to change their preferred mode of communication, we will store the member’s preference in our system.

Question 8.5, #3

3. Describe how electronic communications will be received.

Receipt of Electronic Communications

Amerigroup will collect and store e-mail addresses of those members wishing to receive information electronically. Those members will receive e-mails alerting them to log on to the secure member website at: www.myamerigroup.com to get information containing Protected Health Information (PHI) and other communications.

Amerigroup will provide members appropriate documents in electronic format as quickly as possible. Members choosing to receive electronic communications will:

- Receive an alert anytime an electronic notice is posted to the member website
- Receive a notice by regular mail if e-mail is returned as undeliverable
- Be informed as to how they can contact Amerigroup’s Member Services Helpline to restore e-mail communications

This website also allows members to ask questions about their benefits as well as any type of customer service question and an Amerigroup employee provides a response within one business day of receipt of the member’s question.

Leveraging Technology

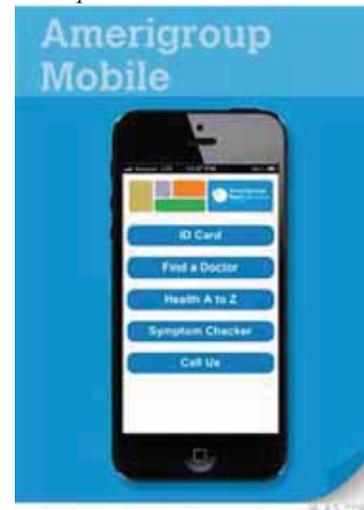
Amerigroup Mobile Application

Through Amerigroup Mobile, members and families can access resources from the convenience of their smartphones. As shown in Figure 8.5-1, member functions now available through this application include:

- ID card (view, fax, email)
- Find a Doctor (searchable provider directory accessible before login or from the primary menu once logged in)
- Health A to Z (health topics powered by Healthwise)
- Symptom checker (powered by Healthwise)
- Call Us! (member service information and clickable phone number)

Amerigroup Mobile App is available for free to users of iOS or Android OS through the iTunes App Store or Google Play. Members must know their member identification number and ZIP code to log in to Amerigroup Mobile. The downloadable ID card is not stored on the phone but will generate a copy to the provider via e-mail and print functionality. Our Member Handbook and other fliers offer directions on how to install and use Amerigroup Mobile.

Figure 8.5-1. Amerigroup Mobile Delivers Communication to Members Through Their Smartphone



Mobile Text Program

In 2014, Amerigroup’s affiliates launched a pilot program, which delivers important text messages to adult members participating in the SafeLink program (a free phone program described in detail in Section 3.2.14) across all markets. Participating members may opt in to receive text messages from Amerigroup affiliates upon receiving their new SafeLink phones and may opt out at any time. There are three series of text messages:

- **Administrative:** Texts are focused on benefits and provide information on the value of the *Nurse HelpLine*, ID cards, assistance finding a doctor, and more. They focus heavily on our newest members as a tool to engage them with the health plan.
- **txt4hlth:** These text messages focus on member health and give individuals the date of their last physical exam and reminders for dental check-ups and mammograms and include health quizzes. They are sent throughout the year.
- **txt4baby:** These text messages focus on pregnant members and provide them with important information and reminders for prenatal care. Via two-way texting or live chat, members can get their questions answered and receive timely, relevant information about their pregnancy or infant care.



Through May 2014, *more than 1.4 million text messages have been delivered to our affiliates’ members.* The program has experienced a *91 percent retention rate* for member participation. Further, records indicate *99 percent of all text messages are opened*, and *8 percent of our users directly respond* to the messages. Amerigroup is committed to this new avenue, as it will allow us to directly engage our membership.

Linking Members to Useful Apps

Amerigroup has developed customized apps to support health, wellness, and self-care for chronic conditions such as diabetes, asthma, and hypertension.

Apps also provide a fun, interactive venue for children and adolescents to independently learn about conditions they are diagnosed with and alerting them of symptoms for which to seek help. We collaborate with organizations such as school-based health centers to further support access to appropriate apps that promote self-management skills for our adolescent and young adult members. Apps will be carefully vetted by Amerigroup, and we will seek approval from DHS 30 days prior to distributing apps through our website.

Figure 8.5-2 illustrates apps that we plan to make available to our members.

Figure 8.5-2. Better Self-care Through Mobile Applications



Social Media

Amerigroup uses Facebook and Twitter to share and receive information from members. Sharing articles and news stories stimulates active member participation. Our social media sites are used to provide information to and solicit feedback from our “followers,” keep members and followers actively engaged in healthy topics, and alert them to community events.

Amerigroup uses YouTube to highlight videos of our success stories. On our National Medicaid Division’s YouTube channel, there are videos featuring our Real Stories, corporate social responsibility

stories featuring our philanthropic arm, presentations and seminars, short features on our volunteer efforts on our "In Your Community" page, and Amerigroup news and media clips.

Member Website (8.6)

Question 8.6, #1

1. Describe your plan to develop a member website and mobile applications in English and Spanish, and the kinds of information you will make available to members in these formats.

Amerigroup understands that Iowa Initiative members, including seniors and individuals with disabilities, are evolving in their use of computers and smartphones. We maintain a robust, secure, and user-friendly member website that allows greater ease of access to information and more active management of healthcare. Available 24/7, our website will feature vital tools and resources for Iowa Initiative members, where they can access a broad range of information and capabilities in English and Spanish. In addition to information about our plans and benefits, the provider network, and important contact information, members will find links to community resources, community events, and health and wellness information. The website also features health-related topics and seasonal reminders, such as flu shots, and our Healthwise link to help members understand their symptoms with a "symptom checker."

All information available on the website and the mobile application will be submitted to DHS at least 30 days prior to posting to secure approval. Further, our website complies with Section 508 of the Rehabilitation Act, optimizing accessibility for members with disabilities. All confidential member information is protected according to HIPAA privacy and security requirements.

User-friendly Member Website Information and Tools

Amerigroup's member website provides a quick, personal way for members to learn about and research their health plan services and benefits. The Amerigroup Iowa website will include capabilities and services that facilitate members' easy access to information about their benefits including cost and quality information. The site architecture and navigation platform is user-friendly, accessible, and can be accessed on a smart phone. Website content includes culturally appropriate information, written at a fifth grade reading level, and available in English and Spanish. The website can be easily converted to Spanish simply by clicking the translation button found in the upper left-hand corner on the landing page. Our content will be tailored toward identified populations and health conditions relevant to Iowa Initiative members. Further, it will be fully optimized for those who have visual, auditory, physical, speech, cognitive, neurological, multiple, and age-related disabilities. We consider the needs of those who may:

- Require screen reader technology to narrate content
- Lack the ability to navigate using a mouse
- Have visual disabilities and may have difficulty discerning colors and/or text elements on a screen
- Be deaf or hard of hearing and may not be able to hear multimedia content

The website offers the following features:

- Easy, more secure access to personalized member services
- Quick access to common member tasks such as finding a Member Handbook, ordering a new ID card, choosing an electronic communication preference, and updating personal information
- Access to searchable tool of community resources and services that can be displayed by ZIP code or community
- A searchable provider directory (updated nightly)

- A formulary look-up feature
- Resources for community stakeholders such as foster parents or case workers
- Ability to take our Health Risk Assessment tool
- Electronic library of documents including the Member Handbook
- Request for replacement ID cards
- A secure message center

For this Contract, Amerigroup will offer additional functionality tailored to our diverse and specialized populations and interactive features designed to promote nutritional education, peer support, member engagement and self-care, and health and wellness activity tracking.

Additional functionality includes:

- Caregiver section identifying tools and resources for support
- A searchable member benefits tool
- Healthy Rewards incentives allowing members to track rewards progress
- Health cost estimator tool (for those members with premium or cost sharing provisions)
- Resources for members managing behavioral health conditions including materials for their families and access to peer support

Knowing that there are approximately 20,000 households in Iowa without Internet connectivity, Amerigroup is in discussions with senior centers and public libraries to identify ways to promote the use of these web-based resources by visiting any of the 544 public libraries spread throughout the State. Amerigroup has already engaged with the Iowa Library Association (ILA) to expand access.

Amerigroup will propose to the ILA's Board of Directors that ILA member libraries include links to the DHS Iowa Initiative website on every public library computer in the State to assure that Medicaid beneficiaries can easily navigate to State information on the Iowa Initiative and information on participating MCOs.

Amerigroup uses our website and several social media sites for the benefit of our members and providers. Our current websites have public and secure login-only areas. Our public areas enable members and the community to access general information about Amerigroup, our programs, and the benefits available to our members, as well as links to community resources and informational materials. Our secure login-only areas give our members and providers a secure environment where information specific to their needs can be located in an easy-to-use, compliant location.

Members can register for secure website access by providing their Amerigroup ID number, last name, date of birth, and home address ZIP code. After information is validated, the member is asked to create a user name and password. Members can contact the Member Services Helpline for assistance. Website tools are available to assist members who forget their user name or password.

An example of public and secure member website content for Iowa is presented in Table 8.6-1.

Table 8.6-1. Public and Secure Content on the Member Website

Public Website Content	Secure Member-only Website Content
<ul style="list-style-type: none"> • Iowa health plan overview with information • Available benefits/services • Searchable provider directory • Member rights and responsibilities • Frequently asked questions • Safety and privacy information • Member Handbook • Tool to report fraud, waste, and abuse • Tool to submit questions or comments • Community resources with links to area websites • Login to the secure member area 	<ul style="list-style-type: none"> • HIPAA-compliant registration process that will enable members to generate a new user name and password for simple login on their return to the site • Demographic information with option to update • PCP information with option to change • Additional program-specific “Resources in Your Area” • How to request or contact a Case Manager/Care Coordinator • Information on our Integrated Medical Management Model written in a way that is relevant for members and includes behavioral, social, and physical health information • Details on eligibility • Access to member and plan documents, such as the Explanation of Benefits requested electronically by the member • “Call Me!” allows Members to enter their phone number (during normal business hours) and get a response from a MSR at their preferred call back time

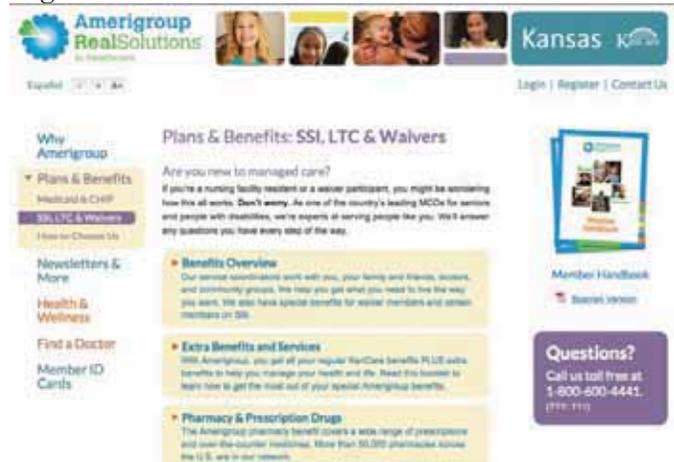
Our website also includes detailed information on programs and services, specific member benefits, an area to ask questions, helpful links to area resources, and other audience-tailored and program-specific information.

A password-protected member portal stores and facilitates members’ changes to demographic and primary care provider (PCP) information. Additionally, we include an innovative, interactive provider search tool that enables our members to search for providers by location and includes provider names, locations, telephone numbers, office hours, and non-English languages spoken by current Network PCPs and specialists; hospital listings, including locations of emergency care and post-stabilization services; and a list of providers accepting new patients. This information is updated nightly. Upon a member’s request, Amerigroup will send the member a hard copy of the directory. Members may also contact Member Services for assistance.

Additional tools under the selections list above include:

- Are You Pregnant?—a survey for members to tell us about their pregnancy and any special needs they may have, as well as numbers to the Tobacco Quitline, Member Services, and 711 Telephonic Relay
- Find a Provider—a tool that guides members to quickly find PCPs or specialists, hospitals, laboratories, and behavioral health providers

Figure 8.6-1. Members May Also Access an LTSS Web Page



Long Term Services and Supports

We develop web pages that describe specific benefits in more detail such as our Kansas affiliate's member web page describing SSI, long-term care, and waiver programs. We will offer our Iowa members a similar web page encompassing information on Iowa's LTSS benefits and programs.

Updating Content and Monitoring for Accuracy

Amerigroup's overall quality framework includes targeted audits, telephonic outreach, and proactive and reactive responses to any website information discrepancies identified through various sources, including automated reports and provider outreach. We will maintain policies and procedures for monitoring the content of the member website for accuracy and incorporating changes to content as needed. Our employees will review the general volumes and trends of web transactions. We will query transaction logs to research specific web events on an as-needed basis. This information helps guide our efforts to modify and update the website to encourage members to seek it out as a useful resource. Currently, we do this in our affiliate health plans.

Health Education and Initiatives (8.7)

Question 8.7, #1

1. Describe your proposed health education initiatives including topic areas and strategies for communication. Provide sample materials.

Health Education and Communication Strategy

Engaging members in accessing healthcare resources appropriately and adapting healthier lifestyles begins in the community. To that end, *we customize our health education approach to address community priorities and health concerns*. We work with both State and local resources to communicate and engage members in a culturally and linguistically responsive way. We do not take a “one size fits all” approach. Rather, our efforts range from general health education initiatives that seek to build health literacy and empower all members to take responsibility for their health status to high-touch, personalized outreach strategies tailored to the preferences and needs of individual members. Building on the success of our affiliate health plans operating state-sponsored health programs in 19 states and serving more than 5.2 million members, Amerigroup brings comprehensive and thoroughly vetted health education initiatives to Iowa.

We communicate our health education initiatives through a variety of methods with consideration for members' culture, ethnicity, language, sexual orientation, age, and other socioeconomic needs. We provide members with tools, information, and resources in a clear, actionable, and accessible format. We make all materials available in English and Spanish, have bilingual Member Services Representatives on staff, and provide interpretation services for more than 200 languages to assist members with limited English proficiency. We also offer alternative communication forms for members who are deaf or hard of hearing (through video relay) or who have low vision or are blind (through Braille and audio versions of materials). Our health education strategies enhance access to information, empower members to make informed health decisions, and improve quality of care and member satisfaction. Strategies include:

- Member incentives that promote well checks and participation in preventive or routine healthcare, such as PCP well visits and various screenings (Refer to Section 10.3 for a complete list of member incentives planned for the Iowa Initiative)
- Collaboration with community- and faith-based organizations to help deliver important healthcare messages through health fairs and special events, at which educational materials are readily available; free health screenings and immunizations can also be offered through these events
- Dedicated, local case managers who use best practices for engaging, educating, and coordinating care of members who may be challenging to locate (such as those who are homeless)
- Online and mobile technologies to give our members credible and reliable health information (materials can also be easily downloaded on our website or mailed upon their request)
- Specialized programs tailored to address specific member conditions (such as asthma and diabetes) or special healthcare needs such as maternal-child program and disease management
- Use of social media (Twitter, Facebook, YouTube communities) and partnerships with existing community-based organizations' websites to promote local educational events and programs
- Highly trained and knowledgeable Member Services staff coupled with sophisticated technology to assist members in addressing their healthcare conditions

Innovative Health Education Initiatives (8.7.1)

Our health education initiatives will focus on the health issues most prevalent to Iowa members. We will work to influence the behavior of our Iowa members building on the existing programs that are proven successful in other states and implementing new strategies to further educate and motivate members in making healthy decisions. Our proposed health education initiatives include, but are not limited to, maternal and child health, preventive and general health, member engagement and empowerment, appropriate use of emergency services, community outreach and education, substance use disorder prevention and treatment, and education for members and caregivers about suspected abuse and neglect.

Maternal and Child Health Education Initiatives

Nurse-Family Partnership®

The Nurse-Family Partnership will give Iowa members who are pregnant critical information to help facilitate a healthy pregnancy and a healthy baby as well as promote parenting skills and child safety. Through the Nurse-Family Partnership, public health nurses visit women who are low-income, pregnant for the first time, and at risk during their pregnancy and until the baby is two years old. The program offers additional support, education, and resources for the new mom and helps her transition to the community after having a baby. The nurses teach parenting and life skills and help new moms gain access to job training and education programs. The nurse becomes an essential resource for the woman by offering her knowledgeable guidance and resources to assist her in the community. Please see Attachment 8.7.1-1 for our Nurse Family Partnership brochure.

Taking Care of Baby and Me

This maternal-child health program provides quality, culturally competent case management services to pregnant members during the prenatal and postpartum periods and to their infants. Nurse case managers encourage pregnant women to optimize the outcome of their pregnancies, to prepare for the delivery and homecoming of infants, and to participate in their infants' care should an NICU stay be required. Taking Care of Baby and Me includes a full array of support tools that foster close communication between Amerigroup and the member and that promote a healthy pregnancy and baby:

- **Prenatal Incentive Packet** – Includes information and incentives to encourage pregnant members to attend pregnancy and postpartum office visits as well as *Planning a Healthy Pregnancy* booklet. Members may receive \$25 for attending prenatal appointments during the first trimester and \$50 for attending postpartum appointments between 21 and 56 days after delivery. Members continue to receive informational materials throughout the pregnancy and after delivery, including a booklet, *Caring for Your Newborn*. Please see Attachment 8.7.1-2 for a sample of our maternal and child health materials.
- **SafeLink Phones** – Qualified members will receive a free cell phone with up to 250 minutes per month, and as a Value-Added Service, 100 additional lifetime minutes. These additional minutes give case managers real-time access to members to encourage them to keep appointments and fill prescriptions. Numbers pre-programmed into the phone give pregnant women an easy way to contact their obstetricians, case manager, and other essential service providers. Pregnant members also receive a series of messages developed by our maternal health and pediatric specialists.
- **March of Dimes Centering Pregnancy®** - This multifaceted model of group care integrates three major components—health assessment, education, and support—that may help reduce the disparities that exist among women in Iowa who are childbearing (preterm birth affects Hispanic and African-American women at disproportionate rates). Preliminary studies of participants in this program show increased birth weight, decreased incidence of preterm birth, and greater knowledge about pregnancy. Amerigroup works closely with the March of Dimes to support this and other programs to improve the health of women and children.

Smoking Cessation during pregnancy – We coordinate with the CDC and the March of Dimes on educating women about the dangers of smoking during pregnancy. During the risk-screening survey, we ask every woman about her recent smoking history. Through the one-on-one relationship established by the case manager with every woman who is pregnant and high-risk, we urge members to take advantage of the smoking cessation benefits available. Emphasizing that pregnancy is an ideal time to stop smoking, all our case managers are trained in coaching techniques on how to approach the topic of quitting.

- **Community Baby Showers** – We honor mothers through health, education, and fun activities by hosting a Community Baby Shower. Community partners that participate in the baby showers provide educational information to the participants. Resources include Departments of Family and Children Services, WIC, health departments, pregnancy resource centers, Toys R Us, Babies R Us, Safe Kids, technical schools, dental offices, and many more. Participants also have access to health screenings such as blood pressure, vision, and glucose.
- **txt4baby** – We joined the text4baby program to promote this free text message information service. Once pregnant members enroll, they receive educational messages and helpful reminders tailored to particular weeks of their pregnancy and through their baby's first year.
- **Warm Health** – We use Warm Health to support our maternal outreach and education program. This tool educates pregnant women and new moms via interactive voice response, texts, and smart phone applications. Enrollees receive twice weekly messages during the prenatal phase and weekly postpartum and well-child messaging. Via two-way texting or live chat, members can get their questions answered and receive information about their pregnancy or infant care. Data validates that women who participate attended 30 percent more prenatal care visits and six percent more postpartum visits. Obstetric screenings increased 3.5 percent.

Preventive and General Health Education Initiatives

Healthy Families Program

A Value-Added Service we will offer in Iowa is our Healthy Families program. Healthy Families is a six-month program created to reduce childhood obesity and to help families adopt healthier lifestyles. The program connects mind and body, physical and behavioral health, parents and children to focus on healthy lifestyle choices through a family-centric approach, multiple levels of support via the family and community, availability of tangible materials for participants, and web-based resources for further information. Nurse coaches telephonically engage and educate families to make positive behavior change in healthy eating and activity. They also provide nutrition counseling, send educational material via mail, and refer members to online resources and local activities. Additionally, the program features fitness and nutritional education programs that range from interactive demonstrations of cooking and exercise to lectures showing how video games can help keep kids active.

We will also introduce Weight Management for specialized populations, leveraging components of Healthy Families, to support tailored health initiatives for members with physical, intellectual and/or developmental disabilities. We will coordinate with nurses serving these populations, ICF/IDs, adult day care centers, day habilitation programs, other providers and community-based organizations on health promotion, social and recreation programs, and nutrition education.

AmeriTips Promote Healthy Lifestyles

Amerigroup provides easy-to-read, appealing tip sheets on preventive healthcare and management of chronic disease conditions to our members at providers' offices, community organizations, and community events. AmeriTip topics include immunizations, creating a healthy lifestyle for your child, lead poisoning, diabetes, hypertension, and flu shots, just to name a few. Members may request AmeriTips on specific topics of interest from their assigned case managers or from Member Services as

well as through our member website portal. Attachment 8.7.1-3 Health Ed – Initiatives AmeriTip Flyers includes samples of AmeriTips flyers.

Farmers' Market Initiative

Amerigroup's farmers' market events highlight healthy eating in an educational and fun environment. The market provides fresh produce from local farmers, provides a community gathering place, strengthens the local economy by redirecting dollars to local growers and producers, and educates the community about the importance of healthy eating. During the event we provide free health screenings, children's activities, and tips about obesity, diabetes, wellness, and nutrition. In our Georgia health plan, over 3,000 people attended these events. As an adjunct, Amerigroup's Community Outreach Vehicle Farm Station provides healthy snacks and vegetables in the community and also provides information on healthy eating and lifestyles.

Smoking Cessation

Another Value-Added Service we will offer to our members is our Smoking Cessation program. The program consists of individual smoking cessation counseling, coaching to quit, cessation planning and support, and follow-up member outreach. The program's coaching sessions include assessment tools with personalized feedback, strategies for reducing harm and secondhand smoke exposure, information on setting a meaningful quit date, and preparation for high-risk situations.

Flu Campaign

Through seasonal flu campaigns, we outreach and educate members on the importance of receiving the flu shot, with specific focus on high-risk members. We include flu shot reminders in our AmeriTips flyers, member and provider newsletters, provider and member websites, and seasonal mailers and via telephonic notices to high-risk members who have not received their annual flu shot.

Txt4health Initiative

Given our adult members' busy lives, texting is a proven reliable and convenient method for health education. In 2014, we launched a texting program to deliver key messages to members participating in the SafeLink program. These members can opt in to receive text messages from us upon receiving their new SafeLink phones and may opt out at any time. Currently, over 185,000 of our affiliate health plans' members across the country participate, and only four percent opted out of receiving text messages. Our messages focus on member health and give individuals the date of their last physical exam as well as provide reminders for dental check-ups and mammograms. We also include health quizzes. Through May 2014, we delivered 1.4 million text messages. The program experienced a 91 percent retention rate for member participation. Records indicate 99 percent of all text messages are opened, and 80 percent of our users directly respond to the messages. Of members who responded, 72 percent stated that the texts helped them remember to go to the doctor. Members who received texts about certain programs/phone numbers (such as the Nurse HelpLine or coaching) were six times more likely to call the promoted phone number within 30 days of the text. Members who received texts reminding them to get a screening/physical were three times more likely than non-members to get a physical exam within 90 days of the text.

Member Engagement and Empowerment Initiatives

Interactive Member Website, including Health A to Z

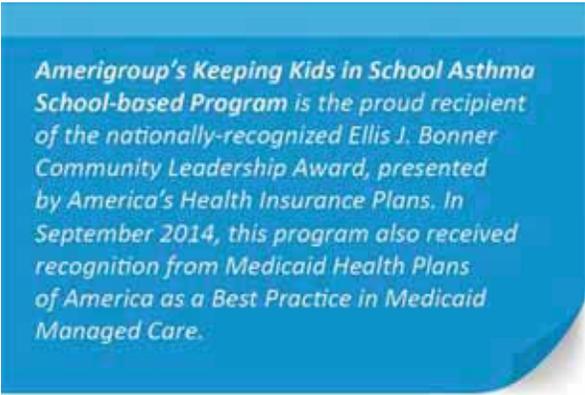
To promote member engagement and responsibility in their health status, we make our member website available 24/7, which features vital information, educational materials, and tools to empower members to make fully informed healthcare decisions. Members can access health-related topics and seasonal reminders (such as flu shots) as well as information related to specific symptoms and health issues. Section 8.6 fully describes the content and functionality of our member website. Through *Health A to Z* (powered by the Healthwise® KnowledgeBase), members can access a variety of tools and resources on

our website that include the breadth and depth of health content that people need to make the informed healthcare decisions. Members with chronic conditions such as serious and persistent mental illness, diabetes, congestive heart failure, chronic obstructive pulmonary disease, and many others can easily find information and decision tools about their conditions. There are more than 7,000 topics on health conditions, medical tests, procedures, medication, and everyday health and wellness issues.

Asthma Management Outreach and Education

Our award-winning Keeping Kids in School Asthma Education Program uses a one-of-a-kind approach to promote asthma awareness and control. Our health educators conduct sessions designed for children, parents, teachers, and adults at numerous places and times throughout the week. Sessions are also offered in various languages. The program consists of three components:

- **School-based Hands-on Asthma Education in the Classroom** – A 45-minute classroom presentation for children and teachers in grades three to six that engages students in role playing and demonstrates asthma management tools like inhalers and spacers.
- **Parents/Adults Asthma Workshops** – Parents and adults participate in a one-hour session taught at schools, health centers, social service agencies, and community- and faith-based organizations to learn about asthma causes and symptoms, triggers and how to control them, and how to avoid missing school or having to go to the emergency room (ER) or hospital.
- **Annual Asthma School Poster Contest and Awards Ceremony** –Public schools can take part in the annual asthma poster contest with winners recognized at an awards ceremony.



Amerigroup's Keeping Kids in School Asthma School-based Program is the proud recipient of the nationally-recognized Ellis J. Bonner Community Leadership Award, presented by America's Health Insurance Plans. In September 2014, this program also received recognition from Medicaid Health Plans of America as a Best Practice in Medicaid Managed Care.

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In addition to this program, we also use dedicated outreach employees to contact parents/guardians of children who have had ER visits with asthma issues. They work with parents/guardians to gauge their comfort level in dealing with asthma, make sure the child has appropriate medication, provide information on Nurse HelpLine, and provide a referral to an Amerigroup case manager if necessary. Members will also receive "My Asthma Action Plan," a guide to understanding the severity of different asthma symptoms and when to contact the doctor or go to the ER. We also provide AmeriTip handouts to educate members on asthma triggers and how to avoid them. During the spring, we mail a *Spring Into Asthma Care* flyer to members reminding them to know their triggers, take their medication, and visit their doctor. Please refer to Attachment 8.7.1-4 for a copy of our member education material on asthma tips and triggers.

Additionally, another innovative solution we will provide for our high-risk members are inhaler sensors to track adherence to asthma controller medications. The inhaler sensors will help case managers identify members so they can provide outreach to help members avoid symptom escalation. We will focus on members with acute symptoms resulting in ER visits or inpatient admissions for asthma-related events.

Appropriate Use of Emergency Services Initiatives ***Access to 24/7 Education***

Our Nurse HelpLine, part of our Amerigroup On Call Program, is accessible 24/7 to link members to physical and behavioral health resources who will answer their questions and locate the most appropriate

point of care to address their needs. This program helps minimize unnecessary use of ERs by providing members access to information and resources, such as:

- **Nurse HelpLine.** Nurse HelpLine callers can speak to nurses with physician oversight through Amerigroup On Call. Amerigroup On Call offers translation services for over 200 languages and guides members on appropriate next steps for non-emergent medical conditions.
- **Urgent Care Services Network.** Amerigroup On Call can connect members to a comprehensive urgent care services network—including PCPs who have extended hours, urgent care centers, and retail clinics—all of which broaden access to care and provide ER alternatives, especially after hours.
- **Emergency Room Care.** Amerigroup On Call nurses and physicians educate and direct members to nearby ERs when those services can provide the most appropriate treatment.

LiveHealth Online Offers Alternatives to ER Visits

LiveHealth Online will provide members a convenient alternative to visiting the ER. We will offer online physician visits, when appropriate, given members' conditions and ability to access secure video streaming online services. As we implement this option for Iowa members under the statewide Contract, we will fully comply with all State statutes, regulations, and rules on virtual healthcare services.

Emergency Room Education in Action

Amerigroup mails postcards to members who live in areas with urgent care clinics, where providers have walk-in hours or extended office hours, or when a new PCP becomes available, informing them of alternatives to the ER. We focus these mailings on areas with high ER utilization and send to all members when we identify a new provider with extended office hours.

Community Outreach and Education Initiatives

Community-Based Partnerships for Health Education

Our affiliate health plans in 19 states have forged strong bonds with faith- and community-based organizations that educate, advocate, and serve our members. Our goal is to increase awareness of our programs, promote healthy behaviors through health education, and build trust within the communities we serve. We are meeting with key Iowa organizations to establish relationships, such as:

- Community Health Charities of Iowa
- The Arc of Iowa
- Vera French Foundation
- Healthy Birth Day
- Rick's House of Hope
- Child and Family Policy Center
- March of Dimes Iowa
- Caregivers Association
- Community Action Association
- Alzheimer's Association
- Boys and Girls Clubs of Central Iowa
- Johnson County Case Management
- Child Advocacy Board
- Public Health Association
- Homestead Center for Autism
- Coalition for Family and Children's Services
- Alliance in Home Care
- Association of Community Provider

As an example, our Georgia health plan establishes partnerships with approximately 1,400 groups each quarter to sponsor events, conduct health education meetings, and promote wellness and preventive care. These groups include government agencies, faith- and community-based organizations, federally qualified health centers, schools, youth associations, chambers of commerce, employers, vendors, and Boys and Girls Clubs. In Georgia, we sponsor or participate in more than 5,100 events annually, ranging from birthday parties, family nights, and healthcare screenings, Farmers' Markets focusing on healthy eating, and back-to-school events where we provide children with school supplies and a variety of other events designed to engage and educate members.

Amerigroup designs events to be fun and informative. We highlight our healthy message in a variety of ways, including our superhero Captain Amerigroup mascot making appearances at schools, health fairs, and other community events. Captain Amerigroup is a “crusader for health,” who helps families learn how to be healthy and safe. He is accompanied by an Amerigroup Health Promotion employee or marketing officer who delivers our health-related messages about exercise, healthy eating, regular checkups, immunizations, and a variety of other topics. He also distributes health education collaterals and giveaways including sunscreen, healthy snacks, flashlights, Frisbees, and toothbrushes.

Clinic Days Promote Education

Our affiliate health plans partner with physicians, health departments, and other primary care delivery sites to hold clinic days where members can obtain timely preventive services, screenings, and diagnostic tests to close identified gaps in care. In partnership with Network Providers, we will host Clinic Days for Iowa members who have not received immunizations, other preventive services, or postpartum care or who are due for diabetes or other chronic condition care. During a Clinic Day, Amerigroup's Health Promotions Team will be available to provide health-related information and offer healthy snacks. Clinic Days are an effective way to help make sure members receive necessary preventive services and screenings to maintain health or avoid exacerbation of chronic conditions.

Education and Outreach for Children and Their Families

Head Start programs are proven to positively affect immunization rates and other preventive and screening-related measures, and a high percentage of children enrolled in Head Start programs are also enrolled in Medicaid. To reach young children and their families, we will work closely with Head Start programs in Iowa, providing financial assistance to the programs and education and outreach to parents. We will also sponsor health promotion activities for Head Start programs, affording an opportunity to connect with young children and their parents to educate families and promote wellness compliance. To reach our Iowa school-aged members and their parents, we will sponsor back-to-school events. Our affiliates in other states have seen great success and participation with distributing backpacks filled with school supplies and member education materials, including information about the EPSDT periodicity schedule and healthy start checkups.

Prevention and Treatment of Substance Use Disorder

Screening, Brief Intervention, Referrals, and Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and screening for individuals with risky substance use and referral to treatment for those members who meet criteria for a substance use disorder. In Iowa, we will promote use of SBIRT with our adolescent population. We will begin working closely with our larger at-risk provider groups to implement SBIRT, expanding to other pediatric practices as the program strengthens. SBIRT is demonstrated to reduce both alcohol abuse and healthcare treatment for the abuse. We are committed to increasing the use of this covered service through education and provider partnerships.

To further promote prevention and treatment of substance use disorders, we provide members with our “*I want to stop substance use*” flyer—a six-question quiz to see what members know about stopping substance use, other resource contact information, and a contact for Amerigroup Member Services. Please refer to Attachment 8.7.1-7 for a copy of the Initiatives Ameritip Flyer on substance abuse.

Education for Members and Caregivers about Suspected Abuse and Neglect

Amerigroup educates members and caregivers about suspected abuse and neglect and evaluates members and their environment to determine their current needs and confirm the appropriate delivery of services.

Our health risk assessment informs the care manager of specific health and/or safety concerns that may require attention. If any results imply suspected abuse or neglect, the care manager will arrange immediate services for the member and report the issue to the appropriate authorities. One of our assessments, *Potential Abuse and Neglect Assessment*, focuses on the member's home and safety of their environment. This assessment identifies potential issues that the case manager uses to educate members to signs and potential triggers in their environment that may be harmful, such as neglect by a family caregiver or abuse of the member. When appropriate, we make available a copy of our educational flyers that provide valuable information to assist members with understating the different types of abuse and immediate access to the telephone number for protective services.

Question 8.7, #2

2. Describe how you would propose to participate and interface with the Healthiest State Initiative.

Partnering with Healthiest State Initiative

Through its Healthiest State Initiative, Iowa has committed to improve from Number Ten on the Gallup-Healthways Well-Being Index to Number One by 2016. We are excited to collaborate with the State on this bold effort and will appoint a local Amerigroup team that includes key members from our clinical, network, marketing and outreach, and innovation departments, led by a senior plan executive. The team will meet biweekly, or more frequently as needed, to develop strategies for participating and interfacing with the Healthiest State Initiative.

Our team will collaborate with key constituents, community organizations, providers, designated State workgroups, and others to support, participate, and cross-promote Healthiest State Initiative events, like the annual Healthiest State Walk, to engage our members, local staff, and the community. We also plan to participate in Healthiest State Conferences and will send quality leads and encourage them to maximize the opportunity to learn, network, and share best practices. Leveraging our commitment to wellness and prevention across our portfolio of state partnerships, we will build on the most relevant programs to target key performance gaps. Specifically, we will implement programs that target each of the five key goals of the Healthiest State Initiative. To support these goals, we have identified specific programs planned for deployment in Iowa—many of which have been proven effective by our affiliate health plans in other states. The programs identified thus far are detailed below, according to the goal they support.



Goal 1: Decreasing the Number of Iowans Who Smoke

Amerigroup is committed to helping Iowa reduce high smoking rates and our Smoking Cessation Value-Added Service provides telephonic coaching to engage and empower members to make positive behavior changes to reduce and ultimately stop smoking. Our smoking cessation benefit is specifically structured to enhance Iowa's QuitNow Program by offering additional counseling services for members. Together with coverage of smoking cessation medications on the Iowa Medicaid formulary, these programs will help establish the Iowa Initiative as a best practice for the smoking cessation model. In 2014, 31.75 percent of our affiliate health plans' members receiving coaching and medication achieved the six-month quit metric. In addition to coaching and medication, we provide general smoking cessation education. For example, our Member Services call center's on-hold messaging provides health tips related to smoking cessation and prevention.

Goal 2: Increasing Consumption of Fruits and Vegetables

Another Value-Added Service is our Healthy Families Program, where we provide education and coaching on nutrition and fitness. The program helps parents and their children focus on adopting healthy lifestyles through a family-centric approach with multiple levels of support and education materials. Our Healthy Families Program has been highlighted by Medicaid Health Plans of America Diabetes Care Best Practice Compendium. It is currently deployed in five affiliate health plans in Kansas, Florida, Washington, Louisiana, and Kentucky with the following positive results:

- 57 percent of members increased fruit/vegetable intake
- 58 percent increased H2O consumption
- 42 percent increased activity level
- 30 percent decreased screen time

Another program that focuses on helping members make healthier dietary decisions is our Diabetes Prevention Program. This nationally recognized, 16-week, community-based program is conducted by trained lifestyle coaches to teach people with pre-diabetes how to modify their eating and physical activity habits and to sustain those changes overtime. We will also leverage our experience participating in other state diabetes performance improvement initiatives to develop a best-in-class approach tailored to the Iowa population. For example, our New York health plan is participating in a two-year performance improvement project aimed at diabetes prevention and control with the Department of Health. The goal of the program is to help members with high risk of developing diabetes reduce their weight through a healthy, low-calorie, low-fat diet and by engaging in at least 150 minutes per week of moderate physical activity.

Goal 3: Increasing the Number of Iowans Who Have Visited the Dentist in the Last Year

We successfully work with dental subcontractors across our affiliate plans and will leverage best practices from other states to foster positive working relationships with dental vendors. We will use established protocols to help coordinate with the incumbent dental vendor and the State to optimize oral health and the number of members who visit the dentist. This includes regular communication to identify opportunities for improvement and to share treatment information as well as prevention via member education on decreasing/preventing dental caries and stressing the importance of dental preventive care. We will also coordinate care, including cases where members require a medical setting for a dental procedure, and with other medical, behavioral, or dental providers where needed (for example: cases where a member may be at risk for seizures or have co-existing health issues). Additionally, through Text4Health text messages, we will outreach and remind members to visit the dentist and provide helpful information to schedule an appointment.

Goal 4: Increasing the Number of Iowans Who are Learning or Doing Something Interesting Daily

We have a number of "on-hold" messages that provide health and wellness tips to members. An example on-hold message is included in new member household welcome calls to encourage members to socialize and participate in an interesting activity: *"Many of our members enjoy the fun health tips we sometimes share. So, we'd love to share a quick one with you right now. Did you know that laughing for 15 minutes a day can give your immune system a boost, help decrease stress, and just make you feel better? So invite your friends over for a night of karaoke or a game of charades. Bring on the laughter and let the good health flow!"*

Goal 5: Increasing Number of Iowans Who Feel Their Boss Treats Them Like a Partner at Work

We believe in leading by example: We promote collaboration among all employees, regardless of position. We will support the **Blue Zone** project to help Iowans “live better, longer” by promoting infrastructure and policy to “make the healthy choice the easy choice.” We have policies already in place that promote health and well-being. To drive Blue Zone achievement in Iowa, we will:

- **Get certified** - Amerigroup Iowa health plan will become a Blue Zone Certified Workplace.
- **Support provider certification** – We will include this commitment in our PCP Quality and Access to Care Provider Incentive Program to align with our operating model.
- **Build on experience** – We work closely with Healthways and others on Blue Zone–like programs in several other states, and we will expand that relationship to Iowa.

We are a leader in workplace health and prevention as well as a socially responsible employer. We believe there is no better means of communicating commitment and generating momentum than setting the standard in how we operate and leading by example. We support the 10 characteristics of a Socially Responsible Employer per the Healthiest State Initiative and will be proud to build on our established policies and successful workplace model in Iowa:

- 1) **Sustain a work environment founded on dignity and respect for all employees** – Our town halls, informal workgroups (huddles), committees, subcommittees, and other routine meetings make sure that every functional area has a regularly scheduled time to communicate with other related areas. Our Associate Resource Groups help develop a deeper understanding of diversity and cultural competence in the workplace and in the marketplace. They promote opportunities for leadership development and growth among all employees and act as internal consultants by providing cultural insight on initiatives for different segments of our multicultural marketplace.
- 2) **Make employees feel their jobs are important** – Our annual employee satisfaction survey helps us focus our approach to continually improving the experience of our employees. Over 80 percent of employees in our 2014 survey indicated that they would recommend our organization to their informal networks while reporting high levels of engagement in their work.
- 3) **Cultivate the full potential of all employees** – We know that unlocking our employees’ full potential is critical to driving performance and engaging employees in becoming high performers. We have several programs to acknowledge employees for longevity, professional growth, and exemplary job performance. This includes monetary awards for first-time completion of approved certifications relevant to a profession, job-related licensure reimbursement, and education reimbursement toward the completion of a degree that will assist employees in their current role.
- 4) **Encourage individual pursuit of work/life balance** – We understand that work-life balance is vitally important to our employees and encourages engagement, productivity, and accountability, which in turn drive company success. We offer employees programs that include flexible work schedules, work-at-home options, job sharing, part-time employment, and phased retirement.
- 5) **Enable the well-being of individuals and their families through compensation, benefits, policies, and practices** – We offer employees competitive compensation and rewards for achievement. We structure base pay at competitive levels, while also sharing our financial success through employee incentives. All of our employees are eligible to receive an annual or quarterly bonus, depending on the type of job they perform. We also offer a competitive benefits package, which includes a comprehensive selection of health, dental, and vision benefit options.
- 6) **Develop great leaders at all levels that excel at managing people as well as results** – We fully support ongoing learning and development for our employees to grow their careers. We offer an extensive library of online learning in over a dozen skill areas. In addition, we sponsor several

- year-round leadership development forums, which are a blend of classroom and online learning and include the assignment of a mentor to each program participant.
- 7) **Appreciate and recognize the contributions of people who work there** – We have several means of recognizing contributions. For example, our *Values in Action Program* rewards employees on the spot for specific accomplishments that exceed expectations. The program is designed to recognize high performers who exemplify Amerigroup's values and who contribute to the overall success of our company. We also engage in *Informal Recognition activities*, which reward an employee's contribution toward a department goal or objective. Rewards may be gift certificate/card; cash; occasional tickets for such events as movies, sporting events, and amusement parks; occasional team parties; and other appropriate gifts or outings.
 - 8) **Establish and communicate standards for ethical behavior and integrity** – Our management team builds training into the annual development plan for each employee. These trainings are at various levels from leadership training and career development to current job enhancement skills. Annual required training includes cultural sensitivity and diversity training, compliance, ethics, and HIPAA and privacy training.
 - 9) **Get involved in community endeavors and/or public policy** – We strongly encourage participation in volunteer and community events. In 2014, nationally, our organization's employees completed 35,375 volunteer hours in the communities that we serve. We also believe in giving back to those communities. Through our *Associate Giving Program*, employees have the opportunity year-round to give back by contributing to nonprofit organizations focused on health and human services in our communities. The Anthem Foundation matches employees' contributions 50 cents for every dollar. In 2014, nationally our associates raised \$3 million with \$1.5 million matched by the Anthem Foundation. In addition, 90 percent of giving is for healthcare-related causes in the communities served by Amerigroup and our Parent Company, Anthem. Since 2000, we have collectively raised over \$160 million to such causes, including active lifestyles, cancer prevention, diabetes prevention, and maternal practices. We strive to find ways not only to help those in the communities we serve but our own employees as well. Through the *Anthem Cares Fund*, employees can help their coworkers who experience a natural disaster or personal hardship. The Anthem Foundation matches their contributions 50 cents for every dollar.
 - 10) **Consider the human toll when making business decisions** – Our employees are at the heart of what we do for our members. In many of our organizational units, we cross-train our employees to handle a variety of tasks and responsibilities, which allows us to redeploy our resources to other areas of the business, when necessary, to avoid job reductions. In addition, our leaders are expected to motivate, develop, and retain employees. Every management-level employee has a "people leadership" goal, which is weighted to at least ten percent of his or her overall annual performance goal metrics.

Cost and Quality Information (8.8)

Question 8.8, #1

1. Describe proposed strategies to provide price and quality transparency to members.

Providing Quality Transparency

Amerigroup Iowa (Amerigroup) and our affiliate health plans have extensive experience and leadership in implementing and providing innovative strategies to provide price and quality transparency for our members. These strategies support the migration from volume- to value-based delivery systems – working to improve the quality of care and health outcomes while decreasing the overall cost of care. For example, in our affiliates' commercial markets, we offer quality comparisons of our healthcare providers through a secure member website. Through the member website, our Provider Finder is linked to a secure tool, which provides quality comparisons of our healthcare providers, as well as the National Committee for Quality Assurance (NCQA) Health Grades, and other provider rating sites.

To support DHS's objective of providing quality and price transparency to members, we will leverage our experience and propose the following strategy.

- Establishing a workgroup across other health plans in the State of Iowa and with DHS to establish a consistent way to measure provider quality. Amerigroup is willing to help lead these workgroups
- Developing a common definition of quality and using common tools will provide a consistent measurement approach. Creating an equitable measurement process across all health plans will allow providers to be measured on an equal basis and provide consistent quality information members need to help facilitate more responsible use of healthcare services and inform their healthcare decision-making.

We expect that the 3M Value Index Scoresm (VIS) will be utilized to measure quality for high volume PCPs and ACOs, and are fully supportive of this concept. However, we recommend that the above workgroup be tasked to develop a diverse view of provider quality. This would include developing measurements of quality for independent LTSS providers, behavioral health providers, OB/GYNs as well as other high volume specialists, independent hospitals as well as PCPs with lower volumes of membership. ***We will use organization-wide expertise to developed provider incentive programs for each of these types of providers that include quality measurements. We can take a leadership role on this workgroup regarding the development of diverse provider quality measurement.***

Our affiliates have experience bringing other payers together from other initiatives such as the CMMI Comprehensive Primary Care Initiative. Through our affiliate plans in New Jersey, Colorado, Ohio, and New York, we participated in the CMMI Comprehensive Primary Care Initiative, which brought payers together to agree to a set of common quality measures.

Providing Cost Transparency

Providing cost and quality information gives members the opportunity to make more informed choices for their healthcare services, which in turn has the potential to reduce costs and improve member satisfaction and quality. It also promotes members taking responsibility for their healthcare. Our Iowa member portal will provide quick access to comparative cost information for members. We will base initial development for the cost comparisons on the Iowa Medicaid fee schedule, including region, provider type, and setting. The portal will provide members access to average costs for common procedures including comparisons such as PCP visits versus emergency room visits, free-standing radiology setting high-technology diagnostic exams versus radiology diagnostic exams in a hospital

setting, and outpatient surgery in an ambulatory surgery center versus outpatient surgery in a hospital setting.

In addition, we reflect what the plan paid for delivered services in the member Explanation of Benefits (EOB), which is made available to members based on their preference, either via paper or web-based portal. Providing access to this information further facilitates members' ability to take responsibility and make informed choices for their healthcare services.

Explanation of Benefits (8.8.1)

Question 8.8, #2

2. Provide sample EOBs as an exhibit or attachment.

Member Explanation of Benefits

Explanation of Benefits (EOBs) provides valuable member information. EOBs give members a record of services received, inform members of any obligations they have, notify members about services not covered, and ask members for verification of services to prevent fraud. Amerigroup will provide EOBs within 45 days of the payment or denial of claims to:

- **A statistically valid sample of members each month.** This includes members in the Iowa Health and Wellness Plan (IHWP) and hawk-i. These EOBs will be sent to verify services and help identify fraud. We tell members to confirm that they received the services and contact us immediately if there is a discrepancy.
- **All members who received services that are not covered or will otherwise not be paid.** We tell members about denied claims because we want them to have accurate information if a provider attempts to bill them. We explain that members may appeal denial decisions.
- **All members who may be responsible for coinsurance for nursing facility services or home- and community-based services.** We explain the services that require coinsurance and how members can pay for the coinsurance.

EOBs contain all required elements as specified in 42 CFR 433.116(e) and (f). We will include information about the delivery of EOBs in our member handbook and on our member website. We will ask members their preferred choice of receiving EOBs and provide EOBs to members based on their preference either via paper or secure web-based portal. To maintain confidentiality, EOBs will not include family planning confidential services. We will track and monitor the delivery of EOBs and quickly respond to resolve any issue if one should arise.

Attachment 8.8.1-1 Member Explanation of Benefits is a sample member EOB that Iowa program members will receive.

Quality Information (8.8.2)

Question 8.8, #3

3. Describe processes for making provider quality information available to members.

Members Receive Provider Quality Information

Amerigroup will make provider quality information available to our Iowa members to facilitate informed healthcare choices and more responsible use of healthcare services. We will capture quality information on our Network Providers, and members will have the ability to view providers' quality and select the

provider that best meets their preferences and physical health, behavioral health and/or social service needs in the fashion described below. This type of transparency promotes both member responsibility and healthcare quality improvement.

We believe there is great value in using a consistent methodology across payers to measure providers' quality and value across the State of Iowa, and we fully support the Iowa State Innovation Model (SIM) concept of using VIS, which shows how well a primary care physician cares for patients, irrespective of a patient's health status. This approach provides opportunity for providers to work toward the same goals and focus on the same measurements and allows for the delivery of consistent quality information to members. We have been in discussions with 3M to explore the ways in which we can leverage and use their VIS product. As described more fully in our response to 10.3.2 Provider Incentive Programs, we propose to use the VIS generated through 3M's software product, which is included in Iowa's SIM, to establish quality scores for our ACO Shared Savings/Shared Risk program.

Furthermore, we intend to work collaboratively with DHS and across all contractors to devise a consistent system for displaying relative provider VIS performance to our members for the ACO providers. One potential example of a solution is to develop a five-star rating system, driven by VIS performance, and to display the star rating of providers who achieve three or more stars in our online provider directory, or via other means, depending on the member's preference of receiving contractor communications. We will update ratings at least annually. As a part of making this information available to members, we will identify and communicate any limitations of the data including communication in the online provider directory.

Advance Directive Information (8.9)

Respecting Members End-of-Life Decisions

Amerigroup Iowa (Amerigroup) understands the importance of supporting members to make informed end of life decisions that reflect their personal and cultural values, preferences and beliefs. End of life planning guides members discussions about care options that may optimize the quality of the member's life while he or she is living with a life-threatening illness, is in the final stages of a terminal illness, or as a part of health decline due to aging. We will support members and when appropriate their family or surrogate, to develop plans in accordance with state regulations.

Policies and Procedures (8.9.1)

Advance Directive Policies and Procedures

Amerigroup will implement and maintain written policies and procedures concerning advance directives. These policies and procedures will meet the requirements set forth in Iowa State law and Subpart I of 42 CFR 489, including:

- Informing members about advance directives and their rights
- Acknowledging that advance directive provisions will not be construed to prohibit the application of Iowa law, which allows for an objection on the basis of conscience for any provider or agent of such provider
- Informing members with a clear and precise statement of limitation if we cannot implement an advance directive on the basis of conscience
- Clarifying any differences between institution-wide conscience objections and those that may be raised by individual physicians
- Identifying the state legal authority permitting objection
- Describing the range of medical conditions or procedures affected by the conscience objection

- Outlining how Amerigroup or the provider, as applicable, will notify members of the objection and advise them of their right to file a complaint with the state survey and certification agency
- Documenting whether or not members have advance directives
- Declaring that Amerigroup places no conditions on care provided to members and does not discriminate against members, based on whether or not they execute advance directives
- Informing members of their rights to file complaints concerning advance directive requirements with the state survey and certification agency
- Training Amerigroup employees on advance directives
- Educating and documenting the education of Iowa communities about advance directives, defining what constitutes an advance directive, emphasizing that an advance directive is designed to enhance member, family, or surrogate control over medical treatment decisions through end of life planning and describing applicable Iowa laws
- Furnishing advance directive information to members in various settings:
 - Hospital at time of inpatient admission
 - Skilled nursing facility at time of residential admission
 - Home health agency and personal care services at time of first home visit before care is provided
 - Hospice at initial receipt of hospice care
- Stating that Amerigroup will not provide care that conflicts with members' advance directives
- Acknowledging that Amerigroup and its network providers are not required to implement an advance directive in matters of conscience, State law permitting
- Working with members' families on advance directives if members are incapacitated

Member Notification (8.9.2)

Advance Directive Notification

Members receive information about advance directives in the member handbook they receive upon enrollment. This information:

- Explains what an advance directive is
- Informs members if they are incapacitated at the time of initial enrollment and are unable to receive information or articulate whether or not they have executed advance directives, the information may be given to their family members or surrogates, and that once they are able to receive the information, they will be given the information directly
- Outlines members' rights to file complaints with the state survey and certification agency about noncompliance with advance directive requirements, and how to file such complaints
- Asks members to discuss advance directives with their PCPs
- Provides a clear and precise statement of limitation if we cannot implement an advance directive on the basis of conscience. The statement will:
 - Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians
 - Identify the state legal authority permitting objection
 - Describe the range of medical conditions or procedures affected by the conscience objection
 - Outline how Amerigroup or the provider, as applicable, will notify members of the objection and advise them of their right to file a complaint with the state survey and certification agency

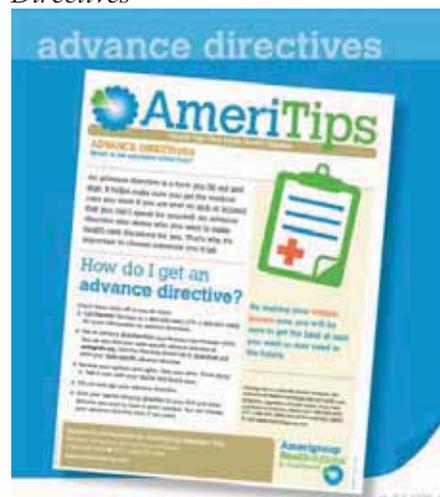
If Iowa law regarding advance directives changes, we will inform members as soon as possible and no later than 90 days from the effective date of the change.

Member Education

Members have access to advance directive information through the following:

- Member website—Website that provides ready access to members informing them of their options and importance of completing an advance directive.
- Member Education Materials, such as an AmeriTip—This is a fact sheet that explains what an advance directive is and the value of having one and instructs members to contact their PCP to obtain the appropriate forms. The Advance Directive AmeriTip shown in Figure 8.9-1 may also be mailed to members to reinforce verbal education provided by an Amerigroup employee as needed. We will make these materials available through provider offices, health fairs, and other community events to educate the community about advance directives.

Figure 8.9-1. Engaging Materials to Educate the Community about Advance Directives



Upon initial enrollment or the start of care, we will confirm if the member has executed an advance directive; in the event that a member is considered incapacitated and/or is unable to receive information (due to his or her medical condition), we will provide the member’s family or legal guardian advance directive information in accordance with Iowa State law. If the member returns to a status in which he or she can receive information about and discuss advance directives, the member’s Case Manager will follow up provide information and discuss options. We will have follow-up procedures in place to work with the member and family, as necessary, to inform a member who is no longer considered incapacitated about his or her advance directive rights at the appropriate time.

Employee Education

Employees interfacing with members receive advance directive training at the time of initial employment, annually thereafter, and upon changes to relevant laws. Staff may assist members if they have questions about advance directives and will advise members that their PCP can also be a resource for this information when requested by the member. Our Member Services Representatives may access a knowledge repository that includes information on our advance directive processes and procedures. We provide all of this education in the interest of serving our members most effectively and respecting members’ decisions regarding their end-of-life care.

We will evaluate and update advance directive policies and procedures as needed to make sure internal processes remain aligned with Iowa law, and we do not and will not discriminate or make treatment conditional based on whether or not a member has executed an advance directive. We instruct employees that they may not serve as a witness to an advance directive or as a member’s authorized agent or authorized representative, and no employee may provide any legal advice to members or providers. We will advise members to contact the local Iowa Ombudsman’s Office for further guidance and assistance with these services.

Provider Education

As part of the provider orientation process, we educate PCPs about the importance of advance directives and recommend they ask members about their choices at the first appointment. If the member has an executed advance directive, the PCP is expected to obtain the signed directive and include it as part of the member's medical record.

If an advance directive has not been executed, we request that provider's office staff answer member questions about advance directives and assist the member with completing the appropriate advance directive documents when requested by the member. The provider and office staff may also refer to the Amerigroup Provider Manual, which further explains advance directives. We instruct providers during training and through provider relations communication to inform members of their options and stress to members the importance of having an advance directive.

We require PCPs to document all activities related to advance directives in the member's medical record and supply this information regarding the end-of-life process directly to the member. We will encourage providers who are using Electronic Health Records (EHRs) in their practice to record all pertinent advance directive information in a member's EHR. We will require all network facilities to respect all lawfully executed advance directives that meet the requirements of federal and state law.

Member Rights (8.10)

Question 8.10, #1

1. Describe your process for ensuring member rights as described in Section 8.10.

Amerigroup Iowa (Amerigroup) respects and works to protect members' rights. We believe members want to understand, engage in, and take responsibility for health care that will promote good health, wellness, and quality of life. In accordance with 42 CFR 438.100, we will implement a multifaceted approach to notifying members of their rights and responsibilities when receiving care and/or services. This notification will include assurance that exercising these rights will not result in retaliation or discrimination from our employees, subcontractors, or network providers. We will also inform members on how to notify us if and when they believe that their rights have been violated. We use multiple avenues to notify members of their rights including:

- The member handbook posted on the member website and included in each member Welcome Packet
- During welcome activities and outgoing/incoming calls as appropriate to the reason for the call
- Periodic notices in the member newsletter directing members to the member handbook, the member website, or to the Member Services Department to obtain a copy of their member rights
- We also notify our employees, providers, subcontractors, and vendors of member rights with clear expectation that they adhere to and protect member rights at all times:
 - **Employees:** We address member rights during orientation for all employees and during additional program and role-based trainings for Members Services and Utilization/Care Management staff.
 - **Providers, subcontractors and vendors:** We include notification of member rights and language requiring subcontractors, vendors, and providers to protect member rights in our contracts. We also address member rights and responsibilities during subcontractor, provider, and vendor orientation activities.
 - **Stakeholders:** We will work with the Amerigroup Iowa Stakeholder Advisory Board and solicit meaningful input and advice on ways to continuously improve our processes to inform members of and protect their rights.

Additionally, we will develop collaborative relationships and cross-training opportunities with a wide range of stakeholders to make sure that our communication of member rights is tailored for the many different member audiences in Iowa including individuals with intellectual and developmental disabilities, individuals with brain injuries, people with serious mental illness or chronic conditions or children, adolescents and young adults in foster care, and all members who may find the information difficult to understand or navigate. We will include consumer advocacy and protection groups to cross train and address issues regarding communications and understanding member rights and benefits.

Amerigroup will include member rights notification along with other member communications materials for review and approval prior to dissemination. We will notify members, caregivers, subcontractors, and others of any significant changes to member rights. Our policies and processes will assure protection of all member rights as detailed below.

Receipt of Information (8.10.1)

In accordance with the SOW Section 8.10.1 and 42 CFR 438.10, Amerigroup will implement policies and procedures that assure timely communication with members and potential members (see Section 8. 2 for a full description of that process) in appropriate language and via formats that are easily understood.

Dignity and Privacy (8.10.2)

Our written policies and procedures require employees, providers, and subcontractors to treat members with dignity and respect. These documents make it clear that any inappropriate disclosure or breach of private information is unacceptable and a violation of HIPAA regulations, and thus, treated very seriously. Our Member Rights and Responsibilities Policy will clearly articulate that members have the right to be treated with dignity and respect for their privacy.

Information on Available Treatment Options (8.10.3)

Amerigroup has written policies and procedures that require PCPs and other treating providers to provide each member with information on all available treatment options. Provider discussions on treatment options will not be limited based on the cost of an option. Amerigroup encourages and supports members in gathering information, making good decisions, and taking responsibility for their health care. Member services representatives are available to help members identify relevant sources of treatment information, such as Health A to Z, find specialty providers, and answer questions about referrals and authorizations. Our 24/7 Nurse HelpLine staff, community-based case managers, and care coordinators are available to answer member's health care-related questions within the scope of their licenses. Community-based case managers and care coordinators coordinate treatment options with members enrolled in case management, their families or caregivers, and treating providers providing the level of support needed to make informed health care decisions.

Participation in Decisions (8.10.4)

Our approach to community-based case management and care coordination supports the right to self-determination through partnership and collaboration with members, families and legal representatives (if applicable). Planning processes are member and family driven to facilitate holistic care, treatment and/or service plans that include medical, behavioral health, social and educational support needs to maximize health, well-being, and independence through informed decision-making. Members are supported self-direct services and to select providers they believe to be qualified to meet their care and/or service needs and you match their values and preferences. Service plans as well as other care/treatment plans as a part of the their system of care are monitored, assessed and evaluated to be responsive to changes in member preferences, support needs and personal goals.

We also make it clear to the members that they have the right to refuse care, treatment and services. Should a member decline medical or behavioral care or treatment and/or long term services and supports, Amerigroup employees and providers are required to explain the consequences in a non-coercive manner and reassure the member that exercising this right will not result in discrimination.

Freedom from Restraint or Seclusion (8.10.5)

Our member handbook addresses a member's right to receive care and services without the use of restraints and/or seclusion. Our written policies and procedures strictly prohibit employees, providers, and affiliates from using restraints and/or seclusion unless there is a threat of imminent physical danger to the member or others. We clearly state that each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. When we become aware of, or receive notification of, a member restraint or seclusion at a facility or by a community-based provider, we immediately launch an investigation and work with that facility or provider to determine why such action was taken, if federal regulations were violated. We will institute training and corrective actions to make sure best practices are in place are used eliminated the restraints or seclusion. Amerigroup and its contracted providers, subcontractors, and vendors will comply with the Iowa critical incidents reporting requirements, including categorization of incidents as minor or major, and as warranted, requiring and monitoring corrective actions in accordance with those requirements. We will also comply with any additional mandated reporting to protective service agencies.

Copy of Medical Records (8.10.6)

Amerigroup policies and procedures require our employees, providers, and subcontractors and vendors to provide members with copies of their medical records within 14 calendar days of request at no charge. Our member handbook describes member's right to receive a copy of their medical record, and request amendments or corrections. Notification regarding this requirement is included in our contractual agreements with providers and subcontractor.

Treatment Setting (8.10.7)

The member handbook informs members of the right to receive services in the least restrictive setting. Amerigroup's employees, subcontractors, and providers must comply with the requirement when considering treatment options for a member's health care needs and facilitate treatment in the least restrictive setting that will result in the best possible outcome for the member.

Community Participation (8.10.8)

Our person-centered approach to service planning focuses on working in partnership with members to create a service plan that reflects their strengths, preferences, supports needs, and personal goals across physical health, behavioral health and social services systems of care to optimize independence, well-being and full participation in their community. We work with our members, providers, advocacy groups and community organizations to enhance success at school, increase opportunities for meaningful community involvement, increase competitive employment and support self-determination.

Health Care Services (8.10.9)

Amerigroup will comply with contractual requirements regarding access to care and services and make sure that all health care and services are provided in accordance with 42 CFR 438.206 through 438.210. We will provide adequate and timely access to all covered services through a network of culturally competent providers adequate to serve the needs and preferences of the enrolled population. Members will also have access to non-network providers, when necessary to assure continuity of care as described in Section 3.3.

Redetermination Assistance (8.11)

Question 8.11, #1

1. Describe in detail your plans to assist members in the eligibility redetermination process and control against prohibited activities.

Timely eligibility redetermination is essential so that members do not experience gaps in coverage. Our experience has taught us that some members need assistance in navigating the healthcare system, including completing the redetermination process. Amerigroup conducts redetermination outreach in over 92 percent of our affiliate health plans where permitted. As a result, we have reduced our overall disenrollment rate within our affiliate plans from 6.0 percent to 4.4 percent.

Our strategy to inform members of approaching renewal dates involves several modes of communication. These may include outreach calls to members and/or caregivers, postcards sent via direct mail, emails, texts, and reminders/instructions listed on the member website. We also provide redetermination assistance through a call from our retention center from an employee who helps members understand what they need to do in order to keep their benefits.

Permissible Activities (8.11.1)

Amerigroup understands we are permitted to perform specific redetermination activities such as conducting outreach calls to current members, reviewing State redetermination requirements, answering questions regarding the redetermination process, and assisting the member in obtaining the required documentation and collateral verification needed to process his or her redetermination application.

In successfully performing the permitted activities, Amerigroup generates rosters each month of members whose eligibility is due to lapse in 45–60 days using State-provided redetermination dates. In turn, we conduct outbound calls in English or Spanish, as well as mail State-approved reminder postcards. Those members who speak languages other than English and Spanish or languages not spoken by staff are connected to an interpreter to facilitate the call.

- Understanding the importance of members keeping their redetermination appointments, we conduct telephonic and mail outreach to support members in the following methods:
- Reminding members of the recertification requirements for the Iowa Initiative and the importance of renewing their eligibility
- Tracking members' approaching renewal dates
- Monitoring what sort of notice, if any, members will receive from the State
- Distributing phone numbers to call, websites to visit, and/or social services office locations to contact if members do not receive or have misplaced the re-enrollment forms
- Giving instructions on where to submit completed forms
- Clarifying that only the State determines eligibility and that Amerigroup plays no role in that decision

Our outbound communications provide members and/or their caregivers the option to speak with Amerigroup Retention Unit employees who will answer questions regarding the redetermination process. Employees also assist members in obtaining required documentation and collateral verification to process their application.

Our automated call service places multiple calls to members and/or their caregivers to alert them of pending redetermination deadlines. Calls are made on different days and at different times of the day, including evening hours, to increase the likelihood of reaching the member. We augment outbound calls with reminder postcards mailed during the same 45- to 60-day period as shown in Figure 8.11-1 and Figure 8.11-2. Amerigroup recognizes that our members increasingly use the Internet and their phones on a daily basis. We are expanding our use of emails, texts, and member website reminders as important tools to communicate with members when we have their consent and accurate information to do so.

Prohibited Activities (8.11.2)

Amerigroup will comply with and not engage in prohibited activities when assisting members with the redetermination process. The prohibited activities include:

- Discriminating against members, particularly high-cost members or members who have indicated a desire to change MCOs
- Talking to members about changing MCOs (if a member has questions or requests to change MCOs, we will refer him or her to the Enrollment Broker)
- Providing any indication as to whether the member will be eligible (we will inform members that the decision is at the sole discretion of the State)
- Engaging in or supporting fraudulent activity in association with helping members complete the redetermination process
- Signing members’ redetermination forms
- Completing or sending redetermination materials to the State on behalf of members

We train our staff on State requirements and maintain a Compliance Plan that provides clear guidance for staff on best practices for supporting members. Amerigroup routinely monitors employee compliance with requirements related to assisting members with the redetermination process. We will leverage our current practices and lessons learned from our affiliate health plans across the country to develop and implement ongoing monitoring. Our goal throughout this process is to support our members in maintaining their eligibility while complying with State and federal requirements. Staff are monitored continually, trained regularly, and tested annually on our Compliance Plan to help assure compliance.

Amerigroup requires all staff involved in any form of marketing to complete training specific to marketing and outreach guidelines. The training will cover DHS marketing guidelines, including general provisions, permitted and prohibited redetermination activities, provider compliance, State licensure and appointment laws, telephone activities, written materials requirements, and other elements related to marketing compliance. All staff will receive extensive training before interacting with members. Part of this training will include a review of Amerigroup’s Policy and Procedure for Redetermination. The training will occur with new hires and is also required as a semi-annual training event for all marketing employees.

Figure 8.11-1. Redetermination Postcards Remind Members to keep Their Healthcare Coverage



Figure 8.11-2. Redetermination Postcards Remind Members to keep Their Healthcare Coverage



Our Iowa Medicaid Compliance Plan will include examples of best practices pertaining to permitted and prohibited activities. It will also address applicable State and federal requirements related to marketing; State-required notifications; and approval processes for advertisements, materials, telephone marketing scripts, and other related communications. It is our policy to require all employees to become knowledgeable of and comply with Amerigroup's Compliance Plan. All new hires are trained on the Compliance Plan, with all staff receiving regular reminders through email blasts, targeted trainings, and managerial supervision.

Member and Stakeholder Engagement (8.12)

Question 8.12, #1

1. Describe in detail your member and stakeholder engagement strategy.

Amerigroup's strategy for member and stakeholder engagement includes several key components that allow us to offer a comprehensive and broad-based approach built on strong partnerships with community-based organizations and provider groups and the member advocacy groups that serve our members and their families.

Amerigroup has and will continue to meet and partner with key provider groups and community-based organizations such as Iowa's six area agencies on aging (AAAs), Iowa Association of Community Providers, the State's six Centers for Independent Living (CILs), Statewide Independent Living Council, Developmental Disabilities Council, IowaHealth+, the Iowa Primary Care Association and its member federally-qualified health centers (FQHCs), LeadingAge Iowa, Iowa Health Care Association, Iowa Center for Assisted Living Iowa Behavioral Health Association, and Easter Seals. We have met individually with these and other groups and will work with them to identify opportunities for partnering on their provider conferences, community events and activities. We will continue to meet with these organizations to learn more about their ideas and to answer questions regarding transition to the new managed care program and to obtain their input on what they would like to see us consider doing as we further develop the planning, structure, and implementation for our Iowa program.

We have and will continue to engage with member advocacy groups such as NAMI Iowa, AARP Iowa, Brain Injury Alliance of Iowa, the Iowa Foster and Adoptive Parents Association, and Iowa Association of People Supporting Employment First to gain further understanding of their ideas and perspective on the HQHI program. We will explore ways to partner with them and sponsor events and activities to provide us opportunities to engage with advocates, member advocates, members, and their families and caregivers. We want to have opportunities to help educate our advocates about the new program and to hear what they need most for us to provide and what gaps in services are most important for our new program to fill.

Amerigroup will develop partnerships with a range of stakeholders and member groups to help promote good health care, personal health, and quality of life outcomes. For example, we may find an opportunity to sponsor a program that promotes health, fitness, and exercise activities for members. We may also be able to sponsor nutrition or falls prevention education programs for members. We will work with each community-based organization and member advocacy group to identify meaningful opportunities.

Amerigroup will employ our proven comprehensive member education, outreach, and engagement strategies that are informed by our routine analysis of local member information and how members respond to our engagement efforts in the communities. We use this information to develop our multi-pronged approach to facilitating members' active participation in care. When engaging members in the Iowa Initiative, we will tailor our existing processes to meet their unique individual and geographic needs.

For example, we will offer innovative tools to enhance their participation in managing their health, chronic conditions and support their independence and well-being such as:

- **The Healthy Rewards Program** which promotes overall member responsibility and engagement as well as targeted improvement in specific HEDIS and other preventive care measures via incentives. Healthy Rewards will include physical, behavioral, oral social and LTSS components in order to engage members in an integrated approach to improving holistic health
- **MySupport** is a new platform designed to help older adults, people with chronic health conditions and disabilities connect with personal care attendants (PCAs) and other support workers with skills that match their individual needs, preferences and values.
- **Taking Care of Baby and Me** is comprehensive case management and care coordination program that offers: Individualized, one-on-one case management support for women at the highest risk; Care coordination for moms who may need a little extra support; Educational materials and information on community resources; Incentives to keep up with prenatal and postpartum checkups.
- **Financial Education and Coaching** via the National Disability Institute. This Value-Added Service financial management program provides individuals with disabilities tools to decrease their financial stress including a financial health assessment tool, 12-modules of the self-paced online financial capability education program including interactive real-life case studies to test skill development, and financial education webinars.

We listen to our members and stakeholders and incorporate their feedback, requests, and comments to refine our processes and approaches in a systematic and consistent manner. Member education and tailored services are at the heart of our member engagement philosophy.

Community-Based Activities for Members and Stakeholders

Our robust community outreach efforts will foster better knowledge and understanding of the Iowa Initiative and the opportunities available to our members. We will designate geographically-distributed staff throughout Iowa to engage with people in the community and provide information about important health topics and the benefits we offer. ***Our staff will participate in community events, presentations, and health-related contacts in which they interact with members, advocates, providers, and other community partners each week.***

We will provide members, providers, and the community-at-large with information and events focused on health, wellness, and the benefits available through the Iowa Initiative. We also provide relevant information that helps members make informed choices while promoting meaningful life in the community. We will actively promote the benefits of the Iowa Initiative, as well as preventive care and healthy behaviors, through the following methods:

- Reaching out to members at community partner sites to answer questions and provide assistance
- Sponsorships of health fairs, Amerigroup Clinic Days, community organizations, conferences, and seminars (such as employment first, foster parent trainings), luncheons and other health education forums
- New member outreach activities, as we work with Federally Qualified Health Centers (FQHCs), community mental health centers (CMHCs), Public Health Departments, Centers for Independent Living (CILs), Area Agencies on Aging (AAAs), community- and faith-based organizations, providers, and other stakeholders to deliver new member orientations.

Ongoing Member Outreach

Amerigroup's outreach and engagement strategies, honed over many years, emphasize the inclusion of all stakeholders and the value of initiating grassroots-level involvement with community organizations to enhance improvements in our programs. Our community-based approach helps us better understand local health issues, including barriers and gaps that may be driven by cultural, geographic, or other challenges unique to certain communities and populations. Our approach also helps us more fully partner with members, their caregivers, and providers. Our member outreach activities for the Iowa Initiative will build upon strategies our affiliates have used to effectively engage members in other state-sponsored programs.

Stakeholder Advisory Board (8.12.1)

Question 8.12, #2

2. Submit your Stakeholder Advisory Board strategy and discuss how meaningful representation from member stakeholder groups will be ensured.

The Amerigroup strategy for establishing a robust and active Stakeholder Advisory Board is to organize a board for the purpose of providing communications and education about the new managed care program and receiving input from Stakeholders about how Amerigroup is implementing the program. Obtaining input and advice from each board participant ensures we have a continuous feedback and advice on our programs and operations, which will solidify a sustainable approach through actionable changes. The Stakeholder Advisory Board strategy must include a strong effort to have input on all aspects of the managed care program to ensure we have a program that meets the needs of the community, the providers, and most importantly the members.

We know that building strong communities contributes to the health and well-being of everyone. That's why *we help national and local community-based organizations make a real difference in our members' lives by becoming part of the neighborhoods we serve*. In addition to engaging members and their families, Amerigroup engages government agencies, schools, and community organizations, among other stakeholders.

Amerigroup's affiliates have strong experience convening and facilitating Stakeholder Advisory Boards in several states. Most recently, our Georgia health plan created the Georgia Families 360⁰ Monitoring and Oversight Committee. The Georgia Families 360⁰ Program *serves members in foster care or receiving adoption assistance and select youth in the juvenile justice system*. The committee serves as a steering committee for oversight and quality of the program. The Georgia Families 360⁰ Monitoring and Oversight Committee encourages collaboration on quality improvement activities, focused studies, and other improvement initiatives between Georgia state departments, relevant agencies, and the Georgia Families 360⁰ care management organization.

We will thoughtfully *plan meeting logistics and locations to make sure that meeting sites are geographically and physically accessible*. Information provided will be available in alternative formats. Interpreters and translators will also be available for members requesting those services. For a location to be considered, it must support individuals who have accessibility challenges (such as individuals who use wheelchairs or who are blind) to participate easily.

Amerigroup will assist with travel costs and assist with providing transportation as needed. In addition, meetings that take place via teleconference access will be supported to help make sure those who have difficulty traveling can participate.

Advisory Board Plan (8.12.1.1)

Within 30 days of Contract execution, Amerigroup will submit a plan to DHS for the Stakeholder Advisory Board subject to the review and approval of DHS. The plan will include procedures for implementing the Stakeholder Advisory Board and details discussing how Amerigroup will assure meaningful representation from stakeholder groups' participation from around the State and describe how we track feedback from participants and actions taken based on that feedback.

During the initial Stakeholder Advisory Board meeting, Amerigroup will introduce health plan leaders who will serve as board facilitators. Stakeholder Advisory Board participants will be introduced and a member selected as the advisory board leader, if that is what participants choose. During this meeting, we will give special emphasis to the importance of having input, ideas, issues, and solutions from committee participants. We will present the board with an overview of the Iowa Initiative and Amerigroup's design. The advisory board leader will have a roundtable discussion of the priority topics the participants want to have on the agenda for future meetings. The board leader, in partnership with Amerigroup leadership, will compile the list of topics and develop a work plan for addressing each topic at future meetings. In addition, the work plan will introduce components of the program to the board, including the outreach plan, the quality improvement plan, the care coordination plan, and the member advocacy plan to get input from the participants on implementation plans for the new program.

Advisory Board Composition (8.12.1.2)

Stakeholder Advisory Board participants will reflect geographic, socioeconomic and cultural diversity. Amerigroup has a strong cultural diversity program that is an integral part of daily health plan operations. In planning the Stakeholder Advisory Board, Amerigroup's Marketing and Outreach Director will make sure Board participants are culturally and geographically diverse, reflecting the populations served and providers who participate in the Medicaid program. In addition, the director will make sure key community partners who also serve Medicaid populations are represented.

All of the specialized Iowa Initiative populations, including foster children and parents, individuals with disabilities, low income families, and members with mental health or substance use conditions, will be represented on the Stakeholder Advisory Board, along with providers, caregivers and advocacy groups. The Advisory Board will have an equitable representation of its members in terms of race, gender, populations, and Iowa geographic areas. More than 51 percent of the Stakeholder Advisory Board will be composed of members and/or their representatives. Provider membership will be representative of the different services covered under the Contract, including and not limited to Centers for Independent Living, Area Agencies on Aging, support coordinators, transition and employment specialists, nursing facility providers, behavioral health providers, primary care, hospitals, 1915(c) HCBS waiver providers, disability service providers, and a range of HCBS providers.

Documentation (8.12.1.3)

Amerigroup will maintain written documentation of all attempts to invite and include members in the Stakeholder Advisory Board meetings. Additionally, Amerigroup will maintain meeting minutes that will be made available to DHS upon request. Amerigroup will report to DHS participation rates, engagement strategies, and outcomes of the committee process in the timeframe and manner required by DHS.

Facilitating Member Participation (8.12.1.4)

Amerigroup will implement strategies to facilitate member participation in the Stakeholder Advisory Board meetings, including through the provision of transportation, interpretation services, and personal care assistance. Meetings will be accessible and will provide information in accessible formats. We will strive to host the meetings in locations that are accessible by public transportation. To support

participation of individuals with travel challenges, we can support virtual attendance by phone or video-conferences as needed.

Meeting Frequency (8.12.1.5)

Because the Iowa Initiative is new to Medicaid members and providers, Amerigroup proposes monthly meetings of the Stakeholder Advisory Board in Year One to keep stakeholders informed of progress, elicit early feedback on program issues, and respond quickly to questions and concerns. In the years following Year One, meetings will be held at least quarterly. All meetings will be held in a central location, and Amerigroup will notify DHS of all meetings at least 15 calendar days in advance of the meeting.

Meeting Outcomes (8.12.1.6)

Question 8.12, #3

3. Describe how feedback obtained from the Stakeholder Advisory Board will be utilized.

Amerigroup finds genuine utility and value in the recommendations from and perspectives of our members and stakeholders. The feedback we receive from our Stakeholder Advisory Board will inform our policy and procedure development processes and drive our quality assessment and performance improvement programs.

The Stakeholder Advisory Board meetings will have a structured feedback loop, resulting in issues being reviewed, addressed and reported on by Amerigroup leadership. The list of issues and recommendations will be reviewed and addressed by the plan leadership, and decisions made by Amerigroup's CEO to take action on those items will be reported back to the board. In this way, Amerigroup will promote transparency in how it operates and invite stakeholders to hold plan executives and leadership staff accountable for answers and execution.

Stakeholder Education (8.13)

Question 8.13, #1

1. Describe your plan for stakeholder engagement including proposed timelines and topics.

Amerigroup recognizes the important roles various stakeholders play in state-sponsored care programs and has extensive experience partnering with state agencies, advocates, providers, community organizations, and other stakeholders to implement progressive managed care programs across a variety of populations. We understand the challenges with implementation, such as advocate support, member adoption and understanding, and provider participation. From pre-award to post-go live, we employ proven strategies to facilitate a successful transition. We will publicize methods for members to obtain support and ask questions during the implementation of the Iowa Initiative, including: information on community partners who can help, the Member Services Helpline, and information on how to contact our Ombudsman.

Amerigroup has begun developing relationships in Iowa with key member constituencies and community groups. Listening to and learning about the challenges, preferences, and needs of these organizations and their clients enables us to tailor our program to the unique personal and geographic service and support needs of our members. This approach has proven successful in gaining advocacy groups' support of new programs, which – in turn – contributes to member acceptance.

Amerigroup proposes to launch a two-stage education program for stakeholders.

Stage One is slated for October through December of 2015, will cover the following topics:

- Member marketing materials and member letters
- Provider contracting and training – to educate stakeholders on the Amerigroup provider experience
- Provider education and training: how to submit claims, online access and claims submission, electronic funds transfer, and related topics
- Member enrollment process, including: the state notices, timetables for selection of plans, and enrollment decisions
- Member Value-Added Services
- Transition from traditional Medicaid to managed care – how we assure members' continuity of care
- Member contacts from Amerigroup: what to expect from us as we start the program, welcome letter, welcome calls, health risk assessments, and home visits for those on the waiver programs

Stage Two will continue from January through June of 2016, encompassing:

- Amerigroup's Complaints and grievance processes
- Care Coordination with the key health care providers and CBOs
- Integration of Behavioral Health services and Physical Health services with LTSS
- Member outreach and health education activities and materials
- Transportation services
- How to access Amerigroup if you are a provider and if you are a member
- Quality program and performance standards
- Coordination with Medicare services for members

Our Stakeholder Advisory Board will monitor the success of this curriculum and inform the development of subsequent topics and educational materials. Details on the Stakeholder Advisory Board can be found in sections 8.12.1 – 8.12.1.6.

Question 8.13, #2

2. Describe how you will identify and outreach to stakeholders.

Amerigroup recognizes establishing a deliberate planning process that leverages input from all stakeholders is required for a program to be successful. Open, continual dialogue beginning early in program development is crucial. In Iowa, we have begun to identify and reach out to key stakeholders called out in Section 8.12; stakeholders which include members and caregivers, advocates, families, providers and community organizations.

Finally, we have set up an office in Iowa and are recruiting an Ombudsman to be trained and ready for members' questions once the award is announced. Like all of our employees, the Ombudsman will be well-versed in the benefits and methods of community integration, home- and community-based services, and managed care programs, as well as Iowa's goals for citizen health and well-being.

Our strong partnership model applied from the outset between the State and MCOs fosters collaboration and problem-solving toward agreed-upon goals. As a result, program development and policy transparency in rate-setting supports long-term program sustainability.

Amerigroup tailors engagement for members, their families, providers, community organizations, and other stakeholders in ways that:

- Build strong communities
- Connects members to the services and care that contribute to their health and well-being
- Enables informed decision-making by members, caregivers, providers, and others

Descriptions of how Amerigroup will use stakeholder outreach and engagement to support these initiatives are provided below.

Community Organizations and Partners

We identify and reach out to community organizations long before Amerigroup is awarded a contract. Both nationally and in Iowa, we are:

- Uniting with community organizations, schools, faith-based groups, and local businesses to foster access to health care, provide health education to families, and offer resources to educate and improve neighborhoods
- Giving grants and resources to organizations that set out to improve the lives of people who need a little help. We've donated more than \$15.5 million to community organizations and events in the states we serve
- Collaborating with Community Mental Health Centers to improve communities by providing mental health and addiction services that are accessible and effective
- Doing volunteer work on the ground in the communities we serve. Across our organization, our employees have donated over 64,000 hours helping at local community events and health fairs, rebuilding housing for people impacted by disaster, and serving the elderly, children, and people with disabilities
- Being the solution. Amerigroup believes it is our social responsibility to continue to maintain and improve the environment we all live in. Our family of companies hosts an annual educational Eco fair, maintain a telework program to reduce the carbon footprint caused by commuting, and strive to use green power whenever possible

Members, their Families and Caregivers

To engage members in their own care effectively, members and their caregivers must understand what their benefits are and how to access them. Our programs and services will be easy to identify and access. The Amerigroup engagement strategy for members will feature:

- Ongoing member education designed to address challenges and concerns common to the populations we serve. For example, educational messaging and calls to action for vaccines, annual well-visits, and healthy behavior are designed to guide members into making informed health care choices and understanding the value of making those choices
- Early and ongoing, culturally relevant outreach appropriate for each individual
- Highly trained Member Services Representatives who use sophisticated technology to make sure callers receive accurate information and can access the care they need
- Strategic partnerships with schools and community-based organizations who offer significant insight into the challenges and service gaps experienced in Iowa communities and populations

Providers and Advocates

Amerigroup engages and educates its network providers to make sure they have the tools they need to serve members. We engage and support providers using:

- An in-person orientation session at the provider's office, facility or clinic
- Ongoing training
- Dedicated Provider Services Staff and Internal Claims Resolutions Specialists
- Online tools and resources

Using provider training meetings and webinars, Amerigroup will tailor information to give providers personalized assistance, which helps make sure providers have the information and tools needed to support good care and provide services.

Orientation – Amerigroup will invite newly contracted providers and their billing and office staff to participate in an orientation session. The sessions will communicate DHS and Amerigroup policies and procedures, identify resources such as the provider website and provider services call line, and introduce the roles of Provider Services Representatives and how they can assist providers.

Ongoing Training – Amerigroup provides educational sessions for network providers several times a year. Amerigroup will develop and offer educational sessions for network providers. Training will be tailored to meet the particular needs of local providers and the particular populations they may serve

Provider Services Representatives – Provider Services Representatives support providers by connecting providers to Informational resources, provide ongoing training, and proactively share information that assists providers in being successful partners with Amerigroup.

Implementation Support (8.14)

Question 8.14, #1

1. Describe proposed strategies to support members during program implementation.

Through our parent company and affiliate health plan experience serving over 5.2 million members in 19 states, we bring a long-standing history of implementing new programs and seamlessly transitioning members from a fee-for-service to a managed care model. Our organization successfully managed the startup of Medicaid health plans in Kansas, Louisiana, and Washington – representing and supporting more than 180,000 new members within a 15 month timeframe. We do this time and time again – without fail.

We have the experience, infrastructure, and proven processes that will be required to seamlessly support all members. Our previous experiences with implementation will minimize disruption for members, providers, and our state partners. We know how to stand up complex Medicaid programs covering diverse populations quickly and smoothly.

We will draw on our affiliates' extensive national experience serving similar populations, and we will also use the insight gained from Iowa stakeholders. To support members during program implementation, we have engaged many Iowa stakeholders already. This includes state agencies, advocacy groups, community-based organizations, and provider associations. These Iowa stakeholders can provide us with valuable insight into the overall Iowa healthcare landscape as well as local community needs and nuances. We've reached out to over 50 community-based organizations and stakeholders to learn about what is and

is not working. We have also learned where there are opportunities to positively impact the health and well-being of members from Day One.

We understand that members live busy lives, and we have designed the program implementation member support strategy accordingly. We will support Amerigroup members during program implementation by proactively reaching out to each and making sure they have easy access to the information they need and want. We understand that this direct contact is critical. We will also reach potential enrollees and members through several community-based outreach strategies. Our experience shows that combining both direct and community-based outreach will lead to a successful transition. As a result, potential enrollees and members will understand where and how they can access care, ask questions, and be connected with providers and services.

Amerigroup’s Proven Direct Member Engagement

Amerigroup understands the critical importance of effectively communicating with new members during program implementation. Our primary strategy to promote awareness of available services will focus on direct engagement – in person and through telephone calls. This high-touch outreach gives Amerigroup members an opportunity to have their questions answered immediately and maximizes our opportunity to inform them of the benefits and services available. We will also use written communications and online resources for additional opportunities to increase awareness and understanding of the Iowa Initiative. We know from our vast experience that multiple communication methods help assure members understand the available health care options.

We will welcome new members with the tools and information they need to understand and access the benefits and services available to them. Our communication with new members will begin when they enroll in Amerigroup. Table 8.14-1 provides a summary of our member communication methods, materials, and timeframes.

Table 8.14-1. Summary of Member Communication Methods, Materials, and Timeframes

Material	Method	Focus and Information	Timeframe
Pre-Enrollment Welcome Flyers	Direct Mail	Provided enrollment data becomes available in time, we will send a mailer to welcome members in advance of the ID card and new member packet. The flyer describes what the member will experience over the next one to two months, reassures them that we are dedicated to providing good service, and provides contact information.	Within 10 days of receipt of enrollment data
Welcome Call	Telephone	We will reach out to new members with a welcome call. During this call, members will learn how to change their PCP and access services. Members will be directed to go online or call Member Services if they wish to change their PCP at any time, not just upon enrollment.	Within five business days of the notice of enrollment from the State
Member ID Card	Direct Mail	Amerigroup will send each member an ID card via first-class mail. Member ID cards are sent separately from the welcome packet to make sure that the member knows and has access to his or her PCP as soon as possible.	Upon notice of enrollment from the State, and prior to the member’s effective date of coverage (with exceptions for newborns and emergency enrollments)

Material	Method	Focus and Information	Timeframe
Member Welcome Packet	Direct Mail	Each new Amerigroup member will receive a new member packet that will include a: <ul style="list-style-type: none"> • Welcome letter • Member handbook • Member grievances, appeals, and State fair hearing rights information 	Within 10 business days of the notice of enrollment from the State
Member Website	Internet Site	Our Amerigroup member website will deliver a variety of information and self-service tools to our members, including plan and benefits, provider directories, health surveys, community resources, and health and wellness information.	Our Amerigroup member website will be continuously available to support our members covered under the Iowa Initiative.

Successful Community-Based Implementation Strategies

Supporting members during program implementation will also include community-based efforts. These strategies will complement our direct contact efforts by providing additional avenues for potential enrollees and members to engage with Amerigroup.

- We will provide and publicize a toll-free number for prospective members, their families, and guardians to call with questions regarding the program. The hotline will be staffed with employees who have been extensively trained on the Iowa Initiative. These employees will be trained to provide assistance, answer questions, and route calls to the Member Advocate/Non-Discrimination Manager (Ombudsman) when appropriate. The number will be publicized on every marketing and member communication. It will be included on all launch materials, print materials, mass media materials, and our website.
- We will host community forums and orientations for all stakeholders, including members, providers, families, and caregivers. At the forums, we will explain the program change, introduce Amerigroup, and instruct forum attendees on how to contact the Member Advocate/Non-Discrimination Manager (Ombudsman) and our Member Services Department for assistance. The forums will provide an opportunity for members and stakeholders to ask questions in person.
- We will orchestrate health fairs and other community events to reach as many members, families, and caregivers as possible to share information about the program, enrollment process, and Amerigroup. These events will provide an additional opportunity for individuals to have questions answered in person.
- We will use DHS-approved mass media to introduce the new program and Amerigroup to members and stakeholders. We will submit all materials, presentations, and advertising to DHS for review and approval and clearly communicate both State and Amerigroup contact information.

Grievances, Appeals, and State Fair Hearings (8.15)

General (8.15.1)

Question 8.15, #1

1. Describe in detail your system for resolving inquiries, grievances, and appeals, including how your system ensures all policy and processing requirements are met.

Amerigroup Iowa (Amerigroup) respects members' rights to make inquiries, file grievances, and appeal decisions. Amerigroup's affiliate health plans bring 24 years of experience managing and resolving member inquiries, grievances, and appeals. Our policies and procedures comply with applicable federal Medicaid managed care requirements and will be modified to meet Iowa-specified time frames and requirements for noticing, monitoring, and reporting. We will provide members with several levels of recourse in accordance with Iowa Contract requirements, inclusive of federal and state laws and regulations. We maintain robust and effective procedures and systems for tracking and monitoring member inquiries, grievances, and appeals from initial receipt to escalation processes and resolution time frames to investigation processes and follow-up responsibilities.

Amerigroup's Iowa-based Grievance and Appeals unit oversees the entire grievance and appeal process, including the intake procedure, documentation in the medical management system, investigation, and resolution and file closure. The unit's Manager will oversee compliance with regulations and timely case handling. We train all employees on standards for appropriately managing member inquiries, grievances, and appeals. The training will include reinforcement of the fact that employees will not review or make decisions on cases where they were involved in previous levels of review or decision-making. Additionally, Amerigroup's Iowa Medical Director will oversee the Grievance and Appeals Unit's processes for the Iowa Initiative. The Medical Director reviews data and issues, identifies trends and actions that require immediate attention during the grievance and appeals processes, and renders decisions on the resolution of clinical grievances and appeals.

Our systems support ongoing tracking of all grievances and appeals via a daily report sent to designated grievance and appeals personnel on all open and unresolved cases. We monitor status, track timeliness of resolutions, identify and quickly address patterns or concerns, and ultimately improve the quality of care provided to our members. Through this system, we will report on the data elements required by Iowa and are prepared to submit all required grievance and appeals information in the required format and time frames stipulated by the State of Iowa.

Informing Members of Their Grievances, Appeals, and State Fair Hearing Rights

Members are notified of their right to file a grievance or an appeal and of the State Fair Hearing Process through clearly written materials that are easy to understand and access as well as are in accordance with contractual requirements for written member communications. We train Member Services Representatives, Care Managers, and Utilization Management staff to inform members of their rights and responsibilities during each contact when a member or his or her authorized representative expresses dissatisfaction with any aspect of care.

- Member rights, including the right to file a grievance or appeal or to request a Medicaid Fair Hearing, are described in the member handbook, which is posted on the member website and included in the new member enrollment materials (the Amerigroup Welcome Packet).
- We provide forms for filing a grievance or appeal that includes instructions on completion and submission of the form, the time frames for submissions and determinations, and how to obtain assistance completing or filing the form. These forms also describe a member's right to request a State Fair Hearing and the process and time frames for making this request.

When a service request is denied, reduced, or approved in an amount or duration less than requested, we provide a Notice of Action letter that explains the steps to appeal an adverse decision.

Amerigroup Notices of Action will include the information specified in Scope of Work (SOW) Section 8.15.8 and will confirm that a member; member's authorized representative; or estate representative of a deceased member, including a provider who has the member's written consent, may file a grievance or appeal and to be parties. Providers and subcontractors are also notified of our processes at the time they enter into contract with us and via other administrative processes. Out-of-network providers that provide services to Amerigroup members will be provided with this information at the earliest opportunity, either within 10 calendar days of approval for a service or immediately upon receipt of a claim. We will also provide materials that will help members and other parties distinguish between those grievances and appeals that are directed to Amerigroup for resolution and those that are to be directed to DHS, including grievances and appeals related to eligibility, effective dates of coverage, and patient liability such as copayments and premiums.

Grievance, Appeal, and State Fair Hearing Process

When a member, parent, or an authorized representative wishes to make an inquiry or file a grievance or appeal, they typically call the Amerigroup Member Services Helpline. Our Member Services Representatives receive in-depth training on our internal inquiry, grievance, and appeal policies and procedures and are skilled at identifying grievances and appeals. They present the greatest opportunity to address members' needs before an issue escalates to complaint status. They are trained to resolve concerns raised during the initial call if possible and to alert Care Managers for those members enrolled in care management to assist with resolution. We focus on responding to members in a courteous and professional manner and make every effort to resolve any issues that may arise through a well-defined and documented process that supports the member every step of the way.

Oversight and Responsibilities

A full-time, Iowa-based Complaints, Grievance, and Appeals Manager, and his or her team, will be devoted to overseeing Amerigroup's compliance with regulations and timely case investigation and processing for the Iowa Initiative. They will serve as a liaison between the member and the health plan. As appropriate, they will interact with members, caregivers, or advocates throughout the grievance and appeals process, verifying that members understand their rights and the decisions made. In all cases, the Quality Management leader will be available to facilitate the process, coordinating language assistance where needed and making sure all materials are in the member's primary language.

Additionally, Amerigroup executives, including the Iowa Medical Director, will have the authority to require corrective action. If a grievance is related to a quality of care issue or a denial of an expedited appeal, the Quality Management Lead reviews the issues and involves the Medical Director (or external specialists) as appropriate. We retain inquiry logs and use them for trending and identifying patterns or potential areas of concerns. We also record random calls for quality review monitoring.

We track and trend all expressions of dissatisfaction, regardless of whether they are filed as a formal grievance or appeal, including potential quality of care issues. We track findings at the provider level so we can identify repeated concerns involving a given provider. This information highlights opportunities to

initiate service improvements and corrective actions to enhance our service delivery system. When we identify concerning issues, our Provider Services Representatives contact non-compliant providers and coordinate with our Quality Management Department to develop corrective action plans with providers.

Appeals (8.15.2)

Appeals Process

Our members or their authorized representative may communicate dissatisfaction with any adverse determination. We notify members of their rights to file an appeal within 30 calendar days of the initial Notice of Action through our member handbook, website, and newsletters. In addition, all Notice of Action letters indicating an initial denial notify members of their right to file a grievance and to appeal.

Members may file an appeal in the same manner as a grievance. They may call our Member Services Helpline, where a Member Service Representative will describe the appeal process and help the member file an oral appeal request. Members may opt to file an appeal in writing by either mailing or faxing a letter. We record the date we receive the initial appeal request. If a member files an oral appeal on a matter with a standard resolution time frame (45 days) we will send the member an acknowledgement letter and include the appeal form, requesting completion and return with any additional information that the member may have. We use the date of receipt of the oral appeal to calculate the final date for resolution.

When we receive a mailed, faxed, or oral appeal, we record the appeal in our electronic medical management system. This system documents all data elements needed to investigate, track, trend, and record appeals. Additionally, the electronic medical management system initiates the mailing of a written acknowledgment to the member regarding his or her appeal request within three business days of its receipt. The letter notifies the member of the right to present evidence and allegations of fact or law in person, as well as in writing. It also notifies the member of his or her right to examine the case files including any medical records or other documents and records both before and during the appeals process.

After receipt of a request for an appeal, a Grievance and Appeals Nurse reviews the case and obtains information relevant to the appeal, including clinical detail, any additional information, and medical records as necessary. The nurse summarizes the case and any subsequent actions taken within the electronic medical management system. The Grievance and Appeals Nurse then routes the case to an appropriately licensed physician in the same or similar specialty as the provider on record. The Medical Director or reviewing physician will not participate in the review if they have been involved in the initial determination or are subordinate to any person involved in the initial determination. The Medical Director or physician reviewer contacts the provider as necessary to discuss possible appropriate alternatives. They render a decision and document the decision in the electronic medical management system.

Expedited Appeals

Members may request an expedited appeal if the turnaround time for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Medical judgment is used in reviewing all requests for expedited appeal. No punitive action will be taken against anyone who requests an expedited resolution. Amerigroup has comprehensive policies and procedures for managing expedited appeal requests. The request is logged into our information system, including the document management system. The Appeal Nurse researches the information and documents the issue in a case file. Additional information is requested as needed. Within 24 hours of receipt of the request for an expedited appeal, the Medical Director receives the case for review. The Appeal Nurse confirms that the Medical Director or designee is not the same physician or a subordinate to the physician involved in the initial adverse determination. The Medical Director or designee makes a determination to approve or deny the request within three business days of receipt of an appeal, unless this time frame is extended pursuant to 42 CFR 438.408. Amerigroup provides the member with a written notice of the decision within two

business days of the expedited appeal request and will make a reasonable attempt to provide oral notification when feasible. If a request for an expedited appeal is denied, the appeal is reviewed within the standard 45 calendar day time frame. The member may file a grievance if his or her request for an expedited appeal was denied.

Grievances (8.15.3)

Grievance Process

If a member calls to report a complaint or dissatisfaction with some aspect of service, Member Service Representatives identify this as a grievance and escalate the issue to the Grievance and Appeals Unit. Our Grievance and Appeals staff document and track all member inquiries in our existing customer service system and send an acknowledgement letter to the member or the member's authorized representative. This system documents all data elements needed to record, investigate, track, trend, and report on the status of all grievances. We monitor all grievances via a daily report that notifies the Grievance and Appeals Lead and Grievance and Appeals Manager of all open and unresolved cases. The Lead and Manager will follow up with unit employees to discuss and resolve any issues that may jeopardize timely resolution of the grievance.

We handle all grievances by reviewing the specifics, analyzing records and other information, interviewing persons involved, and making a disposition within the time frames specified by the State (within 30 calendar days for standard grievances and within three business days for expedited grievances in Iowa). If the disposition of the grievance cannot be completed in the appropriate time frame, we notify the member of the expected date of disposition in writing prior to the expiration of the time frame.

The Grievance and Appeals employee will send an acknowledgment letter regarding a grievance to the member within three business days of receiving the grievance. The letter informs the member of the right to present further information he or she feels should be considered in the grievance investigation. The employee will route the grievance to the appropriate department and staff level for review, investigation, and resolution. The unit employee will monitor progress to make sure that the information necessary to complete the investigation is provided in a timely manner allowing us to provide written notice of the disposition of the grievance within the 30-calendar-day resolution timeframe. On rare occasions we may extend the time frame up to fourteen calendar days, pursuant to 42 CFR 438.408(c). If extended, for any extension not requested by the member, Amerigroup will give the member written notice of the reason for the delay. Once a grievance is resolved, the notice of the disposition provides Amerigroup's decision and the reasons, policies, and procedures used as the basis for the decision; the contact telephone number and address for the member to contact Amerigroup regarding the decision; and all other content specified by the State of Iowa.

State Fair Hearings (8.15.4)

State Fair Hearing Process

Upon exhaustion of Amerigroup's appeal processes, members who are not satisfied with our appeal resolution may request a State Fair Hearing. We include information describing the State Fair Hearing process as part of our written internal process for the resolution of appeals. We also describe the State Fair Hearing process in our member handbook. Appeal resolution letters inform the member of his or her State Fair Hearing rights and how to request a hearing. We cooperate fully with the State Fair Hearing processes and decisions. Amerigroup will inform the member, the member's authorized representative, or a provider authorized by the member that they may request a State Fair Hearing within 90 calendar days of Amerigroup's date of notice. We document Fair Hearing requests in our electronic medical management system and produce a position statement, which is forwarded to the State. Amerigroup representatives from relevant departments within the health plan may attend the hearing and present

testimony, arguments, and all related documentation such as physician adviser's case notes, medical management case notes, medical records, and contract benefits.

Contractor Appeal Policies (8.15.5)

Filing a Grievance or Appeal (8.15.5.1)

Amerigroup's affiliates have extensive experience managing Medicaid grievances and appeals processes for members, their authorized representatives, estate representatives for deceased members, or providers with written consent from the member. We will modify our processes and internal policies to include any Iowa-specific requirements, and we will provide members with reasonable assistance to file a grievance or appeal, including help completing forms and others procedural steps including as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreters available.

General Process for Appeals (8.15.5.2)

In accordance with SOW Section 8.15.5.2 and 42 CFR 438.406 & 408(c), Amerigroup will notify members of the right to examine their case file, including medical records and any other documents or records considered during the appeals process, and will afford them an opportunity to present evidence and allegations of fact or law in person or in writing. Once a final determination has been made regarding an appeal, we will notify the member and other authorized parties. The notification will describe the actions taken, the reasons for the action, the member's right to request a State Fair Hearing, the process for filing a Fair Hearing, and other information set forth in 42 CFR 438.408(e).

Staff Processing Requirements (8.15.5.3)

In accordance with SOW Section 8.15.5.3, Amerigroup's policies and procedures will clearly denote that the employees making the decision were not involved in prior levels of review and that they have the appropriate expertise treating the condition or disease for the services being appealed. We will implement appropriate oversight and monitoring procedures to assure compliance.

Expedited Appeals (8.15.5.4)

In accordance with the SOW Section 8.15.5.4, Amerigroup will establish an expedited appeals process to resolve appeals when the standard appeal may jeopardize the member's health or ability to regain or maintain function. We will provide general and targeted education regarding our expedited appeal process to providers. The information provided will detail requirements for submission of an expedited appeal, and guidance on when it is appropriate to file an expedited appeal.

Appeals Processing Timeline Requirements (8.15.5.5)

In accordance with SOW Section 8.15.5.5 and 42 CFR 438.406, 408, and 410, Amerigroup will implement policies, procedures, and oversight processes to comply with the appeals processing timeline requirements.

State Fair Hearing Process (8.15.6)

In accordance with SOW Section 8.15.6 and 42 CFR 408, Amerigroup will implement policies, procedures, and oversight processes to comply with the State Fair Hearing process inclusive of timelines and notification requirements.

Continuation of Benefits Pending Appeal & Reinstatement of Benefits (8.15.7)

In accordance with the requirements in Sections 8.15.7.1 -8.15.7.4 and as outlined in 42 CFR 438.420, Amerigroup will develop procedures so that certain members may continue receiving benefits pending the outcome of an appeal. It is understood that:

- For benefits continued or reinstated while the appeal is pending, we will continue the benefits until the conditions outlined in Section 8.15.7.2 are met.
- If the final resolution of the appeal is adverse to the member, we may recover the cost of the services furnished to the member while the appeal was pending if the services were furnished solely to maintain benefits in accordance with 42 CFR 431.230 and 42 CFR438.420.
- As outlined in 42 CFR 438.424, if the State's Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, we must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires.

Notices of Action & Grievance, Appeal, and Fair Hearing Procedures (8.15.8)

In accordance with SOW Section 8.15.8, and as cited in 42 CFR 438.10(g)(1), we will update our policies and procedures to include Iowa-specific requirements including citation of the Iowa Code and/or Iowa Administrative Code. All policies will be submitted to DHS for approval and we will notify members, their authorized representatives, providers, and subcontractors in the format and time frames specified.

Exception to Contractor Policy Process (8.15.9)

Question 8.15, #2

2. Describe your proposed exception to Contractor policy process.

Amerigroup will implement an exception policy process that will consider potentially authorizing coverage for an item or service not otherwise covered under the terms of the managed care contract with the State of Iowa or by Amerigroup, when a member has exhausted all other options for a service request and Amerigroup's physical health, behavioral health, and/or LTSS professionals, and the Medical Director as appropriate, believe that the member's needs may best be met through an alternative service. Amerigroup will:

- Request a coverage exception from DHS in writing and document the original service request, basis for denial, and rationale for requesting an alternative service
- Accompany the request with supporting information from the member or the member's authorized representative, the member's treating provider(s), and appropriate health plan clinicians
- Present evidence that the requested service exception will be cost-effective and consistent with evidence-based treatment of the member's condition or need and will not be excluded from coverage by federal or state law

The clinical review team will present the exception request to the Amerigroup Iowa Chief Executive Officer and/or the Chief Operating Officer to review the case and determine if the case warrants an exception. We will notify the member or the member's authorized representative of the decision.

General (9.1)

Care Coordination Overview

With 24 years of experience coordinating care for low-income populations and currently serving more than 5.2 million members in Medicaid and other state-sponsored programs across 19 states, Amerigroup Iowa (Amerigroup) and affiliate plans have vast experience providing integrated, member-centric care coordination to all populations included in the Iowa Initiative. *We serve our members through a “whole person” approach that supports their physical, behavioral, cognitive, functional, and social strengths and needs across the full spectrum of health care settings.* Our member-centered model helps members optimize their benefits and available services to get the high quality health care and support they need. Our care coordination model incorporates health promotion and preventive care services, coordinating care among treating providers, and including social supports that reinforce positive health and quality of life outcomes.

We will bring to Iowa our years of experience and hard-earned lessons, national expertise, population-specific programs, and innovative technology to give our Iowa members voice and choice in receiving the support they need to access the services that enable their health, wellness, and quality of life. In addition, we are also excited to introduce CareMore to Des Moines. CareMore offers a breakthrough model of care delivery that combines wellness, medical supervision, and a revolutionary approach to care coordination for at-risk members who require higher levels of clinical intervention due to complex and/or chronic conditions.

In compliance with 42 CFR §438.208 and all the requirements outlined in the Scope of Work, our integrated case management program drives the processes, policies, procedures, and tools that support the following activities:

- Identification of members with potential or actual case management needs through early screening, comprehensive assessments, and periodic reassessments
- Stratification of risk level for each member based on a multifaceted consideration of available information for each individual
- Placement of members into care coordination based on needs assessment
- Development of integrated care and service plans that addresses physical health, behavioral health, and Long Term Services and Supports (LTSS) needs for members as they transition across all settings
- Reciprocal referrals and information sharing
- Formation of an interdisciplinary team to support the member, providing consistency and continuity of contact with a familiar support system, as well as the expertise of a broader team of specialists as members' needs evolve over time
- Care coordination support for the member in accessing the services he or she needs, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation, member progress, and need for service adjustment and incorporation into the care plan
- Ongoing evaluation of our care coordination program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and performance improvement

Between 2012 and 2013, Amerigroup and our affiliate health plans experienced an overall reduction of 20% in emergency room visits and 26% for inpatient admissions based on claims analysis across disease management programs.

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- Proactive referral to and coordination with Integrated and Chronic Health Homes, as appropriate
- Emphasis on disease prevention, chronic condition management, and increasing member compliance with recommended treatment protocols
- Member education to enhance understanding of healthcare conditions and prescribed treatment
- Member empowerment to take responsibility and self-direct their care and services

Fully Integrated Model

Amerigroup has an established history of systems-level integration administering both physical and behavioral health benefits, as well as integrating disease- and condition-specific expertise in addressing physical and behavioral health conditions with a focus on healthy behaviors. We have built the operational systems and infrastructure and developed programs and services that promote integration and a holistic approach in addressing member health service needs. Moreover, integration addresses psychosocial needs such as housing, education/employment, and meaningful participation in the community through linking and coordinating with community services and supports.

Amerigroup strongly believes in taking a fully integrated approach across the members' systems of care, to meet the holistic support needs including, but not limited to, physical health, behavioral health, oral health, and social and functional supports through LTSS programs and community-based resources. We believe this integrated approach is crucial to improving the member's health and welling and quality of care and services while proactively managing cost efficiencies, emphasizing member informed choice, preferences, access, wellness, independence, and responsibility. We will bring our interdisciplinary team approach to Iowa to assure integrated care delivery in supporting the State's health goals. ***Our approach does not subcontract core components of our care coordination model. Services are integrated internally and promoted with our provider network.***

Our integrated care system incorporates a broad array of services and supports that are organized into a comprehensive service network that promotes collaboration and coordination. The system identifies and addresses health disparities, is culturally competent, and builds on Iowa's strengths.

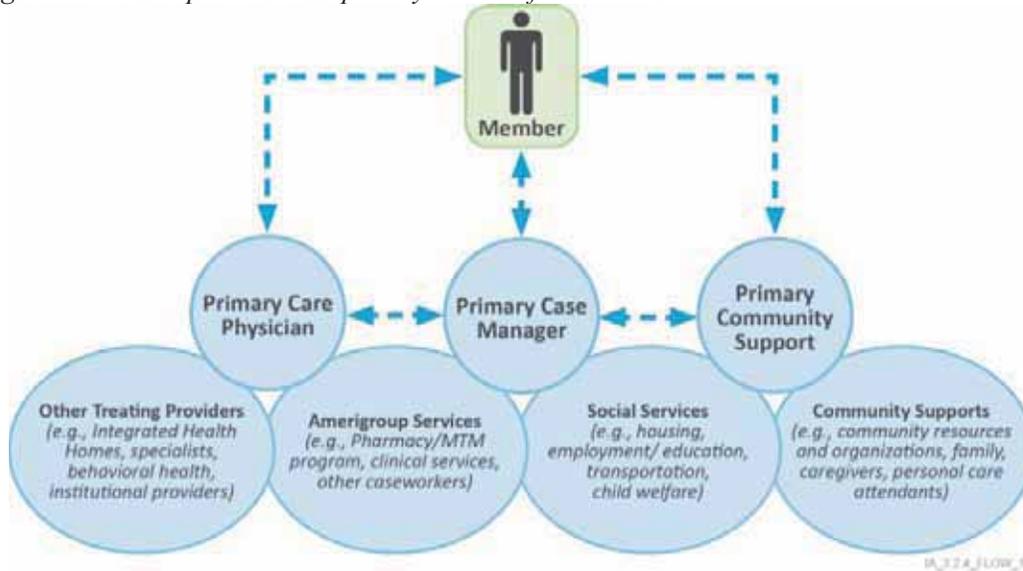
In Iowa, we will use our proven interdisciplinary team infrastructure, processes, and technology tools to assure integration and coordination to promote high quality, cost efficient, and well-coordinated care:

- The member's interdisciplinary team (see Figure 9.1-1) includes the member, family, our medical and behavioral health professionals, LTSS community-based Case Managers, and our health care specialists, Integrated Health Home and Chronic Condition Health Home staff, and HCBS providers who work together on a day-to-day basis and during joint rounds to design and execute a single, member-centered care and services plans based on members' holistic needs and goals
- Providers are a critical partner in integrating care and a key component of the interdisciplinary team. This includes medical, behavioral, and LTSS providers as well as the Iowa dental vendor and community partners providing social supports. We provide a feed of comprehensive, actionable information to empower providers to take a coordinated approach to providing high-quality, cost-effective care and services. We link integration to provider incentive programs and encourage providers to flow information back to the health plan and the State to improve data integration. We have already had discussions with the Iowa Primary Care Association, community mental health centers (CHMC), and the Regional Service Systems for Mental Health and Disability Services (MHDS). We plan to work with these partners and others to collaborate on evolving integrated care clinics and supporting integrated data sharing
- Our interdisciplinary team uses a flexible and member-centered process to meet members where they are, assess needs, risk stratify, and work with members and providers to deliver integrated care and services, emphasizing member choice, access, safety, independence, and responsibility

- Innovative technology tools are available to the interdisciplinary team, our provider partners, and other extended members of the “treatment team” to support integration. This includes our multifaceted, bi-directional care coordination and member information system as well as telehealth platforms

Our interdisciplinary team approach is flexible, such that the team assigned to a given member will include different specialists or shift emphasis based on the member’s evolving situation. We will use specific strategies to serve specialized populations’ unique needs and address key transitions of care and services.

Figure 9.1-1. Sample Interdisciplinary Team Infrastructure



Section 9.1, #1

1. Describe proposed strategies to ensure the integration of LTSS care coordination and Contractor-developed care coordination strategies as described in Section 9.

Amerigroup’s fully integrated care coordination model includes integration of LTSS. Like all other Amerigroup members, members participating in LTSS programs are served by highly collaborative interdisciplinary teams in constant communication and working on the same platform. The consistency of our care coordination model, our team structure, our care coordination processes and procedures, as well as our integrated platform, assures that our members experience the same consistency of high quality support and services from our care coordination programs as their needs evolve in their interactions with us over time.

We deploy a number of strategies to make sure that LTSS remains fully integrated with our other care coordination programs and services:

- *For every member, we assign a Community-Based Case Manager who serves as the main point of contact and leads with the member service planning along with the interdisciplinary team*, selected by the member. Members are matched with a Community-Based Case Manager experience, knowledge, and skills are matched with our members based on diagnosis, complexity of medical and/or behavioral health conditions, and intensity of service and support needs. The assigned

community-based Case Manager has clear overall accountability for coordinating care and services for LTSS members

- We use the same integrated care management platform across physical health, behavioral health, and LTSS
- Our clinical staff operates in co-located regional teams, facilitating constant daily communication among our Case Managers
- Our clinical staff engages in case rounds at least twice per month to strategize on ways to meet the needs of members with complex healthcare needs, including LTSS members. When needed, ad hoc discussions occur on a routine basis with team members so that they can address member needs in a timely manner.

CONTAINS CONFIDENTIAL INFORMATION

- We provide members with a single phone number (a direct line to the Case Manager), which is included in the care management welcome letter

See Section 4.3.2 for more detail on LTSS care coordination.

Initial Screening (9.1.1)

Question 9.1.1, #1

1. Describe your plan for conducting initial health risk screenings.

Initial Health Risk Screening Process

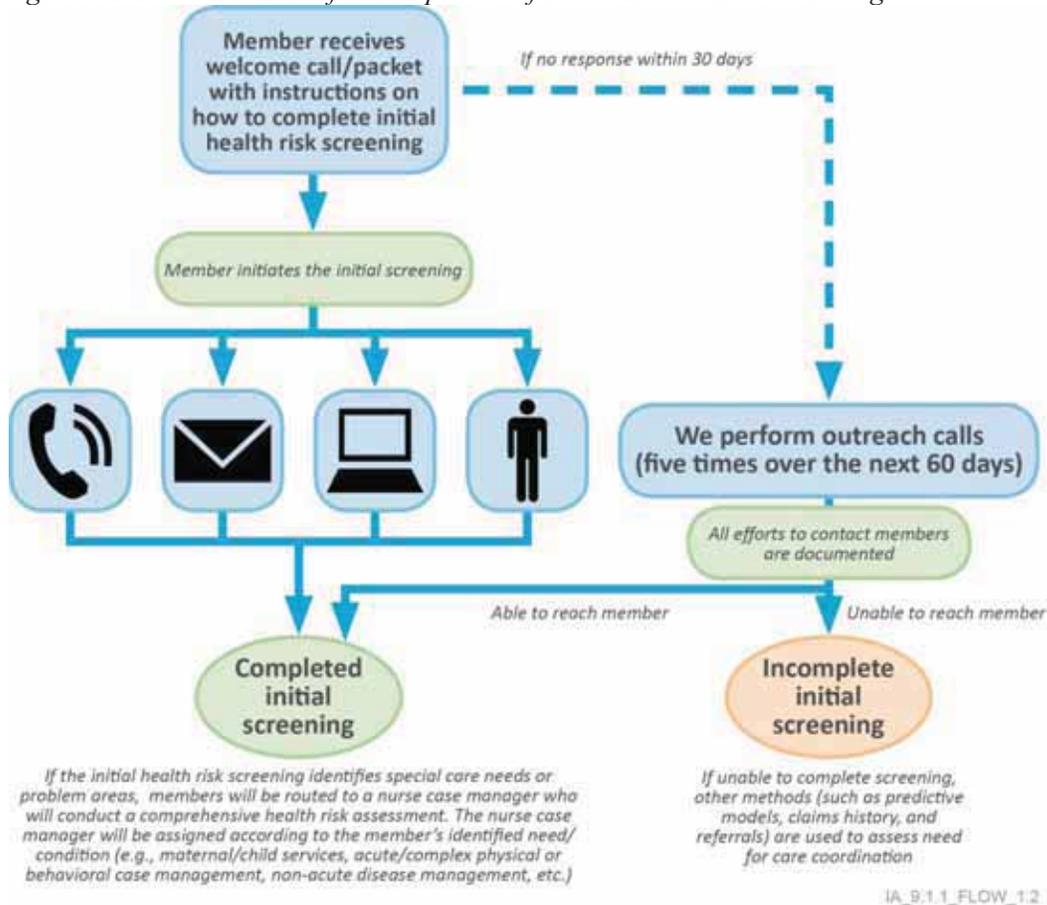
As part of our comprehensive approach for identifying needs of our new Iowa members, Amerigroup will conduct an initial screening on all of our members within 90 calendar days of enrollment. ***The initial screening is our first opportunity to identify immediate physical health and/or behavioral health needs that require expedited appointments with providers, as well as to identify members for disease management, complex case management, behavior health, care coordination, or other programs and services.*** We have established processes to conduct initial health risk screenings for new members, members who have not been enrolled in the prior twelve months, and members for whom there is a reasonable belief they are pregnant. We provide a variety of time-tested approaches to encourage participation and engagement and provide members the opportunity to obtain assistance if needed to complete the screening.

New Members

All new members will receive a welcome packet and member handbook upon enrollment. The packet will include a copy of the initial screener and will give instructions to members on how to complete it via mail (paper form), over the phone, or online through the member portal. In addition, we place welcome calls to all reachable newly enrolled members (except for our institutionalized members), subject to all applicable state and federal regulations. During the call, we will remind the member to complete the initial screening questionnaire from the welcome packet if he or she has not yet done so. The member will be offered to complete the survey telephonically at the time of the welcome call.

If the initial screening is not completed within 30 days of receipt of the welcome call, we will conduct outreach calls to members who have not completed the screener. We will attempt to contact the member by telephone on up to five different occasions to meet the required timeframe for completing the initial screening within 90 calendar days of the member’s enrollment. If we have not received a response by mail or through the member portal, we will complete the initial screening process with the member while on the telephone. All attempts to contact the member will be documented in our care management system. Figure 9.1-2 provides an overview of the process to reach out to members to complete the initial screening.

Figure 9.1-2. Process Flow for Completion of Initial Health Risk Screening



During the welcome call, we will assist our members in choosing a primary care physician (PCP) if the member has not chosen one and assist members in making their first appointment with their PCP. If members indicate on the phone that they have an issue or a need that would benefit from advice from a nurse, a behavioral health specialist, or member services representative, they are connected with that requested resource upon completion of the initial screening. We provide this opportunity while the member is engaged to assist with immediate needs, whether they are clinical or administrative in nature. When appropriate, we will arrange an expedited appointment with a provider.

To encourage all members to complete the screener in a timely manner, we will offer our Iowa members a \$20 member incentive as part of our Healthy Rewards program. Completing the initial screener will officially initiate the Healthy Rewards Program and trigger Amerigroup to send the Healthy Rewards card to members. Our Healthy Rewards Program is described in detail in Section 10.3.

Members Who Have Not Been Enrolled in the Prior 12 Months

Any member who was previously enrolled in Amerigroup, but not within the prior 12 months, will be asked to complete the initial screener again. The process is the same as for first-time new enrollees, as described above.

In addition, when a member transfers from another health plan to Amerigroup, we will:

- Obtain state notification of the member's transfer into Amerigroup from the other health plan
- Evaluate the member's immediate health care needs through outreach and screening
- Review claims and authorization data information received from the prior health plan, as available
- Contact the member's PCP or specialty provider to coordinate care
- Document the member's information in our clinical management system

Upon state agency notification of the member's transfer to Amerigroup, we will quickly engage members in the services and supports they need (including those that the member needs to avoid disruption of treatments, care, or services already underway), encouraging appropriate utilization of services and giving them the information they need to learn for self-management. We will contact the member through a welcome call within 30 days from the date of the state agency notification of the member's expected enrollment date to identify the member's previous health plan and request relevant member information from that plan.

Members for Whom There Is a Reasonable Belief They Are Pregnant

Early identification of members who are pregnant is essential to impact positive pregnancy and birth outcomes. We have established processes and systems that support early identification of members who are pregnant:

- Network providers who develop relationships and engage in preconception discussions with their patients are often among the first to know when a woman becomes pregnant. Our providers are required to furnish notification of pregnancy to Amerigroup upon the member's first prenatal visit.
- New member outreach, including the member handbook, welcome calls, and the self-administered health risk assessment, will include targeted information and questions to help identify women who may be pregnant. Amerigroup will actively work to educate members on the importance of notifying the health plan as soon as possible to access the health care that will support their own pre- and perinatal wellness and that of their baby.
- Members will have 24/7 access to our Member Services and Nurse HelpLine call centers to notify us if they suspect or have confirmed a pregnancy.
- We conduct frequent and ongoing analysis of enrollment files, claims data, laboratory reports, hospital census reports, provider referrals, and self-referrals. Currently, approximately 60 percent of our members who are pregnant are identified upon enrollment.

Amerigroup screens all pregnant members for possible referral into our High Risk OB Program, which is a component of our Taking Care of Baby and Me[®] program. We will initiate a call to provide case management services, particularly reproductive health education, to reproductive-aged women with a history of prior poor birth outcomes, including those with pre-term deliveries at less than 37 weeks. For more information regarding Taking Care of Baby and Me, refer to Section 9.1.3.

Initial Health Risk Screening Tool (9.1.1.1)

Question 9.1.1, #2

2. Submit a proposed initial health risk screening tool. Exhibits and attachments may be included.

Early engagement with our Iowa members will encourage appropriate use of health care services and result in better health outcomes. Amerigroup and our affiliate health plans have extensive experience using and developing different screening and assessment tools that are tailored to the unique needs of the market. We believe that an effective screening tool requires a careful balance of brevity and comprehensiveness. ***Our collective experience across our 19 affiliate health plans suggests the optimal tool must be quick and easy for members to complete, yet provide sufficient insight to uncover areas for additional probing into our members’ physical, behavioral, social, functional, and psychological health needs to further explore their need for enrollment in a care coordination program.***

Amerigroup concurs with DHS’s preference to have a uniform tool across contractors. We understand that the tool ultimately used will be designated by DHS. We are flexible and will adapt, as necessary, to whichever tool DHS designates. Further, we are willing to lead, or at a minimum participate in, a workgroup across contractors and DHS to agree on a uniform screening tool.

As a starting point, Amerigroup proposes a 13-question initial health risk screening to assess the needs of Iowa’s Medicaid populations, as shown in Table 9.1-1. Amerigroup affiliates have had success with similar questionnaires due to the brevity, ease of use, and ability to complete on paper copies for return by mail.

Table 9.1-1. Our Proposed 13-question Initial Health Risk Screening Tool

Initial Health Risk Screening Tool Questions	
1	Do you have any of the following urgent medical or behavioral health conditions? <ul style="list-style-type: none"> • Shortness of breath • Chest pain • Lightheadedness or fainting • Severe pain • Wanting to hurt yourself or others, etc.
2	Do you feel your health is: excellent, very good, good, fair poor?
3	Do you have a history of: <ul style="list-style-type: none"> • Heart disease • Asthma /respiratory illness • Diabetes/pre-diabetes • Cancer • Back pain • Mental illness • Substance abuse • Overweight/obesity
4	In the last year, have you seen your: primary care provider, dentist, specialist?
5	Do you have (a) specialist(s) that you see on a regular basis?
6	How many times have you been to the emergency room in the last year?
7	How many times have you been admitted to the hospital in the last year?
8	How many prescription medications do you take per month?
9	Are you currently pregnant?

Initial Health Risk Screening Tool Questions	
10	During the last two weeks, have you felt: <ul style="list-style-type: none"> • Little or no interest in doing things • Down, depressed or hopeless • Bad or guilty about drinking and/or recreational drug use • Criticized by family or friends about your drinking and/or recreational drug use
11	Do you need help with finding: <ul style="list-style-type: none"> • Transportation • Food/shelter • Quitting smoking • Alcohol/drug treatment • Weight/blood pressure
12	Would you like to discuss ways in which we can assist you to change how you are currently managing your health? If yes, in what area (s)?
13	Would you please provide your current height and weight?

Subsequent Health Status Screenings (9.1.1.2)

Question 9.1.1, #3

3. Describe the methods that you will use to determine whether changes in member health status warrant subsequent screening.

Changes in a member’s status will require additional subsequent screenings to make sure that we continue to properly identify those needing care coordination promptly as needs arise – across physical, behavioral, social, and functional needs. We will ascertain health status changes through continual data mining and claims review, as well as provider notifications and referrals.

Continual Data Mining and Claims Review

Once a member is enrolled in our program, our continual data mining and claims review will help us quickly identify trigger events which would require subsequent screening. Trigger events that will warrant a subsequent assessment include:

- A hospital admission or unexpected facility placement
- New diagnoses (such as chronic obstructive pulmonary disorder, congestive heart failure, diabetes)
- A change in the ability to perform activities of daily living and instrumental activities of daily living
- A significant change in caregiver status (such as a serious illness)
- Homelessness, significant changes in housing situation, or inadequate housing that may necessitate a reassessment and an alternate plan for a member

Each month, the entire member population is evaluated, and candidates for subsequent screening are identified. As we receive data, we monitor our membership through multiple layers of predictive modeling analyses. Our system reviews 12 months of rolling member historical information, including diagnosis and demographics, to predict future outcomes.

Provider Notifications and Referrals



We recognize that a member’s health status is highly fluid. Members who have not been identified through our predictive modeling may still be in need of subsequent screening for care coordination. Our providers and community partners have information and experience working with our members that are invaluable for informing us of the member’s level of service. We therefore have a “no wrong door” policy for accepting referrals. We believe this joint approach to stratification, using both predictive

data analysis of indicators and real-time “eyes and ears” detection of emerging member needs, will enable us to accurately and appropriately assign our members to the level of service that best meets their evolving, individualized needs. Our “no wrong door” policy for care coordination referrals allows us to accept referrals for care coordination from:

- Members (or family/caregivers)
- Providers
- Community-based organizations
- Family and Social Services Agencies
- 24/7 Nurse HelpLine
- Member Services Representatives
- Discharge Planning staff
- Pharmacy Benefits Manager staff

Methods to Maximize Contact with Members (9.1.1.3)

Question 9.1.1, #4

4. Describe methods that you will use to maximize contacts with members in order to complete the initial screening requirements.

Medicaid members can present special challenges and complexities to outreach and engagement by the health plan. Engaging newly enrolled members to participate in the required initial screening is critical to effectively identifying needs and providing members with the care, supports, and services to improve their health.

Frequent, timely contact is one of the most important parts of engagement for effective care coordination. At each contact with our members, we proactively validate their address and phone number and ask for their preferred method of contact. This validated information can be updated in our system by any Amerigroup employee. We can then focus our strategic outreach on members who are identified as having complex health care or psychosocial needs and who may be transient or homeless or face other challenges that affect our ability to engage these members in need.

Based on our experience, we recognize that for many members, significant effort may be required just to reach out and conduct the initial screenings. To provide ease of access and personal choice to our members, we present them with multiple avenues for completing the initial screening. We have several processes in place to conduct initial screenings:

- In person
- By phone
- Electronically through a secure website
- By mail

In Person Communication

Our experience in working with Medicaid members over many years across many states has taught us that, despite all efforts, some members simply cannot be reached through conventional phone, web, and mail outreach methods. ***Our engagement strategies emphasize the inclusion of all stakeholders surrounding the member, and the value of initiating grassroots-level involvement with community organizations to enhance efforts to locate members who are homeless, transient, or otherwise difficult to locate.*** We will work on behalf of our members to engage stakeholders and enlist their support for placing members in our care coordination program.

We will use strategic field-based approaches across local Iowa communities to assist us in locating and engaging our members. The examples that follow demonstrate how we will engage with members in the community in Iowa:

- Facility visits
- Clinic days
- Community Partner Organizations

Facility Visits

Amerigroup works with physical and behavioral health hospital partners, nursing facilities, and intermediate care facility for individuals with intellectual disabilities (ICF/IDs) to facilitate timely notification of admissions, discharges, and transfers as close to real time as possible. We are able to speak with members, either in person or by telephone, during their inpatient stay. These collaborations with facility staff and clinicians also provide our care coordination teams with the opportunity to complete necessary screenings and assessments and to work with the member and family to identify the member's service and support needs prior to discharge, enabling a smoother transition home.

Clinic Days

As we have done effectively in affiliate Amerigroup markets, our plan in Iowa is to partner with physicians, health departments, and other primary care delivery sites to hold Clinic Days. Clinic Days provide the opportunity for members to obtain timely and convenient preventive services, screenings, and diagnostic tests to close identified gaps in care. ***In partnership with network providers, we will host a series of Clinic Days for members who have not received immunizations, other preventive services, or postpartum care or who are due for diabetes or other chronic condition care.*** Our outreach specialists will be on site to engage the members to complete an initial screening, if not already completed. Members will be directed to the office of the provider identified as their PCP. We will coordinate transportation for members, as needed, and members may be eligible for related Healthy Rewards incentives. Clinic Days are another effective way to engage hard-to-reach members and to help assure that members receive necessary preventive services and screenings to maintain health or avoid exacerbation of chronic conditions.

Community Partner Organizations

Amerigroup is committed to building community partnerships in Iowa to reach our members wherever they are. Across all Amerigroup markets, we have a track record for quickly establishing deep collaborative relationships with providers, consumers, advocates, and other organizations to enable creative, local solutions. In cooperation with established community-based organizations, we will deploy outreach specialists to help overcome barriers and engage members for their screening and assessments.

For example, Amerigroup has experience working with Women, Infants, and Children (WIC) Programs in other states. We will require our in-network providers to document and refer eligible members for WIC services. As part of our initial member screening and as part of the initial evaluation of newly pregnant women, our in-network providers will provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC

Program. We also partner with WIC centers to co-locate our clinical and care coordination staff, using this as an opportunity to engage members for screening assessments for our maternity programs.

We also expect that these strategies, shown in Table 9.1-2, will serve to spread awareness of our care coordination programs across organizations throughout Iowa. This awareness will lead to additional avenues for referral of members who may need care coordination support services.

Table 9.1-2. Strategies for Partnering with Community Organizations

Strategy	Approach
Develop relationships with community resources and community access points	We will develop relationships and partnerships with community-based resources, such as locally-based food banks, school-based health clinics, and other community networks. We recognize that the types of barriers our members face may force them to choose between providing food for their children or filling a prescription. It is critical to have partnerships in place with local community resources that can provide members access to food and other basic needs. By assisting members with these needs, we can eliminate barriers and develop trusting relationships that engage members to participate in their health care.
Develop relationships with faith-based organizations throughout Iowa communities	Faith-based organizations may be among the main pillars of working with individuals who are homeless or at risk of becoming homeless. Churches are often the place that people in crisis go for assistance. We will look to develop relationships and garner support in our efforts to locate and engage members who would benefit from care coordination. Faith can play a strong role in people’s approach to their health. Forming strong and trusting relationships with faith-based community organizations informs our Case Managers about our members’ beliefs and cultural preferences. Understanding an individual’s beliefs and adapting our engagement strategies and the delivery of our initial screening will ultimately improve our care coordination for the member.
Develop relationships with and coordinate/participate in events at housing complexes	Across all of our markets, Amerigroup coordinates events at housing complexes. This outreach is a productive avenue for reaching members who may be difficult to contact and who are at risk of becoming homeless. We typically work with public housing and low-income communities to bring multiple resources together for health events. In Iowa, we will continue to create social forums, offer health education screenings, and leverage our outreach with existing community development projects and housing authorities.

Since March 2015, we have identified and met with dozens of community organizations to discuss how we could collaborate. For example, we have already begun to develop relationships with key community partners in Iowa including:

- Brain Injury Alliance of Iowa
- The Iowa Developmental Disabilities Council
- The University Center for Excellence on Developmental Disabilities
- The University of Iowa Center for Child Health Improvement
- Centers for Independent Living

Telephonic Communication

We place welcome calls to all reachable newly enrolled members (except for our institutionalized members), subject to all applicable state and federal regulations. During the call, we will remind the member to complete the initial screening questionnaire from the welcome packet if he or she has not yet done so. The member will be offered to complete the survey telephonically at the time of the welcome call.

All member contact numbers that are found to be no longer connected or accurate are investigated:

- Using Member 360, we analyze data against medical and pharmacy claims to find more current contact information for invalid addresses and unreachable members

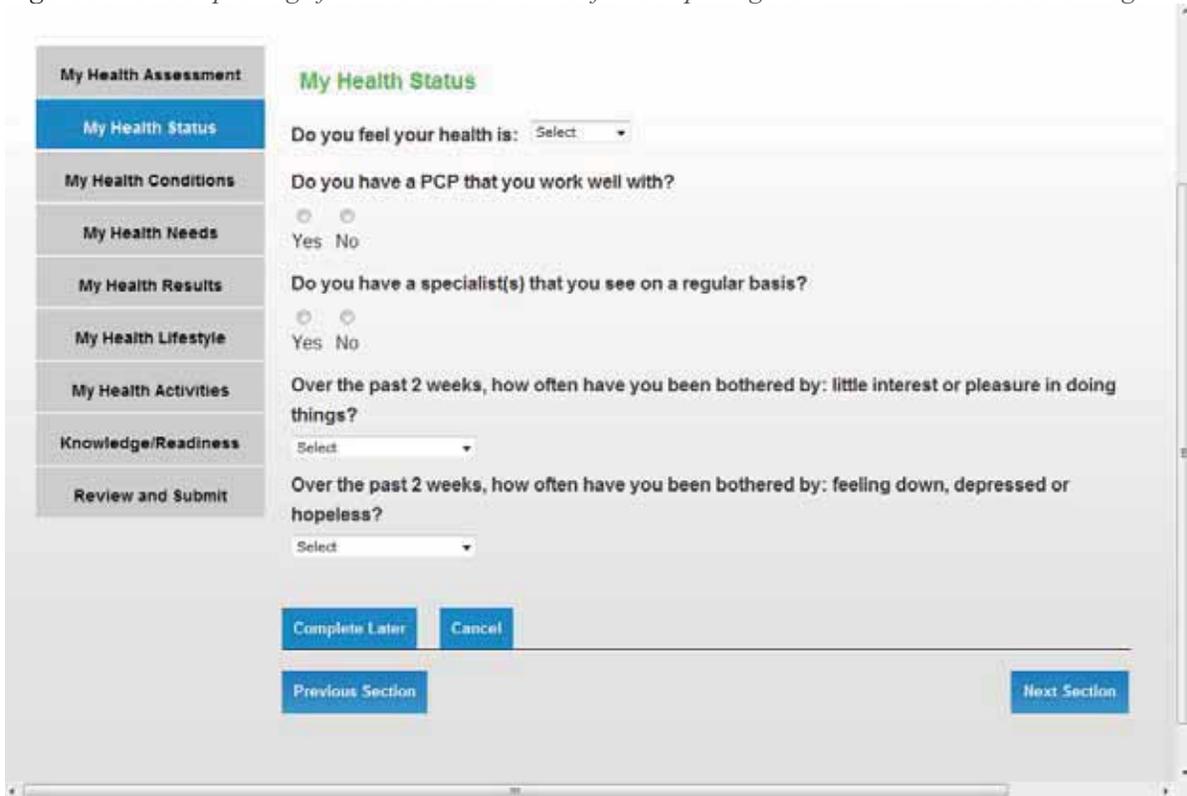
- We analyze data against any other public programs' data that the state may have available – an opportunity that we would like to explore during program implementation
- We mail an approved Unable to Contact letter to the member with a phone number and contact instructions if the we are still unable to reach the member by telephone

If we learn that the member does not have reliable phone service, Amerigroup will help the member obtain a free cell phone through the federal SafeLink Program. Amerigroup facilitates the SafeLink Wireless process by helping members get the phone and, depending upon the wireless plan, up to 250 minutes per month. Additionally, as a Value-Added Service for our members, Amerigroup provides 100 extra lifetime minutes. Amerigroup members can use these cell phones to contact their Case Manager or providers. By providing our members with a free cell phone, our care team and providers will have more consistent and reliable access to these members as well as a communication channel for healthy reminders and text messaging, should they sign up for those programs. This service improves member participation in assessments and care planning and helps members keep appointments, remain adherent to care plans, and complete appropriate follow-up. The SafeLink phones provided to the members will have Amerigroup's Member Services phone number pre-programmed into the device to assist members in contacting us.

Electronically through a Secure Website

While some members may prefer to conduct the screening over the phone, others may prefer to complete the screening on their own using our online format shown in Figure 9.1-3. Members may go online to complete their initial screening using the link provided in the welcome letter as well as shared on the welcome call. If a member has opted to complete the initial screening online and requires additional assistance, we will have resource available by telephone to help walk the member through the questions while online.

Figure 9.1-3. Sample Page from the Online Format for Completing the Initial Health Risk Screening



Mail Communication

Members also have the option to complete the initial screening by mail. Along with the welcome letter, all members will receive a paper copy of the initial screening questionnaire. The welcome packet includes instructions on how to complete the questionnaire and return it to us by mail. We include a return envelope and postage in the welcome packet.

We know from experience that inaccurate contact information is often a significant barrier. We investigate all mail that comes back as undeliverable through:

- A comprehensive analytics program to improve access to accurate, current contact information, and support our ability to engage members (We accomplish this by using a wide range of data sources to gap-fill or correct invalid or outdated member contact information)
- External partners for member data cleansing, as needed, when internal data analytics cannot secure accurate contact information
- Contact with the PCP, hospitals, pharmacies, or other providers that the member has recently visited (based on claims data) to ask for updated contact information

Comprehensive Health Risk Assessment (9.1.2)

Comprehensive Health Risk Assessment Process

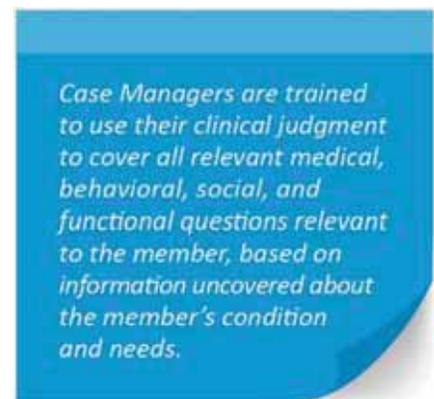
If the initial health risk screening identifies special healthcare needs or problem areas, members will be routed to a Case Manager who will conduct a comprehensive health risk assessment. The comprehensive health risk assessment includes:

- Review of the member’s relevant history (including encounters and pharmacy history)

- Telephonic or face-to-face contact with the member to administer standard assessments (which may include, with appropriate authorization, contact with relevant family members/caregivers and/or significant others)
- Review of the member's referral and/or any completed assessments
- Discussion with the member, caregivers, and/or significant others to identify health- and social-related needs and goals that are important to the individual
- Contact with relevant providers for input on the member's history and current healthcare needs
- Review of relevant disease-specific, evidence-based clinical guidelines

The comprehensive health risk assessment will be tailored to each member based on demographics and areas of need. For example, only pregnant members are asked obstetrics questions, and only children's parents or authorized guardian are asked pediatrics questions. Our Case Managers are trained to use their clinical judgment to cover all relevant medical, behavioral, social, and functional questions relevant to the member, based on information uncovered about the member's condition and needs. At a minimum, every comprehensive Health Risk Assessment will probe on the following areas:

- Health status, including condition-specific issues
- Documentation of clinical history, including medications
- Activities of daily living
- Behavioral health status, including cognitive functioning
- Life planning activities (for example, living wills, advance directives)
- Culturally background and linguistic service needs, such as translation services
- Visual and hearing services
- Caregiver resources and involvement
- Available Medicaid benefits and community resources
- Medical and non-medical fact-finding
- Medical equipment needs



Case Managers are trained to use their clinical judgment to cover all relevant medical, behavioral, social, and functional questions relevant to the member, based on information uncovered about the member's condition and needs.

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Case Managers who administer comprehensive health risk assessments will be registered nurses and social workers experienced in working across all Medicaid populations. All such Amerigroup personnel will hold a valid Iowa professional license in their respective specialties. Amerigroup Case Managers will conduct comprehensive health risk assessments with the member, the authorized representative, and family or caregivers, when appropriate, and with member consent. Prior to contacting a member, the Case Manager will review all available documentation in CareCompass, our care coordination and management system, to determine whether an in-home assessment is indicated.

Amerigroup understands that proactive identification of the correct level of care coordination support is critical to meeting the member's needs and improving health outcomes. Therefore, there are several avenues for our members to receive a comprehensive health risk assessment:

- When a member is ***identified in the initial screening process*** as having a special health care need or when there is a need to follow up on problem areas identified in the initial screening
- When members are identified for additional care coordination needs through ***subsequent screenings*** as members' needs evolve over time

- When *referred for care coordination* (we accept referrals from all sources, including providers, self-referrals, caregivers or family members, and community-based organizations)
- When *analysis of claims* reveals a major change in status (such as a hospital admission, new diagnosis, change in ability to perform activities)
- When *predictive models* identify members with high-risk, complex, chronic, or co-occurring needs

Special Health Care Needs or Problem Areas Identified in Initial Screen

A Case Manager will evaluate all members whose initial screening indicates that they may benefit from complex case management services. Using risk scores generated through initial screening questionnaires and predictive modeling, we contact those with the highest scores first, making sure that members with the most imminent needs receive a comprehensive health risk assessment quickly as a first step to identifying specific care coordination needs and developing an individualized care or service plan.

Our predictive models will support prompt identification of newly enrolled members as well as those whose scores may escalate between periodic assessments, such as members with newly diagnosed chronic conditions or members newly at risk for facility placement because of a recent fall, the death/disability of a caregiver, or other acute behavioral or physical health needs. If we have exhausted all our attempts to complete the initial screen, we will be able to identify candidates for care coordination programs by running our predictive models, even without data from the initial screening questionnaire.

Referrals for Care Coordination

Our “no wrong door” approach supports identification of members with special health needs through multiple sources. In addition to using the initial screening results, a variety of sources may refer members to one of our programs when they identify a need during contact with a member or based on review of a member’s electronic health records. These sources include:

- Concurrent reviewers/discharge planners
- Staff who review the results of members’ assessments and screenings
- Case Managers
- Disease managers
- Outreach specialists
- Member Services staff
- Nurse HelpLine staff
- Primary care providers
- Other physicians
- Specialists and mental health/substance abuse providers
- Other community providers
- Pharmacy staff
- Family members, caregivers, and guardians
- Member self-referral

Claims Analysis

Amerigroup proactively reviews claims, internally generated reports, screening and assessment results, referrals, and provider information to identify members who may need care coordination services. Our predictive model assigns a risk score based on the member’s attributes, claims, and utilization history, enabling Amerigroup to determine the likely required level of care based on the severity of the score. The predictive model considers past utilization (claims, authorizations), general demographics, and information on aid categories to home in on those members who will benefit most from care coordination. For additional information on our predictive models, refer to Section 9.1.4.

The types of member characteristics we identify for care coordination include:

- Clinically manageable conditions, such as asthma, cardiovascular or pulmonary disease, diabetes, or metabolic disorders – those conditions where care coordination interventions and support have proven to have the highest potential impact on outcomes
- Members with more than three non-emergent emergency room visits and an emergency room Triage Score indicating a likelihood of continued emergency use for low-level visits

- Members at high-risk for admission and readmission to an inpatient setting
- Women with high-risk pregnancies and newborns with complications at or following birth
- Members with serious mental health conditions, such as schizophrenia, bipolar disorder, recurrent major depression, and substance use disorder (see Section 3.2.8 for more detail)
- Multiple medication prescriptions with high or low utilization
- Co-occurring or co-morbid physical and behavioral health

We will identify members who may benefit the most from care coordination through our Continuous Case Finding process that includes predictive modeling tools that enable monthly data mining to identify and prioritize candidates. The process begins each month with a review of the entire eligible member population. Members are identified through review of their available past 12 months of claims data. Additionally, the system considers member historical information, including diagnosis and demographics, to predict possible future risks and care coordination needs. Once members have been identified as potential candidates for care coordination, we will reach out and conduct a comprehensive health risk assessment to further determine the level of care needed.

Health Home Assignment

The results of the comprehensive health risk assessment, in conjunction with our claims analysis, will help to identify members with complex needs – including those with behavioral health conditions, diabetes, or other chronic conditions – that may be appropriate candidates for enrolling in the Integrated or Chronic Health Homes. If a member meets our criteria to be managed by Amerigroup's Complex Case Managers, while also being eligible for chronic condition or integrated health home services, our Case Manager will specifically reach out and coordinate with the health home care coordinator. We will also proactively reach out to these members, inform them about health homes, and assist in enrolling them, as appropriate.

Our Case Manager is alerted once health home enrollment is complete through our data systems, which track members assigned to a specific health home, as well as the member's primary care physician with enrollment dates. The collaboration and coordination with the health home care coordinator facilitates a robust care coordination plan without duplicating activities and services.

Additional details on health homes are included in Section 3.2.9 and 3.2.10.

Comprehensive Health Risk Assessment Tool (9.1.2.1)

Question 9.1.2, #1

1. Submit a proposed validated comprehensive health risk assessment tool. Exhibits and attachments may be included.

Amerigroup proposes for Iowa our proprietary comprehensive health risk assessment tool, which we use across our affiliate plans in 19 states. It has been developed specifically to assess the needs of different Medicaid populations and meet NCQA requirements. *Amerigroup Case Managers use our comprehensive health risk assessment tool to conduct an in-depth clinical assessment in which they gather information about the member's health status and needs, across physical, behavioral, social, functional, and psychological health.* The assessment uses a hierarchy and branching logic to probe into more than 20 potential clinical areas for risk factors and includes specialized assessment modules for specific conditions or populations, such as behavioral health, maternal health, or pediatrics. See Figure 9.1-4.

For example, when the Case Manager identifies during assessment an existing or potential mental health or substance abuse issue, the Case Manager asks the behavioral health questions to gather more detailed information on the member’s specific diagnoses, mental health and substance abuse history, current providers, co-morbidities, and service needs. The Case Manager initiates additional questioning as needed to gather details on the acuity level for a member’s conditions. This information helps determine the member’s need for case management services based on complexity, severity, intensity, and risk.

Figure 9.1-4. Sample of Specialized Assessment Modules



Table 9.1-3 shows the minimum assessment that adult Medicaid members receive before branching off to further specialized assessments. While the full set of questionnaire permutations is too long to include as an exhibit in this document, we would be happy to supply it to the State upon request.

Table 9.1-3. Questionnaire from the Comprehensive Health Risk Assessment

Question	Branching logic
General Information 1	
Is the address and phone number correct?	
If no, please explain	
Do you have an alternate contact person/phone?	
If yes, please explain	
Are you being case managed by another agency?	
If yes, explain	
General Information 2	
Do you have a spoken language preference?	
Does the member speak another language at home?	
How well does the member speak English?	
Do you have a written language preference?	
Does the member require a translator?	
What is the member’s race? Note: Explain that Asian is: Asian Indian, Chinese, Filipino, Japanese, Korean, or Vietnamese. Explain that Other Asian is Native Hawaiian, Guamanian, Chamorro, Samoan, or Other Pacific Islander.	
What is the member’s Ethnicity? Are you of Hispanic, Latino/a or Spanish origin (such as Puerto Rican, Latin American, Mexican, or Cuban)?	
General Information 2-Race/Ethnicity Questions	
If Asian was selected, please ask member if they are Asian Indian, Chinese, Filipino, Japanese, Korean, or Vietnamese.	
If Other Asian was selected, please ask the member if they are Native Hawaiian, Guamanian, Chamorro, Samoan, or Other Pacific Islander.	
If yes was selected in the Ethnicity question, please ask the member if they are Mexican/Mexican American/Chicano, Puerto Rican, Cuban, or Another Hispanic/Latino.	

Question	Branching logic
General Information 3	
What, if any, beliefs do you have that you feel may impact your ability to make healthcare decisions or follow your doctor's instructions ?	If N/A, branch to General 3
Do you have any other Health Insurance coverage?	
If yes, explain	
In general, would you say your health is excellent, very good, good, fair, or poor? On a scale from 1-5, 5 is excellent, 4, Good, 3 is Average 2 is Fair 1- Poor.	
Do you see your Primary Care Physician regularly for check-ups?	
Is the PCP an Amerigroup provider?	
When was your last PCP visit?	
Are you Pregnant?	If yes , go to OB Assessment, (next page final) If male, do not show; if female, show.
CM Program Summary	
Would you like assistance with the management of your health by participating in our intensive care coordination program?	
If no, please explain	
When is a convenient date to call?	
When is a convenient time to call?	
ER Use 1	
How many times have you visited the ER in the last year? (Note: For any answer other than "None" you will be directed to the condition list to enter the related diagnosis after completing this page).	If "None", branch to Inpatient 1
ER Use - Condition List	
Condition List Module	
ER Use 2	
Did you try to call your PCP/regular doctor/Nurse Helpline before you went to the ER?	
Did you call your PCP/regular doctor after you went to the ER to update them that you went to the ER?	
ER Use 3	
For your visit(s) why did you use the ER?	
If other, please explain	
What instructions were you given or what happened after you left the ER?	
If other, please explain	
Inpatient 1	
How many times have you been IP in the last year? (Note: For any answer other than "None" you will be directed to the condition list to enter the related diagnosis after completing this page).	If none, branch to health history If none and the focus area is DM, branch to BMI
Inpatient- Conditions List	
Condition List Module	Link to condition list

Question	Branching logic
Inpatient 2	
Date of your last IP admission?	
What was the reason for your admission?	
If other, please explain	
How much time between admissions? (CM note the number of weeks)	
Was the diagnosis the same?	
Health History	
I'm going to run through a list of conditions with you and you can tell me if you've had any of these conditions?	
What is the date of onset of each condition?	
Are there any other conditions that have not been mentioned?	
If yes, explain	
What is the date of onset of each condition?	
CM: If the member has Allergies, would you like to be brought to the Allergy List?	If yes, branch to Allergy (Module)
Allergy	
Allergy List Module	
Medication 1	
Do you take prescription or OTC meds? (Note: If yes you will be directed to the Medication List after completing this page).	If yes, branch to Medication List If yes, and the focus area is DM, branch to DM Medications
Medication List	
Medication List Module	Branch to Medication List
Medication 2	
Have you been able to take your medication(s) as directed?	
Any difficulties getting RX filled?	
If yes, please explain	
Are side effects keeping you from taking your Rx?	
If yes, please explain	
Has your medication been checked for potential OTC/Prescription Interactions?	
Healthcare Provider Utilization	
Have you seen a dentist?	
If yes to dentist, when was your last visit?	
(For CM response only. Do not ask member this question). Has member been to the dentist within the past year?	
Are you seeing any other Healthcare Providers other than your PCP?	
Diabetes Content	
CM: If the member has Diabetes, ask the following questions:	
Have you seen an Ophthalmologist (Eye Specialist)?	
If yes, when was your last visit?	
Have you seen a Podiatrist?	
If yes, when was your last visit?	
Other Healthcare Providers Address Book Content	
CM: If the member answered Yes to any other Healthcare Provider, you will be directed to the Address Book to review or update other Health Care Providers?	
Other Health Care Providers- Address Book	
Address Book Module	Link to Address Book

Question	Branching logic
Cognitive	
Does the member show signs of cognitive impairment?	
If so, please explain	
What is today's date?	
(Directions to CM: say all three words below at once and ask to repeat) I would like to test your memory. Please say these words: Pencil, Apple, Table	
If unable to assess, please explain why.	
Mental Health 1	
In the last year have you received treatment for a substance abuse problem?	
Do you use drugs other than the medicines your doctor wants you to take? (Recreational or Illicit)	If answer to this and the previous question are both "No", go to the Mental Health 2 section (skipping the next 2 questions)
Do you drink Alcohol?	
Mental Health 1a	
Have you been told you should cut down on your drinking or drug use in the last 3 months?	
Have you felt guilty or bad about how much you drink or use drugs in the last 3 months?	
Mental Health 2	
In the last year, have you been treated for depression or any other mental health condition?	
During the past month have you been bothered by feeling depressed, down or hopeless every day or most days?	
Have you recently noticed any symptoms such as seeing or hearing things that are not there, your mind playing tricks on you, or other "thinking" problems?	
Have you had periods of feeling excessively tense or anxious or overwhelmed by anxiety in the last 6 months?	
In the past three months have you had thoughts of hurting yourself or anyone else? (CM if answered YES assess immediately for imminent danger)	Show: If Yes, assess immediately for imminent danger
CM: IF MEMBER ANSWERED YES TO ANY OF THE MH QUESTIONS OR IF YOU HAVE CONCERNS ABOUT BH ISSUES, ADMINISTER THE BH GENERAL ADULT OR BH PEDS HRA.	
Smoking/Tobacco	
Current smoker status	
When was the last time the member smoked?	
Special Needs/Functional Status	
Is the member blind or have serious difficulty seeing even when wearing glasses?	
If yes, do vision problems interfere with the ability to carry out normal daily activities?	
If yes, how does the vision problem affect you?	
Does the member have a communication preference? If yes, please explain.	
Do you have hearing problems?	
If yes, please explain.	
Assistance	
Do you need assistance with any of the following activities of daily living?	
If you need assistance with any other daily living activities not listed, please explain	
Does the member have difficulty doing errands alone such as visiting a doctor's office or shopping due to a physical, mental, or emotional condition?	

Question	Branching logic
Do you have family/caregiver to assist you if needed?	
Describe support system and/or need.	
Describe the level of involvement.	
Nutrition	
Do you have any problems with nutrition?	
Any difficulties obtaining food?	
If yes, please explain	
Do you have someone to assist you in your care?	
If yes, please explain	
If yes, describe the level of involvement.	
Are you involved in any program or receiving services that help support your care?	
If yes, please explain	
If no, does the member need community resources?	
If yes, provide list of resources given.	
Fall Risk	
Have you fallen within the last month?	
If no, do you feel you are at risk for falling?	
If yes, please explain.	
DME/Supplies	
Do you have any Durable Medical Equipment (DME) or Supplies in your home?	If yes, branch to DME/Supplies 2
DME/Supplies 2	
Do you have any of the following Durable Medical Equipment (DME) or supplies in your home?	
If DME/Supply is not listed above, please explain	
Has your physician suggested other medical equipment/supplies that you are unable to obtain?	
Home Health Care	
Are you currently receiving Home Nurse/Therapy Visits?	
If you are receiving Home Health Visits/Private Duty Visits not listed, please explain	
Outpatient Professional Services	
What outpatient service are you currently receiving?	
If you are receiving Outpatient Professional Services not listed, please explain	
How are these services meeting your needs?	
Any interruptions or difficulties?	
If yes, please explain	If the focus area is DM, branch to Vital signs
Preventative Health	
Which of the following you've had in the last two years?	
Have you had the flu shot in the last year?	If yes, Go to Vaccination Tracker
Other	If yes, Go to Vaccination Tracker
Preventative Health - Vaccination List	
Vaccination List Module	
Social Issues/Barriers	
Do you have any of the following social concerns?	
If other, please explain	

Question	Branching logic
Do you have a Housing concern?	
Do you have a Safety concern?	
Do you have a Violence/Abuse concern?	
End of Life Planning	
Do you have any of the following in place?	
Does the member have any of the following?	
Member Rights	
Did you know that Amerigroup has a Nurse HelpLine that is available 24 hours a day/7days a week for our members?	
If no, you can contact our Nurse HelpLine at 1-800-xxx-xxxx?	
Did you know that you have the right to “opt-out” of Intensive Medical Coordination programs?	
Member Rights – 2	
For CM only: Information concerning CM Services can be found on our member website www.amerigroupcorp.com . If you have any questions regarding recommendations given to you by the CM Coordination Team, please contact your PCP	
Did you know that as an Amerigroup member you can expect that our medical records and communications will be treated confidentially and will not be released without your permission?	
Did you know that you have the right to have Amerigroup act as a patient advocate?	
You have the right to file a complaint with Amerigroup and be told how to make a complaint. This includes knowing how Amerigroup answers complaints on time. It also includes knowing how quality issues are taken care of.	
If you have any questions or need help understanding or reading information received from Amerigroup please call member services at 1-800-xxx-xxxx.	
Assessments	
Select additional Assessments at this time?	
1- None (default)	
2- Asthma	
3- BH Adult	
4- BH Depression	
5- BH Peds	
6- CAD	
7- CHF	
8- COPD	
9- CVA/Stroke	
10- Diabetes	
11- GERD	
12- HIV	
13- HTN	
14- LBP	
15- Lead Tox	
16- Migraine	
17- MS	
18- Neuro	
19- Obesity	
20- PDN	
21- TBI	

Timeline for Completion of Health Risk Assessments (9.1.2.2)

Question 9.1.2, #2

2. Propose the timeframe in which all comprehensive health risk assessments shall be completed after initial member enrollment.

It is our goal from program launch forward to perform all initial screenings and comprehensive health risk assessments promptly so that we can rapidly engage members in care coordination services when appropriate. Amerigroup will conduct initial screenings within 90 calendar days of the member's enrollment and will complete comprehensive health risk assessments, as applicable, within 30 days of the initial screen. *We know that the sooner we perform an assessment, the sooner the member's unmet needs can be addressed and continuity of care and services can be promoted.* Therefore, we will prioritize the scheduling of comprehensive health risk assessments so that members with the most urgent needs can be assessed as soon as possible after identification. All members will be assessed based on this priority ranking.

To make sure that we complete the comprehensive health risk assessments within the above timeframe, our care management system will generate a list of all members who need to receive one and will flag and send reminders for any approaching due dates. Our Case Managers will initiate a comprehensive health risk assessment for identified members within five business days of receiving the referral, not to exceed two weeks of accepting the member into care coordination. At minimum, our Case Managers will call twice and send out one letter as attempts to contact each member who needs to complete the comprehensive health risk assessment. In some cases, in-person assessments may be required. It may take multiple visits/calls to complete the assessment; however, the entire assessment will be completed within 30 calendar days of the initial screen. If we have not been able to complete the assessment in 30 days (after making and documenting the above efforts), we will close the case and monitor for further needs.

Question 9.1.2, #3

3. Describe how the assessment process will incorporate contact with the member and his/her family, caregivers or representative, healthcare providers and claims history.

Comprehensive Health Risk Assessment Process

As stated in Section 9.1.2, the comprehensive health risk assessment process includes multiple inputs with focus on the following:

Review of the Member's Claims History

Review of the member's relevant history through claims analysis is a core part of our standard approach to comprehensive assessment. Claims and encounter data are a valuable source of information about a member's health care utilization, and lack of claims can indicate gaps in care. As a part of the comprehensive health risk assessment, our Case Managers review the member's relevant history, including utilization, encounters, and pharmacy history. If the State of Iowa provides Amerigroup with two years of claims history for members enrolled in our program, we will incorporate this data into our health risk assessment process as of day one.

Contact with the Member and His/Her Family, Caregivers, or Representative

We conduct comprehensive health risk assessments either over the phone or in person, as requested by the member. Face-to-face assessments will be conducted in the setting of the member's choice. We will conduct the assessments in the member's primary spoken language, using a qualified interpreter when

needed. If necessary, the assessment can be completed across more than one contact for members who tire easily or need additional time. With appropriate authorization from the member, we will invite relevant family members, guardian, caregivers, and/or significant others to participate in the assessment. Through a discussion with the member, caregivers, and significant others, we will identify health- or social-related needs and goals that are important to the individual and any potential barriers to those goals.

Contact with the Member's Health Care Providers

Amerigroup Case Managers will contact the PCP and other relevant treating providers or professionals for input on the member's history, current health care needs, and plan of treatment when completing the comprehensive health risk assessment. As applicable, we will inform the member of who is being contacted to obtain information.

Our Case Managers also consult on complex situations or diagnoses during integrated rounds with our clinical staff, which includes our Chief Medical Officer, nursing staff, Behavioral Health Medical Director and behavioral health clinicians.

Care Coordination (9.1.3)

Question 9.1.3, #1

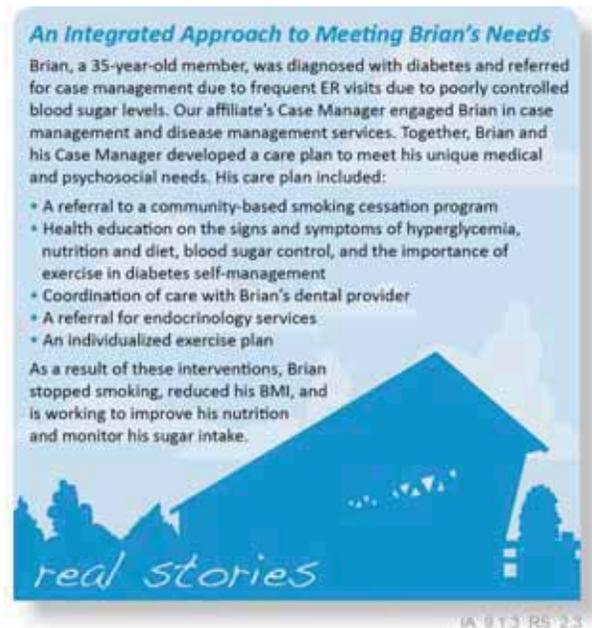
1. Describe in detail your proposed care coordination program including selection criteria and proposed strategies.

Overview of Care Coordination

Amerigroup will bring to Iowa our member-centric, integrated care coordination program developed over 24 years to monitor and coordinate the care for our members with special health needs across all Medicaid populations. We do not subcontract any key part of our care coordination model, giving us superior consistency and quality control and enabling a seamless member experience. The physical health, behavioral health, LTSS, and pharmacy needs of our members are managed by a consistent, assigned team, using a consistent process, in a fully integrated manner.

Our established processes, robust systems, and experienced people support early and effective identification of members with special health needs and members with new, unmet, or undiagnosed needs, including the following:

- Members who have identified physical or behavioral needs
- Members with recent inpatient admissions, including physical and behavioral health facilities
- Frequent users of emergency room (ER) services
- Reproductive-aged women who are expecting or recently delivered a child with a poor birth outcome
- Children with multiple gaps in care or not participating in such services as EPSDT visits, annual well checks, dental care, and early intervention screening



- Members with existing or potential chronic care or disease management needs
- High or concerning utilizers of pharmaceuticals, such as two or more prescriptions in one drug classification

Using retrospective two-year claims data from the State, Amerigroup will quickly and effectively be able to identify members new to our plan who may have initial or ongoing high-risk, complex, chronic, or co-occurring needs and those members who may need additional support or referral during and after the transition. We will review provider types, procedure codes, dates of service, and other indicators to identify existing care coordination support needs among our members.

Each member is stratified based on his or her level of risk for adverse outcomes. This allows us to identify members with complex and specialized health needs and conduct outreach to provide them with the services and supports they need for positive health outcomes.

Our comprehensive care coordination program will include the following components:

- Catastrophic/complex case management
- Disease management
- Programs to target members overusing and/or abusing services
- Discharge planning
- Transition planning
- Care coordination for populations with specialized needs
- Health promotion

Catastrophic/Complex Case Management

Amerigroup’s most intensive level of support is our catastrophic case management program (which we refer to as complex case management), a fully integrated physical health, behavioral health, and LTSS model designed to address each member’s health care and social support needs.

Amerigroup uses local and national expertise, specialized programs, and innovative technology to give our members voice and choice in receiving the care needed to support their health, wellness, and quality of life goals. Our case management model is person-centered and helps members optimize their use of benefits to get high quality health care across settings. It emphasizes coordinating health care services, supports, and resources that address all members’ needs, incorporating health promotion and preventive care services, coordinating care among treating providers, and integrating social supports that reinforce positive health and quality of life outcomes.



COMPLEX Case Management

- Identification**
Members are identified for enrollment into case management from data analysis, risk stratification, or referral. The Continuous Case Finding process reevaluates our entire membership monthly helping to ensure members receive the appropriate level of case management support.
- Enrollment**
Members are enrolled into complex case management (longer term) or stabilization case management (short term).
- Assessment**
Case Manager (CM) completes a comprehensive health risk assessment with member and his or her family.
- Care Plan Development**
CM develops an individualized, member-centric care plan with the member, family, and PCP.
- Care Plan Implementation**
CM implements the care plan, providing health education and coordinating physical health, mental health, substance abuse, and social support needs with providers, community-based organizations, and agencies.
- Care Plan Assessment/Reassessment**
CM periodically assesses member’s progress, revises goals, and modifies level of support up or down as needs change.
- Care Plan Completion**
CM, member, and his or her family determine support needs are met. Member transitions to a lower level of support such as disease management or health promotion.

Our complex case management model includes the following seven core components as detailed below:

1. Identification
2. Enrollment
3. Assessment
4. Care plan development
5. Care plan implementation
6. Care plan assessment/reassessment
7. Care plan completion

Identification

Proactive identification of individuals in need of complex case management is critical to improving the health outcomes of Iowa Medicaid members. We identify members for enrollment in complex case management through data-driven risk stratification and manual referrals.

Amerigroup's evidence-based predictive modeling tools enable us to stratify all members appropriately based on their level of risk for adverse outcomes. Our tools consider a member's chronic illnesses, likelihood of inpatient admission including the risk of first time admission for a mental health or substance abuse condition within two months, and risk for future emergency room use. Each member is assigned a risk score that correlates to a projected level of care coordination support. Members stratified into the highest risk group are assigned to complex case management. We continually evaluate our entire membership's risk level by mining updated data and claims monthly and applying our predictive modeling tools.

In addition to prospectively identifying members for enrollment into care coordination, a variety of sources or individuals may refer members to one of our programs when they identify a need during contact with a member or based on review of a member's electronic health records. These referral sources include but are not limited to providers, Case Managers, family/caregivers, and the members themselves.

Enrollment

Each member enrolled in complex case management is assigned a single Case Manager best qualified to meet the member's needs.

- Members with clinically manageable conditions, such as asthma, cardiovascular or pulmonary disease, diabetes, or metabolic disorders, are assigned to a physical health (nurse) Case Manager
- Members with serious mental health conditions, such as schizophrenia, bipolar disorder, recurrent major depression, and substance use disorders, are assigned to mental health and substance abuse Case Managers, who address members' co-morbid mental health and substance abuse issues
- At-risk pregnant members are assigned to a maternal and child health Case Manager who addresses the full range of the member's needs

Following assignment, the Case Manager contacts the member to complete a comprehensive assessment.

Assessment

The assigned Case Manager contacts each member to confirm interest in complex case management services and to help ensure active participation and the greatest benefit from case management services. Members who decline case management may be reengaged when they experience a change in health care status such as an inpatient admission.

Once the member agrees to engage complex case management, the Case Manager assesses the member's clinical and social support needs, identifies gaps in care or potential barriers to success, and initiates member-centric care planning.

The Case Manager uses our comprehensive HRA tool to conduct an in-depth clinical assessment in which he or she gathers information about the member's health status and needs across physical, behavioral, social, functional, and psychological health. The assessment uses branching logic to probe into more than

20 potential clinical areas for risk factors and include specialized assessments for specific conditions, such as behavioral health or maternal health.

Care Plan Development

Case Managers develop an individualized, person-centered care plan that incorporates the interventions necessary to improve the member's health status across all conditions and reflecting each individual's goals and preferences. Amerigroup's care management platform includes templates for complex case management care plans with evidence-based interventions for specific diagnoses, such as bipolar disorder, diabetes, or substance abuse, and specific needs such as nutritional management. The care plan helps engage the member, family, PCP, treating providers, and, as appropriate, other agencies and programs providing services to the member by:

- Identifying and prioritizing member biopsychosocial needs and the strengths that will support achievement of health goals and objectives
- Developing achievable, measurable, short- and long-term goals and objectives with members
- Engaging families, caregivers, and natural supports for planning and member support
- Identifying specialty or other providers that are aligned with the member's condition and needs
- Linking members to community-based supports and resources
- Using clinical practice guidelines (CPGs) that support member adherence to prescribed medications and monitor provider prescribing practices
- Emphasizing personal responsibility, healthy lifestyle choices, and routine preventive care



For members new to Amerigroup who were receiving complex case management services at the time of transition to our health plan, our Case Managers will facilitate a seamless transition. Our Case Managers will review the previous care plan, arrange continuity for all medically necessary and preventive and specialized care and services, identify any gaps in care, and arrange services to close the care gaps.

Care Plan Implementation

The member's PCP and other treating providers are an integral part of the interdisciplinary team. The PCP plays a key role in overseeing the member's primary care needs, including receipt of preventive care and coordination of specialty services. The PCP and other treating providers are engaged by the member's Case Manager, who coordinates the member's care plan with treatment plans to provide holistic management. Providers may also participate in our complex case rounds by teleconference, facilitating coordination of the member's care and treatment plans.

Providers also may access information to support coordination of care and services through the provider facing Member 360 application. Member 360 combines data and information from various sources into a single record comprising a holistic picture of the member's utilization, care coordination services, and gaps in care. Providers who have members attributed to them can see their records through the Amerigroup secure provider portal, giving them simple, easy-to-access data and information to assist them in engaging members in their health and well-being.

The integrated data are displayed, making it easier for providers to act and verify that their patients are getting the services they need. This view enables any provider treating our members to see the full picture, including care plans and assessment information.

Our Case Managers work closely with members, their family, PCPs, and other providers, including noncovered services providers, schools, social service agencies, and community-based organizations, to deliver services that support the outcomes identified in the member's care plan. Because we hire our Case Managers from the local community, they are experts on community resources and the local provider network. Our mental health and substance abuse Case Managers are experienced working with members who may be involved with multiple agencies or who have co-occurring mental health, substance abuse, and physical health conditions that make it challenging for them to navigate the system.

Additionally, Amerigroup will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can help support our Iowa members in directing a meaningful plan with their desired health and quality-of-life outcomes.

Care Plan Assessment/Reassessment

A care plan is a dynamic roadmap that changes as members' needs progress or evolve. Case Managers regularly monitor member progress at a frequency indicated by the member's risk level and work with the member and his or her family/caregivers to evaluate the member's progress and identify solutions to overcome barriers that may stall progress. Case Managers also work closely with the member's PCP and other providers as necessary to assess the member's progress and needs in order to properly adjust the care plan to meet the member's health goals.

Amerigroup conducts complex case rounds at least once per week: our Chief Medical Officer, Mental Health Director, and Substance Abuse Medical Director lead a team of nurses, mental health and substance abuse clinicians, social workers, a nutritionist, pharmacist, and other Medical Directors to strategize on how to meet the holistic needs of members with complex co-morbid needs. The team collaboratively shares information and jointly recommends changes in care plans to best serve members as they move toward achieving their goals.

For members readmitted to an inpatient setting for a physical health, mental health, or substance abuse condition, we review their previous discharge plan, the factors that led to the readmission, and any unmet needs that must be addressed for the member to successfully transition the member back to the community.

Care Plan Completion

Through the process of continual assessment and reassessment of a member's health status during the case management process, if our Case Managers determine with the member and his or her family/caregivers that the member's goals for complex case management have been met and the member's condition has improved sufficiently, members will be transitioned to either a lower level of care coordination (such as disease management) or will be removed from active case management and put on continued surveillance and health promotion.

The primary goal of our case management model is to provide members with needed support during difficult times in their lives, while providing them with the necessary education and tools for them to take ownership and responsibility for their own health care. We realize achieving this goal is different for every member and is based on his/her condition, symptomatology, engagement, progress, literacy, and support system. Therefore, Amerigroup has written processes, policies, and procedures for closing case

management services and is careful to only terminate these services under acceptable circumstances, especially for members with specialized health care needs. These circumstances include:

- Upon agreement between the member and Case Manager when the member achieves goals identified in the care plan and is stabilized through access to primary care, home and community-based services and supports, as well a natural support involvement
- When the member no longer participates in case management activities or communicates with the assigned Case Manager
- When the member is no longer enrolled with the health plan

Prior to closure, Amerigroup's behavioral and medical clinical leadership will review cases considered for case management termination during weekly integrated clinical rounds with the assigned Case Manager. They will identify the reason for closure and any potential opportunities for a member in need to continue in case management. Upon approval, the assigned Case Manager will enter case management closure in CareCompass and send written notification to PCPs.

Disease Management

We have established processes, policies, and procedures based on 24 years of experience serving members with chronic illnesses who receive their health care from government-sponsored programs across the nation. The key feature of Amerigroup's Chronic Care/Disease Management program is our member-centered focus and approach. ***We support member behavioral, social, and physical health care needs by providing individualized services by screening, assessing, and developing tailored member interventions while working collaboratively with the member, family, guardians, caregivers, providers, and others involved in the member's care.***

Amerigroup offers twelve Chronic Care/Disease Management programs for our members, including eight programs with NCQA accreditation.

NCQA accredited programs:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV/AIDS
- Major Depressive Disorder
- Schizophrenia

Additional Chronic Care/Disease Management programs

- Bipolar Disorder
- Hypertension
- Substance Use Disorder
- Weight management services

We realize our members often must make significant changes to their lifestyles and daily living behaviors to achieve sustainable progress in health outcomes related to chronic conditions. Delivering health education has limited impact unless it is framed by members' readiness to make those changes and addresses their individual ambivalence about adopting new behaviors. Amerigroup achieves positive outcomes by encouraging member education and self-care through motivational interviewing, collaboration, and coordination of health care services and supports through our providers and by providing interventions within a holistic care coordination model.

Disease Management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with or at risk for chronic medical conditions and identifies the gaps, incidence, and prevalence of these conditions within the populations. Disease Management programs are selected based on analysis to identify high volume conditions in which there is a potential to improve member self-management.

As detailed below, each of our Disease Management programs include the following seven core components:

1. Population identification processes
2. Chronic disease care gaps identification
3. Evidence-based practice guidelines
4. Collaborative practice models to include both the member’s primary health care practitioner and other members of the health care team
5. Member self-management education
6. Process and outcomes measurement, evaluation, and management
7. Routine reporting and feedback loops

Population Identification Processes

Under the direction of our Chief Medical Officer, we conduct frequent and ongoing prospecting activities to identify conditions that are chronic in nature, usually lasting three months or more, that are impacted by health-damaging behaviors, such as tobacco use, lack of physical activity, poor hygiene, and poor eating habits. We review and analyze available data, including any claims data provided by the State; daily census reports; open authorizations; member demographics, including diagnoses; behavioral health, pharmacy, and dental utilization reports; notification of pregnancy for members with prior poor birth outcomes; and case management enrollment.



Disease Management

- Identification**
Members are identified for enrollment into disease management from data analysis, risk stratification, or referral. The Continuous Case Finding process reevaluates our entire membership monthly helping to ensure members receive the appropriate level of disease management support.
- Gaps in Care**
Gaps in care are identified through case manager evaluations, claims history, data analysis, predictive modelling, screening and assessment results, and referrals.
- Evidence-based Practice Guidelines**
Our disease management efforts are based on nationally recognized standards and are continually reviewed to ensure quality.
- Collaborative Practice Models**
Our disease management models include working with PCPs and other providers.
- Member Self-Management Education**
Our disease management program fosters member education on how best to self-manage chronic conditions, address gaps in care, work with disease managers and providers, and achieve health goals.
- Measurement and Evaluation**
We measure and assess the quality of our disease management program, and identify and implement steps to improve.
- Reporting and Feedback Loops**
Disease managers assess members’ progress, revise goals, and modify levels of support up or down as needs change.

Chronic Disease Care Gaps Identification

Amerigroup has a variety of means to identify and continually assess members who may have chronic disease care gaps, including:

- Clinical expertise of Case Managers who develop relationships with our members and their families or caregivers
- Claims history
- Data analyses that identify risk indicators, such as under- or over-utilization of medications, frequent emergency room visits, and recent inpatient admissions
- Predictive modeling and risk stratification results
- Screening and health risk assessment results
- Real time referrals from providers, community partners, and others who have ongoing “eyes and ears” on our members on a daily basis

We recognize that our members' needs may frequently fluctuate across the spectrum of services and supports needed to prevent deterioration of their functioning, manage difficult or painful symptoms, and preserve their emotional and physical well-being. Our Case Managers continually monitor members through telephonic or in-person contacts and are trained to adjust the level of intervention as required by the member's physical and behavioral health status.

Evidence-based Practice Guidelines

Amerigroup has adopted standardized definitions to clearly define our disease management program that draw upon industry standards, guidelines, and regulatory requirements. Our disease management program content is based on current evidence-based guidelines referred to as clinical practice guidelines (CPGs). These CPGs are systematically-developed, evidence-based tools that help practitioners make decisions about appropriate health care for specific clinical circumstances.

The guideline adoption process begins when the proposed guideline is reviewed by a minimum of two board-certified practitioners in the related specialty. They are asked to review, comment, and offer recommendations for adoption or rejection of the guideline. Nationally endorsed clinical guidelines may not be available for every condition managed. In these situations, guidelines may be developed. A minimum of two board-certified practitioners from appropriate specialties will be involved in the development of the guidelines.

Guidelines are reviewed every two years. Guidelines are reviewed sooner than the next scheduled two-year review if national guidelines have changed or substantively new scientific evidence is published in the interim. The Clinical Practice Guideline Review Team (CPGRT) reviews monthly updates from the National Guideline Clearinghouse to identify changes to national guidelines and substantive changes to the scientific evidence.

In addition, systematic review of new scientific evidence occurs annually for all disease management CPGs. The CPGRT conducts a literature search to determine if there have been any relevant substantive scientific advances in treating the medical condition the clinical practice guideline addresses. At least two board-certified practitioners from appropriate specialties are involved in the review of the literature relevant to each CPG. If new scientific evidence warrants adopting a new guideline from a recognized source or changing an internally developed guideline based on the clinical judgment of the reviewers, the process described above is followed.

All staff training materials and program content, whether directed toward members or practitioners, is developed in accordance with adopted guidelines, the professional clinical and technical literature, governmental research sources, and the recommendations of professional societies and relevant foundations. Amerigroup provides copies of approved guidelines, as well as guideline updates to

practitioners as changes occur. With respect to our members enrolled in disease management, Amerigroup provides practitioners information about their performance relative to established benchmarks, guidelines, and/or disease-specific standards of care.

Collaborative Practice Models which Include the PCP and Other Providers

Across markets, Amerigroup maintains a close working relationship with our provider partners. We leverage this relationship to inform providers about the benefits of our program, available education, services, and materials, reciprocal sharing of information requirements, and how they can access chronic condition information to improve member care. Moreover, we establish that our care team is available to support and collaborate with providers (and their office staff) to ensure that the care coordination and support needs of our members are identified and addressed. Rather than working redundantly or in conflict with providers' efforts, the Amerigroup care team works to complement and support the providers in addressing the needs of our members.

Our clinical staff facilitates the information sharing process by ongoing collaboration with the member's health care team to assure services are synchronized, unduplicated, and consistently delivered for every individual. The member's health care team may consist of various types of providers, including PCPs, medical and behavioral health specialists, and social workers. Examples of reciprocal sharing of information can include diabetic information that goes to both the cardiac specialist who will educate the member on diabetes and heart health and the behavioral health provider for behavioral modification.

We educate our providers on reciprocal sharing of information, as well as other important components of our program during our initial, ongoing, ad hoc, and annual training. Information includes:

- Provider rights
- Services provided by Chronic Care/Disease Management programs, including how Amerigroup works with members in those programs
- How to enroll a member in the program and use its services
- Provider access to provider facing Member 360 tools
- Reciprocal referral and sharing of information policies and procedures
- Disease manager contact information, including phone number, address, and email
- How to provide feedback or communicate complaints
- How Case Managers furnish feedback to providers about their members

Member Self-Management Education

Chronic illnesses and conditions are among the most common, preventable, and costly of all health care issues. These chronic illnesses include diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease. We understand there are primary risk behaviors that can cause or exacerbate chronic illnesses, such as poor nutrition, lack of physical activity, and substance use, as well as the social and environmental barriers that can compromise member adherence to the care plan or medication regimen. Adding to the complexity, the rate of comorbid physical and behavioral conditions among populations, such as children with specialized health care needs and adults, seniors and members with physical and behavioral disabilities, requires an approach that considers the whole individual, not just a diagnosis.

We have adopted a holistic chronic care/disease management approach that promotes member engagement in the interventions most appropriate for their conditions. Rather than simply educating members about a single condition, such as diabetes, our disease managers educate them on and coordinate the care for many of their needs – physical, behavioral health, and social support. As described below, our disease managers, guided by our evidence-based CPGs, are skilled at understanding and coordinating care across diagnoses.

In our experience, members achieve positive outcomes when we take a hands-on approach to assessing their awareness and understanding of their condition(s), helping them obtain their personal goals, and identifying any gaps in care, knowledge, or access. Then, in collaboration with each member, family, and treating providers, we develop an integrated care plan that is a road map to improving the member’s health, well-being, and quality of life.

Amerigroup is committed to understanding and addressing the challenges our members face that compromise their ability to take charge of their health status to improve outcomes. For many of them, this requires more than one approach. We help our members select the best providers to treat their conditions and have the tools they need to monitor their health – peak flow meters for asthma, blood glucose meters for diabetes, weight scales for congestive heart failure, or blood pressure cuffs for hypertension. We also assess whether their environment is conducive to care plan adherence.

Member Education

Members have 24/7 access to chronic care/disease management educational materials through our web-based member portal, as well as written materials sent directly to the member for easy reference. Our educational materials include easy-to-understand information that is aligned with the member’s diagnoses and the symptoms the member is likely to experience. We have materials that address chronic condition-specific information, such as symptoms, types of treatment, and self-management tools. For example, our written materials include booklets on “Facts about Alcohol,” including information on Alcoholics Anonymous or Alanon community meetings and common reactions to being diagnosed with a chronic condition.

We also make information available for members and families dealing with end-of-life issues. This information covers advance directives, hospice, and respite care. Other educational materials that address behavioral change and that we make available to all members in our program include: “Making a Change – How to Start,” “Making a Change – Making it Last,” and “Making a Change – My Action Plan.”

Further, we also send out invitations to community events, promoting events where we can share with our members different types of health information such as immunizations, prenatal/postpartum care, health lifestyles, childhood lead, and how to talk to your PCP.

Process and Outcomes Measurement, Evaluation, and Management

Amerigroup establishes measurable benchmarks for disease management that promote credibility and consistency in educating our network providers about the care they deliver. We focus on those benchmarks with the most significant impact across all our members. To assess provider effectiveness meeting quality targets, we typically select performance metrics based on the emergency room HEDIS Data Sharing scorecard report:

- **Widest impact for our members** – We selected a mix of adult and child measures, as well as those that reflect the greatest disease prevalence in our covered Medicaid populations, to focus on those that affect the greatest number of our members



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- **Historically low-performing results** – We included measures with the greatest potential for improvement within our health plan, promoting our own accountability in positively impacting our under-performing quality metrics
- **Ease of reporting** – We selected measures we can report using administrative data only, enabling us to deliver periodic, consistent data to providers without the burden of ongoing record reviews.

Our Quality Management leadership evaluates our performance measures periodically to assess their continued significance.

Through our comprehensive Chronic Care/Disease Management programs, we identify, educate, and coach members with chronic conditions to take greater responsibility for their health, wellness, and quality of life. We empower them to adopt improved self-management skills – thereby improving participation in primary and preventive care, enhancing health outcomes, and reducing preventable emergency room visits or inpatient admissions.

Annual Disease Management Program Assessments

We evaluate our disease management program annually. Assessments verify compliance with internal policies and procedures and are used for retraining and continuous quality improvement initiatives (CQI).

Assessment results are compiled from but are not limited to the following sources:

- Process and outcome measures
- Clinical outcomes
- Health services utilization outcomes
- Member self-reported adherence to treatment plan
- Staff performance appraisals
- Staff productivity measures

At least two clinical measures are monitored annually for each Disease Management program. Each measure utilized will:

- Capture a relevant process or outcome
- Be population-based
- Be measured with quantitative methodologies
- Have a benchmark or performance goal
- Have data and methodology that are valid for the process or outcome measured
- Have results analyzed in comparison with the benchmark or goal

We will target at least four clinical quality measures for improvement, implement interventions to improve performance for each measure, and measure the effectiveness of interventions to improve each measure. Significant or meaningful improvement will be demonstrated, and meaningful improvements will be documented through the Quality Improvement Activity (QIA) form.

Clinical measures reported will include:

- Definition of the population included in the denominator for each measure
- Description of how individuals are placed in the numerator for each measure
- Description of the time period each measure covered and how it impacts inclusions and exclusions in the numerator and denominator

Routine Reporting and Feedback Loops

Upon the member's enrollment in case or chronic care/disease management, Amerigroup captures the members' information in a secure, centralized care management system to support timely access to the most appropriate services for the member's conditions and prevent duplication.

Through the provider facing Member 360 tools, providers who have members attributed to them can see the member record via the Amerigroup provider portal, giving them simple, easy-to-access data and

information to assist them in engaging the member in his or her health and well-being. The integrated data will be displayed to make it easy for the provider to act on it and make sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care.

We also send the provider a letter of introduction explaining the individual's participation, provider responsibility in the care planning process, the CPG associated with the member's condition, and a copy of the care plan.

We engage all treating providers in the case management planning process - soliciting feedback and sharing of information throughout the member's care planning and case management. In addition, we communicate with all treating providers as appropriate throughout the process to:

- Provide regular status updates to the provider regarding the member's stratification level, changes in health status, and contact frequency
- Assist with scheduling appointments or arranging transportation
- Address provider questions about the member's care
- Monitor the member's engagement in services and supports
- Share provider collaboration and communication details
- Reinforce evidence-based CPGs

Contacts are primarily telephonic, but we also regularly deliver updated case management plans by mail or fax to the provider.

Programs to Target Members Overusing and/or Abusing Services ***Data Mining to Identify High Utilizers***

Amerigroup seeks to identify members with the potential for inappropriate utilization of services and quickly intervene, providing the member with support and connection to preventive care. We proactively mine utilization data using the Chronic Illness Intensity Index (CI3), our predictive model, to identify members with high rates of utilization. We also continually analyze emergency room (ER) utilization patterns to understand which members are most likely to have avoidable ER visits. Within our suite of predictive models, our TRIAGE tool synthesizes member data (such as diagnoses, claims history, and authorizations) and assigns a risk score to indicate the likelihood of ER visits for Ambulatory Care Sensitive Conditions.

We further assess member utilization through our Member 360 tool. Member 360 combines member data and information from various sources into a single record to provide a holistic picture of the member's utilization, care coordination, and gaps in care. Member 360 includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data. This gives our Case Managers a whole picture of the member's needs and the services they receive, allowing us to target intervention with the members and their providers to promote appropriate service utilization.

We produce performance reports to identify members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans. Practice and utilization data elements included in the analysis are:

- Re-admissions
- Pharmaceuticals (drug-seeking behaviors or patterns)
- Specialty referrals
- Emergency room utilization
- Home Health and Durable Medical Equipment (DME)
- Utilization relative to diagnostic entity

Outreach to High Utilizers

When a member’s utilization pattern shows that outreach and education are warranted, our Nurse Medical Management clinical team will collaborate with the Chief Medical Officer to determine appropriate member interventions, to include outbound telephone calls to educate members about appropriate use of services, the importance of preventive care, or the need to refer to care coordination.

Pharmacy Lock-In

Amerigroup is able to restrict members to a particular pharmacy when it has been determined that the member may benefit from coordinating prescription care or that the member has inappropriately utilized Amerigroup pharmacy services. Amerigroup’s Pharmacy Restriction process limits members to a single pharmacy to obtain their medications. The need for restriction is determined as a result of medication claims review and is implemented only in those health plans that have a state-approved program. Using pre-defined queries, the Pharmacy Department identifies members that meet the criteria for lock-in. Members identified with uncoordinated care, excessive utilization, or suspected patterns of fraud and abuse may also be referred to the Pharmacy Department from a specific health plan or providers.

Members identified with uncoordinated care, excessive utilization, or suspected patterns of fraud and abuse may also be referred to the Pharmacy Department from a specific health plan or providers.

Medicaid Special Investigations Unit (MSIU)

Amerigroup will deploy a team of highly trained and experienced individuals to manage our fraud, waste, and abuse program both at the national and local plan level. Our teams comprise former law enforcement offices, former Medicaid regulators (federal and state level), and a wide variety of other experienced healthcare investigators. This wide ranging and diverse set of expertise has allowed us to implement a best in class approach to detecting and reducing Medicaid fraud and positions us to be fully compliant with all required activities. The Medicaid SIU is an internal proprietary function, fully dedicated to the detection, prevention, and prosecution of fraud and abuse in Amerigroup and its affiliate health plans’ state-sponsored program business.

Abuse of Ambulance Services
Using data analytics our TX affiliated health plan identified a significant number of Basic Life Support ambulance services with no corresponding medical service claims. A review of transportation logs from a sample of ambulance providers identified common behavioral health provider destinations. During surveillance, SIU investigators observed a number of questionable practices; up to five members being transported in the same ambulance per ride; transportation provided in van then billed as ambulance services; and members being transported in an unsafe manner.

How Detected—*Referral from health plan, advanced data analytics and member interviews.*

Actions Taken—*A total of forty four investigations were initiated and eleven ambulance providers and six behavioral health providers were terminated from the network. To date, 40 ambulance providers and six behavioral health providers have been referred to the state for credible allegations of fraud. This investigation is ongoing. Overpayment of approximately \$12 million has been identified and approximately \$12.3 million in inappropriate expenditures were avoided. We also contacted Adult Protective Services.*

Appropriate training is key to avoiding fraud, waste, and abuse. We educate our employees, providers, and members on signs of fraud and abuse and how to report suspected cases. Additionally, the SIU publishes monthly tips, available on our website and in provider publications, on how to identify and report fraud, waste, and abuse. We use these same mechanisms to widely publicize our disciplinary guidelines and how we enforce standards.

In addition to corporate compliance training, Program Integrity employees are annually required to receive 40 hours of specialized fraud, waste, and abuse training through professional organizations, including the National Health Care Association, Association of Certified Fraud Examiners, American Academy of Professional Coders, and the National Health Care Anti-fraud Association (NHCAA).

Amerigroup Provider Relations Department employees provide fraud and abuse education to providers during orientation and in-service trainings and through the Provider Manual, e-mail alerts, newsletters, and our provider website. We advise providers and subcontractors of the consequences, including provider termination, of participating and/or contributing to fraud, waste, and abuse via our contractual agreements. We include fraud, waste, and abuse information in the Provider Manual and review it during provider orientation. We periodically include fraud, waste, and abuse training during in-person provider forums and webinar training sessions held during morning and afternoon sessions to allow flexibility to providers to attend based on their schedules. These have proven to be a convenient and economical way to keep providers informed. We also use blast fax communications to update providers on important fraud, waste and abuse issues. The Provider Manual, quick reference cards, and blast faxes are always available to providers on our website.

See Section 12.3 for more detail on fraud and abuse activities.

Discharge Planning

The goal of our discharge planning process is to engage members in services, supports, and resources that minimize the risk of member readmission. In order to accomplish that goal, we have processes in place to coordinate service planning and delivery with the member, family members, guardian/caregivers, providers including the home health agencies, and health plan employees.

Amerigroup developed a transition of care program in alignment with the nationally recognized Coleman model that outlines best practices for care transitions as shown in Figure 9.1-5. The transition of care program facilitates member access to outpatient services by connecting them with these services prior to

Figure 9.1-5. Transitional Care Program



9.4.3_D08_3.0

their discharge. Our care coordination approach integrates the transition of care model, working in collaboration with clinicians located on-site at specified hospitals or providing this level of service directly through the care coordination team. By facilitating outpatient follow-up services, we have reduced admission rates while ER rates have remained flat, evidence that we are facilitating access to the right care in the right place and at the right time. The tenets of this intervention include:

- **Pre-Transition Visits.** Prior to discharge, we will contact the member at least once to discuss discharge planning and assess the risk of re-admission.
- **Follow-up Care.** We verify that follow-up appointments for all services, including home care, after-treatment, and therapy, are scheduled prior to or at the time of discharge. They also verify that the member attends these appointments, including making sure they have a follow-up appointment with their PCP or mental health provider within seven calendar days of discharge. If home health services will be provided, the visits will be initiated within seven calendar days of discharge. The Coach will provide all necessary support, such as arranging for transportation when necessary to make sure the member keeps his or her appointments.
- **Post-discharge Check-In.** Within 48 hours from discharge, we or the PCP will follow up to confirm that all services are appropriate, evaluate care coordination activities, and confirm that the discharge plan is being followed. A second home contact will occur approximately seven to ten days following discharge.
- **Medication Reconciliation.** Members are often discharged without medications that were prescribed to them before their admission. To address this gap, we obtain the hospital discharge medication list from the hospital nurse, hospital discharge planner, or the member and compare prescriptions to the list of medications previously prescribed. We resolve any discrepancies by reviewing discharge medications with the outpatient provider.
- **“Red Flag” Education.** The care coordination team creates a potential problem list, or list of red flags, and educates members and caregivers about condition changes that might require a call to their PCP so that the PCP can address any potential complications.
- **Disease-specific Interventions.** The care coordination team works with members and caregivers to build their knowledge about their specific condition(s) and to boost their ability to take care of themselves, empowering individuals to take charge of their health and promoting optimal recovery. For example, coaching may be complemented by information found in our online health library, Health A to Z. Members may also be enrolled in one of our NCQA-accredited disease management programs.
- **Discharge Plan Reminders.** Within three working days, we will contact the member by telephone to remind him or her of upcoming appointments and to offer assistance if barriers arise to following through with the plan. This is particularly important with regard to well-care appointments that are scheduled for the member. If they have not had a regular checkup with their PCP or other preventive care services, we will facilitate the scheduling and enabling member attendance at these appointments.

Amerigroup understands the unique challenges members can face when transitioning back home from a hospital stay. To help make this transition as smooth as possible, we will provide a post discharge kit and free home-delivered meals to eligible members and their families as Value-Added Services. The discharge kit provides tools for family members and caregivers to successfully help transition members from hospital to home, aid in recovery, and help decrease the chances for readmission. The meal program provides nutritious home-delivered meals, which allows members to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare them.

Co-located Medical Managers Collaborate with Hospital Discharge Planners

We have learned that the most efficient and effective way to coordinate discharge planning for our members is to co-locate Nurse Medical Management clinicians within hospitals. This allows us to begin discharge planning with the member, the hospital staff, and their PCP on the day of admission. With appropriate permission from our hospital partners, we intend to co-locate Nurse Medical Management clinicians in Iowa in hospitals with high volumes of discharges.

By working side-by-side with hospital staff and discharge planners, our Nurse Medical Management clinicians have direct knowledge of the treatment provided in the hospital, direct access to the medical team serving the member, and near real-time information from the medical record. Additionally, our staff has the opportunity to meet regularly with the member and family, gaining a deep understanding of the issues that may affect the member's successful transition to the community.

By building close working relationships with facility staff, our Nurse Medical Management clinicians become part of their team, creating an environment of collaboration. Our employees participate in discharge planning meetings at the facility, make clinical recommendations for appropriate services upon discharge, conduct authorization reviews, and arrange for the member to receive follow-up services and supports post-discharge.

Our Nurse Medical Management clinicians co-located at hospitals contact Amerigroup's care coordination program upon notification of a member's admission. A Case Manager with the expertise that is most closely aligned with the member's condition(s) initiates the discharge planning process by contacting the member and, with the member's permission, family members, caregivers, and other natural supports. The Case Manager also contacts the hospital employees responsible for the member's care and current providers to develop the discharge plan. With the member taking the lead, the discharge plan is jointly developed, identifying the services and supports the member needs to transition to and remain safely in the location of the member's choice.

Transition Planning

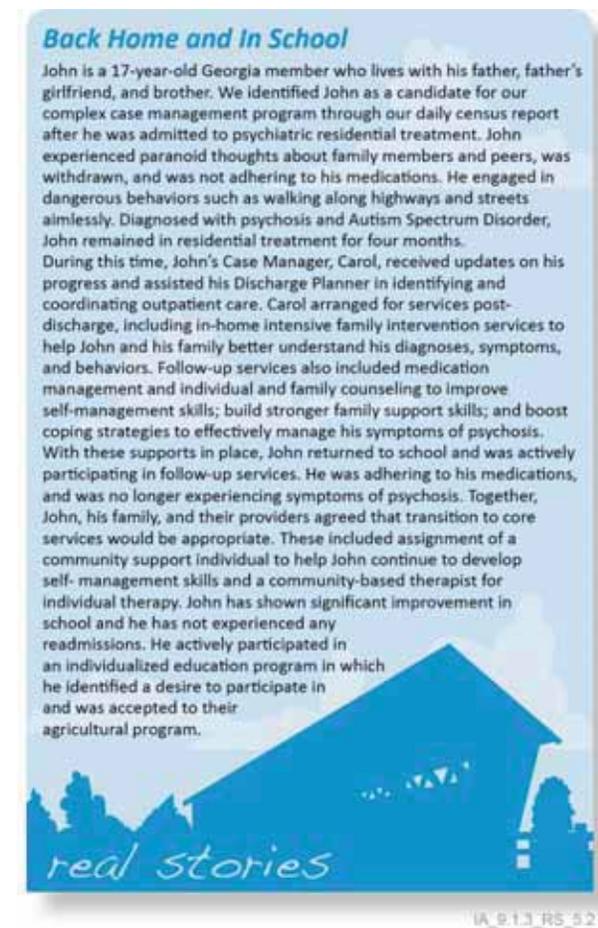
Amerigroup's transition planning program provides enhanced support to members and their families during transitions, including changes in level of care, setting, or providers. Case Managers work with members, their families, and the providers involved in their care to connect members to appropriate services following a transition. Our clinical team also reviews each member who is in an inpatient setting, including mental health and substance abuse setting, during our daily rounds, assessing the member's status and post-discharge needs to help assure appropriate aftercare planning. Our transition planning goals include a reduction in overall 30-day readmission rates for members discharged to lower levels of care or home and improved seven- and 30- day follow-up after discharge appointment adherence.

We use a four-phase approach to work with members identified for transition planning – identification, engagement, stabilization, and maintenance. We have also developed specialized interventions designed to address members' support needs and provide care coordination in different settings:

- Emergency department case management
- Inpatient case management
- Transitional case management

Emergency Department Case Management

Members with more than three nonemergent emergency room visits in a year and an emergency room (ER) TRIAGE score indicating a likelihood of continued ER use for low-level visits receive focused case



management interventions that identify reasons for these visits and methods to reduce future use. Case Managers work with the member and family to make sure members can access timely appointments and necessary specialty care for hard-to-treat conditions and educate members about Amerigroup’s after-hours resources, including our 24/7 Nurse HelpLine and contracted urgent care centers.

When a member requires additional medical management for conditions like chronic pain or substance abuse that are contributing to emergency room use, the Case Manager works with the interdisciplinary care team, including medical and mental health and substance abuse directors, to identify specialized providers and additional resources needed to address the member’s needs in the most appropriate ambulatory care setting.

Inpatient Case Management

Amerigroup’s experience validates that a member’s highest risk of readmission to an inpatient setting is within the first 48 hours following hospital discharge. Amerigroup concurrent review nurses begin discharge planning when a member is admitted to a hospital or inpatient mental health and substance abuse setting, coordinating with hospital employees upon member admission, identifying member needs,

addressing those needs, and confirming ongoing medical necessity of the continued stay to reduce the risk of re-admission or of an acute episode. The concurrent review nurses are the eyes, ears, and feet on the ground at the hospital and the primary liaison with hospital employees: they arrange services necessary to transition a member back home or to a more appropriate level of care based on the member’s needs.

Transitional Case Management

Amerigroup’s transitional case management program is designed to provide one-on-one intensive short-term support to at-risk members who are transitioning from a mental health and substance abuse or physical health inpatient admission, taking into consideration each individual member’s unique health care needs. The goal of transitional case management is to reduce overall 30-day re-admission rates and to facilitate a smooth transition between inpatient settings and the home or other community settings by providing intensive, short-term support.

Transitional case management includes post-discharge follow-up calls, medication reconciliation, and member and family education and assistance with making follow-up appointments to PCPs and other practitioners involved in the member’s care. Every Amerigroup member transitioning from an inpatient stay to home receives a call from a Case Manager immediately prior to or following discharge to confirm that discharge supports are in place and to provide the level of post-discharge support each member needs.

For example, for a member with medically complex conditions who is transitioning to home from acute care hospitalization, the Case Manager ensures that prescriptions are filled and follow-up appointments are scheduled. We identify the member's needs for such things as durable medical equipment, home health care, and transportation services and coordinate with providers to assure that all services and supports are in place prior to the transition.

Care Coordination for Populations with Specialized Needs

Our integrated, member-centric care coordination program will take into account the specialized needs of our members across all Medicaid populations. Amerigroup has specialized, more intensive care coordination areas of focus for our members who have complex, chronic, or specialized health care needs requiring a higher level of care coordination for multiple issues or more challenging benefits and services. These include:

- Children in foster care
- High-risk pregnancies and newborns
- Members with behavioral health needs
- Members with Hepatitis C
- Integrated and Chronic Health Homes

Foster Care – Early Childhood Intervention (ECI)

Amerigroup recognizes that many children involved in the Foster Care system may not have received the screening, evaluation, assessment, and services critical to early identification, intervention, and ongoing care for members with specialized health-care needs (MSHCN) prior to entering into the system. We believe that the sooner children's specialized needs are identified, the more likely they can be supported in reaching their development and learning potential. To accomplish this for Iowa, we will build upon our established Early Childhood Intervention (ECI) policies and procedures, proven service coordination processes, and integrated programs in our affiliate health plans.

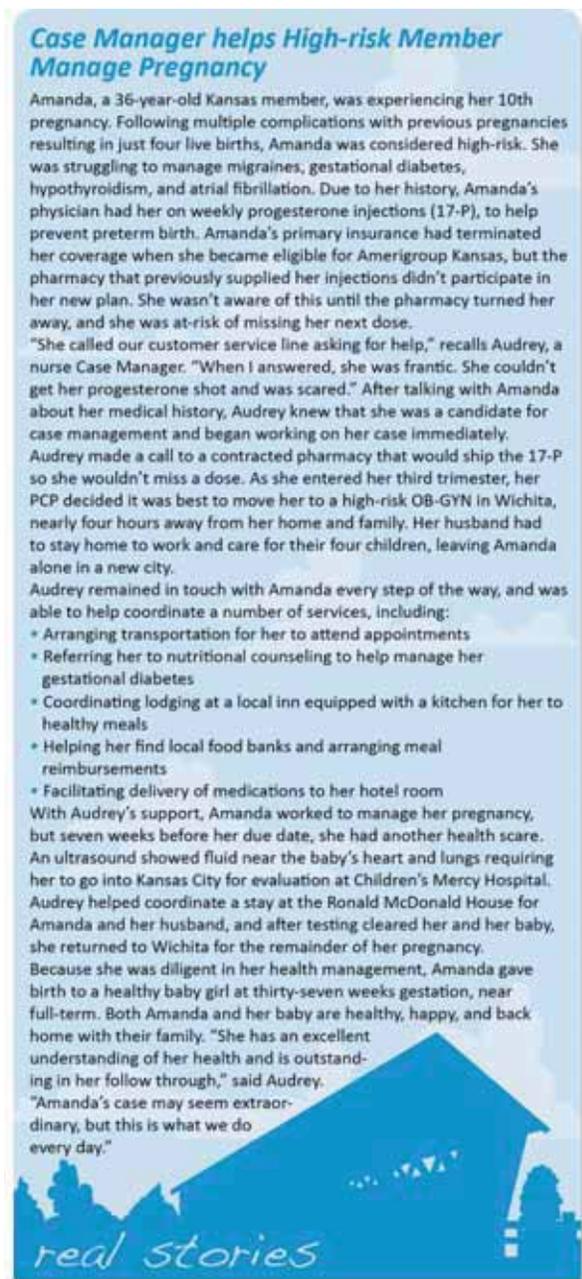
Amerigroup has the expertise and experience needed to rapidly engage infants and children with specialized needs such as disabilities or developmental delays in the screening, assessment, referral, and coordination of ECI services tailored to their individual needs. ***Our affiliate health plans currently serve more than 41,000 children and youth in Foster Care, adoption assistance, and juvenile justice systems in nine states, including Georgia, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Virginia, Washington, and Wisconsin.*** We recognize that approximately one-third of members in Foster Care may have unmet needs related to developmental delays and disabilities across a spectrum from minor to more significant needs.

Amerigroup's Comprehensive Foster Care Solutions program will adhere to all federal, state, and Contract requirements, as well as establish processes, procedures, and policies, for the following:

- Identifying MSHCN through a “no wrong door” approach that promotes referrals from caregivers, medical consenters, conservators, providers, Case Managers, child placing agencies, school-based health clinics, and other participants, as well as review of the eligibility file and claims activity that may indicate potential concerns
- Capturing and regular monitoring of members' ECI information to promote timely, accurate, and complete information sharing
- Assigning Case Managers to all members in the ECI program
- Referring members to the ECI program as expediently as possible and within required time frames
- Participating in the Individual Family Service Plan (IFSP) development as requested
- Coordinating services on the IFSP as requested

We will also maintain a strong provider network experienced in delivering services for children with specialized diagnoses such as Autism Spectrum, Fetal Alcohol Spectrum Disorder, and Severe Emotional Disturbance (SED). Our provider network will include board-certified/board-eligible pediatricians; pediatric specialists (including audiologists and speech, physical, and occupational therapists); ECI specialists; and children’s specialty centers such as teaching hospitals, tertiary care centers, and children’s hospitals.

Caregiver and Key Participant Education. Amerigroup will provide information about ECI services, including early identification, possible indicators, and referral processes to medical consenters, conservators, guardian/caregivers, and other key participants through our Foster Care Academy training and education program, member handbook, and member/caregiver web-based portals. We will also



Case Manager helps High-risk Member Manage Pregnancy

Amanda, a 36-year-old Kansas member, was experiencing her 10th pregnancy. Following multiple complications with previous pregnancies resulting in just four live births, Amanda was considered high-risk. She was struggling to manage migraines, gestational diabetes, hypothyroidism, and atrial fibrillation. Due to her history, Amanda’s physician had her on weekly progesterone injections (17-P), to help prevent preterm birth. Amanda’s primary insurance had terminated her coverage when she became eligible for Amerigroup Kansas, but the pharmacy that previously supplied her injections didn’t participate in her new plan. She wasn’t aware of this until the pharmacy turned her away, and she was at-risk of missing her next dose.

“She called our customer service line asking for help,” recalls Audrey, a nurse Case Manager. “When I answered, she was frantic. She couldn’t get her progesterone shot and was scared.” After talking with Amanda about her medical history, Audrey knew that she was a candidate for case management and began working on her case immediately. Audrey made a call to a contracted pharmacy that would ship the 17-P so she wouldn’t miss a dose. As she entered her third trimester, her PCP decided it was best to move her to a high-risk OB-GYN in Wichita, nearly four hours away from her home and family. Her husband had to stay home to work and care for their four children, leaving Amanda alone in a new city.

Audrey remained in touch with Amanda every step of the way, and was able to help coordinate a number of services, including:

- Arranging transportation for her to attend appointments
- Referring her to nutritional counseling to help manage her gestational diabetes
- Coordinating lodging at a local inn equipped with a kitchen for her to healthy meals
- Helping her find local food banks and arranging meal reimbursements
- Facilitating delivery of medications to her hotel room

With Audrey’s support, Amanda worked to manage her pregnancy, but seven weeks before her due date, she had another health scare. An ultrasound showed fluid near the baby’s heart and lungs requiring her to go into Kansas City for evaluation at Children’s Mercy Hospital. Audrey helped coordinate a stay at the Ronald McDonald House for Amanda and her husband, and after testing cleared her and her baby, she returned to Wichita for the remainder of her pregnancy. Because she was diligent in her health management, Amanda gave birth to a healthy baby girl at thirty-seven weeks gestation, near full-term. Both Amanda and her baby are healthy, happy, and back home with their family. “She has an excellent understanding of her health and is outstanding in her follow through,” said Audrey. “Amanda’s case may seem extraordinary, but this is what we do every day.”

real stories

conduct initial welcome calls to all new members/conservators/caregivers at the time of member enrollment. During these calls, we will provide information about the ECI program and the unique abilities, strengths, and needs that may qualify a child for ECI services.

Provider Expertise. We recognize that our providers play a critical role in identifying children with potential developmental delays or disabilities and that the referral to the right provider is essential to achieving the best outcomes for our members. Amerigroup will require and train all our provider partners to identify potential developmental delays and disabilities, submit timely referrals to the ECI program, and participate in developing the IFSP and transition activities if requested. We also recognize that children receiving ECI services may have a level of need that is best met by a specialist who assumes the role of PCP. Therefore, if a MSHCN receiving ECI services requires specialized care, the conservator, Primary Care Provider Team, or Case Manager may request that the specialist function as the member’s PCP. To promote the best care for the member, we will allow a specialist to function as the member’s PCP upon request.

Care Coordination. We believe strong, sound care coordination is essential to helping our MSHCN reach their potential by accessing medically relevant, high-quality, and cost-effective care; supports positive outcomes; and encourages safety and well-being for members through consistent and frequent communication. Our Case Managers will rapidly access and coordinate services and supports identified for the member during the service planning process upon request and assure the efficient and comprehensive sharing of information with all parties involved in the health care of members.

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Taking Care of Baby and Me

Amerigroup's Taking Care of Baby and Me® program provides an individualized, one-on-one, comprehensive case management program supporting pregnant women at the highest risk. Educational material, information on community resources, and incentives to keep scheduled prenatal and postpartum visits, as well as well-child visits after the baby is born, provide extra encouragement and motivation for our members.

This program builds an array of services around the pregnant woman and her newborn to provide the best opportunity to have a healthy baby and to be a successful mom. From identification through the birth of the child and the postpartum period, Amerigroup supports the woman in each major stage, helping her achieve a healthy outcome. We address each case individually, one mom at a time, using innovative and proven strategies to identify, assess, inform, engage, and support our members.

Care coordination plays a critical role in this program, in collaboration with Case Managers who perform key functions in this program, such as conducting an assessment, setting goals, and providing interventions. Care coordination activities provide links to community-based resources and health education material.

In 2010, the National Minority Quality Forum (NMQF) awarded Amerigroup Corporation, Amerigroup Iowa's parent company, the first Health Promotion and Disease Awareness Award, which recognizes an individual or organization making an outstanding contribution to the promotion of wellness in minority communities, for its efforts to help moms enrolled with Medicaid have healthy babies.

Through Taking Care of Baby and Me®, Amerigroup Iowa will identify our members who are pregnant as early as possible, referring them to a Case Manager who will conduct a thorough clinical assessment to determine risk and develop individualized care plans that correspond to each woman's risk level. We will offer a full array of support tools that foster close communication between the health plan and the member while promoting a healthy pregnancy and baby, including:

- **Prenatal Incentive Packet.** Incentive signature cards will be sent to encourage prenatal visits within the first trimester of pregnancy or within the first 42 days of enrollment. Once her physician signs a signature card at a prenatal care office visit, the woman will mail the card to our offices, and in return, we will mail her our Healthy Rewards debit card pre-loaded with her \$25 dollar incentive amount.
- **Post-partum Packet.** After a pregnant member gives birth, she will receive a postpartum packet. This packet includes a flyer congratulating the mother on her newborn, a booklet on caring for the newborn, a brochure on baby blues vs. postpartum depression, and "Making a Family Life Plan." A \$50 Incentive will also be provided via the Healthy Rewards debit card for completing a postpartum appointment between 21 and 56 days after giving birth.
- **SafeLink Phones.** In cooperation with SafeLink Wireless and funded by a U.S. government program that ensures that telephone service is available to eligible Medicaid recipients who lack another communication source, Amerigroup Iowa members whom we identify as in need of this service will receive a free cell phone. Amerigroup facilitates the SafeLink Wireless process by helping pregnant members get the phone and, depending upon the wireless plan, up to 250 minutes per month. We also have a partnership with the program, so as a Value-Added Services, our members receive 100 extra lifetime minutes. These additional minutes will give Amerigroup Iowa clinical staff real-time access to members to ensure that appointments are made and kept, prescriptions are filled and taken, and transportation arrangements are made. It gives the pregnant woman an easy way to contact her Obstetrician, Case Manager, and other essential service providers through numbers pre-programmed into the phones. In addition, our pregnant members receive free text messaging from Amerigroup staff so that they can receive alerts at any time. They also receive a series of messages developed by our Maternal Health and Pediatric Specialists. These Amerigroup-specific pregnancy messages assist our members throughout their pregnancies, and infant-care messages continue after their child is born.

- text4baby.** As a designated outreach partner, Amerigroup has joined with the text4baby program to promote this free text message information service. Once pregnant members enroll, they will receive educational messages and helpful reminders tailored to their particular weeks of pregnancy and through their baby’s first year. Over 185,000 of our members have enrolled in this program; only four percent have opted out of receiving the texts. Approximately 72 percent of recipients responded that the texts helped them remember to go to the doctor. Members who receive texts about a certain telephonic program (such as Nurse HelpLine, coaching, etc.) are six times more likely to call the promoted phone number within 30 days of the text than non-recipients. Members who receive texts reminding them to get a screening or physical are three times more likely to comply within 90 days of the text than non-recipients.

My Advocate

The My Advocate program shown in Figure 9.1-6 provides pregnant members proactive, culturally-appropriate outreach and education through a multi-faceted technology tool. It does not replace our high-touch OB case management approach for high risk pregnant members, but instead serves as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high risk, to facilitate connections between them and our Case Managers, and improve member and baby outcomes.

My Advocate is a screening and health promotion program for pregnant Medicaid recipients, which is offered as an IVR call, text or smart phone application. It is integrated with our case management platform, Care Compass. Outreach begins with a 20 question risk screening call and continues with two contacts per week until delivery. It is then followed by two contacts per week targeting post-delivery and newborn topics for up to three months after birth. Responses to questions posed during the outreach can generate Case Manager “alerts.” Members also have access to the My Advocate website including additional information and a chat feature.



Maternal Child Services

Amerigroup offers several services related to maternal and child health. These include behavioral health services (screening, post-partum depression care, and substance use disorder care), breastfeeding support, smoking cessation, diabetes management, and preconception/interconception health materials.

The Centering Pregnancy

The Centering Pregnancy is a group prenatal care program for women of similar gestations. It has proven benefits for increasing birth weight, decreasing prematurity, improving pregnancy readiness, and increasing provider satisfaction.

Nurse Family Partnership

The Nurse-Family Partnership is a free, voluntary program that partners first-time moms with nurse home visitors that reinforce the importance of getting good prenatal care, eating healthy, exercising, and quitting smoking. Services have been shown to help break the cycle of poverty, strengthen communities and improve lives.

Neonatal Intensive Care Unit Case Management

Amerigroup also offers services and support to families with babies in the Neonatal Intensive Care Unit (NICU). As the mother and the family are the most valued members of the NICU team, we encourage them to:

- Ask questions and share their feelings
- Visit the baby often and be involved in his/her care
- Ask about Kangaroo Care (placing the NICU baby skin-to-skin onto the parent directly from the incubator or isolette)
- Learn about breast-feeding
- Get to know the NICU staff
- Get postpartum care for the mother
- Prepare for the baby to go home

Behavioral Health

Amerigroup will bring a behavioral health program to Iowa that delivers highly coordinated covered benefits that are fully integrated across our health plan. ***Amerigroup will directly administer the delivery of mental health and substance use disorder treatment and support services that are localized, customized, evidence-based, and above all, recovery and resilience-driven.*** We will build upon the experience of 15 of Amerigroup's 19 affiliate health plans that coordinate the delivery of fully integrated physical health and mental health and substance use disorder treatment services, and in seven states, long-term services and supports (LTSS). Amerigroup affiliates coordinate the full spectrum of behavioral health services, including home and community-based services for children with a serious emotional disturbance. Amerigroup affiliates coordinate the full spectrum of behavioral health services, including home and community-based services for children with a serious emotional disturbance. We also currently cover services similar to Habilitation Program services for members with a serious mental illness in many of our health plans, including in Kansas, Tennessee and Texas. Additionally, we will cover 1915(i) services along with a full spectrum of physical and behavioral services as a Health and Recovery Plan in New York beginning the summer of 2015 and, in December 2015, as a Bayou Health Plan in Louisiana.

Our approach in Iowa will extend the significant work done by the State, advocacy groups, consumers, families, and local providers, to further evolve behavioral health services coordination, integration, and delivery. We will combine clinical evidence, member needs, and State customer needs with Amerigroup's deep and extensive knowledge and experience to implement a recovery-based, integrated, and collaborative model that welcomes and engages members in their personal recovery efforts.

- Our staff will promote recovery and resiliency throughout the provider network and in our interactions with members and their families with the goal of maximizing community integration. A recovery philosophy that is hope-based and focusses on member self-determination, developing empowering relationships, having a meaningful, productive role in society, and eliminating stigma and discrimination, is the foundation for collaboration and integration of health services.
- As a leader in offering a truly integrated model, we do not separate the management and delivery of mental health and substance use disorder services from physical health care, pharmacy services, and LTSS, including social supports. Our highly experienced national behavioral health management team will be a seamless component of the Iowa Health Plan, who will have the support of this national behavioral health expertise. The Iowa Health Plan behavioral health, physical health, and LTSS clinicians will work together as a single team, using a single care coordination and management system to deliver fully integrated care as a seamless part of the member's overall health experience for populations served.

- We will use the Amerigroup Member 360 capability to support coordination and delivery of recovery-based and integrated care. Member 360 is a member dashboard that displays HEDIS® care alerts; authorizations; prescriptions; lab results; and claims organized by type, such as inpatient, emergency room (ER), office visit, and behavioral health. It also provides a timeline of clinical events for the member across a number of domains, including diagnosis, providers, and medication history. Member 360 is available to our clinical team and will be available to providers through our provider portal.
- Amerigroup will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness.
- We will collaborate with local and state-based stakeholders (i.e. families, natural supports, advocacy organizations, and network providers) to ensure access to integrated mental health and substance use disorder services and to the social supports families and children need to maintain a stable and safe family environment and that adults need to live independently.

We will focus on:

- Prevention—working with providers, the community, and consumers around evidence-based interventions for prevention of behavioral health disorders; for example, evidence-based, targeted, time-limited, parent-infant communication training for at risk families, that has a clear connection to improved outcomes
- Early detection—using comprehensive screening programs to identify and treat member’s needs early
- Peer support and recovery—growing Iowa’s strengths- based program grounded in member choice and recovery
- Enhanced access to mental health and substance use disorder services through provider development activities and the use of innovative care delivery technologies, including telehealth and online consultations
- Enhanced access to community supports - especially housing, education and employment - through collaboration with community-based organizations (CBOs), county agencies, advocacy groups, providers and the State
- Provider collaboration and partnerships to pay for value rather than volume (pay for performance) — recognizing that this transition may take more time for some and less time for others. This collaboration is provider specific and takes into account provider experience and preferences
- Innovative, integrated physical and behavioral health care model design—promoting, supporting, and developing additional integrated care model capacity, including patient centered medical homes, established Iowa Accountable Care Organizations (ACOs) and Chronic Care and Integrated Health Homes. For example, one of our recent agreements with a primary care provider group includes quality threshold targets for both physical and behavioral measures.



For additional detail on Amerigroup's approach to behavioral health, see Section 3.2.8.

Case Management for Members with Hepatitis C

Amerigroup recognizes the high cost of medications available to treat this condition. As part of our fully integrated case and disease management programs, we will work to provide solutions that empower members and providers with information, education, and resources to help members adhere to treatment plans and take their medications as prescribed. With many available treatment options depending on the individual's unique situation, it is crucial that members understand and adhere to their individual treatment plans. Through specially-trained pharmacists and pharmacy staff, we will provide personalized outreach consultation to members and their providers, with the primary goal of assuring completion of therapy. Additionally, we will help educate and manage members' care, including assessing and addressing any drug interactions, potential side effects of medication, contraindications, and possible co-morbid concerns through targeted reviews where appropriate.

Integrated and Chronic Health Homes

Amerigroup is committed to supporting DHS's goals to expand and evolve health homes to reduce fragmentation in care and enhance access to services that address the holistic service needs of members experiencing serious mental illness, serious emotional disturbance, or chronic health conditions by increasing service coordination, facilitating transitions in care, promoting self-care and health promotion, and linking to community services and supports. In establishing the rationale and goals for the health home, we embrace the principles that the individual is front and center in addressing his or her preferences, self-identified needs, and health goals consistent with the member's cultural values and beliefs. It is important for the health care system to evolve into one that reduces fragmentation in attending to the physical, behavioral, and social needs of the individual.

Amerigroup will make sure that key Health Home Services specified by DHS in the Health Home Provider Agreement are provided by all Health Homes:

- **Comprehensive Care Management.** Providing for all health care needs/arranging care, developing a Continuity of Care Document, and implementing a formal screening tool for behavioral health
- **Care Coordination.** Assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes; utilizing health information technology (HIT) to facilitate the processes and communicate results
- **Health Promotion.** Coordinating/providing behavior modification interventions aimed at supporting health management, improving disease outcomes, disease prevention, safety, and an overall healthy lifestyle, using Clinical Decision Support within the practice workflow, and implementing a formal Diabetes Disease Management Program.
- **Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings).** Transitioning patients from inpatient to other settings, confirming receipt of updated information through a Continuity of Care Document and receipt of information needed to update the patient's care plan, and following up with the patient after transition
- **Individual and Family Support Services (including authorized representatives).** Communicating with the patient, family, and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions
- **Referral to Community and Social Support Services.** Coordinating or providing recovery services and social health services available in the community (for example, understanding eligibility for various healthcare programs and disability benefits and identifying housing programs)

For additional detail, refer to Section 3.2.9 and 3.2.10.

Health Promotion

Members with low-risk health care needs receive health promotion outreach, including health promotion materials and well-care reminders, to help them seek out and access timely preventive care such as periodic checkups, screenings, and immunizations. Examples are shown below in Figure 9.1-7 and Figure 9.1-8. To make sure that the right groups receive the appropriate type and amount of information, our efforts range from providing general member education that builds health literacy (the ability to comprehend and apply information to address issues) and empowering members to take responsibility for their health status to offering high-touch solutions for targeted outreach and education for individual members.

All members and families have access to:

- Our single, toll-free point of contact for all questions through our Member Services call center
- Assistance with referrals that result in timely appointments
- Communication and education regarding available services and community resources
- Assistance developing self-management skills to effectively access and use services

Our health promotion programs are reinforced through periodic outreach to members with identified gaps in care (such as missed check-up appointments).

We have also developed an entire suite of Value-Added Services dedicated to promoting member health and wellness. Within this suite are nine unique benefits, from tobacco cessation counseling to no-cost Weight Watchers® or other similar program vouchers, all designed to promote healthier outcomes, increase member and family self-management and adoption of healthy habits. Detailed descriptions all benefits within our 'Health and Wellness Value-Added Services Suite' are outlined in Section 3.2.14.

Figure 9.1-7. Sample Health Promotion Flyer for Healthy Eating



Figure 9.1-8. Sample Health Promotion Flyer for Heart Health



Question 9.1.3, #2

2. Provide data on outcomes achieved in your care coordination programs operated in other states, if applicable.

Over 24 years of serving Medicaid and other state-sponsored programs, Amerigroup affiliates have established a successful track record of delivering superior care coordination and quality outcomes, increasing member compliance and empowerment, and improving quality of life across all Medicaid populations. Below are just a few examples of the successful outcomes from and recognition for our care coordination strategies:

In 2014, Amerigroup produced approximately **\$91 million in aggregate utilization reduction and incremental savings** across its 19 affiliate health plans through its combined efforts in utilization management, case management, and disease management across medical, behavioral health, and pharmacy utilization

Between 2012 and 2013, Amerigroup and our affiliate health plans experienced across disease management programs an overall **reduction of 26.1 percent in emergency room (ER) visits and 20.4 percent for inpatient admissions** based on claims analysis as shown in Table 9.1-4.

Table 9.1-4. Our Disease Management Program Has Successfully Reduced ER Visits and IP Admissions between 2012 and 2013

Disease Management Program	ER Visits/1,000	IP Admits/1,000
Asthma	-39.8%	-27.3%
CAD	-20.3%	-22.2%
CHF	-10.2%	-14.0%
COPD	-5.8%	-22.8%
Depression	-9.9%	-17.5%
Diabetes	-12.2%	-17.8%
HIV/AIDS	2.1%	-18.0%
Schizophrenia	-14.7%	-14.1%
Total	-26.1%	-20.4%

- In 2012-2013, for a subset of our members with multiple behavioral health admissions, our Tennessee affiliate **reduced inpatient admissions and readmissions by 47 percent and ER visits by 25 percent**, while increasing outpatient visits by 17 percent
- Amerigroup’s Florida health plan increased follow-up rates for members discharged from the hospital with a behavioral health diagnosis; in 2012, **follow-up rates for seven-day post-discharge visits increased by 14 percent** for members in this program, and increased 19 percent for 30-day follow-up visits as compared to members not in the program
- In our Nevada affiliate health plan, we implemented a stabilization program which **reduced readmission rates for our 75,000 TANF members from 2009 to 2010 by 35 percent** for like conditions and by 20 percent for any condition
- In 2012, our Texas plan implemented our transitional care program, focused on discharge planning efforts and intensive, short-term supports; as a result, **total 30-day readmission rates dropped from 14.9 percent to 7.2 percent**

- In 2014, Amerigroup partnered with a care transition solutions provider to pilot a program in Maryland which enrolled high-risk members in community health programs prior to hospital discharge; so far, that program has resulted in a **15.7 percent reduction in readmission rates for high-risk members** across five Baltimore hospitals
- In a 2009-2012 study on our diabetes care efforts in New Mexico, we demonstrated **improvement in our New Mexico members' HbA1c testing rates from 72.5 percent to 86.2 percent**; for the same timeframe, we brought our members' LDL-C testing rates from 60.5 percent to 72.9 percent
- In a 2008-2010 study measuring the outcomes of our Taking Care of Baby and Me program, we succeeded in **reducing NICU bed days by 8,997**, resulting in savings of more than \$17.83 million across all Amerigroup health plans

Amerigroup and its affiliate health plans also have been recognized by the NCQA for our care coordination programs across the nation:

- We have been **NCQA accredited since 2007 and achieved Commendable level in 2013**. We have achieved NCQA or similar accreditation across all of our state contracts
- In 2010, the National Minority Quality Forum awarded Amerigroup Corporation the first **Health Promotion and Disease Awareness** award, which recognizes an individual or organization making an outstanding contribution to the promotion of wellness in minority communities, for its efforts to help moms enrolled with Medicaid have healthy babies

Risk Stratification (9.1.4)

Question 9.1.4, #1

1. Describe your proposed risk stratification methodology.

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Question 9.1.4, #2

2. Describe your proposed risk stratification levels.

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Question 9.1.4, #3

3. Describe how care would be managed for members in each risk stratification level.

Intensity and Frequency of Follow-up Care

The stratification of our members into risk groups informs how we prioritize our outreach efforts and who conducts the outreach. Members in the highest risk groups as identified by our CI3 and LIPA predictive model are prioritized for immediate contact so that we can complete a comprehensive health risk assessment (HRA) and promptly assign the member to the appropriate care coordination program. As previously shown in Table 9.1-6, members in Risk Groups 3 and 4 are targeted for a focus in complex case management, whereas members in Risk Groups 1 and 2 are targeted for a focus in disease management. Nurse Case Managers and disease managers will be assigned to these members accordingly and will reach out to the members to schedule a comprehensive HRA. Based on the results of the HRA, our Case Manager/Disease Manager will assign a high, medium, or low acuity level, which will then inform the intensity and frequency of follow-up care, as detailed further below.

Case Management

Once a member is stratified into Group 3 or 4, indicating complex clinical issues and high risk for readmission, we will perform outreach to engage the member and conduct a comprehensive HRA. We will assign a Case Manager to the member with the most relevant expertise and focus area for the member's identified conditions and needs. Based on the results of the HRA and previously gathered information, the Case Manager will assign a high, medium, or low acuity level to the case. The acuity

level assignment is guided by applicable operational guidelines and the appropriate medical management system classification tool.

The acuity levels inform the intensity and frequency of contact made by the Case Manager. In determining the optimal contact frequency, the Case Manager will consider the member’s medical condition, self-management, psychosocial status, barriers, utilization, and medication, among other factors. Contacts may involve interaction with the member, physician, or others involved in the member’s case. Based on assessed acuity levels, contact frequency will typically fall in the following ranges:

- High — Case Manager contact once or twice per week
- Medium — Case Manager contact two or three times per month
- Low — Case Manager contact monthly at a minimum

The contact frequency is updated on a periodic basis as the member’s condition warrants. The Case Manager will develop a schedule for follow-up and follow a standard process to assess progress against goals. As the member’s status and needs evolve, the Case Manager may recruit additional experts into the interdisciplinary team to make sure that the member is served by the right team members with the right expertise.

Disease Management

Once members are stratified into Group 1 or 2, indicating clinical comorbidities but lower risk of inpatient admission, we consider them eligible for disease management. Members are further assessed through a comprehensive clinical intake process that identifies needs along the continuum of care. The intake process utilizes health risk assessment to identify and confirm both physical and behavioral health conditions; identify additional health conditions, including cognitive disorders and physical disabilities; screen members for depression and substance use; assess health risk behaviors; and assess both psychosocial and environmental needs, including family, network, and/or caregiver support.

Data collected through the clinical intake process is documented in the disease management data registry and automatically channeled through a standardized stratification algorithm to calculate an additional risk ranking that is used to determine both the intensity and frequency of interventions and care planning tailored to the individual member’s need.

Upon completion of the assessment, members are stratified into three acuity levels — High, Medium, and Low — based on database logic using responses to clinical assessment questions. Our clinical staff can override system logic stratification level assignment based on clinical judgment. In these cases, the rationale for the override is documented in clinical comments. The final stratification level determines ongoing intervention and assessment. Stratification levels and interventions are outlined in Table 9.1-7 below.

Table 9.1-7. Acuity Levels Determine Intensity and Frequency of Outreach

Stratification	Criteria	Member Contact Frequency	Member/Provider written communication
High	5+ gaps/needs identified	Biweekly	Upon enrollment and every 4th member follow-up assessment
Medium	1-4 gaps/needs identified	Monthly	Upon enrollment and every 2nd member follow-up assessment
Low	Gaps resolved and member stable with self-care plan in place	Quarterly	Upon enrollment and quarterly to correspond to the quarterly outreach

Member Identification for Care Coordination (9.1.5)

Question 9.1.5, #1

1. Describe how you will identify members eligible for care coordination programs, including how the following strategies will be utilized:
 - a. Predictive modeling;
 - b. Claims review;
 - c. Member and caregiver requests; and
 - d. Physician referrals.

Member Identification Strategies

Amerigroup's goal is to intervene early – before members even have symptoms or are diagnosed with a chronic condition. We accomplish this by reaching out to our members to develop relationships, conducting assessments as needed, and developing a member-centric care plan that includes our members' strengths, conditions, symptoms, needs, goals, and preferences. We also continually monitor and analyze member health status, risk factors, and family history to assess their risk for existing, potential, impactable, and preventable chronic conditions.

Proactive identification of members for the correct level of care coordination support is critical to meeting the member's needs and improving health outcomes. We identify members for enrollment in our care coordination program through:

- Predictive modeling
- Claims review
- Member/caregiver self-referrals
- Referrals from physicians and other stakeholders
- Initial screening

Predictive Modeling

Amerigroup continually mines data to identify and prioritize candidates for case management. Through our Continuous Case Finding (CCF) process, we evaluate the entire member population each month through our CI3 and LIPA predictive models, allowing us to identify new candidates and prioritize those with the highest expected need for interventions and care coordination services.

Our evidence-based predictive modeling tools enable us to stratify all members appropriately based on their level of risk for adverse outcomes. Our tools consider a member's chronic illnesses, likelihood of inpatient admission including the risk of first time admission for a mental health or substance abuse condition within two months, and risk for future emergency room use. Each member is assigned a risk score based on characteristics that correlate to a projected level of care coordination support. The results of our predictive modeling are reported back to the case management team for appropriate action, as necessary. See Section 9.1.4 for more detail on our predictive models.

Claims Review

Claims review is an integral part of our Continuous Case Finding process and reflected in the monthly CI3 reports. Claims information that feeds our predictive models and may indicate a need for case management involvement includes but is not limited to the following:

- Hospital readmission
- Three or more hospital admissions within the previous 12 months
- An unplanned hospital admission by a member who was recently followed in case management (within previous 30 days)
- Catastrophic illnesses and injuries

- Potential transplant candidates
- Patterns of inpatient and outpatient utilization

Changes in living or support situation that could have direct health status implications, particularly for LTSS members and others who may be dependent on caregivers

In addition to predictive modeling, we review claims on an ongoing basis to identify triggers which generate case management referrals, irrespective of the CI3 score. Cases with specified triggers and criteria are evaluated for eligibility and referred to a Case Manager for case initiation when appropriate. These triggers include high-dollar claims and diagnoses of certain conditions, including hepatitis C, sickle-cell anemia, hemophilia, and end stage renal disease.

Member/Caregiver Requests

While Amerigroup has very robust systems to identify and stratify members' risk and capture the information that supports their engagement and progress, we know that the human factor is one of the most important elements in engaging them in healthy behaviors and self-care. Our program connects people to collaborate and coordinate care that is holistic and individualized to our members' conditions. We encourage open communication with our members and their caregivers. Through our "no wrong door" policy, members and caregivers can contact any Amerigroup employee and request consideration to be placed in a care coordination program. We will honor all such requests – regardless of risk stratification score – and will promptly assign a nurse Case Manager to schedule a comprehensive health risk assessment (HRA). Based on the findings from the HRA, we will assign the member to a care coordination program, as appropriate.

Physician and Other Stakeholder Referrals

In addition to our data-driven processes and self-referrals, a variety of sources or individuals may refer members to one of our programs when they identify a need during contact with a member or based on review of a member's electronic health records. Our multifaceted, proactive approach allows us to intervene quickly and engage members in the level of support they need to achieve positive health outcomes and enhanced quality of life. Our "no wrong door" approach to identifying members includes but is not limited to the following types of referral sources:

- Physicians, vendors, and other healthcare providers
- Utilization management employees
- Disease management referrals
- Customer service employees
- Grievance and Appeals employees
- 24/7 Nurse HelpLine employees
- Health information lines
- Members or their families/caregivers
- Hospital staff, including discharge planners and social workers
- Community social service organizations/agencies
- IVR Outreach Surveys

Initial Screening

Our initial screening of members identifies members' immediate physical, behavioral health, psychosocial, and functional needs, gathers information regarding the level and type of existing care coordination, and reviews information to identify the member's strengths, needs, and available resources to enable person-centered planning in conjunction with the member. Data from the initial screening for newly enrolled members is considered in the risk stratification process and allows us to include a "rush" designation for members found to have immediate needs identified during the initial screening or during any contact with a member.

Care Plan Development (9.1.6)

Question 9.1.6, #1

1. Describe in detail how person-centered care plans will be developed for each member.

Amerigroup will develop individualized, person-centered care plans for each Iowa member who is eligible for care coordination, based on the findings of the initial screening and comprehensive health risk assessment, available medical records, and input from members, their family members/guardians/representative, and their health providers. Because our care model is fully integrated, the physical health, behavioral health, LTSS and pharmacy needs of our members are all seamlessly addressed through an integrated care plan. Throughout the care plan development process, *our approach and emphasis are to empower members to take responsibility and self-direct their care.* The result is a care plan that helps to identify the problems, issues, or barriers for the member; realistic and optimistic goals; member's preferences; and the interventions and actions needed to achieve the goals. The care plan also addresses barriers to goals such as members' lack of understanding, motivation, financial need, insurance issues, or transportation issues.

Our care plans are designed to:

- Establish prioritized person-centered goals and actions
- Facilitate seamless transitions between care settings
- Create a communication plan with providers and members
- Monitor whether the member is receiving the recommended care

Establish Prioritized Goals and Actions

We will document a care plan for every member enrolled into our care coordination program. Only Case Managers (licensed clinical professionals) may lead the planning process, consistent with their scope of professional licensure. After establishing contact with the member, our Case Manager will complete a comprehensive health risk assessment using an integrated, standardized, best practice tool (as detailed in Section 9.1.2).

The Case Manager will assess the member's total health care needs holistically, including physical, behavioral, functional, cognitive, and social factors, as well as access to care. The assessment affords us a full understanding of the member's history, current health needs, perceptions, and overall goals. The comprehensive assessment focuses on determining the member's functional, physical, mental, and support status, then asks targeted questions about the individual's and caregiver's perceptions of needs.

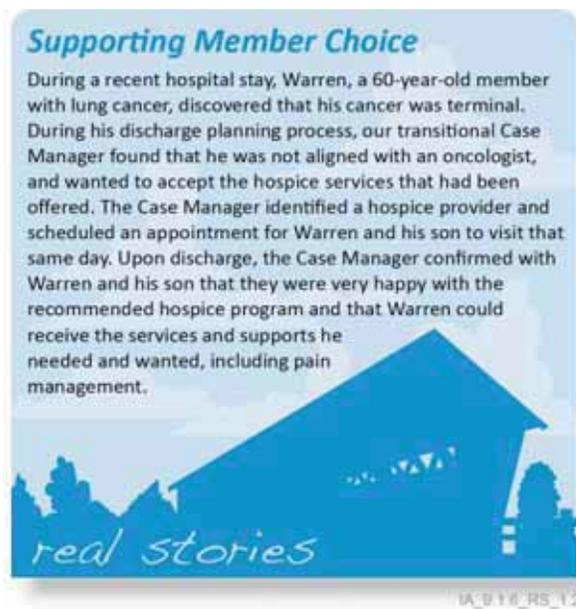
The thorough assessment process enables the Case Manager not only to learn about the member's needs in detail, but also to build trust and credibility with members, their providers, and natural supports. This trust is essential to person-centered care planning. The Case Manager will review any identified concerns, barriers to health, or other specific needs with the member. Together, they will set goals and develop a care plan to meet those goals. The Case Manager will also confirm that the member is fully aware of any potential outcomes if the member does not do his or her part to meet care plan goals. In general, the Case Manager will initiate a care plan within 14 calendar days of accepting the member into care coordination, but not exceeding 30 calendar days for completion.

The goals and actions developed in the person-centered care plan are designed to be:

- **Outcome-Specific:** Care plans will identify prioritized, measurable short-term and long-term goals. Prioritized goals consider the member and caregiver needs and preferences with clear prioritization. Goals shall include target dates and timeframes for reassessment of progress toward and accomplishment of desired outcomes. Short-term goals usually address the immediate health status of

the member. A long-term goal aims to achieve sustaining health improvement or optimal health status.

- **Individualized:** Care plans will specify individualized, prioritized goals for the member and identify the needed resources and collaborative approaches utilized to meet specified needs. The care plan addresses the member's needs and concerns found in the assessment findings.
- **Time-specific:** Care plans will establish goals with designated target dates for achievement. They will include scheduled timeframes for follow-up and evaluation of progress toward goals, based on the severity and intensity of the issues identified. Scheduled times for monitoring are captured through automated follow-up prompts in the care management system.
- **Collaborative:** The Case Manager involves the member or member's representative/caregiver and interdisciplinary team in the ongoing plan of care. The Case Manager will communicate progress toward and/or accomplishments of desired goals/outcomes of the care plan to the interdisciplinary team.
- **Evidence-based:** As appropriate, care plans incorporate evidence-based interventions and goals when evidence-based criteria are available, such as corporate clinical practice guidelines.



Facilitate Seamless Transitions between Care Settings

Under our transition of care model, moderate- to high-risk members leaving inpatient care receive more intensive outreach and one-on-one coaching until they are stabilized at home. It is modeled on transitional care programs that have proven successful reducing readmission rates and improving overall health outcomes. The program incorporates strategies for filling the gaps that most often drive readmissions, including inadequate access to follow-up care or poor coordination of follow-up services at and after discharge.

We recognize that our members' needs change frequently, and supporting them during critical transitions among care settings is one of the most crucial care coordination functions. These transitions comprise some of the most vulnerable times for our members; therefore, our Case Managers are dedicated to facilitating safe, seamless, and successful movement between health care settings for our members. To enable these goals, our Case Managers:

- Assess the member's health status during telephonic and face-to-face interactions to identify changes in the individual's condition
- Conduct a comprehensive health risk assessment when members experience a change in condition to verify whether the plan of care continues to meet their needs, and make adjustments to services and settings where required
- Coordinate with acute facilities to begin the discharge planning process at admission, assuring that those plans are appropriate to the member's level of care
- Share information and obtain input from the member's PCP and specialty providers
- Update the member's plan of care to reflect current health status and needs

- Make referrals for services and assist with scheduling caregivers and physician appointments
- Collaborate with the member, family/caregiver, facility staff, and providers to develop a transition plan

Create a Communication Plan with Providers and Members

As part of the Case Manager's responsibility in facilitating the care planning process, the Case Manager will develop a communication plan and actively engage the member, member's family/guardian or representative, treating physician(s), and other members of the interdisciplinary team, as appropriate and with the member's permission.

The Case Manager engages the member in the planning process as the primary decision maker and goal setter. During the planning process, the Case Manager will communicate directly with the member to understand and incorporate priorities of the member and to educate and empower the member to make informed decisions. Member input and participation in care planning encourages acceptance of the plan and maximizes the potential of achieving the specified goals.

Collaboration with the member's treating physician(s) in developing the care plan is critical to effective case management. As part of the facilitation process, the Case Manager communicates with the physician directing the member's care, notifies the physician that the member is engaged in the care coordination program, and solicits input. This communication should occur within one month of obtaining verbal consent for case management and may take the form of a verbal phone call, letter, or via a verified fax to the physician directly or the physician's office. The method of communication (phone call, verified fax, or letter) is documented in the notes.

The care plan serves to provide a common method for Case Managers to document and plan their involvement in a case. Communication of the care plan to providers will be promoted through the provider portal to ensure they are abreast of all updates and progress. It is also a tool to help ensure timely coordination of services that increase the effectiveness and efficiency of care/services provided. Care plans are dynamic, evolving, and require ongoing evaluation of progress. Input from the member/caregiver, primary care physician, and other health care professionals will be obtained throughout management of the care plan.

Monitor Whether the Member Is Receiving Recommended Care

A care plan is a dynamic roadmap that changes as members' needs progress or evolve. *Case Managers regularly monitor member progress at a frequency indicated by the member's risk level and work with the member, family, guardian, primary care physician, and other providers as necessary to evaluate the member's progress and identify solutions to overcome barriers that may stall progress.*

Case Managers and members will conduct routine reviews of care plans, including updates and revisions based on progress and changes in needs, to support and recognize achievement of goals. This process will also provide information for our quality management processes. See Question 9.1.6, #9, below, for more detail on monitoring strategies.

Question 9.1.6, #2

2. Describe how the care plan development process will be individualized and person-centered.

Individualized and Person-centered Care Planning

Our approach to member care planning emphasizes choice, personal responsibility, and the relevant linkages to community-based services, supports, and resources for each individual. We help our members enhance their quality of life and feel better empowered to take responsibility for contributing to their own health and wellness in a supported, structured way through the setting of clear, achievable, and mutually agreed upon goals.

From the outset, we will engage members to learn about their individual history, goals, preferences, values, and priorities and to identify all relevant treating providers. This information becomes the foundation for building a person-centric care plan. We will encourage participation throughout the care coordination process, including recognizing the member as the center of his or her interdisciplinary team (IDT). The member and family/guardian or representative are involved in the development of the care plan to the extent the member desires and that is feasible.

The care plan will include the member's perspective by:

- Scheduling a date, time, and location for completion of the Comprehensive Health Risk Assessment and health care planning that is agreeable to the member. For example, health care planning may occur by phone or face-to-face at the member's home or in a care setting
- Identifying the suggested members of the IDT. In addition to the member and the Case Manager, the IDT may include the member's PCP, other treating provider(s), providers of other services such as behavioral health services, family members, caregivers, and others of the member's choosing
- Asking the member to state who should participate in the care plan and arranging participation of these other IDT members
- Reviewing the purpose of the care plan with the member and asking the member to identify needs and desired outcomes, services, and providers
- Responding to the member's questions
- Reviewing and obtaining the member's agreement with the final care plan

We meet with members wherever they are or like to be, whether at home, in a restaurant, at a shelter, or at another location, as needed. By meeting and engaging members in their home, other community living arrangement, or facility, we gain significant knowledge of the needs and preferences of each individual. Establishing and maintaining personal bonds that reflect an interest in members overall lives, not just their chronic condition state, demonstrates our commitment to their well-being, care coordination, and recovery and rehabilitation.

The Case Manager will develop the care plan in concert with the IDT based on multiple medical and behavioral factors and discuss the needs with the member and family/caregiver. Preparation of the care plan will include an evaluation of the member's wishes, values, and degree of motivation to take responsibility for meeting each of the care plan goals. Through the use of behavioral interviewing skills, the Case Manager will encourage members to identify their own meaningful goals and achievable milestones. This level of engagement and involvement may increase their investment in following the care plan and successfully achieving their goals. The Case Manager will regularly communicate with the member and providers in an effort to monitor achievement of the goals set within the care plan. Through these communications and reviews of data and other information, the Case Manager and the IDT may

refine the care plan to identify changes to or additions to services and supports or refinement of goals identified in the care plan.

Question 9.1.6, #3

3. Describe how the care plan development process will incorporate findings of the initial health risk screening, comprehensive health risk assessment, medical records and other sources.

Data Inputs for Care Planning

As Case Managers lead the development of a care plan, they will consult all available data sources. The primary framework that informs the care plan is the comprehensive health risk assessment (HRA). However, the results from the initial screening, historical member claims data, and predictive model output will also contribute to a holistic view of the member's strengths, barriers, and needs.

Upon enrollment, each member will be encouraged to complete an initial health screening questionnaire, available through multiple channels including telephonic, mail, online, and in person where appropriate. This brief questionnaire is designed to optimize engagement and identification of those members who may require an in-depth assessment and potential care plan development. It will also help the case manager pinpoint areas across the member's physical, behavioral, and functional status to examine more closely during the comprehensive risk assessment.

In the care planning process, our Case Managers will gather and review any additional available data, including claims and utilization data, clinical information through medical records, and information provided from provider and other referrals. Relevant information from these sources is discussed with the member and IDT during the care plan development. In this way, the care plan is a living document, designed to reflect up-to-date care needs, goals, and interventions for each member in the care coordination program at any given time.

Question 9.1.6, #4

4. Submit a sample care plan for each proposed risk stratification level.

Our member's care plans are goal-focused and have clear milestones and action steps. In Figures 9.1-11, 9.1-12, and 9.1-13 show three sample care plans for members at the low, medium, and high acuity levels, as they would appear in our care management system CareCompass. In these specific examples:

- The low acuity member is fairly well managed, but needs some additional self-management around condition monitoring and nutrition counseling
- The medium acuity member needs more intervention and has gaps around complications, nutrition, and connecting with a PCP on a regular basis to help avoid a crisis resulting in emergency room visits
- The high acuity member not only has needs around complications and nutrition but his or her condition is compounded by depression and a neurological condition

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Involved Parties (9.1.6.1)

Question 9.1.6, #5

5. Describe how you will ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development process.

Active Member Involvement in Care Planning

Trusted and most familiar with the member's abilities and preferences, families, guardians, advocates and caregivers are a critical part of the member's care and often the linchpin to supporting the member in their care plan development. From our experience in providing care coordination across affiliate plans, we recognize that **members are more likely to comply with care plans if they and their families, guardians and caregivers are involved in the planning process and driving their own care decisions.** Case Managers will work closely with the members to communicate in a manner that is appropriate and that helps make sure understanding of the full range of options. When members are unable to become active participants or wish to involve their families, guardians and caregivers, Case Managers will collaborate with the authorized representative and/or those individuals whom the member identifies and consents to participating.

A designated Case Manager will act as the single point of contact for the member and family/caregiver to make communicating easy. Care coordination will involve members, authorized representatives, and families/caregivers in developing the short- and long-term goals of the care plan. With appropriate approval from the member, the Case Manager will engage the authorized representative/family/caregiver to participate in the IDT and help to develop goals for the member's care plan and document their participation. During the care coordination process, the Case Manager will work closely with the authorized representative/family/caregiver to provide information and education that empowers them, in concert with the member, to make informed decisions on necessary care, services and supports. The Case Manager will facilitate agreement among the IDT and the member on the proposed care coordination interventions. The member's consent will be documented in CareCompass. Where authorized representatives or legal guardians are involved, their agreement and signature will represent the consent of the member.

The care plan is a living document. To make sure that it remains current, the Case Manager will maintain ongoing communication with the family/caregiver to assess the member's progress along the care plan goals and to identify new needs. Follow-up communications with the family/caregiver are most critical when a member experiences a change in status, such as a visit to the emergency room or an admission to inpatient. The Case Manager will include the family/caregiver on any and all communications with the IDT during these events and post discharge.

Additionally, Amerigroup will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can help support our Iowa members in directing a meaningful plan with their desired health and quality-of-life outcomes.

Amerigroup understands the critical role families and caregivers play in the lives of many members in our care coordination program. We are sensitive to the emotional, physical, and financial toll this role can take on families/caregivers. Optimizing their own health, resilience, and well-being strengthens the family/caregiver's abilities, promoting stability and quality of life for the member. Our Case Manager will

engage caregivers in a discussion about how they are doing and inquire about needs the caregiver might have that can be supported. Our Case Managers will use free tools, such as the American Medical Association's caregiver assessment, to guide these discussions. Case Managers will have access to resources that can be shared with caregivers throughout the care coordination process. We strive to reduce family and caregiver depression, anxiety, and stress by providing education and information about available caregiver supports, enabling them to provide care longer, thereby avoiding or delaying the member's need for costly institutional care. Family and caregivers can either engage directly with the Case Manager to identify supports available in their community or access resources through our online library.

Question 9.1.6, #6

6. Describe how you will identify other caseworkers to be included in the care plan process and how services will be coordinated to avoid duplication and/or fragmentation of services.

While the Amerigroup care coordination model is fully integrated across physical health, behavioral health, and LTSS, there are situations where members receive care coordination services from additional caseworkers, such as when members are also enrolled in Health Homes, ACOs, or Medicare Advantage HMOs. ***Our coordinated approach places the member in the center to ensure all resource needs are integrated, resulting in better services and allocation of resources, enhancing self-direction, and improved health status with no duplication.*** We are experienced in coordinating the full spectrum of services regardless of whether we or other entities are responsible for payment. The Case Manager synchronizes efforts and draws on the expertise from the member's broader interdisciplinary team (IDT), using technology tools to link all team members and organize activities and interventions.

Care Plan Coordination with External Caseworkers

We will build relationships with other case/care managers or support coordinators, their employees, and the agency to which the employer is contracted. Our Case Managers are trained to identify these types of situation by examining member demographic and historical claims data. We have found that often the most straightforward and effective way to identify other caseworkers that play a part in coordinating a member's care and services is simply to ask the member. We will establish a formal communication process and sign Memoranda of Understanding or Letters of Agreement when appropriate with employers or agencies. We will develop policies and procedures that will elicit coordination with Case Managers or support coordinators and eliminate duplication in services. The IDT structure will provide a mechanism to eliminate duplication of services. For those participants who are enrolled in Home- and Community-Based Services (HCBS) waiver programs, we will collaborate and coordinate services with HCBS care managers, as well as engage with DHS and other State agencies.

Where applicable, Amerigroup Case Managers will coordinate activities with caseworkers from other managed care plans, insurers, programs, and providers. We monitor these activities during a quarterly care plan review process, and we follow up periodically to assess whether the non-covered services have been accessed and are being provided. The Case Manager solicits feedback from the member and the IDT regarding the effectiveness of the process.

To accomplish this coordination, we will establish productive partnerships with other plans and insurers. Case Managers contact appropriate representatives from the programs, plans, and insurers prior to care plan reviews to ensure that all pertinent information is included in the review. Case Managers also communicate with these representatives regarding the status of member care, as appropriate and with expressed permission from the member. When it is necessary to conduct a joint meeting with other programs and insurers, we make these as convenient as possible, offering to schedule a conference call so

that all invitees may participate. As we develop and revise care plans, we distribute copies to all service providers and caregivers.

Preventing Duplication/Fragmentation of Services

Once identified, our Case Managers will maintain open communication and coordinate with caseworkers from other managed care plans, insurers, programs, and providers. As appropriate and with permission of the member, Amerigroup will share the results and identification and assessment of that member's needs to avoid redundant activities.

As soon as the member begins case management, we capture the member's information in Member 360—a secure, centralized information sharing system—to support timely access to the most appropriate services for the member's conditions and prevent duplication. The information we capture for each member includes services and support already in place for each member, so that these can be documented, and duplication of effort to secure such services can be avoided. Through the provider facing Member 360 tools, external Case Managers will be able to see records of members attributed to them via the Amerigroup provider portal, giving them simple, easy-to-access data and information to assist them in engaging their members in their health and well-being. This information will enable all caseworkers serving our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care.

Care Plan Requirements (9.1.6.2)

Question 9.1.6, #7

7. Indicate how you will ensure that clinical information and the care plan is shared with the member's PCP (if applicable) or other significant providers.

Coordination with Primary Care Physicians

Amerigroup clinical staff maintains a close working relationship with the primary care physicians (PCPs), Integrated and Chronic Health Homes, and other significant treating providers in our members' IDTs. We leverage this relationship to inform our provider partners about the benefits of our care coordination program; available education, services, and materials; reciprocal sharing of information requirements; and how they can access chronic condition information to improve member care. ***We see our role as supportive, complementing the providers in their care for our members, and actively work with providers to encourage them to collaborate in providing the best care and coordination of services for our members.***

After acquiring releases of information, our Case Managers facilitate the information-sharing process through ongoing collaboration with the member's IDT to ensure that services are synchronized, unduplicated, and consistently delivered for every individual. The member's IDT may consist of various types of providers, including PCPs, Health Homes, medical and behavioral health specialists, and social workers. An example of this type of reciprocal information-sharing is diabetic information that goes to both the cardiac specialist, who will educate the member on diabetes and heart health, and the behavioral health provider for behavioral modification.

Sharing Information with Providers

Through the provider facing Member 360 tools, providers who have members attributed to them can see the member record via the Amerigroup provider portal, giving them simple, easy-to-access data and information to assist them in engaging the members in their health and well-being. The integrated data will be displayed to make it easy for the provider to act on it and making sure their patients are getting the services they need. This view will enable providers who are treating our members to see the full picture,

including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. See Section 9.1.7 for more detail on provider facing Member 360.

We also send the PCP a letter of introduction explaining the individual's participation, provider responsibility in the care planning process, the clinical practice guidelines associated with the member's condition, and a copy of the care plan.

We engage all relevant treating providers in the case management planning process—soliciting feedback and sharing of information throughout the member's care planning and case management. In addition, we communicate with all treating providers as appropriate throughout the process to:

- Provide regular status updates to the provider regarding the member's stratification level, changes in health status, and contact frequency
- Assist with scheduling appointments or arranging transportation
- Address provider questions about the member's care
- Monitor the member's engagement in services and supports
- Share provider collaboration and communication details
- Reinforce evidence-based clinical practice guidelines

Contacts are primarily telephonic, but we also regularly deliver updated case management plans by mail or fax to the provider.

Communication with Members

We have found that active member input and participation in care planning encourages member ownership of the plan and maximizes the potential of achieving the specified goals. The Case Manager will regularly communicate with the member and caregiver/family by phone, email, and in person to monitor progress and achievement of care plan goals. Through these communications and ongoing data review, the Case Manager and the team may revise the care plan to identify changes or additions to services and supports or refine goals.

Our Iowa members will also have online access to their care plans through the member portal. In addition to the care plans, they will be able to view their completed health risk assessments, their risk score, their PCP, and their summarized demographic information. Our Case Managers encourage members to review their care plan once it has been developed, and regularly with changes in health status. This facilitates working with the member to gather input and update the care plan. For members who prefer dealing with paper copies, summaries of the care plans will be mailed or faxed, upon request.

Question 9.1.6, #8

8. Describe how cultural considerations of the member would be accounted for in the care planning process and how the process will be conducted in plain language and accessible to members with disabilities or limited English proficiency.

We take pride in our ability to encourage members to gather information, make good decisions, and take responsibility for their health care. **Setting the right tone for this individual autonomy and engagement requires careful evaluation and planning to meet the member at his or her current place (physically, behaviorally, and functionally), using tools and language the member can readily understand.** Our care planning process will reflect the cultural considerations of our members in Iowa on a community-by-community basis. Our approach to ensuring culturally competent care to our members includes:

- Training Amerigroup employees on cultural competency and plain language communication
- Promoting ease of readability of written materials
- Facilitating communication with members who have limited English proficiency
- Facilitating communication with members who have disabilities

Training on Cultural Competency and Plain Language Communication

Recognizing and being sensitive to the cultural needs of diverse member groups demands that we approach all communication with a strong cultural competency. Amerigroup's cultural competency training plan fully supports this effort. All employees must complete this training when hired and must pass an exam at the end of the course, as well as complete an annual refresher training.

These training efforts help make sure that our employees understand that delivering services to people of all cultures, races, ethnic backgrounds, abilities, and religions must occur in a manner that recognizes, values, affirms, and respects the worth and protects and preserves the dignity of each member. Our training curriculum includes definitions, benefits of cultural competency, government regulations, values, language resources, and variations in social comfort factors. Amerigroup's policies and procedures fully support all 14 federal culturally and linguistically appropriate services guidelines regarding cultural issues, languages, and readability.

Through this training, our Case Managers are equipped to lead care planning discussions in plain language and in a culturally competent manner. This helps to enhance member understanding and engagement in the care planning process, as well as the member's ability to make informed decisions on the care plan.

Readability of Member Materials

All member materials, including the member's care plan, are drafted to be easy to understand and developed in accordance with our commitment to cultural competency. We also make sure that all member materials are written to the Flesch-Kincaid reading level requirements of Iowa. We enhance written materials with pictures and symbols where possible to help convey the meaning of the written text. In addition, for online materials we also use an innovative, interactive software tool designed specifically for health plan applications. This tool replaces hard-to-read medical terms and phrases with plain-language alternatives and helps ensure that members at every reading level can understand Amerigroup materials.

Members Who Have Limited English Proficiency

For all interactions with the member, including the care plan process, Amerigroup will provide oral interpretation services at no charge to members. The availability of oral interpretation is prominently displayed at the front of the member handbook. Our Case Managers will include employees who reflect the cultural and linguistic backgrounds of the members we serve. As needed or as directed by the State, we will hire representatives who speak other languages.

Our telephone menu script will state that oral interpretation is available for any language, and written information is available in Spanish and English. We train our Case Managers to quickly recognize situations requiring interpreter services so that they can arrange for a representative who speaks the language or an over-the-phone interpreter (OPI) to join a call to speak to the member in his or her native language within 45 seconds. The OPIs with whom we work are fluent in over 200 languages and understand medical terminology.

This interpretation service is also available to members during visits with Amerigroup providers. When a member needs language interpretation to communicate with a provider, the provider contacts the Member call center, and a Member Services Representative creates a conference call between the provider, member, and interpreter.

In these situations, a Case Manager can make arrangements for an interpreter to accompany the non-English-speaking member on a medical appointment so that he or she can communicate with the provider. Our Case Management Department can also arrange for a sign language interpreter to accompany a member who is deaf or hard of hearing on a medical appointment to offer signing services.

Members always have the right to refuse the interpreter service. If they do so, Amerigroup documents that decision in the member's file.

Services for Members with Hearing or Visual Impairment

A separate toll-free number provides Teletypewriter (TTY) and Telecommunications Device for the Deaf (TDD) access for members with hearing loss and/or language disabilities through AT&T Relay Services. The member calls the TDD line, and the TDD operator calls Amerigroup. The TDD operator communicates the member's message to a call center representative. The representative then replies to the member through the TDD operator.

Callers with hearing disabilities can also communicate with Amerigroup using technology that allows them to conduct Video Relay conversations by viewing a qualified sign language interpreter. The member actually sees the Video Relay representative, a sign language interpreter, on his or her television screen and is able to both read the content and see the interpreter's facial expressions. Being able to see the interpreter's facial expressions is a subtle but important factor that can help Amerigroup in connecting with members. Our provider directory includes the languages spoken by each PCP. We will contract with a vendor to provide video conferencing with a qualified sign language interpreter for members with hearing impairment.

We will also offer materials in additional formats at no charge to the member, including large print and Braille, to accommodate those with visual impairments, disabilities, or other specialized needs.

Question 9.1.6, #9

9. Describe how the proposed care plan process will include a system to monitor whether the member is receiving the recommended care.

Monitoring Case Managers

Monitoring whether members are receiving recommended care is a core daily responsibility for our Case Managers. Our Case Managers are accountable for coordinating all of the member's acute, behavioral, psychosocial, and functional care needs. Through our integrated care management tools—CareCompass and Member 360—our Case Coordinators have access to up-to-date data on members' progress along with their care plan. Case Managers are expected to:

- Monitor the care, services, and products delivered to members
- Monitor if the goals of the care plan are being achieved
- Determine whether those goals remain realistic and optimistic
- Determine if modification of goals is warranted
- Determine what actions may be implemented to overcome barriers and enhance positive outcomes

In addition, our Case Managers maintain professional rapport and communication with the member and those providing care/services, including the member's physician(s), to enable effective monitoring. This communication helps confirm that the interventions and goals in the care plan can be discussed, any problems or issues can be identified, and adjustments can be made to the plan as needed.

Integrated Interdisciplinary Team Rounds

Amerigroup's behavioral and medical clinical leadership oversees care plans and actively collaborates to engage providers, members, and their families. Our program incorporates clinical case rounds with an interdisciplinary team of professionals. Weekly chronic condition rounds include our medical and behavioral health medical directors, utilization managers, subject matter experts on issues applicable across Medicaid population, pharmacists, and Case Managers. Case Managers prepare and present cases at rounds for validation of the care plan and to obtain suggestions on how to better manage the member. The team discusses available community resources and receives input from the medical directors regarding medical management, medications, and suggested modifications to the care plan.

Amerigroup's model fully integrates physical and behavioral health and will incorporate specialists as required to help address the member's condition and identified needs. Case Managers participate in both medical and behavioral healthcare rounds and present on shared members. The shared learning in these conferences enhances understanding of the complex needs of these members and assists in developing improved strategies for coordinated care. During these rounds, the behavioral health concurrent review team and the case management staff review all complex cases to ensure appropriate and timely interventions. Collaboratively, the team evaluates each case to identify and resolve any barriers to achieving the goals set in the member's care plan, such as language, medication adherence, co-occurring conditions, transportation, or caregiver issues.

Monitoring Timeframe

Each member's care plan includes a timeline for ongoing monitoring of the member's progress toward goals. At specified intervals, the Case Manager will reach out to the member and family/caregiver, his or her PCP, and other treating providers to assess the member's status. If the Case Manager identifies any barriers to progress or members whose progress may have stalled, the team will assess alternatives to get the member back on track toward achieving his or her goals.

Timeframes for scheduled member follow-up will be consistent with the degree of support and motivation the member appears to require to achieve specific goals on the individualized care plan.

Case Managers will follow up and contact members in accordance with the care plan goals. At a minimum, contact will be made with the member as indicated by the activity/acuity level of the case or at least every 30 business days for ongoing management. The Case Manager will document the scheduled follow up timeframe within CareCompass.

Tracking and Reporting (9.1.7)

Question 9.1.7, #1, 2

1. Describe how you propose to track and report on care coordination programs and share care coordination information with the member, authorized representative and treatment providers.
2. Describe the system that you will use to integrate and share information about members in order to facilitate effective care coordination

Fully Integrated Clinical Management Tools

Amerigroup employs innovative, integrated technology solutions that allow us to provide high-quality services to our members in a highly effective, efficient manner. We have developed robust care coordination tools that support member engagement, facilitate coordination of care, and encourage active member participation in service delivery. Our proprietary care management and member information-sharing technology tools, CareCompass and Member 360, integrate seamlessly with the Core Operations System and represent the system of record for member care coordination information. We will bring to Iowa our innovative technology solutions to reduce employee workload, enhance member engagement, and improve communication across all employees and providers who serve the member.

The fully integrated nature of our platform has delivered proven time-saving efficiency for our clinical staff, allowing them to focus more time on the needs of our members for optimal clinical impact. According to an internal survey distributed to pilot users, the integrated system significantly decreased the amount of time to research member information for initial and follow-up outreach:

- For initial outreach, we reduced the time it takes for research of member data from 16 or more minutes to 1–5 minutes
- For follow-up outreach, we reduced the time it takes for research of member data from 1–10 minutes to 1–5 minutes

Innovative Technology Solutions

CareCompass



The cornerstone of our care coordination model is CareCompass, our proprietary integrated care management system. As illustrated in Figure 9.1-14, *CareCompass houses the care plan and provides information about member conditions and medications and chronologically ordered progress notes, which promote comprehensive care coordination for member needs and issues, regardless of whether the driver is physical health, behavioral health, long-term services and supports (LTSS), or all three.* All of our clinical staff involved in the member's care work in CareCompass, enhancing clinical oversight, facilitating communication across departments, and reducing member risk for fragmented care.

CONTAINS CONFIDENTIAL INFORMATION

CareCompass seamlessly integrates with our core operations system, gathering and organizing information for management and coordination of member care and services. Member utilization data, such as claims history, authorization, immunization records, lab results, and care and disease management data, are readily available in an organized format with tools for Case Managers to identify and manage members' needs. It also includes online access to related attachments such as Power of Attorney documents, clinical records, or additional consent documents that have significant relevance to the member's care. CareCompass captures all member assessment information, including results from the initial health risk screening and any completed comprehensive health risk assessments, as shown in Figure 9.1-15.

CONTAINS CONFIDENTIAL INFORMATION

The information captured by CareCompass is used to drive care plan development, maintenance, and monitoring. The system prompts Case Managers on critical items and tasks to be addressed during the assessment and care coordination process. These tools enable Case Managers to track closely both care coordination activities and barriers to care identified through discussions with the member to verify that we are providing the care and services needed. CareCompass's library of reports enables us to use data to monitor Case Manager caseloads, compliance with accreditation requirements, and compliance with required time frames (such as timely completion of health risk assessments).

CareCompass facilitates communication and collaboration among all participants of the member's interdisciplinary team. For each member, we synchronize care coordination efforts through a single, individualized care plan that is tracked through CareCompass. The tool facilitates care coordination through the use of automated tasks, scheduling, and task reminders. Because all care coordination activities are documented in CareCompass, all team members can readily view data and information about individuals and share activities that have occurred, enabling improved care coordination.

Member 360

An integrated adjunct to CareCompass, *Member 360 allows Amerigroup clinical staff to access a single view that displays members' clinical and claims-based data in an easy-to-navigate dashboard, including HEDIS[®] care alerts, authorizations, prescriptions, lab results, and all claims history organized by type such as inpatient, ER, office visit, and behavioral health.* It organizes information into a timeline of clinical events representing a longitudinal patient record for the member across a number of domains, including diagnosis, providers, and medication history, as shown in Figure 9.1-16.

CONTAINS CONFIDENTIAL INFORMATION

HEDIS Gaps in Care Alerts

The Member Care Summary tab of Member 360 organizes member information in an easy-to-see format that delivers an at-a-glance view of a member's service history, including office visits, inpatient admissions, emergency room visits, authorizations, immunizations, lab results, prescriptions, and durable medical equipment.

To see additional information on any item, users can simply hover their mouse over the item or click on it to drill down. This integrated display makes it easy to take action, filling in gaps in care and making sure members are getting the services they need. We prominently display HEDIS gaps in care alerts in the upper left corner of the Member Care Summary screen, as shown in Figure 9.1-17.

CONTAINS CONFIDENTIAL INFORMATION

Leveraging Member 360's robust reporting capabilities, we will create and submit regular reporting regarding the selection criteria, strategies, and outcomes of care coordination programs as prescribed in the Reporting Manual, including reports on completion of initial health risk screening, completion of comprehensive health risk assessments, and care plan development.

Provider Facing Member 360

In the Iowa market, we will expand the reach of the care coordination footprint by making the Member 360 view available to providers — including Integrated and Chronic Health Homes — for our members under their care through our provider portal. ***Through the provider facing Member 360 tool, providers who have members under their care can see the member record via the Amerigroup provider portal, giving them simple, easy-to-access data and information to assist them in engaging members in their health and well-being.***

The integrated data will be displayed to make it easy for providers to act on it, filling in gaps in care and making sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing the provider's ability to reduce redundant efforts and improve the quality of care. The availability of the 360 view will create an enhanced communication platform between Case Managers and providers so that conversations regarding member care coordination and outcomes easily occur.

Additionally, Amerigroup will extend the reach and collaboration with stakeholders involved in the members care. We will deliver an information-sharing and collaborative platform to share information with all authorized members of the interdisciplinary team. Participants in the team will be able to review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including

individuals with intellectual and developmental disabilities or those with a serious mental illness. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can help support our Iowa members in directing a meaningful plan with their desired health and quality-of-life outcomes.

Our platform will also help the providers achieve the quality incentives defined in the Amerigroup quality programs, as discussed in Section 10.3. For example, the provider will be able to look up the most recent HgA1c results for each of his or her Amerigroup members with diabetes. The tool will assist providers in delivering care for our members by providing not only relevant data related to each member, but also prompts displayed in a succinct view to create obvious, actionable items at a glance.

Because access, use, or disclosure of information related to certain sensitive medical services is strictly limited by federal and State laws, information related to behavioral health or other sensitive services may only be accessed through Member 360 with the authorization of the member or for treatment purposes.

My Advocate: Maternal Health

CONTAINS CONFIDENTIAL INFORMATION

Sharing Care Plan Information

Our Case Managers actively promote information sharing among the member's interdisciplinary team through ongoing collaboration to make sure that services are synchronized, unduplicated, and consistently delivered for every individual. In addition to the member and family/caregiver, the member's interdisciplinary team may comprise various types of providers, including primary care providers (PCPs), Health Homes, medical and behavioral health specialists, and social workers.

The Amerigroup care team engages all treating providers, including PCPs, specialists, and behavioral health providers, in the care planning process, soliciting feedback and sharing information throughout the member's care coordination. Treating providers will have access to comprehensive and detailed member

data reports through our provider facing Member 360 tools. In addition, we communicate with all treating providers as appropriate throughout the member's care to:

- Provide regular status updates regarding member stratification levels, changes in health status, and contact frequency
- Assist with scheduling appointments or arranging transportation
- Address questions about member care
- Monitor member engagement in services and supports
- Share provider collaboration and communication details
- Reinforce evidence-based clinical practice guidelines

Our Iowa members will have online access to their care plans through the member portal. In addition to the care plans, they will be able to view their completed health risk assessments, their risk score, their PCP, and their summarized demographic information. Our Case Managers encourage members to review their care plan once it has been developed and regularly with changes in health status. This facilitates working with the member to gather input and update the care plan. For members who prefer dealing with paper copies, summaries of the care plans will be mailed or faxed, upon request.

In addition, the Case Manager will regularly communicate with the member, caregiver/family, and providers by phone, by email, and in person to monitor progress and achievement of care plan goals. Through these communications and ongoing data review, the Case Manager and the team may revise the care plan to identify changes or additions to services and supports or refine goals.

Monitoring (9.1.8)

Question 9.1.8, #1

1. Describe your care coordination monitoring strategies

Case Management Quality Improvement Program

Amerigroup has an established, comprehensive Case Management Quality Improvement Program for monitoring the care coordination program and processes. It promotes objective and systematic measurement, tracking, and evaluation of services and implements quality improvement activities based upon the findings. We will deploy this program in Iowa to make sure we identify and seize opportunities to continually improve how we deliver care coordination services to our Iowa members.

The purpose of our monitoring program is to:

- Establish a consistent framework for measuring and reporting case management outcomes, both at the individual employee's performance level and the overall program level
- At least annually, monitor and evaluate the effectiveness of each case management quality measure
- Assist in monitoring compliance with standards of practice in case management
- Continuously improve the case management process
- Document compliance with accreditation standards at least annually
- Maintain compliance with accreditation standards

Case Management Program Authority and Accountability

The Case Management Quality Improvement Committee (CMQIC) has oversight of the Case Management Quality Improvement Program. The CMQIC is comprised of senior-level regional, brand, and specialty company leaders. The CMQIC is responsible for reviewing and approving case management

policies, as well as establishing and developing quality improvement projects aimed at achieving accreditation and enhancing the enterprise's approach to continuously improving the quality of its case management activities. The CMQIC meets, at a minimum, on a quarterly basis to provide oversight and guidance for all quality activities and has input into the case management process and quality measures.

Responsibilities of the CMQIC include:

- Overseeing and guiding case management quality activities
- Overseeing implementation and enhancements of the case management program consistent with our case management strategy, industry standards, business needs, and trends
- Helping assure consistency in delivery of Amerigroup's case management program within business unit requirements
- Collaborating and discussing best practices to help drive the development and implementation of a leading-edge case management program across the company
- Reviewing and approving the case management program description annually
- Reviewing and approving all enterprise-wide case management policies annually
- Identifying and monitoring case management performance measures quarterly
- Helping assure compliance with accreditation standards and regulatory requirements
- Approving, monitoring, and providing oversight and guidance on quality management priorities and projects
- Evaluating the effectiveness of the case management program description at least annually

Annual Evaluation of Program

On an annual basis, the Quality Improvement Committee (QIC) will evaluate the care coordination program to make sure that the scope, goals, performance measurements, and planned activities are consistent with national strategic plans and the national case management standards of practice. This evaluation includes:

- Evaluation of the CMQIC to optimize effectiveness
- Evaluation of the results of the case management quality case review process and review of quality and aggregate data from member satisfaction survey reports and complaints
- Input on trends and action plans related to internal case management activities
- Input on trends, philosophy, and benchmarks available from national case management organizations and professional resources/publications

This evaluation results in the development of the Quality Management and Improvement (QM/QI) Program and Work Plan and revision of the annual Case Management Program to meet the upcoming year's needs.

Defined Quality Performance Measures

Performance measures are quantifiable, used to establish acceptable levels of performance, including a baseline measure, measurable goal, and, at a minimum, annual re-measurement. The QIC reviews all performance measure results. Plan/Regional business unit staff receive their specific performance results in staff meetings. When directed to do so by the QIC, areas below benchmark will implement action plans to improve or correct identified problems.

Quality performance measures for case management may include:

- Case management quality case review outcomes
- Collaboration with the behavioral health program

- Complaints about the case management process
- Member satisfaction with case management services
- Documentation of member-identified issues and concerns in the case management plan
- Medication adherence assessment and follow-up in the care plan as an identified issue with interventions and targets

Case Management Quality Case Review Process

Case managers and non-case managers have quality case reviews completed monthly on a random selection of open and closed case records from within the medical management system. Consistent implementation and documentation of the case management process (that is, case initiation, assessment, planning, coordination, monitoring, and evaluation) are assessed through the quality case reviews process.

The manager and the individual employee review all case review results to assess the Case Manager's learning needs. The Case Manager is provided feedback on trends seen and opportunities for improvement, and an action plan for follow-up is developed, if necessary. Actions plans may include but are not limited to:

- Providing education and/or counseling to the employee until improvement is noted
- Conducting quality case reviews on a more focused basis (for example, weekly or biweekly) until achieving a consistent score at or above the designated minimum threshold

The QIC reviews aggregated quality review results for trending and analysis.

Question 9.1.8, #2

2. Describe how case specific findings will be remediated

Remediating Systemic Issues of Suboptimal Performance or Non-compliance

Based on the findings from the care coordination monitoring strategies described above, Amerigroup promptly develops action plans to remediate all case-specific findings identified. For identified systemic issues of suboptimal performance or non-compliance, the CMQIC develops strategies to improve its care coordination program and processes and resolve areas of non-compliance, including process redesign and quality improvement projects. Case management quality projects will focus on improving the effectiveness of case management services and processes. To assess progress in meeting the goal, each case management quality project includes a baseline measurement, quantifiable measures, established measurable goals, and periodic re-measurements, including the following elements:

- Statement of issue addressed
- Baseline measurements
- Analysis
- Intervention design
- Periodic re-measurement following intervention
- Analysis of new information with redesign of intervention if needed

For quality management and improvement strategies that involve engaging providers, we develop performance improvement projects (PIPs) to help increase the quality of care to our members. See Section 10.1.2 for examples of how we have worked with providers in the past to improve outcomes, including:

- Reducing asthma-related emergency room visits
- Non-urgent emergency room utilization
- Improving access to preventive care
- Mental health follow-up post hospitalization

Example: Case Management Stabilization Initiative

Opportunity for Improvement

An analysis of readmissions within a short time frame (30 days or less) among members of Amerigroup affiliate plans revealed an opportunity to improve the effectiveness of discharge planning. Across our Florida, Louisiana, Maryland, New York, Tennessee, and Texas markets, we developed an initiative in 2013 to address preventable readmissions to improve health care quality and to reduce medically unnecessary hospital spend. The goal was to improve the health of the population and to control/reduce the per capita cost of care.

Description of the Initiative

The Case Management Stabilization initiative is a readmission management program that includes a member identification strategy, nurse outreach protocols, and targeted interventions:

- *Member Identification* — A readmission predictive model was built to provide an indicator of readmission within 30 days of discharge. The methodology included demographic, utilization, clinical, and current admission data to predict admission risk. The Readmission Score (RAS) ranged from 0 to 100, where a score of 80 would represent an 80 percent likelihood of readmission within the next 30 days. The RAS appears on the health plan's Inpatient Daily Census and is recalculated daily using the most recent admission information.
- *Nurse Outreach Protocol* — Nurse outreach to the member/caregiver would begin prior to or immediately after hospital discharge. The call protocol allowed for both outbound and inbound contacts. Members were engaged for 30–45 days post discharge.
- *Targeted Interventions* — Once engaged with a member, the nurse's interventions were based on the Coleman Care Transitions model: Medication Reconciliation, Red Flag Recognition, Follow-up Care, and Patient Centric Medical Record. The nurse would work with the member/caregiver to obtain the hospital discharge medication list to review against the medications in the member's possession. The goal of the reconciliation is to resolve any discrepancies through review with the outpatient provider. Our Red Flag Diagnoses were CHF, angina, COPD, and diabetes. A problem list, including the admission diagnosis and comorbidities, was created to identify the diagnosis and root cause of the admission. The nurse made sure that the member had follow-up appointments and contacted the treating physicians/ancillary providers to facilitate timely resolution of questions/issues. The nurse created a care plan, shared with the member and treating physician, which included the problem list, medication list, any red flags noted, and the discussion notes with the member/caregiver/other providers.

Outcomes

An evaluation of the study population (n=1,908) showed that after implementation of the Stabilization initiative, the readmission rate for any condition decreased from 18.6 percent to 16 percent. The greatest improvement was seen in the **readmission rate for like conditions which showed a decrease from 11 percent to five percent**. Given these improvements, the initiative was expanded in 2014 to the Kentucky and Virginia markets.

Reassessments (9.1.9)

Question 9.1.9, #1

1. Describe in detail your process for reviewing and updating care plans.

Process for Reviewing and Updating Care Plans

Amerigroup recognizes that care plans are dynamic and evolving and require ongoing evaluation of progress. When appropriate, the Case Manager will initiate and implement appropriate modifications or revisions to the care plan. For all members enrolled in our care coordination programs, we will review and update care plans as indicated by a triggering event. For a member in complex case management, we will update his or her care plan on an as-needed basis and at least semi-annually following a care conference with the member's PCP. For members enrolled in disease management, care plans will be updated no less than annually.

Care coordination services involve a continuous process of delivering and monitoring interventions designed to meet the goals of the care plan, along with ongoing assessment of progress toward achieving those goals. The care plan is an evolving document that may need to be re-evaluated and updated based on a trigger event as defined under Question 9.1.9, #3, below, or other changes in the member's healthcare or support needs.



Case Managers will follow up and contact members in accordance with the care plan goals. At a minimum, we will contact the member as indicated by the activity/acuity level of the case or at least every 30 days for ongoing management. The Case Manager will document the scheduled follow-up time frame within CareCompass.

The care plan will be revised and updated as appropriate to document any identified changes in issues, goals, and/or interventions. The Case Manager will evaluate progress toward goals at each member contact and document that goals are being monitored on the care plan, even if there are no changes or revisions to the care plan.

An important aspect of monitoring includes identifying that the member remains eligible for case management services by verifying that the member remains active in his or her healthcare plan. The Case Manager or case management support staff will document verification that eligibility for case management services has been completed at case initiation. Verification will be completed periodically as needed, but no less than once per month.

We track all reassessment and care plan due dates by member in CareCompass and through weekly update reports. Flags and triggering systems are in place to notify and alert the Case Managers of upcoming reassessment and/or care plan due dates. This provides the Case Managers adequate time to schedule the reassessments and care plan reviews and to coordinate updates and changes to the care plan with the interdisciplinary team. This process helps assure compliance with care-plan-required time frames.

Question 9.1.9, #2

2. Describe the protocol that you will use for re-evaluating members to determine if their present care levels are adequate.

Protocol for Re-evaluating Members to Determine if Their Present Care Levels Are Adequate

As part of the monitoring process, the Case Manager maintains communication and collaboration with the member, family/caregivers (as appropriate), and all providers (including behavioral health providers) in the member's system of care to monitor the member's health status and progress toward meeting care plan goals. Whether triggered by the identification of a need through monitoring or a reassessment, the Case Manager will reach out to engage the member to discuss the care plan.

The Case Manager will use the results of the reassessment or other data to talk with the member about his or her current health and/or functional status and explain the service or support options available that will meet the member's needs and continue the member on the path to achieving his or her stated goals. Together the Case Manager and the member/family/caregiver may determine that the stated goals need to be adjusted to take into account the member's changed status. During this conversation, which may occur by telephone or in-person in a setting of the member's choice (as necessary), the Case Manager will provide the member and family/caregiver with information to assist in the decision-making process.

Depending on the preferences of the member, the Case Manager may include in this conversation other members of the interdisciplinary team. Their participation will help the Case Manager discuss specialized clinical or support needs with the member. For example, if the care plan update is related to the member's heart condition, the member's cardiac specialist, PCP, or both providers may participate in the discussion. If the care plan update is related to a social need, such as connecting the member to housing, a social worker may be included.

Amerigroup promotes an environment of shared decision-making that honors both the provider's expert knowledge and the member's right to be fully informed and involved in all aspects of care. This collaborative process empowers individuals with cognitive or behavioral health challenges by helping assure that they are the leader in their care planning process and are also supported by their family/caregiver, the Case Manager, and providers, giving them the assistance they need to make decisions for themselves.

Together the Case Manager, member, family/caregiver, and participating interdisciplinary team members will determine updates to the care plan. The Case Manager will document the changes in CareCompass and outreach to any non-participating members of the interdisciplinary team to inform them of the updated care plan. A copy of the care plan will be shared with the PCP, other treating providers, and the member.

Question 9.1.9, #3

3. Indicate the triggers which would immediately move the member to a more assistive level of service.

Triggers for Moving the Member to a More Assistive Level of Service

For all members enrolled in our care coordination programs, we will review and update care plans as indicated by a triggering event. Our Case Managers will evaluate the need for reassessment when we learn of certain trigger events such as:

- A new diagnosis (for example, COPD, diabetes, CHF)
- A change in the ability to perform activities of daily living and instrumental activities of daily living
- A hospital admission or unexpected facility placement
- A significant change in caregiver status (such as a serious illness)
- Loss of or inadequate housing that may necessitate a reassessment and an alternate plan for a member
- Lack of adherence to medication regimes or follow-up with medical providers

We recognize that our members and provider partners may have greater visibility and more timely information on changes in member status and triggering events. As such, we accept all requests from our members and provider partners to initiate a reassessment.

In cases where a reassessment reveals that the member does not require a more intensive level of care coordination, our Case Managers may provide short-term intensive coordination to assist a member and his or her caregiver/family through a more difficult time. If it is determined that the member requires a more intensive level of care coordination, our Case Manager will work with the member, family/caregiver, and the interdisciplinary team to collaboratively update the care plan.

Because our Case Managers are assigned to all members in their region regardless of level of care coordination needed at any given time, as members' needs change and they move between care coordination and complex case management, their assigned Case Manager will not change. Our Case Managers have the skills and expertise to assist members as their needs evolve, leveraging the expertise of the extended interdisciplinary care team as needs intensify or grow more complex. This continuity will benefit the member and improve quality outcomes and consistency across the delivery system.

Contractor Quality Management/Quality Improvement (QM/QI) Program (10.1)

Program Objectives (10.1.1)

Delivering quality care for each member is a driving goal for Amerigroup Iowa (Amerigroup) and our affiliates. Accordingly, we will implement a Quality Management/Quality Improvement (QM/QI) Program that incorporates all Contract areas with the goal of improving both the quality of care and outcomes for all enrollees across the healthcare delivery system. We successfully operate QM/QI programs for all populations included in the Iowa High Quality Healthcare Initiative through our affiliate health plans, giving us a unique understanding of the challenges and opportunities relevant to achieving sustained quality improvement for these populations.

Our QM/QI Program is embedded across all functions of our organization, and integrates medical, behavioral, pharmacy, oral, social, and LTSS components that reflect our holistic approach to member health and wellbeing. *With our affiliates' extensive experience, Amerigroup currently has in place the quality resources, infrastructure, and expertise to assist Iowa in meeting its quality goals and improving health outcomes and quality of life for members across all populations included in the Iowa Initiative.*

Building on the Medicaid quality programs developed during our affiliates' 24 years of experience and across 19 states, Amerigroup will customize our QM/QI Program to focus the entire health plan on achieving sustainable improvements in the quality and coordination of care for Iowa's members. The scope and depth of our QM/QI Program will reflect the demographic and epidemiological needs of Iowa's members and incorporate the key strategies outlined by the State, including the Healthiest State Initiative, State Innovation Model (SIM), and the Mental Health and Disability Services Redesign.



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The purpose of the QM/QI Program is to:

- Objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical, behavioral, and long-term care services
- Identify and implement strategies to improve the quality, appropriateness and accessibility of member care
- Facilitate organizational-wide integration of quality management principles

We will meet, if not exceed, the standards required by the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the State of Iowa. Our commitment to these standards is evident in our affiliates' widespread NCQA accreditations, strong HEDIS and CAHPS performance measures, innovative quality programs that are responsive to the specialized needs of our members, and effective continuous improvement processes. Key achievements across our state sponsored health program affiliates include:

- NCQA accreditation in 13 states
- Various Amerigroup affiliates have achieved the NCQA 90th percentile on critical performance measures such as timeliness of postpartum care, use of appropriate medications for members with asthma, follow-up after discharge for members hospitalized for mental illness, breast cancer screening, HbA1c screening, and adult BMI assessment
- Widespread improvement in HEDIS rates for Follow-Up After Hospitalization, Well Care, and Annual Dental Visit
- Innovative and effective quality strategies that capitalize on technology and community partnerships
- Rigorous and methodical performance improvement projects

To achieve quality goals, we embrace quality as a workplace culture and philosophy, not simply a separate function within the health plan. All of our employees participate in improving processes, services, and the culture in which we work. We implement cross-functional approaches that include representation from local health plan operational areas working with national leaders in their functional areas. Representatives from Quality Management (QM), Utilization Management (UM), Community-Based Case Management, Case Management (CM), Disease Management (DM), Behavioral Health (BH), Credentialing, Provider Services, Communication, Technology, Compliance, and our specialty organizations come together to solve problems and identify quality best practices. Our College of Quality provides an orientation entitled “Quality 101” for all of our employees, as well as ongoing training on our continuous clinical quality improvement structure. Our quality management philosophy extends to every level of management in the organization, and we embed quality goals into every associate’s performance plan to ensure optimal success. As outlined in Table 10.1-1, *Amerigroup’s Culture of Quality is embedded into every aspect of our organization. Every employee is a quality advocate, and quality is the number one priority in every functional area of the organization.*

Table 10.1-1. Organizational-wide Strategies Focus Every Employee on Quality Improvement

Strategy	Goal	Approaches
Member-centric Focus	Engage members to take charge of their health through targeted wellness, outreach, and incentive programs	<ul style="list-style-type: none"> • Outreach • Incentives • Health promotion • Wellness
Provider Collaboration	Collaborate with network providers to drive achievement of our quality goals	<ul style="list-style-type: none"> • Outreach • Education • Incentives • Medical home/Integrated Health Home • Cultural competency
Customer Satisfaction	Measure member and provider satisfaction and take action to maximize performance	<ul style="list-style-type: none"> • Satisfaction surveys • Benchmarks
Patient Safety	Promote the safety of healthcare services delivered to members	<ul style="list-style-type: none"> • Patient Safety committee • Quality of care • Pharmacy • Data
Accreditation Recognition	Validate performance through external accreditation (NCQA/Accreditation Association for Ambulatory Health Care (AAAHC))	<ul style="list-style-type: none"> • Health plans • Disease management

Strategy	Goal	Approaches
Outcomes Management	Authenticate achievements through industry-leading quality measures	<ul style="list-style-type: none"> • HEDIS • Performance improvement projects • Agency for Healthcare Research and Quality
Culture of Quality	Foster a workplace culture grounded in quality through training and alignment of employee objectives with QM/QI goals	<ul style="list-style-type: none"> • Employee training and mentoring • Executive and middle management role modeling of culture • College of Quality Management (computer based training models)
Clinical Research and development	Leverage credible clinical data, both internal and external, to inform QM/QI initiatives	<ul style="list-style-type: none"> • Clinical studies and Performance Improvement Plans (PIPs) • Best practices • Benchmarks • Health disparities • Continuous Quality Improvement (CQI)
Healthcare Reform (CHR) Readiness	Track and proactively address the future challenges presented by national healthcare reform	<ul style="list-style-type: none"> • Alignment of QM Program with healthcare reform quality goals • New research entities • Active participant with public comment requests for impact on quality • HCR quality sub-team
Network Excellence	Facilitate access to a superior provider network through a rigorous credentialing process	<ul style="list-style-type: none"> • Credentialing • Re-credentialing • Board certification • Audit expertise • Access and availability

We use local and community best practices to respond and adapt to changing market conditions. We incorporate input from clinical and quality improvement staff at the national level and from our affiliate health plans across other states. We also collect and incorporate local provider and member input. Our fully integrated medical and behavioral health programs are analyzed systematically to determine continuity of care processes, over- and underutilization indicators, and effectiveness of outreach to members and providers.

We implement creative, proven member and provider incentive strategies to drive performance improvement and favorable outcomes, as detailed in our response to 10.3. This includes partnering with Wellmark to



Amerigroup's distinguishing features for quality management:

- Integrating quality into every part of the organization
- Creatively reaching members through high-touch and high-tech tactics
- Leveraging technology to identify and prioritize members at the greatest risk for poor outcomes
- Actively engaging providers and members through incentives, education, and outreach

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implement the 3M Treo Solutions Value Index Score (VIS) as a consistent measure of value across ACO providers. We use ongoing assessment, tracking, and work plans based on measurable goals to promote member outcomes, drive provider quality and efficiency, and decrease negative outcomes and incidents.

We also work to engage members in taking responsibility for their health outcomes whenever possible. Our Healthy Rewards program includes member incentives and engagement strategies to enhance members' knowledge about, and management of their health and chronic conditions as well as tools to support their independence and integration in the community. We will also design special programs and partnerships in support of Iowa's specific goals, such as the Healthiest State Initiative (see 10.2) including a commitment to becoming a Blue Zones worksite.

Our data-driven quality approaches have been measured, evaluated, and refined. We continuously develop and implement innovative strategies that improve our members' outcomes and support our network providers. These strategies include new online tools and technology to enhance our ability to achieve the quality and financial goals of our State customers. Through data-driven and validated quality improvement analyses, our QM Program implements and improves services for our members and support for our providers. Our information systems and analytic tools along with our individualized member-centric health risk assessments, care and service plans, care teams, and integrated and community-based "feet-on-the street" QM, CM, and NCQA-accredited DM programs provide the basis for the development of quality improvement interventions.

In the following section, we provide the following information:

- Quality Program Overview
- Work Plan
- Continuous Improvement Process
- Provider Collaboration Strategies
- QM/QI Committee
- State Quality Initiative Alignment
- Provider and Member Incentives
- Critical Incident Tracking, Reporting, and Monitoring
- Provider Preventable Condition Process

QM/QI Program Requirements (10.1.2)

Question 10.1, #1

1. Describe your Quality Management and Improvement Program, addressing all elements outlined in Section 10.1.2. Include how you will monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members.

The Quality Management and Improvement Program (QM/QI Program) is comprehensive, systematic, and continuous. It applies to all member demographic groups, care settings, and types of services afforded to Iowa Medicaid, Iowa Health and Wellness Plan, as well as Healthy and Well Kids in Iowa (*hawk-i*) program members. It includes medical, behavioral health, LTSS, and waiver services. ***The QM Program addresses the quality of both clinical care and non-clinical aspects of service.***

The overall goal of the Quality Management Program is to improve the quality and safety of clinical care and services provided to members through Amerigroup's network of providers and its programs and services.

Our QM/QI Program policies and procedures define how departments support quality objectives. This includes how we systematically monitor and evaluate the quality, safety and appropriateness of medical and behavioral healthcare and services offered by Amerigroup and identify and act on opportunities for improvement. We provide all QM/QI Program information and documentation to providers and members and we acknowledge that our Program design must be approved by DHS.

The overall goal is to improve the quality and safety of clinical care and services provided to members through Amerigroup's network of providers and our programs and services. Specific goals are established to support the purpose of the QM/QI Program. All goals are reviewed annually and revised as needed to ensure they are measurable and realistic. QM/QI Program goals are primarily identified through:

- Ongoing activities to monitor care and service delivery
- Issues identified by tracking and trending data over time
- Issues/outcomes identified in the previous year's QM Program Evaluation
- A demographic and morbidity analysis of member age, gender, and most frequently diagnosed disease categories (both inpatient and outpatient)
- Member and provider input
- Internal process reviews (collaboration between clinical and quality staff)
- Accreditation, regulatory, and contractual standards

We also work with the State to establish goals that align with priorities like the Healthiest State Initiative, Mental Health Redesign, SIM, and other programs as they are introduced.

The QM/QI Program is driven by a continuous quality improvement (CQI) philosophy and mode of action (See Figure 10.1-1). Continuous quality improvement processes identified in the Program Description, Work Plan, and Annual Evaluation are approved by the applicable committees and conducted to accomplish identified goals. The strategy incorporates the continuous tracking and trending of quality indicators to ensure outcomes are measured and goals are attained and includes monitoring of quality of care interventions and outcomes through HEDIS[®] measure reviews, external quality review studies, periodic medical record reviews (for chart maintenance, documentation legibility, disease management compliance, continuity of care coordination, information security, etc.), and as required by the Centers for Medicare and Medicaid Services (CMS).

Figure 10.1-1. Amerigroup's Continuous Improvement Process Drives Ongoing Quality Improvement

Quality management activities to monitor and improve behavioral health care are integrated into the overall Quality Management Program and encompass State regulatory requirements as applicable. Areas of focus include but are not limited to:

- Access and availability of services
- Coordination of care (including coordination between medical and behavioral health providers)
- Disease management and case management services
- Assessment of member experience with behavioral healthcare and behavioral services

Behavioral Health HEDIS measures and methodology have been adopted as performance indicators for clinical improvement. Quality initiatives are developed and implemented as indicated by data analysis for process improvements. Initiatives are reassessed on an annual basis to evaluate intervention effectiveness and compare year-to-year performance.



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Integrated operations include both behavioral health and physical health personnel. Integration is further accomplished by behavioral health practitioner representation on both corporate and health plan QM/QI committees.

We understand the specialized approach required for quality management and improvement for populations receiving LTSS. In addition to standard analysis at the health plan level, and when findings indicate a need for improvement, we will implement systemic enhancements and quality projects specific to this population.

Examples of population-specific analyses include:

- Monthly data mining and analysis for all LTSS members to identify trends in gaps in care and services
- HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey data analysis for LTSS members separate from the all member data analysis
- Analysis of member and provider satisfaction surveys from LTSS members and providers including the Participant Experience Survey (PES) for members enrolled in HCBS waivers

Through our affiliates, we have extensive experience meeting the QM/QI RFP requirements and our program in Iowa will leverage our expertise to incorporate the following:

- An **annual and prospective five-year QM/QI work plan** that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results, and assesses progress toward the goals (see Attachment 14.5.1-1, Work Plan and 10.1.2)
- **Dedicated resources** (staffing, data sources and analytical resources), including a QM/QI committee that oversees the QM/QI functions (see 10.1.5)
- An **integrated approach to physical, behavioral, and LTSS** components through our interdisciplinary team approach to member-centered care and service planning. Quality is a critical component of this process and quality staff and functions are embedded through reporting, data analytics, outreach, education, incentives, and member satisfaction efforts.
- Mechanisms to detect and address both **under- and overutilization of services** are monitored using reports that identify both providers and members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans. Intervention strategies are targeted at enhancing appropriate utilization practices and provide member intervention for cases of member over- and underutilization through care coordination and/or health education and outreach (see 11.1.2 for more detail on our approach to addressing under- and over-utilization).
- A process to monitor **variations in practice patterns** and identify outliers; our QM Department tracks and trends provider performance data on a regular basis to identify trends that represent clinical practice patterns that are not consistent with practice guidelines. This information is reviewed with an interdisciplinary team during QM committee meetings, and corrective actions are taken to address identified issues. Specific provider performance issues are shared with the Credentialing Department for consideration during the re-credentialing process.
- Strategies designed to **promote practice patterns that are consistent with evidence-based clinical practice guidelines** through the use of education, technical support, and provider incentives; Amerigroup deploys in-person and online provider training as well as educational materials, a provider handbook, and website to promote practice patterns consistent with evidence-based clinical practice guidelines. We also engage providers on our quality committees and in meetings to discuss practice guidelines and ensure our approach is aligned and reflects the latest clinical findings. We also share data and reports with providers and grant access to provider facing Member 360 to give providers actionable information to support optimal member care. Our provider incentive program,

detailed in 10.3, also promotes alignment and awareness of evidenced-based clinical practice guidelines by financially incenting appropriate practice patterns and high quality, cost-effective care.

- Analysis of the *effectiveness of treatment services*, employing both standard measures of symptom reduction/management, and measures of functional status; our formal UM evaluation consists of a review of the efficacy of the program structure and an assessment of the program activities, including an assessment of potentially avoidable hospitalizations, over- and underutilization, and inter-rater monitoring and analysis. The UM Annual Evaluation Report concludes with an overall summary and recommendations for next year's activities. Our QM Department also performs an annual review of access and availability as well as an over- and underutilization analysis. This is achieved by analyzing both quantitative and qualitative data to detect barriers and identify trends; monitoring areas with the potential for over- and underutilization specific to the membership population, local practice patterns, and national healthcare trends; and acting on the opportunities identified by implementing interventions and evaluating the effectiveness of the interventions implemented.
- Monitor the *prescribing patterns of network prescribers* to improve members' quality of care coordination services through strategies such as: (i) identifying medication utilization that deviates from current clinical practice guidelines; (ii) identifying members whose utilization of controlled substances warrants intervention; and (iii) providing education, support and technical assistance to providers; and (iv) monitoring the prescribing patterns of psychotropic medication to children, including children in foster care. We conduct regular data analysis and use several reporting mechanisms to identify outliers for provider prescribing patterns. When we identify providers whose prescribing patterns do not align with clinical guidelines, we outreach to the provider to share education and technical assistance. We also work with members and deploy our lock-in and MTM program to avoid controlled substance issues. We also deploy a psychotropic drug prescription management program designed to help assure the safety of persons taking psychotropic medications, reduce or prevent the occurrence of adverse side effects, and help the child/adolescent who is taking psychotropic medications function better and achieve positive clinical outcomes (see 3.2.6 for additional detail on our pharmacy program, including detailed descriptions and parameters of our lock-in, MTM, and psychotropic drug programs).
- *Written policies and procedures* for quality improvement include methods, timelines and individuals responsible for completing each task; we will leverage our extensive QM/QI Program administration experience to adapt our best practice policies and procedures for Iowa.
- *System for monitoring services*, including data collection and management for clinical studies, internal quality improvement activities, assessment of specialized needs populations and other quality improvement activities of value or required by the State (see 10.1.2).
- Participate in *clinical studies and use HEDIS rate data*, healthcare quality measures for Medicaid-eligible adults described in Section 1139B of the Social Security Act, Consumer Assessment of Health Plans (CAHPS) survey results and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members (see 10.1.2 and 10.1.3)
- Utilize and report on the *Iowa Participant Experience Survey (PES)* for members receiving HCBS services (see 10.1.3)
- *Report any performance measures required by CMS*; we are accustomed to meeting all CMS reporting requirements in other states and will bring our experience to Iowa to assure compliance
- *Utilize and report on all quality measures required*, as described in Section 14, including, but not limited to quarterly health outcomes and clinical reports, and the VIS measures; we are accustomed to working with State partners to provide all information required for quality reporting and are confident we will be able to help Iowa meet all reporting needs (see 10.2)

- **Procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates** that are consistent with best practice protocols developed in the public or private sector (see 10.1.2)
- Procedures for a **provider pay-for-performance** program (see 10.3)
- **Member incentive programs** aligned with the Healthiest State Initiative and other quality outcomes (see 10.3)
- Procedures to assess **member satisfaction** not already defined (see 10.1.3)

Question 10.1, #2

2. Describe how you will utilize program data to support the development of the Quality Management and Improvement Work Plan.

Amerigroup will incorporate diverse program data points into the QM/QI Work Plan and Annual Evaluation to drive targeted, continuous quality improvement strategies. We will maintain a prospective five-year work plan with long-term goals based on the membership population and State quality initiatives. We will update the five-year outlook each year through the Annual Evaluation process. See Attachment 14.5.1-1, Work Plan for a preliminary plan specific to our quality goals in Iowa. This work plan will be a dynamic document that we will work with DHS and other stakeholders to continuously refine.

We will develop yearly goals in the QM/QI Work Plan. For example, in Year 1 we will focus on understanding and building baselines so we can identify priorities and measure progress in Years 2 and 3. Once we have established the baseline, we will work collaboratively with the State to determine where Iowa wants to be in five years and refine our work plan to meet those goals.

The annual QM/QI Work Plan identifies specific activities and projects to be undertaken by the plan and the performance measures to be evaluated. Work Plan activities align with contractual, accreditation, and/or regulatory requirements, and identify measurements to accomplish goals.

The Annual QM/QI Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and prior years' trending as appropriate.

The Annual Evaluation describes the overall effectiveness of the QM/QI Program by including:

- Description of ongoing and completed QM activities and projects that address quality and safety of clinical care and quality service
- Quantitative and qualitative analyses and trending of clinical care, safety, and service performance measures to assess desired outcomes and progress toward achieving goals
 - HEDIS data
 - CAHPS data
 - Iowa Participant Experience Survey (PES) for members receiving HCBS services
 - Health plan specific data
 - State performance measures as identified
- Major accomplishments, including an assessment of progress made in influencing network-wide safe clinical practices
- Identification and analysis of issues or barriers to achieve goals and limitations of the data or measure



- Recommended interventions/actions to demonstrate improvements for the upcoming year
- Evaluation of the adequacy of resources, training, scope, and content of the QM/QI Program
- Provider and member participation in the QM/QI and UM Programs

The Annual Evaluation is developed with the participation and support of all applicable parties and is presented to the QM/QI Committee and the Board for final approval and additional recommendations.

An integral component of our Program is the Medicaid QM/QI Work Plan, which represents our road map for the future and is built based on detailed analysis of provider and member data.

The Work Plan is the vehicle through which we monitor, evaluate, and take effective action to identify and address all program improvements, including those related to quality of care. Our Work Plan is the tool that guides our QM team in measuring our success in achieving targeted improvement goals.

Amerigroup will refine and evaluate the five-year Iowa QM/QI Work Plan on at least an annual basis. The Work Plan will include the following:

- Objectives for the coming years and program scope
- Activities planned for the upcoming year, including quality and safety of clinical care and quality of service
- Performance measurement, including benchmarks and goals
- PIPs baselines and interventions
- Timeframe within which each activity will be achieved
- Person(s) responsible for each activity, including department collaboration and coordination
- Monitoring previously identified issues
- Planned evaluation of the QAPI Program and Work Plan
- Schedule for reporting to the governing body (or designee)
- Schedule for evaluation of delegated services

The Work Plan is a dynamic document and is updated as needed to reflect changes in processes, priorities, and/or activities. The QM/QI Committee, National Medicaid Quality Improvement Committee (QIC), and the Amerigroup Board of Directors review and approve the QM/QI Work Plan, with final approval coming from the Board of Directors.

The Work Plan lists the measures we will collect; the previous year's performance and Quality Compass benchmark, if applicable; and the current year's target measure, listing the interventions for each aspect. The Work Plan also reflects quality targets for the health plan's Case Management programs, including CM and DM, such as top conditions, member satisfaction, and member engagement rates.

Leveraging both local and national health plan experience and the best practices across our affiliates managing state sponsored health programs in other states; our Work Plan for Iowa will reflect a full scope of quality metrics. Examples of metrics include those specific to our CM and DM programs, HEDIS measures, Iowa PES findings for members receiving HCBS services, and measures that target condition-specific care, such as diabetes, asthma, coronary artery disease, mental health, avoidable emergency room services, and members with special healthcare needs. We will focus on outreach, patient safety, preventive services, closing gaps in care, and provider engagement and profiling. We will encourage the



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use of clinical practice guidelines and high-risk prenatal, chronic, and complex condition management processes. We will also focus on member assessment, care planning, and engagement in their self-management, and we will assist with system of care navigation.

Data Collection and Utilization

Data to support the Program and Work Plan is collected on a routine basis (monthly, quarterly, and/or annually) and on an ad hoc basis from internal and external sources to systematically and objectively monitor, analyze, evaluate, and report health outcomes and indices of quality. Data related to all aspects of member services, departmental operations, and outcomes may be collected to ensure a comprehensive view of quality performance.

Data sources may include, without limitation: enrollment information, claims, encounters, authorizations, appeals, complaints, disease/care coordination documentation, access and availability survey findings, member medical records within provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, quality improvement studies, CAHPS, participant experience survey, and HEDIS results.

Data collection follows protocols established in approved policies or program design. Standardized data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications. Inter-rater reliability is evaluated for all manual data abstraction processes.

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Amerigroup clinical and service performance goals. These analyses take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan are initiated as a result of findings or reprioritization of projects and new events.

Question 10.1, #3

3. Detail your experience in and strategies for improving quality indicators, including HEDIS measures, CAHPS measures and satisfaction surveys. Describe how you will apply that experience in Iowa.

Our Quality Management and Improvement Program not only defines the standards and guidelines for executing State and accreditation quality requirements, but identifies and targets areas most in need of improvement and then dedicates appropriate resources to identify barriers and design and implement effective interventions. *As noted previously, our affiliate health plans have achieved NCQA's 90th percentile on six major HEDIS measures.* To optimize results, our strategy applies the best practices and proven interventions that have achieved superior results in our affiliate health plans managing state sponsored programs across the country. This includes incorporating results from HEDIS, CAHPS, and other surveys such as the Participant Experience Survey (PES) for members receiving HCBS. Our member and provider satisfaction surveys occur annually and include a full range of questions on medical, behavioral, SUD, and LTSS factors. We also solicit input from the community on quality improvement projects and ways to improve member satisfaction through town hall meetings and other in-person or telephonic member, provider, and community interactions.

We actively solicit member feedback through the annual CAHPS survey, benchmarking the results to national NCQA Medicaid CAHPS survey results. This survey solicits members' input on their ability to receive the needed care quickly, how well providers communicated, customer service, and rating(s) of the physician, specialist, healthcare, and Amerigroup.

Amerigroup uses a "Plan, Do, Study, Act/Assess" methodology to identify and evaluate possible clinical or non-clinical improvement opportunities. We use a standard root cause analysis process, which includes data collection, causal factor charting, root cause identification, and action recommendations in our

monitoring activities. If progress toward improvement is slower than anticipated within the timeline of the project, we employ the Rapid Cycle Learning (RCL) process to make mid-course corrections based on the data received. We continue the RCL process throughout the year as we acquire real-time data.

At least annually and through regular meetings and ongoing data collection and evaluation processes, the QM Department facilitates a formal evaluation of the effectiveness of the QM Program and analyzes outcomes realized from Work Plan activities and data trends:

- Key data points include (but not limited to): HEDIS, CAHPS, Iowa PES for members receiving HCBS services, and other Iowa-specific performance measures
- Analysis and evaluation of outcomes including an assessment of the extent to which QM activities were completed and goals met
- Recommended interventions/actions to demonstrate improvements for the upcoming year

As an example of the effectiveness of these monitoring activities, one of our affiliate health plans noticed that the HEDIS seven-day follow-up after behavioral health admission rate was lower than anticipated. The health plan invoked the RCL process and focused on the adequacy of the discharge plan. They found a problem with the post-discharge appointments — members were either not aware of the appointment post discharge, or the appointment was scheduled beyond the post-discharge seven-day follow-up date. The health plan initiated additional discharge planning interventions, including hospital-based visits by a Case Manager to meet with the member and to develop a discharge plan face-to-face that the member agreed to. They also incorporated the Bridge on Discharge Program - where a provider meets the member to provide education, assess the member and home environment, and identify any barriers to keeping the appointment with the outpatient psychiatrist/therapist - and added providers with capacity to the network. As a result, the health plan's seven-day follow-up after behavioral health admission HEDIS rate improved by 10 percentage points.

Amerigroup incorporates member feedback into our QM activities to drive operational change to improve clinical and non-clinical programs. We use the results of CAHPS, PES, and other surveys to identify areas for improvement. We develop and implement performance improvement activities to address areas of concern specific to our members.

For example, at the end of 2014 in our New Jersey affiliate, our performance improvement activities generated the following CAHPS improvements for our members:

- Increased their customer service ranking from 25th to 90th percentile
- Increased their “Getting Care Quickly” accessibility ranking from 25th to 75th percentile
- Increased their “How Well Doctors Communicate” ranking from 10th to 90th percentile
- Increased their “Health Plan Overall” ranking from 25th to 50th percentile



Question 10.1, #4

4. Describe your experience and strategies in working with network providers to improve outcomes.

Amerigroup assures that our QM/QI Program incorporates local practicing physicians and other clinicians in developing our quality goals and processes, incorporating industry best practices coupled with local variations as appropriate. We work with our providers in developing reports to address our member needs. We also monitor for variations in provider practice and prescribing patterns and conduct education and outreach to outliers to promote evidence-based clinical practice guidelines.



We will supply providers with information about their performance relative to their peers, as well as monthly gaps in care reports based on HEDIS measures, to improve visibility into ways to improve VIS.

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We will supply providers with information about their performance relative to quality metrics that compare their performance to that of their peers, as well as monthly gaps in care reports based on HEDIS measures. Our local, on-site provider services representatives and QM nurses review these with our providers. The provider Quality and Population Management Incentive Program is directly tied to individual and other approved performance measures. Provider performance is determined based on achieving quality targets (for example, HEDIS scores) as well as efficiency (cost) targets.

Complementing these initiatives, Amerigroup also seeks to engage providers through participation in our QM/QI Committee as a means to cultivate positive and productive relationships and

achieve sustainable results. We include active physician participation (primary care and specialists, including behavioral health and specialists skilled at working with members with special healthcare needs) through the Iowa QM/QI and Medical Advisory Committee. Providers are included in the planning, design, implementation, and review of our QM/QI Program. With support from our QM employees, providers will be asked to:

- Assess levels and quality of care provided to members and recommend, evaluate, and monitor minimum standards of care
- Provide applicable advice and input over the development and updating of clinical practice guidelines; identify opportunities to improve services and clinical performance by establishing, reviewing, and updating clinical practice guidelines based on the review of demographic and epidemiologic information to target high-volume, high-cost, high-risk, problem-prone conditions
- Conduct a peer review process that provides a systematic approach for monitoring of quality and appropriateness of care
- Conduct a systematic process for network maintenance through the credentialing/re-credentialing process
- Give advice to the health plan administration in any aspect of the policy or operation affecting network providers or members
- Provide oversight of the peer review process
- Provide guidance and feedback regarding technology assessment

We support our providers through several processes, including orientation, bulletins, performance reports, Provider Services Staff on-site visits, manuals, and our provider website. We also publish updates on QM activities in the provider newsletter. Our quality management nurses deliver provider education on HEDIS, CAHPS, and other State-specific initiatives. Our QM nurses also conduct Medical Record Reviews for document requirements (EPSDT, advance directives, behavioral health, and specialist referrals).

Additionally, a core element of our quality management and improvement strategy involves engaging providers in Performance Improvement Projects (PIPs), which are initiatives to help increase the quality of care to our members. Below are a few examples of how we have worked with providers in the past to improve outcomes:

- Reducing asthma-related emergency room visits
- Non-urgent emergency room utilization
- Improving access to preventative care
- Mental health follow-up post hospitalization

Reducing Asthma-related Emergency Room Visits

More than 22 million Americans have asthma, and it is one of the most common chronic diseases of childhood, affecting an estimated six million children. The burden of asthma affects members, their families, and society in terms of lost hours in work and school, lessened quality of life, and avoidable emergency room visits, hospitalizations, and death.

Increasing compliance with asthma medications over time has been shown to reduce asthma symptoms resulting in fewer asthma visits to the emergency room and, since most asthma admissions are the result of an emergency room visit, also a reduction in asthma admissions.

In 2013, an Amerigroup affiliate and their providers worked together to develop standardized provider education and asthma action plans to increase adherence to medications by asthmatic members and reduced avoidable emergency room visits. The following initiatives were implemented:

- Provided care coordination services to members to ensure adherence to medication and assess reason for emergency room visit
- Used interpreter services for member/parents who do not speak/understand English to meet members' cultural/linguistic needs
- Provided care coordination to promote follow up with PCP
- Worked with members to complete asthma action plan
- Provided members with age appropriate educational material (for example, a 12-minute video, coloring book, story book, parent guide, crayons, etc.)

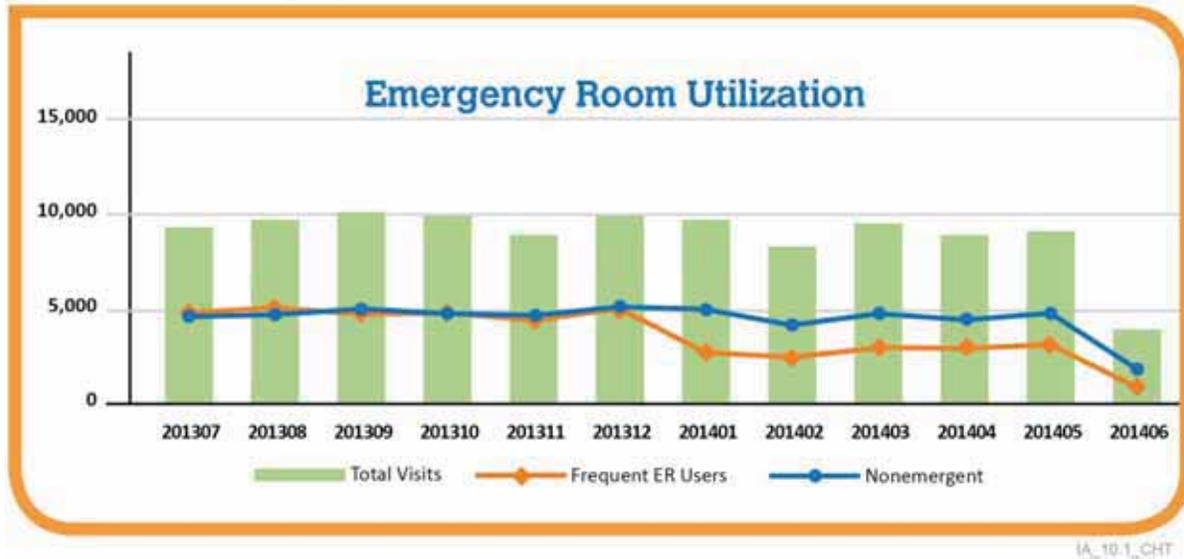
Non-urgent Emergency Room Utilization

In June 2012, our affiliate health plan engaged providers to decrease non-urgent emergency room utilization. To achieve this goal, they implemented the following initiatives:

- Located and contracted with additional urgent care facilities, as well as PCPs with extended hours for non-urgent care, in areas where there is high member utilization
- Assigned care managers to specific high volume emergency rooms to work with providers to assess barriers and drivers of emergency room use, strengthen care management relationships, make PCP appointments, and forward the discharge summary to the PCP
- Deployed UM nurses in specific, high-volume facilities

As illustrated in Figure 10.1-2, the health plan's initiatives steadily decreased the number of non-urgent emergency room visits among members identified as visiting the emergency room significantly more than other members. Additionally, the number of non-urgent emergency room visits among *all members* decreased over the course of a year.

Figure 10.1-2. 2013 Emergency Room Utilization Measurement



Improving Access to Preventive Care

Our Texas affiliate partnered with network providers to combat the lack of preventive care for children and increased access to preventive care through the following initiatives:

- Enhanced provider communication by sending quarterly reports to PCPs indicating which members on their panel required EPSDT visits
- Embedded Health Plan Associates: For those high volume PCP offices that requested assistance with member outreach, Amerigroup “embedded” health plan staff for specific periods to call members with gaps in care and make appointments. If the provider was willing, associates made the calls from the PCP’s office, which resulted in improved member contact success. Additional calls were made by health plan clinical staff to augment standard member outreach efforts
- Our Texas affiliate health plan is now in the NCQA Quality Compass 75th percentile for child and adolescent well care and children’s access to care.

Mental Health Follow-up Post Hospitalization

According to The Commonwealth Fund, about 40 percent of patients hospitalized for a psychiatric condition are re-hospitalized within one year. Amerigroup believes that follow-up care after a hospitalization for mental illness will reduce re-hospitalizations for some individuals or help facilitate necessary readmission before individuals reach a crisis stage.

In 2013, Amerigroup’s affiliate health plan worked with providers to better support mental health patients after their hospitalization through the following initiatives:

- Increased reporting frequency so that rates are calculated once a month, rather than once a quarter, giving greater visibility into the process
- Bridge Program Pilot – outpatient behavioral health providers saw the patient on the day of discharge from the hospital
- Built an in-house behavioral health team to manage the care of members (this included care coordination of chronic members)



Additionally, we will be launching tools in Iowa for HCBS providers that will provide the platform to establish a baseline for measuring quality for HCBS services. With the launch of Careticker, an innovative platform that engages, supports, and incentivizes caregivers and paid personal care attendants to record information to maximize member health, wellness, and attainment of personal goals. Careticker provides a secure web and mobile platform that facilitates real time tracking and reporting related to the member's in-home services and supports. In addition, caregivers and paid personal care attendants submit daily notes and observations regarding the member. This information is reported back to the community-based case manager in real time. The case manager can then communicate and interact with the member, family, and provider to provide necessary support or guidance to meet the improve member experience and outcomes. We believe this platform will provide the basis to develop an additional HCBS quality-based incentive designed specifically for providers of personal attendant services that we plan to develop during the term of the contract.

QM/QI Committee (10.1.3)

Question 10.1, #5

5. Outline the proposed composition of your Quality Management and Improvement Committee, and demonstrate how the composition is interdisciplinary and appropriately represented to support the goals and objectives of the Quality Management and Improvement Committee.

Delivering on our commitment to quality requires orchestration of resources, both local and national, to gather and analyze the data that drive our QM efforts. Amerigroup's QM/QI Program will have the organizational infrastructure necessary to provide effective monitoring, reporting, and analysis and to act on opportunities to improve clinical care and services.

The QM/QI Program contains an interdisciplinary set of resources to provide a more holistic approach to monitoring and improving quality. Aside from national support and leadership from our medical directors (including population-specific directors), we coordinate with Disease Managers, our Clinical Quality Management Department, healthcare delivery systems, Utilization and Care Management departments, as well as practitioners and other health promotion staff.

The Amerigroup Iowa Board of Directors (Board) has responsibility for organizational governance and in this capacity is the governing body of the Quality Management Program. The Board has designated our national Medicaid Quality Improvement Committee (QIC) to oversee the Quality Management Program and activities. The QIC is directly accountable to the national Enterprise Clinical Quality Committee (ECQC). The Board annually approves the QM/QI Program, Work Plan, and QM Program Evaluation.

Amerigroup will have a local Quality Management and Improvement Committee (QM/QI Committee) for Iowa. Its purpose is to provide a forum for local health plan members to engage in review, coordination, and direction of the QM/QI Program. Additionally, the QM/QI Committee:

- Provides recommendations for approval of activities that relate to key processes, clinical guidelines, and Medicaid-specific policies and procedures
- Leads and oversees the Health Plan QM/QI Programs
- Improves the safety and quality of care and services



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- Addresses healthcare disparities

The goals of the QM/QI Committee are to:

- Establish strategic direction - monitor and support implementation of the quality management program
- Establish processes and structure that ensures accreditation compliance
- Review and accept national and local QM policies and procedures, as appropriate
- Analyze, review, and make recommendations regarding the planning, implementation, measurement, and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the Plan
- Review HEDIS, CAHPS, and other quality data and action plans for improvement
- Review, monitor, and evaluate program compliance against Amerigroup, State, federal, and accreditation standards
- Review the annual Quality Management Program description and Work Plan; determine and describe the program's overall effectiveness; consider the adequacy of resources, committee structure, practitioner participation, and leadership involvement in the QM/QI Program and determine whether to restructure or change the Program for the subsequent year based on its findings
- Provide oversight and ensure compliance of delegated services
- Assure inter-departmental collaboration, coordination, and communication of quality improvement activities
- Measure compliance to medical and behavioral health practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability with cultural assessment
- Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety
- Make information available about the QM/QI Program to members and practitioners
- Assure the availability of Program minutes to the appropriate State regulatory agency, as applicable
- Assure practitioner involvement through direct input from the Medical Advisory Committee or other mechanisms that allow practitioner involvement

Our QIC is composed of interdisciplinary health care professionals to verify that all stakeholder perspectives are represented during times of critical decision-making. The Quality Management and Improvement Committee typically consist of the following members:

- Senior health plan leaders of Quality Management
- Senior health plan leaders of Utilization Management
- Senior health plan Medical Directors

Practitioner Membership

The Medical Director develops a proposed list of practitioners to serve on the Medical Advisory Committee (MAC) and Credentialing Committee. The practitioners are representative of the managed care organization (MCO) network provider community and the local healthcare delivery system. The list is submitted to the QM/QI Committee as a component of the annual QM/QI Program and Work Plan approval process. Efforts are made to rotate membership every two years. However, to ensure continuity of committee activity, membership may be extended. Participating providers do not receive incentives or

gifts intended to improperly influence participation on health plan committees. Participating committee practitioners may be paid an honorarium for attendance for participation in committee meetings.

Enrollee Membership

The QM/QI Committee also incorporates input from members and other stakeholders to address State, community, and population-specific issues. Our MAC will identify issues for inclusion on quality committee agendas on a quarterly basis, which will be incorporated in PIPs and quality work plans as appropriate. We have successfully operated MACs as a strategy to incorporate member and stakeholder input in our quality programs across all our state health plans since inception.

Participating members serving on committees do not receive incentives or gifts to improperly influence participation on health plan committees. Participating members may be paid an honorarium for their attendance and participation in an Amerigroup consumer committee.

Committee Minutes

Minutes are recorded at each meeting and reflect key discussion points, recommended policy decisions, analysis and evaluation of QI activities, needed actions, rationale, planned activities, responsible person, and follow-up. Minutes record the practitioner and health plan staff attendance and participation. Minutes are produced within a reasonable timeframe, at a minimum, within one month or by the date of the next meeting and maintained in confidential secure files. Minutes are reviewed and approved by the originating committee and signed and dated within the same reasonable timeframe. A copy of the signed and dated written minutes for each meeting are available on file and made available for review upon request by DHS or its designee.

Notification of Meetings to the DHS

Amerigroup will comply with the requirement to notify the State at least 10 days in advance of committee meetings. From our experience in other states, we are accustomed to sharing meeting invitations with providers and other stakeholders several weeks in advance. We also plan to share a meeting schedule with the State of Iowa when we submit policies and procedures and other required documentation. Information on the next scheduled meeting is also available in the meeting minutes. Our Quality lead in Iowa will work with the regulatory contract manager to make sure the State-identified DHS representative is aware of meetings. We understand the State representative may or may not decide to attend the meetings. Should they attend the meeting, the agenda would also list the date for the next meeting as well. Should the date or time change, the regulatory and QM leads would ensure the DHS representative would be made aware and provide a reminder 10 calendar days prior to the meeting. All meetings that require notifications to DHS will be kept on a Regulatory Contact Log to ensure notifications occur.

State Quality Initiatives (10.2)

Driving quality program execution and leading wellness and prevention are paramount responsibilities of Iowa's health agencies. Amerigroup Iowa's (Amerigroup) mission is to make it easy for the State to deliver superior quality performance for all of its constituents. In the following section, we demonstrate why Amerigroup is uniquely suited to support the State team in achieving its quality goals.

Amerigroup is well positioned to make it easy for the State to achieve its quality goals because of its:

- **Aligned Philosophy** – We believe in building quality into all of our processes and in leading by example within our own organization
- **Extensive Experience** – We will leverage the extensive experience of our affiliate health plans, that have implemented quality programs across varying population groups with differing needs and State priorities
- **Innovation for Iowa** – We will leverage our established innovative processes and our deep base of wellness and prevention programs to help Iowa become a leader in health and wellness

At Amerigroup, we build quality into our processes rather than just auditing the outcomes. Our organizational quality goals are tightly aligned with Iowa's goals. We believe that personal health is tied to organizational health, and at Amerigroup, as well as our parent Anthem, we have always espoused and implemented socially responsible organizational principles. As a result, we are well positioned to be a leader in the Iowa Initiative.

Our time-tested quality programs, developed over dozens of implementations covering specialized populations within each state's unique context, will minimize the time and effort required for MCO quality management oversight. We will provide all the access and data reporting required in the form, format and timeframe required. As a result, State resources can focus on driving quality innovation such as the effective implementation of the Healthiest State, The Mental Health and Disability Services Redesign, and the State Innovation Model (SIM) Initiatives.



We offer our organization's proven track record helping states meet health goals – the State of Iowa does not need to worry about our ability to meet and exceed required quality standards even in the context of an accelerated implementation.

- According to the 2014-2015 NCQA Medicaid Health Plan Rankings, as published by Consumer Reports, Amerigroup's affiliate health plans operating state sponsored programs are the #1 or #2 ranked plan in Georgia, New Jersey, New York, and Tennessee.
- Amerigroup's affiliates have experience delivering superior HEDIS performance and improving outcomes over time for the measures that are of critical important to Iowa as demonstrated in Table 10.2-1.

Customization to fit Iowa's needs is paramount. Our proprietary Quality Management system as well as our Health and Wellness Programs will be tailored to fit Iowa's environment with a keen focus on driving the goals espoused in the State's core improvement initiatives. Amerigroup will work with stakeholders to achieve new performance standards by aligning with Iowa's goals. Our pre-award field teams have already begun to engage with Iowa stakeholders so that we can move quickly once an award announcement is made. We look forward to collaborating with Iowa to deploy our best practices and to develop new strategies to make it the number one Medicaid program in the nation.



Table 10.2-1. Amerigroup Affiliates Achieved Strong and Improving HEDIS Performance Across Key State Quality Initiative Measures

Annual Dental Visits			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	69.07	69.92	66.8
GA	69.68	69.92	69.67
Well Child Visit 3 to 6 Years			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	83.04	82.08	82.69
NY	82.27	84.58	86.23
Well Child Visit 12 to 21 Years			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	64.72	65.45	65.56
NY	61.83	61.42	69.7

Follow-up After Mental Illness Discharge - 7 days			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	69.57	68.79	63.21
NY	53.47	65.67	67.75
ADHD Initiation Phase			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	52.48	51.86	53.03
TN	61.33	60.54	60.59
Comprehensive Diabetes - HbA1c Test			
	HEDIS 2012	HEDIS 2013	HEDIS 2014
NCQA 90th Percentile	91.13	90.97	91.73
NY	90.19	86.97	90.68

In the following section, we outline how we propose to:

- Assist the State in easily fulfilling its quality management responsibilities
- Collaborating to drive important initiatives (for example, Healthiest State Initiative)
- Leveraging experience to support State programs (for example, Substance Abuse Prevention and Treatment Block Grant)

State Quality and External Independent Review (10.2.1–10.2.2)

Amerigroup is committed to supporting Iowa in meeting its quality management requirements. Specifically, we will:

- Comply with the quality standards established by the State and provide all the information and reporting necessary to carry out its obligations for its quality strategy
- Participate actively in external independent reviews of Amerigroup performance-related quality, timeliness, and access to healthcare services covered
- Provide all information required for the external quality reviews in the timeframe and format requested by the External Quality Review Organization (EQRO)
- Incorporate and address findings from external quality reviews in QM/QI Program
- Collaborate with EQRO to assess quality of care and services provided to members and to identify opportunities for improvement

- Collaborate with the State and EQRO to measure identified performance measures to assure quality and accessibility of healthcare in the appropriate setting to members, including validation of PIPs and performance measures
- Respond to recommendations made by the EQRO within the timeframe established by the EQRO, DHS or its designee
- Make results of each and every external independent review available to participating healthcare providers, members, and potential members of the organization, while not disclosing the identity of any individual patient
- We will verify strong performance through deployment of a dedicated, locally-based, quality team which fully leverages our deep experience using training, systems, policies, procedures, processes as well as assistance from key experienced staff from other markets. Amerigroup's Quality Management Manager will be responsible for making medical and other records available for review as requested. Our provider agreements require providers to make medical records and documentation available for reviews by the Plan, State, or federal entities. The Quality Management Manager and the Quality Department, with further support of our Iowa Compliance Officer and our National Medicaid Operations Compliance team, will actively collaborate with DHS and the EQRO on quality measurement and improvement.

We will ensure strong performance through deployment of a dedicated, locally-based, quality team which fully leverages our deep experience via training, systems, policies, procedures, processes as well as assistance from key experienced staff from other markets.

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All quality improvement findings will be operationalized through our quality improvement process.

We report the findings and input provided through the external quality review process to our QM/QI Committee to inform our efforts and Work Plan to improve member health outcomes. We incorporate and address findings from EQRO audits into the QM/QI Program through our annual assessment and Work Plan update process and quarterly quality committee meetings. See 10.1 for more detail on how EQRO findings impact our continuous quality improvement program.

Through our affiliates, Amerigroup has extensive experience and well established processes for supporting State required independent review processes. In the month of March 2015, our affiliate plans participated in activities related to 16 different external review processes.

We believe quality performance is not only a manifestation of our own disciplined operations but also close collaboration with our providers, state partners and other stakeholders.

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Building quality into all aspects of health and wellness delivery and being transparent are core Amerigroup principles. We believe quality performance is a manifestation of not only our own disciplined operations but close collaboration with our providers, State partners and other stakeholders. As such, we will not only make the results of each external review available to all relevant stakeholders, but we will actively promote review through active stakeholder outreach. Specifically, our Network Services and Marketing Departments will inform providers, members, and potential members of the availability of the EQRO results through

our website, newsletter, provider fax blast, Town Hall sessions, and through provider office visits.

Our organization's quality performance has a strong reputation among our State partners for rapid and responsible response to identified quality improvement opportunities.

The State of Iowa has already launched several important initiatives which will contribute to the State's overall goal of cost-effective delivery of superior health and wellness outcomes. ***Amerigroup is committed to building on the initial momentum in Iowa by tailoring our market leading programs to***

Iowa and to each program objective. Specifically, we will actively align to each of the specified State initiatives:

- Healthiest State Initiative
- Mental Health and Disability Services Redesign
- State Innovation Model

Healthiest State Initiative (10.2.3)

Question 10.2, #1

1. Describe how you propose to work with the Healthiest State Initiative.

Through its Healthiest State Initiative, Iowa has committed to improve from #10 on the Gallup-Healthways Well-Being Index to #1 by 2016. We are excited to collaborate in this bold effort and to be part of the number one team. To make this happen, we will appoint Amerigroup's COO as our team lead for this initiative. We will closely collaborate with key constituents (for example, the State, Healthiest State Initiative workgroups, local businesses, community organizations, providers, other MCOs, and our members); we will work to tailor our market leading programs to address key performance gaps; and we will lead by example. Through our commitment to the Healthiest State Initiative, we will not only help drive superior health and wellness performance, but improve quality and cost-effectiveness across the system.



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Leadership and commitment drive successful initiatives. For this reason, we will make supporting the Healthiest State Initiative a primary responsibility of our health plan COO. A supporting team will be comprised of key members of the clinical team, provider services, marketing and outreach, as well as our innovation team. This team will meet bi-weekly, if not more regularly to develop strategies and tactics and monitor implementation. This team will also be responsible for close collaboration with all relevant constituents including member committees and community organizations. Collaboration will include: supporting, participating, and cross-promoting Healthiest State Initiative events, like the annual Healthiest State Walk, to engage our members, local staff, and the community. We also plan to participate in Healthiest State Conferences, and send quality leads and encourage them to maximize the opportunity to learn, network, and share best practices.

Leveraging our commitment to wellness and prevention across our portfolio of State partnerships, we will build on the most relevant programs to target key performance gaps. Specifically, we will rollout programs that target each of the five key goals of the Healthiest State Initiative:

- Decreasing the Number of Iowans Who Smoke
- Increasing Consumption of Fruits and Vegetables
- Increasing the Number of Iowans Who Have Visited the Dentist in the Last Year
- Increasing the Number of Iowans Who are Learning or Doing Something Interesting Daily
- Increasing the Number of Iowans Who Feel Their Boss Treats Them Like a Partner at Work

In addition, we will support the Blue Zone Project by becoming a certified Blue Zone employer and encouraging our providers to do the same.

Following execution of the Contract, Amerigroup will obtain DHS approval of the proposed approach to supporting the Healthiest State Initiative. We will implement and adhere to the DHS-approved approach. We understand that any changes to this approach must receive prior approval from DHS.

To support the five key goals of the Healthiest State Initiative, we have identified specific programs we plan to deploy in Iowa – many of which have been proven to be highly effective by our affiliate health plans in other states. The programs we have identified thus far, grouped by the goal they support include:

1. Decreasing the Number of Iowans Who Smoke

Smoking Cessation Value-Added Service: Amerigroup will offer **smoking cessation coaching** as a Value-Added Service. Additionally, we will offer a **\$30 incentive** for those members using tobacco who receive coaching to quit smoking through the Iowa Tobacco Quitline and/or Amerigroup's value-added smoking cessation program. Combined with coverage of smoking cessation medications on the Iowa Medicaid formulary, these programs will help establish Iowa Medicaid as a best practice State for smoking cessation model. In our most recent participant survey, 31.75 percent of our affiliates' member respondents receiving coaching and medication achieved the six-month quit metric.

Pro-active Referral Systems: To maximize participation in smoking cessation programs, our Disease Management and Care Coordination programs actively refer members to our smoking cessation coaching programs. Members may also self-refer.

General Member Education: In addition to coaching and medication, we take advantage of other member interactions to provide general education on smoking cessation. For example, the Amerigroup hotline provides callers with a number of health tips during on hold messaging. Examples of some of these smoking cessation messages include:

- Tip #1: "The Great American Smoke Out is in November. The American Lung Association sponsors the event each year to challenge smokers to kick the habit. Now is the time to say goodbye to your cigarettes, cigars, chewing tobacco or snuff. Don't forget to throw away lighters and ashtrays, too. Tell your family and friends that you are quitting so they can support you. Keep gum, mints and crunchy vegetables like celery and carrot sticks to snack on. These can be helpful when you get the urge to smoke. There are many programs to help people quit smoking. Your doctor can help you find the best program for you."
- Tip #2: "Cigarettes can hurt more than just the person smoking them. Children who are around smokers breathe the smoke. This can be as bad as smoking. Kids who live where there is cigarette smoke usually have more colds and sore throats. Teach your children that smoking is not healthy and is a hard habit to break. Please hold. Someone will be right with you."

2. Increasing Consumption of Fruits and Vegetables

Healthy Families Program Value-Added Service: This program includes **education and counseling on nutrition and fitness**. We offer a standard program targeting 7 to 13 year-olds, a teen program for 14 to 17 year-olds, a program for adults, and for specialized populations such as ID/DD. Members can be referred by a provider, self-referral, or outbound call campaign. Nurse coaching over a six-month period helps families explore and set goals, resolve ambivalence, develop small doable steps, and assist in removing

We will support Iowa and the Blue Zone Project by becoming a certified Blue Zone employer.

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Together with coverage of smoking cessation medications on the Iowa Medicaid formulary, our counseling programs will help establish Iowa Medicaid as a best practice State for smoking cessation model.

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barriers. Motivational Interviewing and Stage-Based Communication guides conversations for member-centric goal setting and building on successes. The program includes verbal education and guidance to online resources including “Nourish.” Education materials are also sent to families and high-volume providers.

The Healthy Families Program has been highlighted by MHPA Diabetes Care Best Practice Compendium. It is currently deployed in five affiliate health plans (Kansas, Florida, Washington, Louisiana and Kentucky), with results among children ages 7 to 13 shown in Figure 10.2-1.

Figure 10.2-1. Healthy Families Program Encourages Healthy Behavior



Diabetes Prevention Program: We will deploy the Diabetes Prevention Program (DPP) to help Iowa’s Medicaid population make healthier dietary decisions. The DPP, nationally recognized through the Centers for Disease Control (CDC), is a **16-week, community-based program** conducted by trained lifestyle coaches to teach people with pre-diabetes how to modify their eating and physical activity habits and to sustain those changes overtime.

We will also leverage our experience participating in other State diabetes performance improvement initiatives to develop a best in class approach tailored to the Iowa population. For example, our New York health plan is participating in a two-year performance improvement project with the New York State Department of Health. This program is aimed at diabetes prevention and control. The goal is to help members with high risk of

developing diabetes reduce their weight through a healthy low-calorie, low fat diet and by engaging in at least 150 minutes per week of moderate physical activity. The University of Pennsylvania is responsible for the research aspect of the program.

3. Increasing the Number of Iowans Who Have Visited the Dentist in the Last Year

Dental Vendor Collaboration: Based on our experience, collaborating with State dental vendors is critical to realizing improved dental health. Amerigroup successfully collaborates with various dental subcontractors to manage government-sponsored dental benefits across our affiliate health plans in other states. We leverage best practices from other states to develop effective working relationships with incumbent dental vendors to provide the best possible service to both members and providers. Established protocols for coordinating with the incumbent dental vendor and the State to optimize oral health include:

- Regular communication to identify and resolve opportunities for program improvement and to share treatment information
- Prevention through member education about decreasing the incidence of dental care, stressing the importance of preventive care such as annual dental visits and reducing the risk of mouth and jaw injuries
- Established care coordination protocols
 - Direct collaboration on cases where a member requires a medical setting for a dental procedure
 - Collaboration with other medical, behavioral, or dental providers where a member’s health, dental, or behavioral health needs warrant such collaboration (for example, cases where a member may be at risk for seizures or have a co-existing behavioral, dental, and physical health issues)



We will leverage best practices from other states to develop an effective working relationship with incumbent dental vendors to provide the best possible service to both members and providers.

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- Prospective agreement on claims responsibility on shared cases to facilitate seamless coordination of benefits
- Accepting written documentation of prior authorization of ongoing services

Member Outreach: We operate a “txt4health” text message outreach program to remind members to visit the dentist and provide helpful information to schedule an appointment. An example message is shown in Figure 10.2-2.

This text program can also be used for general health education on diet, fitness, and other health and wellness topics.

Oral Hygiene Kit Value Added Service. Additionally, we will offer an oral health hygiene kit as a value added service and opportunity for education about the importance of oral health as a component of overall well-being.

Figure 10.2-2. txt4health Member Outreach Program



4. Increasing the Number of Iowans Who are Learning or Doing Something Interesting Daily

Community Outreach: We have a number of “on-hold” messages that provide health and wellness tips to members. A sample on-hold message that is included in new member household welcome calls to encourage members to socialize and participate in an interesting activity is provided below:

“Many of our members enjoy the fun health tips we sometimes share. So, we’d love to share a quick one with you right now. Did you know that laughing for 15 minutes a day can give your immune system a boost, help decrease stress, and just make you feel better? So invite your friends over for a night of karaoke or a game of charades. Bring on the laughter and let the good health flow!”

As appropriate, we will incorporate the message of learning or doing something interesting on a daily basis into all forums where we engage members such as marketing events or home visits. Through our conversations with members or as closing messages on some of our member handouts and on the Iowa member website, we will remind members that learning or doing something interesting on a daily basis is important to their health.

5. Increasing the Number of Iowans Who Feel Their Boss Treats Them Like a Partner at Work

Leadership by Example: As a leading healthcare organization, we believe it is essential to model the policies we promote. Our organization promotes coordination and collaboration among all employees, regardless of position. We will bring this philosophy and related infrastructure to our Iowa offices to lead by example (see below for more details on key policies and programs, like Associate Resource Groups).



We will also actively support the Blue Zone Project to help Iowans “live better, longer” by promoting the policy and infrastructure to “make the healthy choice the easy choice.” Amerigroup and our corporate parent, Anthem, have a well-established commitment to work place policies which promote health and wellbeing. To drive Blue Zone achievement in Iowa we will:

- **Get Certified** - We believe in leading by example and we will commit to becoming a Blue Zone Certified Workplace
- **Support Provider Certification** – Commitment to becoming a Blue Zone certified workplace will be included in our PCP Quality and Access to Care provider incentive program, creating explicit alignment within our operating model

- **Build on Experience** – We work closely with Healthways and others on Blue Zone-like programs in several other states and we will expand that relationship to Iowa
- **Lead by Example** – Together with our parent company, Anthem, Amerigroup is a leader in workplace health and prevention as well as being a socially responsible employer. By delivering to our employees what we believe and what the State of Iowa believes, we will provide a role model as well as provide the momentum for the Blue Zone initiative. (See below for more details on key policies and programs.)

We believe there is no better means of communicating commitment and generating momentum than setting the standard in how we operate. *Amerigroup is aligned with the 10 characteristics of a Socially Responsible Employer based on the Healthiest State Initiative.* We are proud to build on this established excellence in Iowa:

- 1) **Sustain a work environment founded on dignity and respect for all employees** – Our town halls, informal workgroups, committees, sub-committees, and other routine meetings make sure that every functional area of the health plan has a regularly scheduled time to communicate with other related areas. Our Associate Resource Groups help develop a deeper understanding of diversity and cultural competence in the workplace and the marketplace. They promote opportunities for leadership development and growth among all employees and act as internal consultants by providing cultural insight to business initiatives targeted at different segments of our multicultural marketplace.
- 2) **Make employees feel their jobs are important** – Our Leadership Committees meet regularly within our affiliate health plans and provide operational oversight for all health plan functions to all employees. Our annual associate satisfaction survey informs specific action plans focused on the most critical engagement and satisfaction cited by employees to allow for a highly focused approach in continually improving the experience of our employees. Across our parent company and affiliates, over 80 percent of our employees in our 2014 survey indicated they would recommend our organization to their informal networks while reporting high levels of engagement in their work.
- 3) **Cultivate the full potential of all employees** – We know that unlocking our employees' full potential is critical to driving performance and engaging employees in becoming high performers. We have several programs that acknowledge employees for longevity, professional growth, and exemplary job performance, such as *Certification Awards*, where we give monetary awards for the first-time completion of approved certifications relevant to the professions of those employed by the company. This policy provides recognition and rewards for mastering competencies in an expertise relevant to an employee's current position or mastering skills that would enable them to take on new roles that benefit the company. Additionally, we provide *Job-related Licensure Reimbursement* as appreciation for the effort it takes to maintain required licenses for employees to do their job. Amerigroup reimburses the cost of fees to renew their license to eligible employees holding positions that require licensure. We also offer *Education Reimbursement* to encourage the pursuit of learning opportunities at accredited institutions and earning credits toward the completion of a degree that will assist employees in current or potential roles at Amerigroup. Employees are reimbursed for 100 percent of eligible expenses up to \$5,000 (\$2,500 for part-time employees) per calendar year for a grade "C" or above (or "pass" for a pass/fail course).



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- 4) **Encourage individual pursuit of work/life balance** – We understand that work-life balance is vitally important to our employees and encourages employee engagement, productivity and accountability, which in turn drive company success. We offer our employees the following programs:
- i. *Flexible Work Schedule* –Allows options for determining start/end work times, numbers of hours worked each day, and days worked
 - ii. *Work at Home* – Employees can work all or part of their time from home
 - iii. *Job Sharing* – Allows two employees to share the same position on a part-time basis
 - iv. *Part-time* – For employees who want to work fewer than 33 hours/week
 - v. *Phased Retirement* – This is an opportunity to gradually transition from work to retirement. We support our employees work under flexible arrangements with tools and coaching to help them to do their best work, measured through their achievement and performance goals.
- 5) **Enable the wellbeing of individuals and their families through compensation, benefits, policies, and practices** – Amerigroup is committed to providing employees with a pay package that is market-competitive and rewards results and the way they are achieved. Our philosophy is to target base pay at competitive levels, while also sharing our financial success through employee incentives. All of our employees are eligible to receive an annual or quarterly bonus, depending on the type of job they perform. Our employees' pay package is made up of base pay and incentive (bonus) pay, which together make up their total cash compensation. Additionally, all full- and part-time employees (along with eligible spouses, domestic partners, and/or children) are eligible to participate in our benefits programs, which include a comprehensive selection of health, dental and vision benefit options.
- 6) **Develop great leaders at all levels who excel at managing people as well as results** – We fully support ongoing learning, development, and tools for our employees to grow their careers. We offer an extensive library of online learning in over a dozen areas, such as office skills, project management, leadership, customer service, Medicaid, Medicare, and more. In addition, we sponsor several year-round leadership development forums which are a blend of classroom and online learning and include assigning a mentor to each program participant:
- *Future Leader*: For frontline employees aspiring to move into managerial positions
 - *Emerging Leader*: For current managers who aspire for increasing levels of managerial responsibilities)
 - *Winning Leader*: For current senior leaders who aspire to executive leadership roles
 - *SOAR*: Our newest diversity and leadership development initiative prepares our mid-level leaders for future senior leadership opportunities
- 7) **Appreciate and recognize the contributions of people who work there** – We have several means of recognizing individual contributions. For example, we recognize our employees through our *Values in*



- Action Program** providing an opportunity to reward employees on the spot for specific accomplishments that exceed expectations. The program recognizes high performers who exemplify Amerigroup's values and contribute to our overall success. We also engage in **Informal Recognition Activities**, which includes timely and effective acknowledgements of an employee's contribution toward a department goal or objective. Rewards may include: gift certificates/card; cash; tickets for movies, sporting events, and amusement parks; team parties; and other appropriate gifts or outings.
- 8) **Establish and communicate standards for ethical behavior and integrity** – Our management team builds training into employee annual development plans as applicable. These trainings are at various levels from leadership and career development to current job enhancement skills. Annual required training includes cultural sensitivity and diversity, compliance, ethics, and HIPAA and privacy training.
 - 9) **Get involved in community endeavors and/or public policy** – We strongly encourage participation in volunteer and community events. In 2014, across our parent company and affiliates, employees completed 35,375 volunteer hours in the communities we serve. Through our **Associate Giving Program**, employees have the year-round opportunity to give back to their communities by contributing to non-profit organizations focused on health and human services. In 2014, our associates raised \$3 million with \$1.5 million matched by the Anthem Foundation. In addition, 90 percent of giving is earmarked for healthcare related causes in the communities served. Since 2000, we have raised over \$160 million to such causes, including active lifestyles, cancer prevention, diabetes prevention, and maternal practices. We continuously look to find ways to help those in the communities we serve, as well as for our own employees. Through our **Anthem Cares Fund**, employees have the opportunity to help their co-workers who experience a natural disaster or personal hardship. The Anthem Foundation matches these contributions 50 cents for every dollar.
 - 10) **Consider the human toll when making business decisions** – Our employees are at the heart of what we do for our members. Amerigroup has proven practices and processes in place to verify that business decisions take into account the impact they have on our most valuable asset – our people. In many of our organizational units, we cross-train our employees to handle a variety and diversity of tasks and responsibilities which allows us to redeploy our human capital resources to other areas of the business when necessary in an effort to avoid job reductions. In addition, every management level employee across the company is aligned to a people leadership goal, which is weighted to at least 10 percent of his or her overall annual performance goal metrics – holding our leadership directly accountable for motivating, developing, and retaining our employees.

Amerigroup is committed to retaining its employees by creating an engaging and supporting work environment across all of our affiliates' 19 state-sponsored plans. We live this commitment daily through our internal processes and programs. Maintaining a positive and productive work environment is a priority for us and we have robust menu of programs available to our employees and managers that drives employee commitment and retention. Through our selection, development, wellness, recognition, promotion, and transfer policies and day-to-day processes, we strive to be the best employer possible to retain a highly qualified workforce that reflects the availability of the talent in the communities we serve. In 2014, our organization retained nearly 90 percent of its employees across its state sponsored program health plans, and we continue to see a high level of employee commitment in 2015 with an employee retention rate of nearly 90 percent year-to-date. Most recently, Forbes and Statista.com polled more than 20,000 workers at companies employing more than 2,500 associates across several industries, including ours. *The result was Forbes named our parent company, Anthem, as one of America's Best Employers for 2015.*

Mental Health/Disability Services Redesign (10.2.4)

Question 10.2, #2

2. Describe how you propose to work with the Mental Health and Disability Services Redesign.

In 2011, Iowa embarked on a process to establish a plan to strengthen its community-based services infrastructure to promote recovery, reduce the need for more costly crisis-oriented and institutional settings, and facilitate community integration. Workgroups and Task Forces brought together stakeholders to review, evaluate, and develop recommendations that included best practices and the need to serve persons with serious mental illness in more integrated settings. In 2012, legislation was passed to formalize the mental health and disability services redesign - addressing eligibility for non-Medicaid services, identifying core services, directing knowledge and skills of providers for persons with co-occurring conditions, providing evidence-based services, and providing trauma informed services. Additionally, the legislation addressed finance and a regional management and administrative structure forming 15 MHDS Regions with responsibility to ensure that services are available regardless of funding source.

Building on this important initiative, we will leverage our work with affiliate health plans in Florida, Tennessee, and Kansas where we partner with the States, local agencies, and providers to promote community inclusion and best practices to increase timely access to services for Iowa's members. Amerigroup will partner with Iowa agencies, organizations, and stakeholders such as: Mental Health and Disability Services Commission, the Mental Health Planning Council, the Iowa Developmental Disabilities Council, the Advisory Council on Brain Injuries, the Prevention of Disabilities Council, the Olmstead Consumer Task Force, Iowa Behavioral Health Association, Iowa Behavioral Health Collaborative, and other statewide advocacy groups to identify strategies to support an integrated system of care that is person-centered addressing physical, behavioral health, and social relationships and opportunities for meaningful participation by people with disabilities. Working in collaboration with these organizations, DHS, and the MHDS Regions, we will promote the currently established MHDS goals to:

- Ensure effective use of Habilitation Services
- Establish processes to assure that resources are used for those with the highest need at the time of their need
- Identify innovative services across the State that are successfully supporting individuals with SMI in the community and identify how those programs could be replicated
- Develop processes to streamline eligibility and authorization for 1915(i) Habilitation Services
- Increase quality through monitoring performance indicators and outcomes
- Engage other systems such as criminal justice, child welfare, education and vocational services, and supportive housing

In addition, Amerigroup will work closely with key Iowa stakeholders, and the MHDS Regions to design effective strategies to align the redesign goals with efforts that include building capacity of community supports and services as well as systems to promote rapid response when service gaps or capabilities are identified or health disparities are documented.

"In 2007, Amerigroup [Corporation] and a culturally diverse group of community advocates, health care experts and academics launched a first for the healthcare industry: the National Advisory Board (NAB) on Improving Health Care Services for Seniors and People with Disabilities...In addition to supporting our work, Amerigroup has sought and leveraged our collective experience, perspective and guidance to develop more effective programs and better serve its members."

*Lex Frieden,
Professor and Director,
ILRU at TIRR Memorial
Hermann and Convener,
National Advisory Board
on Improving Health Care
Services for Seniors and
People with Disabilities*

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Through our affiliates, Amerigroup's experiences include strong collaboration with State and community partners as well as engaging advocacy organizations in evolving systems of care that are responsive, innovative, and accountable. Amerigroup Corporation established a National Advisory Board composed of prominent national leaders with lived experience to inform and evaluate our programs and services, and we will tap into this expertise to develop the Iowa program. We will also utilize the experience and guidance of the many State advisory groups across our various projects that were used to establish integrated health systems that will be invaluable in supporting Iowa's mental health and disability services redesign. We will build on the core of this work, best practices, and lessons learned that our affiliates have accomplished to-date across the country, then refine and evaluate Iowa's efforts to-date. We are well positioned to be active participants in this building process, given our extensive expertise in integrated clinical care, program design and implementation, quality and outcomes evaluation, data analytics, public policy, and advocacy. Activities may include, but not be limited to:

- Meeting individually and collectively with the MHDS Regions
- Establishing a Statewide Advisory Group
- Meeting and actively participating in redesign work groups and task forces
- Collaborating with public policy organizations such as the University of Iowa Public Policy Center
- Collaborating with other MCOs
- Evaluating and conducting research on service needs based on the geographic area(s) to promote community inclusion, recovery and resilience
- Establishing and funding innovative demonstration projects and programs

In summary, we are committed to leveraging our experience and proven innovation in the delivery of mental health and disability services across the many states our affiliate health plans serve, as well as our deep knowledge of effective physical health integration that will enable Iowa to achieve the goals of redesign.

Following execution of the Contract, Amerigroup will obtain DHS approval of the proposed approach to supporting the redesign. We will implement and adhere to the DHS-approved approach. We understand that any changes to this approach must receive prior approval from DHS.

State Innovation Model (SIM) (10.2.5)

Question 10.2, #3

3. Propose strategies to incorporate the Value Index Score (VIS) as a tool to drive system transformation, and other strategies to support the State Innovation Model (SIM).

Amerigroup looks forward to working with Iowa's well-developed Accountable Care Organization (ACO) infrastructure. We have learned from discussions with Wellmark that upwards of 80 percent of Iowa's PCP's are currently aligned with an ACO. This strong foundation will springboard the Medicaid delivery system transformation. Amerigroup's sophisticated, integrated care model/interdisciplinary team aligns with the CMS triple aim initiative to optimize population health, experience of care, and per capita cost. The integration of value-based principles into provider workflows will enable even more cost-effective realization of these goals. To maximize the benefit from the State Innovation Model, Amerigroup will actively support its implementation. Specifically, we will pursue the following strategies:

- Drive implementation of value-based shared savings programs with ACOs including VIS
- Seek alignment with other plans, leveraging our Wellmark relationship
- Support broad provider alignment with value-based reimbursement beyond ACOs and PCPs

- Provide support and tools that enable provider transformation
- Use aligned incentives to promote member engagement and participation

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In addition to the range of value-based incentives, and the providers engaged in our incentive programs, Amerigroup will offer the resources and tools that assist in embedding patient-centered medical home-based concepts, such as: enhanced access, integrated and coordinated care, increased patient engagement, and health information technology adoption into their practices. Amerigroup has resources specifically designed to support providers with these processes that focus on outcomes and optimal delivery of care. We also encourage and support practices to improve best practice-based strategies and action plans to address their identified high-value opportunities.

Finally, to fully align the system in a manner consistent with the State Innovation Model, we will leverage member incentives to promote aligned member engagement. The more aligned members are with the value-based system, the better it will work. For example, we will deploy our Healthy Rewards member incentive program, designed to incent members to become and stay healthy. This program includes incentives for smoking cessation, breast health, well-child visits, etc. exercise, etc.

Following execution of the Contract, Amerigroup will obtain DHS approval of the proposed approach to supporting the SIM. We will implement and adhere to the DHS-approved approach. We understand that any changes to this approach must receive prior approval from DHS.

Amerigroup's affiliates have substantial experience participating in multi-payer collaborations to drive aligned incentives and payment reform to achieve the triple aim. Specifically, Amerigroup affiliates have participated in multi-payer initiatives in numerous states including Ohio, Colorado, New York and New Jersey. In those states, our affiliate health plans are participating in CMS' Comprehensive Primary Care Initiative (CPCi), a multi-payer aligned delivery system transformation project. In this initiative, we are partnering with CMS, commercial and Medicaid payers, providers, and others to focus on achieving the Triple Aim – improved care, better health for populations, and lower cost. The collaboration consists of multi-payer payment reform through an aligned payment model, continuous sharing of data to guide practice improvement, and reinforcement of meaningful use health information technology. While still early in the project, the largest transformation appears to be in the application of risk-stratified care management where the primary benefit appears to be reductions in hospitalizations. Leveraging this CMS pilot, as well as our experience in other states, Amerigroup is well-positioned to participate in and contribute to the Iowa State Innovation Model.



Amerigroup and its affiliates have substantial experience participating in multi-payer collaborations to drive aligned incentives and payment reform to achieve the triple aim.

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Substance Abuse Prevention and Treatment Block Grant (10.2.6)

Question 10.2, #4

4. Describe your experience in supporting a State authority in meeting the requirements of the Department of Health and Human Services Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant.

Through our affiliate health plans, we have extensive experience working with states to make sure that all appropriate block grant services are understood and made available to health plan members. We also assist State agencies in ongoing planning efforts to identify emerging needs, identify service gaps related to access and the range and breadth of services, and optimize program evaluation and outcomes reporting. We will collaborate with Iowa to do this in support of the goals of the block grant to:

- Improve access to prevention and treatment services
- Provide primary prevention services
- Provide specialized services for pregnant women and women with dependent children
- Provide outreach and treatment to intravenous drug users
- Make available and monitor tuberculosis services to each individual receiving substance use treatment
- Make available early intervention services for individuals with HIV and STDs
- Verify each pregnant woman be given preference in admission to treatment facilities or referred to IDPH

We will also assure continuity of access to gambling addiction programs funded by the State.

In Kansas, our affiliate health plan collaborated with the State and the other KanCare MCOs in the administration and interpretation of the annual Substance Use Disorder Member Satisfaction survey, detailing member satisfaction with their counselor, coordination of care, access to care, and outcomes of service, etc. We also implemented and support the State's SBIRT initiative, our behavioral and physical health programs coordinate care for substance using pregnant members, and we implemented a strong lock-in program with a significant focus on drug-seeking and using members.



Our affiliates have experience working with states to make sure that all appropriate block grant services are understood and readily available, while also assisting state agencies in ongoing planning efforts and reporting.

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We also have experience through affiliates in other states meeting all block grant reporting requirements. We typically include this information as a standard component of our routine monthly submissions to the State. For example, in several states, our encounter files are used as a data source from which the State extracts information submitted as part of the block grant reporting requirements.

To ensure we meet all reporting requirements, we will work with Iowa to ensure we provide all necessary data in the form, format, and timeframe required. For example, in Kansas we provide a Level of Care report which documents admissions, days/1000, and other metrics for inpatient and outpatient utilization and varying levels of care. Kansas uses this information to support their documentation of the scope and intensity of SUD services provided in the State.

Question 10.2, #5

5. Submit a project plan describing your specific approach and timetable for addressing this section.

Our Iowa Quality Management and Quality Improvement Work Plan includes the activities and initiatives Amerigroup will undertake to support the Healthiest State Initiative, Value Index Score (VIS), State Innovation Model, Mental Health and Disability Services Redesign, and Substance Abuse Prevention and Treatment Block Grant. The Work Plan includes our goals for the year, work steps, timelines, and ownership. Our initial draft work plan is included with this RFP submission (see Attachment 14.5.1-1, Work Plan). An updated, official draft plan will be submitted to DHS within 15 days following contract execution.

Please refer to Section 10.1 for details on how our quality work plan is developed, monitored, and updated.

Incentive Programs (10.3)

General (10.3.1)

As detailed in our responses to 10.3.2 and 10.3.3, we will align our provider and member incentive programs to the clinical outcome goals of the State's pay-for-performance initiatives.

Provider Incentive Program (10.3.2)

Question 10.3, #1

1. Describe your proposed provider incentive programs.

General (10.3.2.1)

At the core of Amerigroup's values is the delivery of member-centric, high quality healthcare. Our network of providers is essential to meeting these objectives and our successful provider incentive programs are critical to our comprehensive collaboration strategy.

Amerigroup will implement performance-based incentive systems for providers, obtaining DHS approval prior to implementation, and before making future changes to any previously-approved incentive programs. Our provider incentive programs will focus on issues prevalent to Iowa's members as data and experience are accumulated and analyzed. Our provider incentive programs comply with all applicable requirements

We view our network of providers as critical and essential partners in delivering member-centric, high quality health care. In fact, over 50% of our affiliate's state sponsored program members across 19 states are impacted by some provider incentive programs.

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including federal regulations. We will provide information on these programs in our marketing materials and to members upon request.

As a recognized leader in Medicaid managed care, Amerigroup analyzes best practices from across the nation that are used in developing and deploying robust provider incentive programs for our clients. Our affiliate health plans offer 24 years of managed care experience in the states they serve. This combined experience offers the State some of the most progressive ideas and programs available to achieve your quality goals. In fact, over 50 percent of our affiliates' state sponsored program members across 19 states are positively impacted by our successful provider incentive programs.



Amerigroup's holistic provider incentive strategy empowers providers to accomplish quality goals, improves the coordination of healthcare services, and reduces duplication of services. We work with providers by specialty and type to help them manage their member populations providing the information, tools, and financial incentives they need to meet incentive program goals. We will implement an Iowa-specific ACO provider incentive model similar to the programs currently in place through Wellmark and the State Innovation Model (SIM).

Our incentive programs will align with how the Iowa provider community is organized, from large volume ACOs and integrated delivery systems to PCP-based organizations, and behavioral health to LTSS providers serving members with specialized support needs. We also consider the direction CMS may be moving with their value-based purchasing initiatives. To align with CMS' January 2015 announcement, our incentive programs strive to build a healthcare system that improves the delivery of care, and spends health care dollars more wisely, resulting in healthier members.

Our provider incentive programs are based on our affiliates' extensive experience serving members in similar programs across the country, our understanding of DHS priorities, and our discussions with Iowa providers. Our PCP Quality and Population Management program is our longest-running, most expansive provider incentive program, serving 414,000 members across our affiliate health plans in 11 markets.

Pending approval by DHS, Amerigroup's provider incentive programs incentivize ACOs, PCPs (including FQHCs/RHCs), OB/GYNs, behavioral health, and LTSS providers to deliver high quality, cost-effective services. Our incentive programs reward providers for connecting members to the behavioral, physical, and LTSS services they need, promoting coordination, integration, and member access to appropriate services to improve health outcomes. We will work closely with DHS as we implement to ensure compliance with all regulatory requirements.

We understand that just working with providers and offering incentive programs will not achieve its full potential unless members, families, and providers actively partner to engage individuals in managing their own health and care. We offer tools that focus on member engagement strategies, such as activation and self-management. We encourage sharing information on community resources that can further engage members, their families and/or caregivers. We have proven that informed, actively involved members are more likely to engage in positive health behaviors leading to improved outcomes.

Clinical Quality Goal Alignment

Our incentive programs will align with Iowa's specific clinical quality goals outlined in the Year Two measures in the State pay-for-performance program. As demonstrated in Table 10.3-1, all 15 of the Year



Tab 3: Bidder's Approach to Meeting the Scope of Work
10 Quality Management and Improvement Strategies

Two DHS performance measures are included as a component of one or more of our proposed provider incentive programs. While these programs include measures beyond this list, we believe this comprehensive alignment will drive improvement in the quality areas and measures that are most important to Iowa in helping the State to become the leading Medicaid program for high-quality, cost-effective care.

Table 10.3-1. Amerigroup's Proposed Provider Incentive Programs

DHS Priorities	Amerigroup Proposed Provider Incentive Programs					
	ACO Shared Savings	PCP: Quality & Population Management	PCP: Quality & Access to Care	Birth Outcomes	Behavioral Health	LTSS (both Nursing Homes and Personal Attendant Care Providers)
LTSS Priorities						
Decreased Nursing Facility & ICF/ID Days of Care						•
Hospital Admission Following Nursing Facility & ICF/ID Discharge						•
Behavioral Health Priorities						
Number and percent of members utilizing inpatient psychiatric services					•	
Follow-up After Inpatient Hospitalization for Mental Illness					•	
Children's Health Priorities						
Well-child Visits Ages 0-15 months	•	•	•			
Well-child Visits Ages 3-6 years	•	•	•			
Adolescent Well-Care Visits	•	•	•			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	•					
Pregnancy Priorities						
Elective Deliveries				•		
Pre-term Births				•		
Chronic Condition Management Priorities						
Comprehensive Diabetes Care	•	•	•			
Controlling High Blood Pressure	•					
Adult Preventive Care Priorities						
Adults' Access to Preventive/Ambulatory Health Services	•	•	•			
Breast Cancer Screening	•	•	•			
Body Mass Index (BMI) Documentation - Adults	•					
VIS Implementation						
Improvements in VIS combined with a decrease in Total Cost of Care	•					

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PCP Quality and Population Management Incentive Program

Using quality and claims data, the PCP Quality and Population Health Management Program to be implemented in Iowa sets quality targets on specified HEDIS-like measures. If those quality targets are met and the provider meets or exceeds cost targets, we will award enhanced pay for PCPs. Since one year of historical quality and claims data are required for baseline rates, we anticipate implementing this program in the second full calendar year of the Contract starting January 1, 2017.

This provider incentive model was successfully implemented around the country by our local affiliate health plans for provider groups with a minimum of 1,000 assigned members. This membership threshold is required to accurately measure quality and financial performance. The goal is to improve both quality of care outcomes and medical cost efficiency for large provider groups. The program is designed to:

- Improve targeted clinical quality results, such as children's health, adult preventive, and chronic condition management

- Promote coordinated, safe, and effective patient care across the healthcare delivery system
- Improve provider operational efficiency through sharing timely, actionable data utilized by providers in transforming workflows to incorporate processes that deliver higher quality, patient-centered care

Improve medical cost management through the reduction of medically unnecessary utilization and costs, such as reducing the incidence of ambulatory care-sensitive admissions and emergency room visits and more efficient use of resources

Nationally, we deploy this model across 11 of our affiliate health plans, encompassing PCPs who serve 414,000 members. For full-year 2013 results (the most recent available), providers showed a year-over-year quality improvement rate that was higher than providers not in the model. For example, one market showed a three percent favorable difference in quality performance for groups participating in the program. In terms of improved total medical cost efficiency, providers in the program showed a 2.8 percent year-over-year improvement in their full-year 2013 efficiency (as measured by the medical-loss ratio of their attributed members) than those non-participating providers, with one market recording an 8.6 percent favorable difference.

PCP Quality and Access to Care Incentive Program

To incent PCP provider groups with lower membership panel sizes to increase access, improve clinical quality, and better manage unnecessary utilization, Amerigroup will implement the PCP Quality and Access to Care Incentive program. This incentive program will measure the PCP's performance against a set of measures such as the following:

- Clinical quality measures based on HEDIS measures covering pediatric, adolescent, and adult preventive visits, diabetes care, cancer screenings, asthma medication, and others
- After-hours availability
- Appointment availability
- Non-emergent emergency room utilization
- Percent of newly assigned members with a PCP visit within 60 days of assignment
- Percent of members with at least one PCP visit per year
- Percent of members with a follow-up visit seven days after an inpatient discharge
- Percentage of members with a completed health risk screening

Additionally, we will tie some portion of the enhanced pay opportunity to whether the provider is a Blue Zone certified employer.

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Behavioral Health Incentive Program

Members with behavioral health needs often have complex or co-morbid conditions that impact their engagement in healthcare services. To address this need, we partner with providers to achieve sustainable gains to members' quality of care.

Amerigroup's Behavioral Health Incentive Program (BHIP) has been implemented in Amerigroup's affiliate health plans in other states, and will be adapted for deployment in Iowa. BHIP offers incentives to Community Mental Health Centers (CMHC) to improve coordination of members' physical and behavioral healthcare needs and for the quality of care they provide to our members with behavioral health conditions.

BHIP offers CMHCs an incentive to provide quality and efficient care while keeping members' healthcare needs as its primary focus. CMHCs receive incentive payments for achieving performance targets on specific measures that are important to the health of our members and in alignment with State goals, such as:

- Reduction in behavioral health inpatient readmission rates
- Follow-up after inpatient hospitalization for mental illness
- Follow-up care for children prescribed ADHD medication
- Adherence to antidepressant medication for adults diagnosed with major depression
- Decrease in behavioral health related emergency room visits
- Increase in PCP visits

Amerigroup will use Year One of the contract to gather benchmark information to support full implementation beginning in Year Two, effective January 1, 2017.



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LTSS Incentive Programs

Amerigroup will implement provider incentive programs for nursing home facilities, as well as personal attendant care providers under the LTSS Incentive Program.

Nursing Home Quality Incentive Program

To incentivize nursing home facilities to improve clinical quality, patient outcomes, patient satisfaction, improved cost management, and alignment with State goals, Amerigroup will implement a Nursing Home Quality Incentive Program (NHQIP). We will use Year 1 to gather benchmark information to support full implementation beginning in Year Two, effective January 1, 2017.

This incentive program will measure the nursing home's performance based on a set of quality, care coordination, and service measures such as:

- Potentially avoidable hospitalizations (PAH) and potentially avoidable Emergency Room visits (PAED)
- CMS Nursing Home Compare Star Ratings for quality measures, health inspections and staffing
- Collaboration and care coordination, such as nursing home facility participation in interdisciplinary care planning conference calls, effective support for discharge planning and transition of members to community settings, ready availability of behavioral health providers, and implementation of in-house staff training programs.



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Personal Attendant Care (PAC) Providers – PACQIP

To incentivize PAC providers to improve clinical quality, patient outcomes, patient satisfaction, and cost management, Amerigroup will implement a Personal Attendant Care Quality Incentive Program (PACQIP). We will use Year 1 of the contract to gather benchmark information to support full implementation beginning in Year 2, January 1, 2017. This incentive program will measure the PAC's performance based on a set of quality, Case Management and service measures such as:



- Potentially avoidable hospitalizations (PAH) and potentially avoidable emergency room visits (PAED)
- Patient care, safety and service indicators, including prevalence of falls and falls with medical intervention, critical incident identification and reporting, health and safety checklist submission, caregiver retention, training, and timeliness
- Patient satisfaction including member complaints or grievances and member satisfaction with caregivers

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Empowering Providers to Improve Member Care and Meet Incentive Goals

We have found that provider incentive programs are most effective when we assist providers in maximizing their incentive payments and we are able to meet our population management and quality outcomes goals by offering an enhanced provider service model featuring online tools, detailed reporting, and additional opportunities to work more closely with us. We have systems and processes in place to provide actionable information and support in effectively using available data to enhance performance as outlined below.

ACO Shared Savings/Shared Risk Providers

As mentioned above, we will utilize the 3M licensed Value Index Score (VIS) tool to measure ACO performance. The VIS tool includes a provider facing online performance reporting capability that allows providers to access timely information to manage member Quality and Care Management. Available reporting examples includes the following:

- VIS composite score reporting for each PCM, providing scoring details and historical performance
- Population management reporting to assist in understanding the clinical category and risk of their attributed members
- Care coordination gap reporting to identify which members are in need of services to improve quality performance

Many ACOs have already-developed their own reporting and analysis systems. They generally prefer to receive bulk claims, membership, and provider data from payers to input into their own systems. We have the capability and experience to perform this function, and we can accommodate this preference.

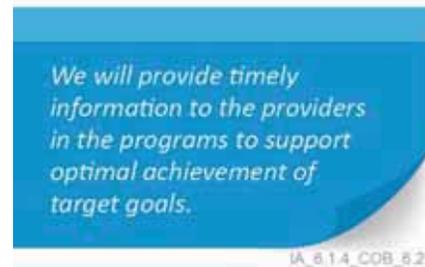
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Providers in Birth Outcomes, Behavioral Health and LTSS Incentive Programs

These programs include provider reporting that is timely, actionable, and relevant to the program. The reporting is based on members that are attributed to the program providers. Members are not required to prospectively select and are not assigned to specific behavioral health or LTSS providers. We use retrospective claims analysis to accomplish the visit-based member attribution to providers in these programs.

We provide timely information to the providers to support optimal achievement of target goals. For example, we will periodically provide updated member attribution reports, as well as relevant information related to any identified gaps in care. We will also provide interim performance reports to support transparency and visibility into provider performance during the measurement period.



For all of our provider incentive programs, Amerigroup assigns a Provider Relations Associate to assist the participating providers in using this information to improve quality. These associates use the above reports to help focus on interventions that improve population health outcomes by maximizing available practice resources and establishing quality improvement structures. They work collaboratively with the providers to establish quality and cost efficiency improvement action plans. Our goal is to empower the provider groups to succeed, which ultimately improves member care and outcomes.

Incentive Payment Restrictions (10.3.2.2)

We will comply with this requirement. Our Shared Savings/Shared Risk Programs are designed to require compliance with all applicable 42 CFR 422.208 and 422.210 regulations. Within the shared savings or risk contracts offered by Amerigroup, providers are specifically informed that it is not the intent of any Amerigroup program to induce the provider to reduce or limit medically necessary care. This is also reinforced within the general provider manual. Additionally, certain shared savings and shared risk arrangements require that providers are protected with stop-loss coverage. Our arrangements either

incorporate that element as a part of the program, or, if the provider chooses to purchase external stop-loss coverage, we verify the appropriateness and existence of the coverage prior to the execution of the arrangement. Amerigroup will always work in a cooperative fashion with DHS to ensure that any program offered within Iowa complies with all State and federal rules and regulations.

Member Incentive Program (10.3.3)

Question 10.3, #2

2. Describe your proposed member incentive programs.

Overview (10.3.3.1)

Amerigroup's "Healthy Rewards" incentive program promotes overall member responsibility and engagement as well as facilitating targeted improvement in specific HEDIS and other wellness and preventive care measures. The goals of our member incentive program are to help engage members in managing their health and any chronic conditions and to gain knowledge about activities that will keep them healthy.

Amerigroup's Healthy Rewards program promotes personal responsibility by encouraging and rewarding healthy behaviors (such as smoking cessation) and age and gender appropriate preventive care. Coupled with our extensive Health Promotion, Case Management, and Disease Management Programs, Healthy



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Rewards builds members' health literacy and self-care skills, improving health and productivity, while reducing the risk of poor long-term health outcomes. Additionally, Healthy Rewards promotes optimal maternal and child health outcomes through our Taking Care of Baby and Me[®] sub-program which provides education and care coordination as well as incentives for attending prenatal and postnatal visits and completing appropriate health risk screenings.

The Healthy Rewards Program provides members with the opportunity to earn credits for completing specific health-related activities, such as, preventive care services, participating in care coordination, or complying with provider recommendations.

Members can convert their credits to dollars, which are loaded onto a prepaid debit card, and then can be used to purchase health related over-the-counter items.

Our Healthy Rewards program aligns with both the State's overall goals as well as the pay-for-performance clinical outcome goals for contractors including incentives to promote improvement across the following challenge areas:

- **Smoking cessation:** Our smoking cessation incentives aim to help lower the adult cigarette use rate, which is currently 20.4 percent for adults and 25.3 percent for high school age youth (as of 2011). This ranks Iowa 21 out of 50 states and 28 of 44 states, respectively.
- **Fitness and nutrition:** Our fitness and nutrition incentives aim to help address the adult obesity rate of 31.3 percent, which has increased each year from 2004 and ranks Iowa as 12 out of 50 states. In addition, statistics show that from 2009 to 2010:
 - 24.2 percent of Iowans reported no physical activity during the past month
 - 65.4 percent of Iowans are overweight
 - 17.2 percent of children ages 2 to 5 are overweight with 14.7 percent considered to be obese
- **Diabetes management:** Our diabetes management incentives aim to improve outcomes for the 8.6 percent of Iowans with diabetes (as of 2012)

Amerigroup acknowledges that our proposed member incentive program is subject to the State's final review and approval and that contract award does not constitute approval or acceptance of the program. Upon contract award, we will submit our program for State approval in the required format.

Program Details

Each member enrolled in Healthy Rewards receives a debit card, which will be credited with the appropriate incentive amount once we verify member eligibility and completion of the incentive-related service. Members can redeem their credits at any participating store within our retail network, offering greater member convenience and flexibility than a single-store debit card.

Members can use Healthy Rewards credits to buy health-related items, such as:

- **Hygiene Products:** deodorant, shampoo, shaving cream, facial cleansers, moisturizer
- **Baby Care:** food, formula, diapers, clothing, bedding, toys
- **Nutrition:** vitamins, dairy, bread, cereal
- **Diabetic Care:** test strips, glucose monitors, diabetic candy, and supplements
- **Over-the-Counter (OTC) Medication Items:** pain relief, antacids, cold and allergy
- **Eye Care:** sunglasses, lens solution, eye drops, magnifying glasses
- **Basic Needs:** first aid, toothpaste, mouthwash, sunscreen
- **Home Health Care:** safety accessories, blood pressure kits, hand exercisers

Member Enrollment and Education

Amerigroup realizes that a simple enrollment process strengthens our ability to maximize member participation so we offer two convenient options, online or by phone. Members can enroll via our easy-to-use online portal or by calling Member Services or their Case Manager, who will complete the enrollment process for them. After a member is enrolled, he or she can access the online portal through our secure member website, review all incentive opportunities and monitor their rewards status. Amerigroup's HIPAA-compliant website offers full accessibility offering alternative language translation and is in compliance with Section 508c requirements supporting assistive technology tools to eliminate barriers for people with disabilities. Website content is currently available in Spanish and can also be translated into 90 languages using Google Translate functionality.

Figure 10.3-1. Our Healthy Rewards Online Tools Promote Member Accessibility



As a component of their care coordination or disease management activities, our local Case Managers, also help educate, engage, and invite eligible members to participate in Healthy Rewards. Our Case Managers understand the importance of integrating care and services for members with co-occurring medical and behavioral health diagnoses. As an example: Case Managers will offer education on incentives for members with schizophrenia or bipolar disorder, and who are currently prescribed antipsychotic medications, to complete diabetic health screenings because they are at a greater risk for developing that condition. Case Managers will also provide education on specific incentives for maintaining medication adherence as well as other appropriate eligible incentives, such as preventive care (shown in Figure 10.3-1). Case Managers serving pregnant members will provide information on our Taking Care of Baby and Me sub-program that includes incentives and member education. In addition to the incentives for timely prenatal and postnatal checkups, our Taking Care of Baby and Me sub-program provides:

- Individualized, one-on-one case management support for women at the highest risk; care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to sustain well-child visits after the baby is born
- Prenatal and postpartum packets containing educational materials and incentive redemption cards

Program Promotion

Our promotion strategy builds on proven approaches that have been successful in our affiliate health plans including:

- Home mailings to all new members with promotional materials that include program descriptions and enrollment instructions
- Quarterly home mailings of program reminders, including enrollment instructions
- Educational and promotional messages when members call Member Services
- Provider education about the program so network providers can educate members in their offices

Amerigroup will also include a \$20 screening survey incentive for all new members. Survey results are essential for proper case management because the results are automatically downloaded into CareCompass allowing Case Managers to see which members trigger nurse outreach. We will educate members about our survey incentive via the member welcome kit and website, telephonic outreach calls, clinic days and community outreach events.

Proven Results

Amerigroup's Healthy Rewards program for Iowa will be built off a solid foundation of administering a similar program in our Kansas affiliate since January 2013, and recently implementing state-specific Healthy Rewards programs in Louisiana and Texas. Healthy Rewards participation across our affiliate health plans has consistently grown due to our comprehensive communication and education campaigns. For example, between July 2013 and 2014, the participation rate in our Kansas affiliate more than doubled. Because we propose a broad array of incentives that promote preventive health and condition-specific screenings for members, we anticipate strong participation by Iowa's Medicaid members as well.



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Amerigroup's robust technology platform supports program administration (card issuance and financial management of incentive accounts) which enables us to tailor the program specifically to the unique priorities of Iowa Medicaid population. Our affiliate's 24 years of experience in Medicaid Managed Care also demonstrate our ability to implement proven tracking and analytic tools to monitor program performance. Our team of data experts is skilled at assessing the impact of these programs and our local Iowa team will receive support from our national Data Analytics team, who bring their extensive experience with similar programs from other affiliate plans.

As the Iowa Initiative Healthy Rewards program matures, we will continually re-evaluate its impact, and our platform allows us to easily modify program design as necessary to reflect evolving State priorities and member behaviors.

Figure 10.3-2 demonstrates the strong impact of our member incentive program for our Kansas affiliate using 2014 HEDIS measures.

Figure 10.3-2. Healthy Rewards Drives Improved Quality Scores in our Kansas Affiliate (August 2014)

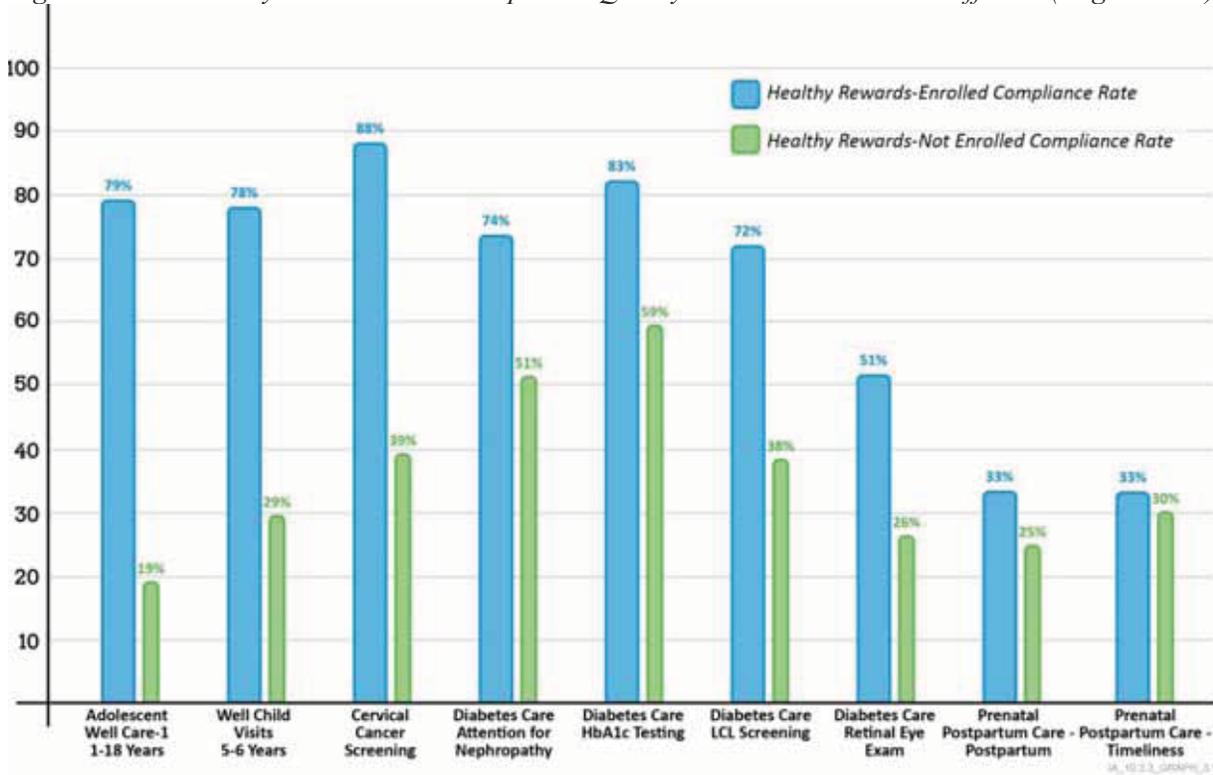


Table 10.3-2 summarizes our proposed Healthy Rewards incentives for Iowa.

Healthy Rewards Incentives

Our proposed Healthy Rewards incentives are summarized in Table 10.3-2 below.

Table 10.3-2. Member Incentives Encourage Preventive Care and Services

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Incentive Payment Restrictions (10.3.3.2)

Amerigroup understands that we must receive written approval from the State before offering any incentives. Incentive materials related to mailers will be approved through requests for health promotion materials using the standard regulatory approval process.

Critical Incidents (10.4)

General and Provider Requirements (10.4.1-2)

Question 10.4, #1

1. Describe your critical incident reporting and management system.

Through our affiliates' 24 years of experience administering government healthcare programs serving populations like those enrolled in Iowa's managed care program, they have developed a well-tested Critical Incident Reporting and Management System. We continually refine our quality management strategy to focus on the development of programs and services that will best meet the members' service and support needs. We quickly respond, report, and track incidents, and develop protocols to reduce the occurrence of critical incidents. We will bring this experience to Iowa to manage critical incidents and document our proven protocols and best practices in Iowa-specific policies and procedures for DHS review and approval.

Our program will promote the protection and safety of all members including children, older adults, people with physical, intellectual, mental or developmental disabilities. In Iowa, our health plan will recognize, report, and address the following types of both minor and major critical incidents, including, but not limited to those listed in Table 10.4-1.



We quickly respond to, report, and track incidents and develop protocols to reduce the occurrence of critical incidents.

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Table 10.4-1. Major and Minor Critical Incidents

Major Incidents	Minor Incidents
Unexpected death of a member	Results in the application of basic first aid
Suspected physical or mental abuse of a member	Results in bruising
Severe injury sustained by a member	Results in seizure activity
Theft or financial exploitation of a member	Results in injury to self, others, or property
Medication error involving a member	Constitutes a prescription medication error
Sexual abuse and/or suspected sexual abuse of a member	
Abuse or neglect and/or suspected abuse or neglect of a member	

Our program is based on our associates and providers serving as the eyes and ears on the ground on behalf of our members. When one of our associates or providers has reasonable cause to believe that a member has been or is being subjected to abuse, neglect, and/or exploitation, he or she must immediately report this information to their direct supervisor, the Quality Management Department, or the appropriate State agency. Additionally, all enrollees in receipt of long term services and supports identified with a potential quality of care issue are referred to the Quality Management Department.

Our health plan staff (for example, LTSS Community-Based Case Manager, Case Manager, etc.) and providers are trained to report any suspected critical incident to quality management no later than the end of the next calendar day of the incident (within 24 hours), or if the incident is a minor incident, within 72 hours.

A dedicated critical incident reporting and management system is available for staff and providers for all incidents that occur in home and community-based long-term care service delivery settings (HCBS), including a member’s home if the incident is related to the provision of covered HCBS.

While we have robust systems in place to document and respond to critical incidents, we recognize the importance of staff and provider training to help drive the effectiveness of our protocols. Our provider education and staff training programs draw from our affiliates’ extensive experience in programs across the nation. We conduct training and maintain oversight of all applicable staff and network providers to assure compliance with critical incident requirements.

Our procedure for handling both major and minor critical incidents includes the following steps to verify accuracy and timeliness of critical incident reporting, to make sure all incidents are addressed and tracked appropriately to prevent further harm to the member - and avoid recurrence:

- As a result of policy and training, staff members or providers will report the suspected critical incident details directly to the abuse hotline, if abuse or neglect is involved. Next, the provider or staff member will report through the designated Quality Management channels within 24 hours of incident occurrence as specified by Iowa requirements.
- Staff members and providers are trained to immediately take appropriate steps to prevent further harm to the member and to respond to emergency needs. The staff member or provider will immediately assess the safety of the member and take the appropriate steps to ensure the member’s safety. If outside agencies need to be involved, the Case Manager and/or provider will initiate this action, (including involving adult or child protective agencies or law enforcement, as needed)
- The manager, after communication with the provider, LTSS Community-Based Case Manager, or Case Manager will enter the applicable information on any suspected critical incident into the Quality of Care Event Tracking System (QOC database) and HCBS system, if applicable.

- In addition to the internal tracking system, the clinical manager or designee will report the incident to DHS and any other relevant agencies (for example, Department of Social Services) in the form and format specified. This will be done as part of the reporting process of the critical incident (within 24 hours of occurrence).
- The manager or designee will document initial notification of relevant agencies in the QOC database.
- If the QM coordinator determines the incident report is reflective of potential fraud, waste, or abuse, the QM coordinator will initiate a Corporate Investigations Department (CID) referral.
- If the provider is incarcerated, the QM coordinator will notify the department manager and compliance officer so they can follow the appropriate protocols.
- Amerigroup will deploy relevant staff (for example, Case Manager /LTSS Community-Based Case Manager), as appropriate, to follow up with the member regarding any changes to the member's service plan. Amerigroup staff will also document notification and findings of member's support needs and any revisions to the service plan.
- Amerigroup staff will comply and assist with investigation of the incident.
- The manager, after communication with the LTSS Community-Based Case Manager or Case Manager, will update the QOC database with any additional information they may receive throughout the investigation and inform the QM coordinator and DHS of such updates.
- The Provider Relations team will follow up with the provider as appropriate.

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Information documented and reported on the critical incident includes, but is not limited to:

- Reporting party
- Member information
- Incident information
- Resolution information
- Type of physical injury/outcome
- Type of mental health outcome
- Law enforcement participation
- Abuse report
- Location of incident
- Staff review
- Member review
- Equipment and supply review
- Environmental review
- Systemic resolution

We will collaborate with DHS and other Iowa stakeholders and MCOs on prevention activities and risk management strategies to promote health and safety with evidence based policies and procedures. For example, a comprehensive training program for providers, particularly providers of in-home services, to avoid providers receiving duplicative trainings.

Critical Incident Provider Requirements (10.4.2)

Amerigroup leverages our deep relationships with providers to support our comprehensive critical



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incident reporting protocols. We require our network providers to report, respond, and document critical incidents to our Quality Management Department, and immediately take steps to prevent further harm to any member and respond to any emergency needs.

Our providers are trained on critical incidents, including what comprises a critical incident, how to report a critical incident, expectations regarding investigation, and process timelines. The critical incident process is reinforced through one-on-one interaction between our staff and network providers when critical incidents occur. Providers are required to have a formal policy and procedure regarding critical incidents in accordance with State and federal law. Providers will sign an attestation that they have policies in place. Through critical incident tracking and trending, we will flag providers to audit their policies and procedures and

internal corrective actions to mitigate minor and major incidents. In our contracts, we also require providers to cooperate with any investigation into a critical incident conducted by Amerigroup or any State or federal agency.

Critical Incident Training for Staff and Network Providers (10.4.3)

Question 10.4, #2

2. Describe strategies for training staff and network providers on critical incident policies and procedures.

We have robust systems in place to document and respond to critical incidents and we understand the importance of continuously training both staff and providers to assure that protocols are consistently and comprehensively followed. Our provider education and staff training program draws from our extensive experience across the nation. We conduct training and maintain oversight of all applicable staff and network providers to assure compliance with critical incident requirements.

We train all staff who have a touch point with the member or provider, including our clinical and utilization staff, our Member Call Center and Provider Helpline staff, provider relations and quality management, and marketing and outreach team members. Staff training is incorporated in continuous quality training programs and based on job function as it relates to potential involvement in the critical incident process. Training is provided by webinar online as well as in-person. We track participation in online training and use sign-in sheets to track attendance for in-person trainings.

Our Quality Management and Provider Relations teams carry out our provider training strategies in the following manner:

- Provider Relations conducts provider training on critical incident requirements and submissions as part of their standard provider training and onboarding program
- Critical incident policies and procedures are contained in the provider manual as well as on the Amerigroup provider website
- Provider Relations educates providers and subcontractors on issues such as timeliness, accuracy, routing and completeness of incident reports
- Providers are educated on required reporting to the appropriate State agencies in case of abuse, neglect, or exploitation
- Quality Management reviews the incident management system, policies, and employee training programs for all applicable providers and subcontractors



Our training and education programs will be supported by consistent and frequent provider education and outreach through several other communication methods, including our provider manual, provider newsletters, provider websites, and toll-free provider services line.

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In addition to our provider training protocols listed above, our established training and education programs are supported by consistent and frequent provider education and outreach through several other provider communication methods, including our manual, newsletters, website, and toll-free services line. We tailor our ongoing training and education programs to meet the unique needs of the local provider community. We periodically hold workshops and seminars to afford our health plan staff with opportunities to communicate program updates, industry trends, and enhancements to our products and services to providers. We offer quarterly group training sessions for a refresh and to enable providers to train new office staff. We conduct individual training anytime we identify a need or upon provider request.

Implementing Corrective Action (10.4.4)

Question 10.4, #3

3. Describe processes for implementing corrective action when a provider is out of compliance with critical incident reporting.

Because all healthcare is local, our Iowa-based quality management team will be responsible for implementing corrective action when a provider is non-compliant with our critical incident reporting policies and procedures.

When we learn of any deficiency, whether identified by the State, a provider, or internally, our Iowa Compliance Officer, in collaboration with other internal stakeholders and business owners, investigates the root cause of the problem and develops an action plan to prevent a recurrence.

Specifically, we will take the following steps to communicate with our providers in Iowa and verify all entities involved understand how to prevent future compliance issues:

- Telephone discussion with the involved provider
- Written correspondence with the involved provider
- Increased intensity of utilization management activity
- Required consultation for specified categories of cases
- Appearance and discussion before the Peer Review Committee
- Satisfactory completion of designated continuing education
- Other action(s) deemed appropriate by the Quality Management team or Peer Review Committee

The corrective action plan is reviewed by the Quality Management team with the provider and agreed to by both parties. If non-compliance continues, we would eliminate the provider from the network.

Monitoring and Reducing the Occurrence of Critical Incidents (10.4.5)

Question 10.4, #4

4. Describe how critical incidents will be identified, tracked and reviewed and how data gathered will be used to reduce the occurrence of critical incidents and improve the quality of care delivered to members.

As part of Amerigroup's ongoing commitment to improve quality of care and reduce occurrences of critical incidents, Amerigroup will review critical incident data on a monthly basis. We will evaluate critical incident trends to identify opportunities for improvement, which are then included and monitored through our Quality Management and Improvement (QM/QI) Program described earlier in Section 10.1.

We will use tracking and trending of data to inform needed provider training, such as positive behavioral supports if trends demonstrate providers are ill-equipped to meet the support needs of members with challenging behaviors, and use baseline data to set performance metrics.

Data Collection and Utilization

Data, including critical incident data used to support the QM Program and Work Plan, will be collected on a routine basis (monthly, quarterly, and/or annually) and on an ad hoc basis from internal and external sources to systematically and objectively monitor, analyze, evaluate, and report health outcomes and indices of quality. Data collection follows protocols established in approved policies or QM/QI Program design. Data related to all aspects of member services, departmental operations, and

outcomes may be collected.

Data sources may be administrative, surveys, medical records, or a combination. Data sources may include, without limitation: enrollment information, claims, encounters, authorizations, appeals, complaints, disease/case management documentation, access and availability survey findings, member medical records within provider offices and facilities, surveys by external bodies such as accreditation entities or CMS, quality improvement studies, CAHPS, and HEDIS results.

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Amerigroup clinical and service performance goals.

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We evaluate critical incident trends to identify opportunities for improvement which we then include and monitor through our Quality Management and Improvement work plan.

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Data collection is the responsibility of the department or functional area conducting the related QM activity. Medical data may be collected manually and completed by qualified staff (for example, data extraction from medical records is completed by or under the direction of licensed personnel). Data collection follows protocols established in approved policies or program design. Standardized data collection tools ensure consistent and accurate abstraction of data per indicator/written specifications. Inter-rater reliability is evaluated for all manual data abstraction processes. There is a written, systematic step sequence process for all administrative data collections. Administrative data completeness and accuracy is identified when reporting data collection and/or findings. We also have mechanisms in place to assess the quality and appropriateness of care and services furnished to enrollees with special healthcare needs.

Quantitative and qualitative analyses are conducted to evaluate the effectiveness of activities in achieving Amerigroup clinical and service performance goals. These analyses take into account, among other things, potential barriers for achieving desired outcomes and interventions or recommended strategies. Data is aggregated to track and trend over time for identification of optimal and suboptimal plan performance. Revisions to the Work Plan are initiated as a result of findings or reprioritization of projects and new events.

Provider Preventable Conditions (10.5)

Question 10.5, #1

1. Describe how you will ensure payment is not made for provider preventable conditions.

General (10.5.1)

In an effort to drive quality and efficiency in the delivery of services, Amerigroup Iowa (Amerigroup) has robust claims protocols in place to systemically determine when issues such as provider preventable conditions arise, well before a payment is issued. We do not reimburse for provider preventable conditions as identified by CMS contracts and requirements. There are no exceptions to this policy. This includes:

- Health-acquired conditions as identified by Medicare other than deep vein thrombosis and pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients
- Wrong surgical or other invasive procedure on a patient
- Surgical or other invasive procedure performed on the wrong body part or wrong patient
- Any future additions to the list of non-reimbursable provider-preventable conditions maintained by DHS or other State or CMS policy
- Claims that are identified as provider preventable or facility acquired will be rejected or denied.

The following process is standardized across our claims system to ensure payment is not made for provider preventable conditions or facility acquired conditions.

Claim Entry: Claims that successfully complete the claims receipt process are loaded into the claims processing system for adjudication where claim editing and payment calculation are performed. Initial edits verify the member's eligibility and benefit plan on the date of service, determine the treatment type, and re-validate the diagnostic codes.



We have robust claims protocols to systemically determine when issues such as provider preventable conditions arise, well before a payment is issued. We do not reimburse for claims related to provider preventable conditions.

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Claim Status Verification: Next, the claim is checked for timely filing (submitted within one year of the date of service). Then, the next series of edits verify the provider's in-network or out-of-network status and the provider's billing information. Network providers undergo an additional check to verify they are contracted to deliver the services billed. Duplication logic then verifies the claim has not been previously submitted and adjudicated.

Authorization Determination: The next set of edits determines if an authorization is required for the service and, if so, checks to see if there is an authorization on file for the procedure code(s) and date(s) of service. If the system is unable to verify if an exact authorization exists, it will pend the claim to a queue for an analyst to review. Specific edits evaluate inpatient claims for the presence of provider-preventable conditions.

Claims Adjudication: Once the authorization process has been completed, the claim is adjudicated. The system evaluates inpatient claims for the presence of provider-preventable conditions or facility acquired conditions. If indicated, we will reduce or deny payment for claims that demonstrate that the patient acquired the condition while in the hospital or if there was a preventable condition based on provider action. If indicated, the system will reduce or deny payment.

Claims Payment: When a claim reimbursement is made to a provider, there is an explanation of why the claim paid as it did. The Explanation of Payment will indicate to the facility the reduction or denial because of provider preventable or facility acquired conditions.

Provider Requirements (10.5.2)

We require all providers to comply with the CMS, DHS, and any other relevant State or federal reporting requirements. This is written into all contracts and provider materials and includes identifying provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available. Erroneous events would be reflected on Type of Bill 0110 (no-pay claim) along with all services or procedures related to the event. Any other procedures or services would be submitted on a separate claim.

Utilization Management Program (11.1)

Question 11.1, #1

1. Describe in detail your utilization management program, including how you will operate and maintain the program.

Amerigroup Iowa (Amerigroup) will have a singular focus on serving the healthcare needs of those enrolled the Iowa Initiative. Our affiliate health plans have a singular focus on state-sponsored programs. Because of this focus, we concentrate our utilization management (UM) efforts on engaging providers in a productive dialogue about getting members the level of care that will drive the best health outcomes.

Rather than using UM as a mechanism for authorization or denial of requested service, we use it to creatively address our members' health challenges and help them access the right care, at the right time, in the right place.

real solutions mean real results

In our New Jersey health plan, our Medical Director recently authorized non-covered services because they would expedite recovery and promote enhanced quality of life for our member. In this case, the member had an Achilles tendon contracture and the health plan authorized bone stimulation and an orthotic device, which resulted in a positive health outcome.

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For 24 years, our affiliates have provided appropriate care and services to more than 5.2 million members in Medicaid and other state-sponsored health programs across 19 states while achieving ongoing improvements in utilization management and quality outcomes. In many of these markets, our affiliates have demonstrated an industry-leading track record of successful implementations from RFP awards similar to Iowa. Such implementations require a tremendous amount of resource dedication and wholesale changes and adjustments to UM protocols for members, providers,

and stakeholders. We have achieved improvements through our management of lower-level services that have increased access to care. Our management has made providers more aware of the need to be available to members and intervene early in the course of urgent medical situations so that they do not escalate and require hospitalization. ***Based on our experience, we are confident we can roll out an effective UM program that is seamless for members, providers, and stakeholders in Iowa's time frame.***

Efficiency, accountability, and results drive our UM program design and operations. Amerigroup strives to identify and implement industry best practices to positively impact our members, providers, and State customers. The Amerigroup UM program, combined with our Service Coordination, Disease Management, and Health Promotion programs, facilitates the delivery of the most appropriate care to members in the most cost-effective setting. Our industry-leading systems and techniques improve efficiency for Amerigroup and our providers while promoting improved health outcomes and well-being for our members.

Collaboration with providers is critical to establishing more efficient patterns of utilization. We facilitate provider access to data, information, and systems that ease the administrative burden of review and approval processes and support the most effective delivery of services. Here are just a few examples:

We make utilization management decisions on a case by case basis, using collaboration across the functional departments, providers, and other stakeholders represented on the interdisciplinary team to assess members' holistic needs, including medical, behavioral, and social factors.

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- We provide real-time authorizations in response to telephone and online requests from providers (providers may also request a fax response). Upon receipt, calls are automatically routed to UM professionals who guide providers through the authorization process.
- Amerigroup frequently evaluates the list of services requiring prior authorization to stay current with industry best practices and utilization guidelines. As a result, we eliminated certain services from the prior authorization list, eliminating unnecessary barriers to care.
- We provide evidence-based clinical practice guidelines, new technologies, and best practices to help providers in delivering optimal care for members.
- We conduct workshops for providers on relevant topics; these workshops often provide credit for continuing medical education.

We make all medical necessity determinations using nationally accepted, evidence-based medical necessity guidelines, described in Section 11.1.2, which promote consistency and integrity in clinical decision-making. In addition, we follow specific protocols to support the integrity of coverage determinations. Any decision that is unsatisfactory to the member or provider can be appealed and further reviewed. Our appeals process is described in Section 11.1.2 as well.

Our UM process takes an integrated approach between service authorization and appeals, streamlining activities in a user-friendly system for members and providers. This integrated functionality will allow us to collect and analyze critical data, leading to a continuous quality improvement process, including the



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establishment of thresholds for grievances and appeals, outlier utilization of certain services, and other important activities. These results will drive ongoing program improvements.

For example, our affiliates have achieved success in steering care away from unnecessary inpatient admissions. Instead, they are moving toward the use of observation beds, reducing the cost of services and efficiently delivering services in the right setting by implementing effective provider education and incentive tools.

Clinical observation units provide a viable cost-effective alternative to short inpatient stays when presenting symptoms need to be monitored to rule out an acute condition. Our Texas affiliate reduced inpatient admissions by 38 percent during our first year in Texas, even though we were not at risk for inpatient services at the time for that program. For the Texas Medicaid population, the plan reduced medical/surgical bed days per 1000 members by 16 percent from 2009 to 2010 and by 20 percent over a three-year period. We also reduced our Medicaid Neonatal Intensive Care Unit (NICU) bed days per 1,000 members by 18 percent from 2009 to 2010 and by 20 percent over a three-year period.

We understand the unique challenges of adapting our UM program for populations receiving LTSS, and our affiliates have 17 years of experience with LTSS populations experience from other states. Our affiliate health plans currently serve more than 200,000 Medicaid members through integrated LTSS plans across seven states. In addition, our affiliates have significant experience managing LTSS benefits offered as part of several states' Medicaid managed care benefits package. By supporting member preferences to live in the community with the person-centered care planning process, we have achieved the following outcomes in local affiliate health plans in other states:



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- Our affiliate health plans transitioned 285 nursing facility members into the community in 2014. The following provides a breakout of our affiliates that had the most nursing facility member transitions during 2014:
 - Our Florida affiliate health plan transitioned 88 of 1,453 members — more than 6 percent
 - Our New York affiliate health plan transitioned 10 of 182 members — more than 5 percent
 - Our Kansas affiliate health plan transitioned 100 of 4,569 members — more than 2 percent
 - Our Tennessee affiliate health plan transitioned 87 of 3,895 members — more than 2 percent

Overview of Utilization Management

The purpose of the Amerigroup UM program is to assist in assuring that eligible members receive the most clinically appropriate care and services in the most efficient manner possible and to enhance consistency in reviewing cases by providing a framework for clinical decision-making.

The UM program includes activities related to inpatient and ambulatory care and collaborates with other departments in care coordination, discharge planning, and case management to meet the physical and behavioral healthcare needs of Amerigroup members. It adopts an integrated medical management model based on the physical, behavioral, and social needs of eligible members. The UM program, in collaboration with other departments such as Disease Management (DM) and Case Management, facilitates the delivery of the most appropriate medically necessary care and services to eligible members in the most appropriate setting. Amerigroup utilizes a coordinated, comprehensive approach to verify that members receive services at the appropriate level of care through the development of individualized, innovative programs and coordination of services with other Amerigroup departments, providers, and community resources.

Our UM program promotes consistent use of nationally recognized, evidence-based medical management criteria and practice guidelines for medical necessity determinations; fosters continuity across care settings; maintains strict confidentiality of clinical and proprietary information; and promotes access to care for our members. Our program meets all NCQA standards, and we continuously evaluate our practices so that UM achieves its intended purpose in a problem-free, easy-to-navigate process.

The goals of our UM program are:

- *To enable service availability and accessibility to eligible members*
- *To maximize appropriate medical and behavioral healthcare*
- *To minimize/eliminate over- and under-utilization of medical care, behavioral health care, and LTSS, including waiver and institutional services*

Our Iowa Medical Advisory Committee (MAC) will review relevant UM information as it relates to quality improvement activities. This information includes identifying quality of care concerns, disproportionate utilization trends, duplicative services, adverse access patterns, and lack of continuity and coordination of care processes. The UM program and the MAC achieve their goals and objectives by working collaboratively with a variety of other local and national departments such as Regulatory Services, Compliance, Provider Contracting/Provider Relations, Clinical Informatics, Quality, Medical Finance, and Member Services. The MAC will be responsible for providing sight of UM activities at the plan, provider, and membership levels. It will convene quarterly but will meet on an ad hoc basis as needed. Our UM systems and processes are designed to facilitate members' access to quality, efficient medically necessary services delivered in a member-centered, culturally, and linguistically competent setting and to enhance consistency in the delivery of those services by providing a framework for clinical decision-making.

Operating and Maintaining Our UM Program

We operate and maintain our UM program by having clearly defined UM processes, established program objectives, clearly outlined structure and accountability, and well-developed policies and procedures that support timely decision-making. The Iowa Medical Director will have day-to-day oversight of UM operations and complete accountability for outcomes. The Iowa Medical Director will collaborate with senior leads from other departments to verify all medical, health, and LTSS needs and issues are addressed in an integrated fashion.

We will communicate all utilization management strategies and/or changes to the community upon DHS approval within thirty days prior to implementation. This includes our members, providers, and the community at large.



Amerigroup will use reporting to identify providers and members with utilization patterns that fall outside the norms. We outreach through case management and education to address outliers.

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UM Policies and Procedures and Program Elements (11.1.1-11.1.2)

Question 11.1, #2

2. Describe your policies, procedures and systems to:

- a. Assist utilization management staff to identify instances of over- and under-utilization of emergency room services and other health care services;
- b. Analyze emergency department utilization and diversion efforts;
- c. Identify aberrant provider practice patterns;
- d. Monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries;
- e. Assure the appropriateness of inpatient care;
- f. Ensure active participation of a utilization review committee
- g. Evaluate efficiency and appropriateness of service delivery;
- h. Incorporate subcontractor's performance data;
- i. Facilitate program management and long-term quality; and
- j. Identify critical quality of care issues.

Over- and Underutilization of ER and Other Services

Overutilization and underutilization of services are monitored using reports made available to the Healthcare Management (HCM), Quality Management (QM), and Health Promotion (HP) Departments by the Plan Performance Management Analysts/Plan Finance Analysts. Amerigroup uses reporting to identify providers and members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans. We target intervention strategies to enhance appropriate utilization practices and provide member intervention for cases of member overutilization and under-utilization through care coordination and/or health education and outreach.

Members

When we identify patterns that fall outside the norms or receive a referral, we are quick to correct the situation and also educate our members on the appropriate use of benefits and services available to them through Amerigroup. Members are identified by either:

- **Data Review:** We will review existing data and establish any necessary reporting that enables us to identify patterns of behavior that are outside of the norm. For example, we currently review a monthly identification report using pharmacy claims data. Routine review of utilization data will identify patterns of over-utilization, while anti-fraud software may help us identify cases of member fraud and abuse. A typical criterion would be to select members with two or more providers and pharmacies and five or more controlled substances with three or more opiates in the last 45 days.
- **Referral:** We can receive referrals via multiple avenues that can include mail, telephone, in-person contact, email, Internet, Intranet, or the Amerigroup compliance hotline. Referrals can come from members, providers, employers, law enforcement agencies, and professional organizations. As an example, a provider may call to report a member who continuously sees multiple similar providers.

When a member's utilization pattern suggests outreach and education are warranted, our medical management clinical team will collaborate with the Chief Medical Officer to determine appropriate interventions, including outbound telephone calls to educate him or her about appropriate use of services, the importance of preventive care, or the need to refer to case management for care coordination.

Providers

Supporting the health plan with utilization data analysis and reporting is an expansive team of professionals in our national Health Care Analytics department, which provides healthcare analysis, consulting, and analytical capabilities to help optimize business decision-making. This group will collaboratively develop reports to monitor utilization each month to drive improvements in utilization patterns with our local health plan business and clinical teams. Where we identify utilization increases not explained by member mix or benefit changes we take the next step to identify outlier providers.

We will review both primary care provider (PCP)-panel utilization patterns and servicing provider billing patterns to conduct the provider-level analysis. The team identifies outlier providers based on relative distribution of services and then refers the cases to appropriate functional areas for intervention. Interventions range from fraud investigation, to pre- or post-payment claims adjudication prompted by possible waste or abuse, to revision of provider contracts, to panel reassignment, to inclusion in our provider quality incentive program.

Underutilization Evaluation

If we identify any underutilized services, we investigate to correct the issue and root cause. In addition, we conduct an ongoing review of service denials and monitor utilization on an ongoing basis to identify services that may be underutilized. We consider the expected utilization of services regarding the characteristics and healthcare needs of the member population. The results of the reviews will be reported to the MAC and the Quality Management and Improvement (QM/QI) Committee and are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse. The reports are reviewed looking for patterns of over-utilization and/or underutilization of services with specific attention given to acute/chronic care and preventive care services, including:

- Acute/Chronic care:
 - Re-admissions
 - Pharmaceuticals
 - Specialty referrals
 - Emergency room utilization
 - Home health and durable medical equipment utilization relative to diagnostic entity
- Behavioral health
- Inpatient utilization
- Preventive care:
 - Well-child/adult PCP visits
 - Age-appropriate immunizations
 - Mammograms
 - Blood lead testing

Examples of Leveraging Utilization Data to Drive Performance Improvements

We target intervention strategies at enhancing appropriate utilization practices and provide member intervention for cases of member overutilization and underutilization through care coordination and/or health education and outreach. Examples of strategies that we have implemented are:

- The **Pharmacy Restriction "Lock-in"** process, which may limit members to a single pharmacy to obtain their medications. We determine the need for restriction through medication claims review and implement it only in those affiliate health plans that have a state-approved program. Members identified with uncoordinated care, excessive utilization, or suspected patterns of fraud and abuse may also be referred to the Pharmacy department from a specific health plan or providers.
- Targeted outreach attempts to members for **early and periodic screening, diagnosis, and treatment (EPSDT)** services and a general mailing program of member birthday card EPSDT service reminders and overdue services postcards.

To identify possible underutilization in providers participating in our Quality and Population Management Incentive Program, we will run and review our Underutilization Monitoring Report every six months to review incurred claims activity for the periods January 1 to June 30 and then July 1 to December 31 each year. The report is used to identify potential underutilization patterns. The report shows both standard deviation results for the current quarter and year-to-date and year-over-year change for the utilization indicators. The data will be analyzed at the same level as the program is administered (for example, solo PCP, PCP group, or independent physician association (IPA), depending on which is the highest contractual level). The report displays the following utilization indicators:

- Non-emergency room physician visits
- Non-emergency room outpatient diagnostic services (includes radiology, lab, etc.)
- Non-emergency room outpatient therapeutic procedures (includes PT/OT/ST, Home Health, and outpatient surgery)

Separate reporting for adults and children is used. Once adults and children have been separated, services per 1,000 members are evaluated.

If any one of the measured utilization indicators falls below the outlier limit, the Medical Director and assigned Provider Services Staff or Member-centered Care Consultant conduct an internal review that includes, at a minimum, review of the following:

- Current utilization compared to peers
- Utilization year-over-year trends
- Member turnover data

The internal review will also include an in-person meeting with the PCP to review the data and discuss whether there are any extenuating circumstances if there is evidence of underutilization. If warranted, the PCP will be notified in writing of the underutilization concern and required to submit a Corrective Action Plan (CAP) to the health plan within 30 days. Failure to submit a CAP within the required time frame will result in the immediate removal of the PCP from the Quality and Population Management Incentive Program. For providers who comply with submitting a CAP, we approve the CAP and monitor progress on a quarterly basis. If no improvement is noted after the first quarter, the PCP will be notified of his or her termination from the Quality and Population Management Incentive Program.

Emergency Room Utilization and Diversion Efforts

We have the following innovative tools and initiatives – developed through our extensive UM experience in our affiliate health plans -- in place to effectively monitor emergency room utilization. See 3.2.5 for more detail on strategies and outcomes.



- **Emergency Room Triage Model** developed by our national Healthcare Analytics team to identify those members who are at high risk for frequent emergency room utilization; it assigns scores to members for case management evaluation
- **Dedicated Case Management** by Case Managers who will monitor members closely for ER utilization and reach out to them with additional education
- **Targeted Member Management** for members with behavioral health, substance abuse, and/or homeless issues that could result in episodic ER utilization in lieu of continuous primary care
- **24/7 Nurse HelpLine** availability of registered nurses to assist members with health care concerns via the toll-free telephone number to Member Services
- **Network Access** to optimize performance of PCP networks by reviewing data with providers on member emergency room visits made during regular office hours and encourage after-hours availability on weekdays and weekends
- **Urgent Care/Retail Clinic Strategies** to increase awareness of and access to these care locations

We have a comprehensive process and back-end systems to verify timely responses to ER providers within one hour 24/7. UM nurses are available at all times, including holidays, to verify eligibility for members with urgent or emergent conditions and to process requests for prior authorizations by phone or fax. **We also operate a 24/7 behavioral health call center.** Behavioral health call center representatives and UM nurses have access to the entire patient record, including medical, behavioral, LTSS, pharmacy, and social information on the member. Amerigroup encourages providers to contact us and/or the member's PCP when a member presents for emergency services, but we will not refuse to cover emergency services based on the emergency room provider failing to notify us.

Identifying Aberrant Provider Practice Patterns

Amerigroup recognizes our accountability for assessing and evaluating contracted practitioners who manage healthcare services delivered to plan members. We review information and data derived from practice experience within the organization, including utilization data, complaints regarding a practitioner site, adverse events, medical record reviews, and internal potential quality-of-care issues. Our monitoring occurs on an ongoing basis, and we take swift action when we identify aberrant provider practice patterns.

Our QM department tracks and trends provider performance data on a regular basis to identify trends that represent clinical practice patterns that are inconsistent with practice guidelines. This information is reviewed with an interdisciplinary team during QM/QI committee meetings, and corrective actions are taken to address identified issues. Specific provider performance issues are shared with the Credentialing department for consideration during the re-credentialing process.

The Credentialing department incorporates internal information regarding a practitioner's performance in the ongoing monitoring process. Credentialing department staff assign point levels to each issue depending on severity and place all information received from the QM department into each practitioner's file. When a provider attains the threshold of 25 points or greater between credentialing cycles (a rolling 36-month period), the Credentialing Committee conducts a review. Concurrently, the MAC may also review the provider depending on the types of issues involved.

Monitor Length of Stay and Re-admissions Data

We will monitor patient data related to length of stay and re-admissions related to hospitalizations and surgeries. Hospital re-admissions are a cost-and-quality issue for Amerigroup members. The first 24 to 72 hours post discharge represent the highest risk time frame for re-admissions, and delay in engagement purports a missed opportunity, especially during the transition from acute care to the home. As such, there has been a strategic focus on analyzing our total number of 30-day re-admissions. Utilizing short-term case management activities, the Stabilization Care Management model demonstrated a reduction in re-admissions. ***For example in our Louisiana affiliate, our Stabilization Care Management model showed an avoidance of approximately 45 readmissions in 2014, which translated in an estimated savings of almost \$250,000.*** The model exploits opportunities for coordination of discharge care and augments our existing UM and case management activities. We welcome the opportunity to work with the State and, if requested, lead a workgroup that will work to design final reports that best align with State needs.

CONTAINS CONFIDENTIAL INFORMATION

Between November 2012 and December 2014, the program prevented more than 600 expected re-admissions (based on RAS Score), resulting in \$2.9 million in estimated savings across Amerigroup affiliate health plans.

To further reduce hospital readmission rates in Iowa, Amerigroup will offer a post-discharge stabilization kit and home-delivered meals as Value-Added Services for eligible members. The discharge kit provides tools for family members and caregivers to successfully help transition members from hospital to home, aid in recovery,

and help decrease the chances for readmission. The meal program provides nutritious home-delivered meals, which allows members to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare them. We are confident that these two Value-Added Services will deliverable meaningful additional value to our members in addition to helping reduce readmission rates.

Evaluating Appropriateness of Inpatient Care

Amerigroup follows established procedures to help assure the appropriateness of care and the applying of medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. These procedures apply to precertification, concurrent, and retrospective reviews. UM clinicians collect and review relevant clinical information to determine if the level of service requested meets medical necessity criteria. Criteria can be accessed via criteria-specific software/web applications.

Clinical information for making determinations of coverage may include but not be limited to:

- Office and/or hospital records
- History of the presenting problem
- Results from clinical exam(s)
- Results from diagnostic testing
- Treatment plans and progress notes
- Psychosocial history
- Consultations with the treating practitioner(s)
- Evaluations from other healthcare practitioners and providers
- Photographs (MRIs, X-rays, ultrasounds, ECGs, and EEGs)
- Laboratory results
- Operative and pathological reports and results
- Rehabilitation evaluations
- Criteria related to request
- Information regarding benefits for services and/or procedures
- Information regarding the local delivery system
- Member's characteristics and information
- Information from responsible family member(s)
- Member's safety issues

Amerigroup does not employ utilization controls or other coverage limits to automatically place limits on the length-of-stay for members requiring hospitalization or surgery. ***We base length-of-stay for a member's request for hospitalization or surgery on the needs of the member***, rather than on arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned Utilization Manager. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the Utilization Manager, working with the hospital, PCP/attending physician, and other parties, will monitor and continually review the case to determine discharge readiness and to facilitate discharge planning. For members found to require extended benefits as identified by the concurrent review of individual needs, severity of illness, and services being rendered, the Utilization Manager has the authority to extend the hospital stay or other services as needed.

Active Participation of the Utilization Review Committee

Our Iowa-based MAC and QM/QI Committees which will serve as our Utilization Review Committee, are governed by our UM program descriptions, allowing them to operate under established parameters. The committee will meet at least quarterly on a regular schedule. Committee members are formally appointed for a two-year term and include network providers from differing specialties. We will also involve providers in the quality process through our MAC. The committee will be accountable to the

Iowa plan Medical Director, and the board and will maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow-up.

Performance Monitoring is a formalized function within Amerigroup. The monitoring activities help identify opportunities for improvement that can lead to delivery of higher-quality services and/or more efficiency of operations, thus cost savings. Monitoring for standardization helps better identify gaps in processes that inhibit efficiency and effectiveness of our programs. The Inter-Rater Reliability (IRR) program is designed to assess the consistency and adherence to Amerigroup policy and process as related to UM practice. The consistency with which healthcare professionals involved in UM apply criteria in decision-making is evaluated at least annually.

Appropriate mechanisms, such as use of hypothetical UM test cases or use of a sample of UM determination files using an NCQA-approved auditing method, are utilized to evaluate the consistency of application of criteria. Physician and non-physician reviewers are assessed in applying medical necessity criteria to promote consistency and accuracy in the application of the criteria. Licensed clinical UM staff, including behavioral health, who apply medical necessity criteria participate in the IRR process. IRR results, as well as aggregate national results, are reported to the UM and QM/QI Committees. Opportunities for improvement are identified and addressed by action plans.

Amerigroup will conduct an annual evaluation of our UM program, including clinical and service outcomes for medical and for behavioral health, in comparison to program objectives and activities. Results will be submitted to the MAC and QM/QI Committee for review and approval annually. Results and recommendations will become the basis for the following year's activities, and unrealized goals/objectives may be carried over to the subsequent year. 2014 IRR results are illustrated in Figure 11.1-1.

Figure 11.1-1. IRR Results for 2014



As a component of the program evaluation, we will conduct provider surveys to determine satisfaction with the UM process. We will identify opportunities for improvement and initiate actions to meet our goals and member/provider expectations. Results will be monitored through ongoing surveys.

Evaluating Efficiency and Service Delivery

We are continuously developing and implementing new, more efficient processes based on feedback from other functional areas and stakeholders. The Annual UM program evaluation serves as a reporting mechanism for progress and outcomes related to goals, planned activities, processes, and initiatives.

Our formal evaluation consists of a review of the efficacy of the program structure and an assessment of the program activities, including non-delegated and delegated UM, special UM programs, an assessment of potentially avoidable hospitalizations, an assessment of over- and under-utilization, and an assessment

of inter-rater monitoring and analysis. The UM Annual Evaluation Report concludes with an overall summary and recommendations for next year's activities.

Our QM department performs an annual review of access and availability as well as an over- and under-utilization analysis. This is achieved by analyzing both quantitative and qualitative data to detect barriers and identify trends; monitoring areas with the potential for over- and under-utilization specific to the membership population, local practice patterns, and national healthcare trends; and acting on the opportunities identified by implementing interventions and evaluating the effectiveness of the interventions implemented.

Incorporating Subcontractor's Performance Data

As detailed in Section 11.1.4, we will not delegate any UM functions to non-affiliate subcontractors.

Facilitating Program Management and Long-term Quality

Our UM processes and procedures are integrated with our Quality Management Incentive Program (QMIP) to facilitate program management and promote long-term quality. Our MAC is charged with overseeing our UM program activities and processing and reporting findings and recommendations for actions to improve quality.



The MAC reviews under- and over-utilization reports; provides guidance to the Medical Directors and UM employees; reviews and adopts UM standards; develops and implements programs based on review of UM data; assesses physician and facility performance; and adopts the annual UM plan, work plan, and evaluation. The UM department provides relevant UM information to the Quality Management (QM) department for quality improvement activities.

Our QM department tracks provider performance data on a regular basis to identify trends that indicate quality-of-care concerns, disproportionate utilization trends, adverse access patterns, and lack of coordination of care. This information is reviewed with an interdisciplinary team during QM/QI committee meetings, and corrective actions are taken to address identified issues.

Identifying Critical Quality of Care Issues

We are committed to identifying, reporting, and addressing critical quality of care issues. Potential issues include misdiagnosis; inappropriate treatment or complication after a procedure resulting in an adverse outcome or causing a minimum one-day increase in length of stay; an access-to-care issue resulting in an adverse outcome or causing a minimum one-day increase in length of stay; delays in care or referral to specialists due to scheduling problems or inability to make contact with the physician resulting in an adverse outcome or causing a minimum one-day increase in length of stay; and an unplanned readmission related to the same condition.

Depending on their severity/complexity, selected cases are presented to the MAC for review and recommendation. The MAC provides input regarding community standards for medical care, considerations for corrective action, and/or recommendation for termination.

Once the case is selected for peer review, the Medical Director forwards the case to the QM department. A QM employee places it on the MAC meeting schedule. The Medical Director submits the case to the appropriate specialty MAC member for review and presentation to the committee. If there is not a member with appropriate specialty on the committee, the case is given to a provider with such specialty to review the case in advance for presentation by the Medical Director.

The MAC makes recommendations on cases brought for Committee review. The Medical

Director governs the oversight of the corrective actions related to clinical quality issues or provider or office staff behavior. The Medical Director may recommend immediate action if the member's health or well-being is in jeopardy. Other corrective actions may include but are not limited to:

- Obtaining the provider's written response to the Committee's questions or concerns
- Obtaining the hospital's response that validates the issue was referred to or discussed in the hospital's QM/QI Committee
- Approving the response previously provided by the physician
- Closing the case with no further action required
- Follow-up medical record reviews
- Referral to the Credentialing Committee for further appropriate action up to and including possible termination from network participation

Once a decision regarding the appropriate action has been made, a QM employee:

- Notifies Grievance and Appeals that the MAC reviewed the case and that a letter has been sent to the provider
- Notifies the Credentialing department in writing of the MAC decision, as appropriate
- Prepares letters regarding MAC and Medical Director decisions to the provider and requests corrective action, as appropriate

Utilization Management Work Plan (11.1.3)

Question 11.1, #3

3. Provide a sample UM Work Plan

An integral component of our UM program is the annual UM Work Plan, which represents a road map for the upcoming year and is built based on detailed analysis of provider and member data. The Work Plan is the vehicle through which we monitor, evaluate, and take effective action to identify and address all program improvements, including those related to quality of care. Our Work Plan is the tool that guides our team in measuring our success in achieving the targeted improvement goal.

Amerigroup develops the UM Work Plan on an annual basis. It includes the following:

- Objectives for the year and program scope
- Activities planned for the year, including quality and safety of clinical care and quality of service
- Performance measurement, including benchmarks and goals
- Performance improvement projects' (PIPs) baselines and interventions
- Time frame within which each activity will be achieved
- Person(s) responsible for each activity, including department collaboration and coordination
- Monitoring of previously identified issues
- Planned evaluation of the UM program and Work Plan
- Schedule for reporting to the governing body (or designee)
- Schedule for evaluation of delegated services

The Work Plan is a dynamic document and is updated as needed to reflect changes in processes, priorities, and/or activities. The UM Work Plan lists the measures we will collect; the previous year's performance and benchmark, if applicable; and the current year's target measure, listing the interventions for each aspect. The Work Plan also reflects quality targets for the health plan's care coordination programs, including case management (CM) and DM, such as top conditions, member satisfaction, and member engagement rates. A sample UM Work Plan is shown in Table 11.1-1.

Leveraging local knowledge, national health plan experience, and the best practices across our state-sponsored health program business that currently supports more than 5.2 million members, our Iowa UM Work Plan will reflect a full scope of quality metrics. Examples of metrics include those specific to our CM and DM programs, HEDIS[®] measures, and measures that target condition-specific care such as diabetes, asthma, coronary artery disease, mental health, avoidable emergency room services, and members with special health needs. We will focus on outreach, patient safety, preventive services, closing gaps in care, and provider engagement and profiling. We will encourage the use of clinical practice guidelines, high-risk prenatal, and chronic and complex condition management processes. We will also focus on member assessment, care planning, and engagement in their self-management, and we will assist with care navigation. Of course, all of these Work Plan features will be layered on top of an Iowa-specific foundation that caters to the unique needs of the State's dynamic populations.

Table 11.1-1. Sample Annual UM Work Plan Features Interdisciplinary Participation and Accountability

ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
Program Development	<p>Develop the annual Utilization Management program descriptions and Work Plan to verify activities meet business goals and objectives:</p> <ul style="list-style-type: none"> To provide coordination and status on the UM and CM programs to members and providers To coordinate UM and CM results with QM improvement To continually improve patient safety 	<ul style="list-style-type: none"> Annual preparation of the 2016 UM Program Work Plan 2016 UM and CM Program Descriptions approval by the MAC committee 2016 UM Annual Work Plan Approval by the MAC committee Continue to monitor/revise the UM and CM programs and work plan as health plans' needs are identified Promote education between department at the health plan and national levels Report physical and BH/SA activities, stats, interventions, utilization, etc. (per Medical Management Program and work plan to QM/QI Committee as indicated) 	Annually	<p>Med. Dir. VP HCMS Director of BH</p>
Annual UM Evaluation	Develop the annual UM Services Evaluation for a comprehensive evaluation of plan programs inclusive of a review of the medical guidelines utilized in the authorization process, as well as a comprehensive review of the case management program	<ul style="list-style-type: none"> Annual preparation of UM Program Evaluation for the prior year's performance 	Annually	<p>Med. Dir. VP HCMS</p>
Training and Education	To offer opportunity for professional growth and to attain knowledge level necessary to support the UM Program	<ul style="list-style-type: none"> Offer training and education for employees throughout the year 	Ongoing	<p>VP HCMS Director BH Director of CM Managers of UM Managers of CM</p>
State Reporting	To submit all State UM reports to meet all contractual standards	<ul style="list-style-type: none"> Submit required reports in a timely and complete manner as per State Requirements 	Ongoing	<p>AVP Regulatory VP HCMS Director CM Managers of UM and CM</p>
NCQA	Verify compliance of all UM and CM standards to maintain commendable NCQA rating and plan for successful NCQA re-accreditation in 2016	<ul style="list-style-type: none"> Continue to meet all NCQA standard requirements for 2016 review Continued gap analysis review and implementation of recommendations to update HCMS policies and procedures based on 2016 standards 	Ongoing	<p>VP HCMS VP of QM Managers of UM/CM Directors of CM and BH</p>



Tab 3: Bidder's Approach to Meeting the Scope of Work
11 Utilization Management

ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
External Quality Review Organization (EQRO)	To verify ongoing quality measurement and continuous quality improvement for Utilization and Case Management	<ul style="list-style-type: none"> • Prepare and pass external review annually • Update P&P's and CM and UM processes as indicated 	Annually	Health Plan: VP QM VP HCMS Directors of BH and CM PCO
Plan Service Indicators	To monitor occurrence rates of key clinical events to meet contractual standards: <ul style="list-style-type: none"> • Receipt, Review, Determination, and Notifications of service requests whether written/electronic will be completed in the following time frames: • Non-urgent pre-service — 14 calendar days • Urgent pre-service — 72 hours • Expedited — 24 hours • Post-service — 30 calendar days 	<ul style="list-style-type: none"> • Continue monitoring performance against service indicator thresholds or service indicators • Identify opportunities for improvement, implement action plans as indicated • 90% TAT for prior authorizations • 80% plan Service Level • Maintain calls answered in 30 seconds or less • Maintain abandonment rate of less than 5% • Monitor grievances toward the UM program and create interventions for resolutions through the grievance system • Monitor the UM and CM process through Provider and Member Satisfaction Surveys and create action plans if indicated 	Ongoing	VP HCMS Director BH Managers of UM
Disease Management (DMCCU)	To monitor the effectiveness of the Disease/Case Management Programs	<ul style="list-style-type: none"> • Monitor effectiveness of DMCCU programs • Review of DMCCU reports • Monitor effectiveness of CM/DM processes/referral process and interdependencies and create new workflows as indicated • Quarterly meetings with the DMCCU team to monitor results • Annually review the DMCCU program evaluations to identify and collaborate for potential changes to the program 	Quarterly	National: AVP DM Health plan: VP HCMS VP QM Medical Director
Transplant	To measure and monitor the effectiveness of the delivery of services to transplant need members	<ul style="list-style-type: none"> • Collaborative efforts between national transplant team and health plan case management • Identify eligible transplant members and direct into case management if indicated 	Ongoing	VP HCMS National Director of Transplants



Tab 3: Bidder's Approach to Meeting the Scope of Work
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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<ul style="list-style-type: none"> Continuation of SCA process to verify care is delivered timely to transplant facilities 		Medical Director of CM
Continuity and Coordination of Care UM/CM	To monitor/take action as necessary to improve continuity and coordination of care: Across our network and between medical and behavioral healthcare	<ul style="list-style-type: none"> Continue to identify and act on opportunities to improve upon coordination of medical care Collect and analyze data and report opportunities and actions taken to improve collaboration between medical and behavioral healthcare Monitor to verify process is in place to notify members affected by physician or hospital terminations or suspensions Continue to monitor member grievances for continuity of care issues to determine if changes to the UM program are indicated Continue to monitor members need for OON care and collaboration with provider relations to mitigate any network gaps for continuity of care; inclusive of creation of a SharePoint tracking tools of all referrals for network intervention for member resolution of provider issues Meet NCQA coordination of care standards Continue to assess for satisfaction with coordination of care between medical and BH providers through monitoring of grievances With use of the CI3 complex member identification process identify members with the most complex needs with either no PCP or poor medical condition control to be sent to a PCMH or other HCDS high-performing provider Use of the CI3 list to identify members with 3 or more Care Delays-Care Gaps(CDCG) for intervention to received needed missed services Continued collaborative effort with a selected vendor for the identification and transition of members requiring the higher benefit level for SSI Successful implementation with DCH in the implementation 	Annually for first two interventions Ongoing for remaining interventions	VP HCMS Director BH VP QM



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
ER Steerage Program	To measure and monitor the appropriate use of the emergency room (ER)	<p>of the Health Information Exchange (HIE) for information sharing amongst providers and the CMOs</p> <ul style="list-style-type: none"> • Obtain and analyze ER utilization rates and provide updated reports to the MAC and QM/QI committees for additional recommendations and/or approval of stated interventions • The focus is on ER utilization and frequent ER usage by members —measure PCP appointment accessibility and after hour access • Verify 24/7 nurse call information is faxed to PCP through the contracted vendor; this is a triage call report that includes patient information, presenting problems, care advice, and disposition • Use of vendor triage reports for referrals to CM for members that may need a higher level of intervention; members needing lower levels of intervention will be referred to the Member Services Unit (MSU) for follow-up • ER utilization education for those members identified by the plan for education on alternative levels of care; education is provided at the plan, as well as national level. • Coordination with HCDS to identify providers with high ER utilization on their panels during the core business hours of 9–5 for intervention by the Medical Directors • Continue execution of the ER case management program at the plan level to impact ER run rate for members over-utilizing the ER for non-urgent conditions; Work Plan will be adjusted to reflect outcomes of program interventions; this is inclusive of case management collaboration with two high-volume providers for member intervention • Continuation of case management outreach activities to include those members with high ER utilization for care coordination and barrier intervention; continued execution of the CMO DCH collaborative PIP for reduction of non-emergent ER utilization 	<p>Semi annual</p> <p>Ongoing</p> <p>Quarterly</p> <p>Ongoing for remaining interventions</p>	<p>VP HCMS Director of CM Medical Director</p>



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<ul style="list-style-type: none"> In collaboration with Operations team, evaluate the potential of an ER level of care program at the physician level to verify appropriate coding of non-urgent ER visits Identify opportunities to further collaborate with QM/QI Committee on the education of members and providers on the treatment of URI conditions most commonly seen in the ER to move members back into the provider for treatment 		
Inpatient and Outpatient Utilization	To monitor the effectiveness of the structure and activities of the Utilization Management Program Denials 100% of Notice of Proposed Action letter meet NCQA UM 7 standard timelines for review and mailing of notice of proposed action letter	<ul style="list-style-type: none"> Monitor Inpatient/Outpatient utilization data, stats, and patterns process via metrics to track and trend: <ul style="list-style-type: none"> Over- and underutilization ER services Inter-rater reliability — meets or exceeds 80% benchmark Denial rate by inpatient/outpatient services meets national PAV targets Continuation of DRG assignment process for concurrent review using the Webstrat application 100% of large cases reviewed in multi-disciple bi-weekly rounding process Monitor over- and underutilization to verify the delivery of appropriate care by analyzing relevant data to detect over-/under-utilization. Develop action plan/intervention strategies and track and trend and determine additional interventions if indicated Continued utilization of appropriate criteria for acute adult and pediatric admissions and outpatient services 100% of UM new hire associates attend required Unicare and other necessary training programs; at least two UM employees attend certification training in 2014 100% utilization of appropriate criteria for short stays of one and two days to achieve and maintain a PAV rate of greater than 20% Continuation of initiatives to verify health plan will achieve 	Quarterly & Ongoing	Med. Dir. VP HCMS. Manager of UM Med Finance



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<p>budgeted medical expense PMPM, revenue PMPM:</p> <ul style="list-style-type: none"> • Implementation of Inpatient Management Solutions reporting for enhanced inpatient reporting of denials and potential avoidable inpatient days. • Continuation of Inappropriate care trends and denial tracking through the IMS PAV reports • Implementation of plan-level IRR reviews for the concurrent review nurses and Medical Directors to verify consistency of application of criteria; formal plan level audits will be held quarterly for all CCRN and Medical Directors • Re-admission reviews for members currently in or have been referred for case management with all interventions documented in the core case management and UM systems • Authorization error rate of less than 10% verified through the auth check and auth error reporting • Transition from NIA to AIM for high-cost diagnostic service reviews with the potential of steerage to outpatient facilities; transition to occur around November 2014; continued execution of NICU Level of Care program to review of those members where a Sick baby is in the newborn nursery and requires authorization; this process is inclusive of continued orientation of hospital providers impacted with this process • Creation and execution of a UM Stabilization program for targeted members who have been recently discharged from the inpatient setting to verify there are no gaps in care that could cause re-admission • Review and approve all clinical criteria and policies and on annual basis • Maintain UM team audit results of >=90%. • Meet or exceed all contractual TAT service levels for authorizations completed within 14 days • Continuation of use of consultants for therapy reviews; program will be expanded to include the peer-to-peer process 		



ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<p>(P2P), as well as execution of denial letters; in 2014 consultants will continue to be responsible for the identification and authorization of therapy services for members that require Children Intervention Services for a non-acute diagnosis</p> <ul style="list-style-type: none"> • Report barriers or obstacles in delivering UM Program • Meet all NCQA and contractual UM standards • Continued execution of the authorization check tool to verify that team scores are at or above 90% • Continued work with the Next Gen UM steering committee for program enhancements inclusive of the creation of productivity reports through the Maccess system • Successful implementation of the Phase 2 of the Authorization Portal in a collaborative effort between DCH and the CMOs to have a central portal for the input of all inpatient and outpatient authorizations; Phase 2 to focus on all BH services and the remaining outpatient services not currently entered into the portal; date of implementation TBD • Collaboration with national teams in the implementation of ICD10 in all HCMS systems by the end of 2014 • Continued use of Telemedicine for accessibility of medical services in rural and underserved populations • Full execution of the re-tooled Amerigroup Provider Authorization Web Portal for those services not currently authorized on the GMCF portal; date of implementation TBD • Integration of member authorization requests into the core UM standards to meet or exceed all contractual turnaround times • Collaboration with the general CM and other care coordinators on the execution of timely discharge plans for all CM members leaving the inpatient setting 		

ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
Case Management	<p>Enhancement of case management for Iowa's Medicaid population as part of a general cost management program and NICU reduction</p> <p>Programs include:</p> <ul style="list-style-type: none"> • Lead • BH • NICU • OB • Adults • Pediatric • ER 	<ul style="list-style-type: none"> • Re-tool at plan level high-risk OB program to decrease NICU occurrences • 12% of deliveries in NICU <ul style="list-style-type: none"> • Continual review for program enhancement of all case management programs • Continued enhancement of the case management solutions program • In collaboration with the Finance department create a standardized ROI tool to be used on an ongoing basis • Achieve MEI target for cost savings for the case management solutions program through the ER CM program • Continuation of the NICU CM program to verify that 100% of members meeting trigger list for program are referred to program • Continued incorporation of Care Wise tools and clinical guidelines into all plan level case management programs • Continued incorporation of DCH-approved clinical guidelines in the care planning process • Meet all NCQA and contractual CM standards • Maintain CM team audit results of >=90%. • 100% care plans documented within 10 days of referral for member opting into case management • 90% of all potential cases contacted within five business days of referral • Verify that at a minimum 15% of all caseloads have face-to-face visit annually; members are identified based on clinical needs for face-to-face interventions, and all members are monitored for intervention outcomes; HCMS managers are responsible for tracking and reporting face-to-face visits of their team members • Monitor and report effectiveness of existing or new 	Ongoing	<p>VP HCMS Director of CM Managers of CM Medical Director PM Analyst</p>



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<p>programs:</p> <ul style="list-style-type: none"> • High-risk OB • NICU • ER • OB • Lead <ul style="list-style-type: none"> • Continue ESRD/SSI program within Case Management to identify and provide coordination and collaboration with the State for member transition to the FFS programs as indicated; program will be enhanced for the creation of more detailed member communication letters and scripting for use in the program • Continuation of coordination of transplant CM with national Director of Transplants • Continued enhancement of collaborative program with the selected vendor to identify members who may qualify for transition to SSI • Through collaborative workgroups, identify and create interventions to verify that at a minimum 80% of members in CM have completed all applicable HEDIS indicators as related to their disease state of diabetes • Collaboration with the HCDS transformation/PCMS (patient-centered medical home projects for the integration of case management to drive providers to clinical improvements) • Continued execution of CM audit tools to verify consistency of application of the CM program • Execution of the annual CM satisfaction tool and with results demonstrating that 80% or greater of members surveyed are satisfied or very satisfied with the program • Continued collaboration with quality management and HCDS for the identification and steerage of members to a chronic care PCMH in all regions 		



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<ul style="list-style-type: none"> • Enhancement of the Nurse HelpLine triage program to help insure those members with chronic conditions or missed chronic care services will be referred to the case management program • Continued collaboration with the QM team to outreach to case-managed members who have missed required preventive services, as well as participated in incentive programs (prenatal and diabetes) • In collaboration with national partners, creation of disease-specific care plan templates to be added to the core CM systems • Execution on the CM transformation program to allow the streamlining of assessment and documentation tools • Refine of CM process tools to verify that all CM members admitted to the inpatient setting have a discharge plan sent to the assigned case manager within 48 hours of being discharged from the hospital • Execute on consultative services for PH member in the Care Coordination program 		
Inter-rater Reliability	Verify compliance and participation in national Inter-rater reliability testing	<ul style="list-style-type: none"> • 100% participation in annual testing • 100% of the UM/CM scoring minimally at the 80% benchmark • 100% Medical Director participation and passing in the annual testing with a combined scores >= the 80% benchmark • Creation and execution of Corrective Action Plans for any UM team member not meeting the minimal standards for passing the IRR or not taking an assigned module 	Annually	VP HCMS Director of BH Manager of UM Medical Directors
Prenatal Care/High-risk Pregnancy	To monitor the effects of screening for high-risk, outreach, and case management on the number of prenatal visits	<ul style="list-style-type: none"> • Continuation of plan level OB program for low- and high-risk members • Continuation of NICU CM Program 	Ongoing (annually for continued execution of P4HB program)	VP HCMS Manager of CM Director of Medical Finance
Inter pregnancy Care and Resource	P4HB for mothers of VLBW infants for Interpregnancy care	<ul style="list-style-type: none"> • Continue educational efforts based on Amerigroup clinical guidelines • Verify providers are aware of OB-related clinical guidelines 		



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
Mother Outreach for members participating in the P4HB waiver program	To measure the effectiveness of the OB Management Program as monitored by birth outcomes	<ul style="list-style-type: none"> and revamp or create new materials to provide education as indicated via newsletter, provider/member manuals, and website enhancements • Continue to work with the State on process improvements for the early identification of pregnant women to the CMO during the presumed eligibility process • Continued execution of the P4HB waiver program to provide case management and Resource Mother outreach to members having a VLBW baby by date TBD • Continued utilization of the re-vamped P4HB outreach program member materials and continued collaboration with the Marketing department for the identification of new opportunities with marketing to promote the program • Execution and creation of a transition of care program for those members leaving the P4HB program as it sunsets • Through collaborative workgroups, identify and create interventions to verify that at a minimum 80% of members in OB CM have completed all applicable HEDIS indicators as related to prenatal visits; continued collaboration with DCH on the reduction of LBW rates in the state of Georgia • Verify that 100% of all members in OB Case Management will receive education on reducing early elective deliveries to achieve C-section rate of less than 30%; key strategies are to work with those key providers whose trend is higher than the IA average, as well as to identify hospital systems with hard stop programs for potential C-sections less than 39 weeks • Implementation of targeted CM care coordination activities for members in the rural expansion areas where there are a noted lack of providers • Execution of educational programs for pregnant members in a group setting regarding OB care(includes postpartum), parenting, breast-feeding, and other OB-related services • In collaboration with the DPH, creation of a collaborative 		



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<p>Prenatal Assessment tool that can be used for all plans for the initial assessment of members to identify high-risk members.</p> <ul style="list-style-type: none"> • Verify that 100% of all members in OB Case Management will receive education on the importance of timeliness and frequency of prenatal and postpartum care for improvement of HEDIS rates • Collaboration with March of Dimes on the execution of Centering for Pregnancy with 1–2 large OB providers/facility • Execute on program enhancements to verify that 100% of all members in OB Case Management with history of having LBWB and history of smoking will be referred for smoking cessation • Under- and over-utilization 		
Inpatient Utilization	To monitor the effectiveness of the structure and activities of the Utilization Management Program 100% compliance with NCQA UM standards	<ul style="list-style-type: none"> • Monitor readmission rates to facility and attending provider level and successfully meet target of 10% or less in overall readmissions • Creation of an Authorization Quality program for those freestanding facilities that meet specific quality indicators for a lower intensity authorization review during the concurrent review process • Implementation of the BH criteria for inpatient services • 100% of BH UM employees attend criteria training • 100% of UM team will complete certification training when offered by national clinical training teams • Revamp and review re-admission prevention program for members post discharge to decrease overall readmission rates to meet targets • Re-admission reviews for all readmits within 30 days with plan from BH Medical Director • Refer all post discharges to plan case specialists to verify that f/u after hospital discharges occur within seven days of discharge; members requiring higher-level intervention will 	Quarterly Ongoing	Director of Behavioral Health VP HCMS BH Medical Director

ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<p>be referred to case management for intervention</p> <ul style="list-style-type: none"> • Review and approval BH clinical criteria and policies and present to MAC and QM/QI Committee as indicated • Maintain UM team audit results of >=90% • Report barriers or obstacles in delivering UM Program • Track and trend all grievances as related to the BH program • Continued execution of Next Gen for the BH process for all UM functions • Implementation of a residential treatment program review process where all requests are reviewed by a dedicated UM reviewer • Creation of targeted UM review program for all freestanding facilities to mitigate utilization trends • Continuation of a national precertification team for all initial reviews to allow increased diversions at the point of admission • Continuation of a utilization review strategy for DRG, freestanding, and RTC facilities • Modify staffing assignments to verify the most senior review employees are assigned to the most complex inpatient facilities • Continuation of the onsite review programs at two facilities in Iowa • Verify that 100% of all members discharged from an inpatient facility are outreached within 72 hrs. of discharge • Collaboration with network on the execution of Bridge appoints to verify members have an f/u apt within seven days of discharge • Collaboration with care coordinators to notify of all inpatient admissions 		



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
Outpatient Utilization	To monitor the effectiveness of the outpatient utilization program and to meet all NCQA and contractual requirements regarding outpatient management	<ul style="list-style-type: none"> • Monitor under-utilization and over-utilization of outpatient behavioral health services through run rate data on outpatient mental health visits/1000 and HEDIS measures • Continue to audit and monitor TAT for authorizations and audit for adherence to NCQA standards • Continue quality provider chart audits for providers with outlier practice patterns • Continued execution of Next Gen for the BH process for all outpatient UM functions • Continued targeted review of IFI and CSI services to verify appropriate utilization • Continued execution on a focused review program for Skills training services to help insure appropriate utilization • Implementation of a BH OP review program for home service code 12 • Continued collaboration with operations to clinically review identified outlier providers for intervention 	<p>Monthly</p> <p>Ongoing</p>	<p>Director of Behavioral Health VP HCMS BH Medical Director</p>



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
Case Management	To verify that members regain optimum health or improved functional capability in the right setting in a cost-effective manner and to meet company targets for engagement of members identified as complex through our CI3 program	<ul style="list-style-type: none"> • Incorporation of Care Wise and clinical practice guidelines management standards into all plan level case management programs • Maintain CM team audit results of >=90% • Verify documentation standards are met as per NCQA guidelines • 100% care plans documented within 10 days of referral for members opting into case management. • 90% of all potential cases contacted within five days of referral • Track follow-up after hospital discharge for members in case management as measure of program effectiveness and case management performance • Retool referral process to verify that members on the CI3 list with BH as their primary driver will be referred and opened within 10 days of receipt • Update case management programs so members with continued readmissions are referred and enrolled in the BH CM program • Achieve and maintain a CM refusal rate of less than 30% • Maintain BH caseloads of 45–50 members on average • CM re-admission rates of less than 5% • BH CM face-to-face visits of 15% of caseloads annually • 100% of all CM members admitted to a facility have a discharge planning discussion documented with the inpatient manager 	Ongoing	Director of Behavioral Health VP HCMS BH Medical Director
Improve ADHD and Anti-depressant HEDIS measures	Meet 75 th percentile for both ADHD and anti-depressant measure	<ul style="list-style-type: none"> • Monitor potential over-utilization of ADHD services • Using HEDIS data identify providers with high failure rates for each measure • Educate providers regarding expectations around medication and monitoring of antidepressants and stimulants • Continuation of pharmacy level data to identify members 	Quarterly Ongoing	Director of Behavioral Health VP HCMS BH Medical Director VP of Quality Management



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ACTIVITY	OBJECTIVES/MEASURES	INTERVENTIONS AND STATUS	REPORT DATE TO COMMITTEE	RESPONSIBLE PARTY (BOLDED)
		<ul style="list-style-type: none"> with new medication starts for outreach through Eliza • Identification of those providers providing initial ADHD prescriptions with no f/u with members within the first 30 days of script for direct intervention either through letter, phone, or face-to-face visits • Creation of AmeriTips, flyers, and letters regarding ADHD for both members and providers 		
Improve Follow-up after hospital discharge measure	Meet and exceed 50 th percentile and/or State targets for both seven-day and 30-day HEDIS measures	<ul style="list-style-type: none"> • Continue 100% post discharge follow-up calls to all members and track in the core CM systems • Provide facility level data to high-volume psych hospitals • Continue Eliza calls for post discharge follow-up • Track failed post discharge follow-up back to provider in aggregate • Continue to attempt to contract with facilities to provide bridge appointments • Collaboration with QM/QI program initiatives to target members to verify follow-up appointments have been maintained post discharge 	Ongoing	Director of Behavioral Health VP HCMS BH Medical Director VP of Quality Management
Improve satisfaction with BH providers	Meet or exceed provider satisfaction with the BH at or above the AGP mean	<ul style="list-style-type: none"> • In a multi-departmental collaboration, review and retool the programs looking at networks, configuration, and UM functions to verify optimal execution • Collaborative JOC meetings with Network Management to increase provider awareness of the BH programs • Continued execution of interdisciplinary monthly BH workgroup meetings to create BH strategies for process improvement 	Ongoing	Director of Behavioral Health VP HCMS BH Medical Director AVP Contracting VP of Quality Management AVP of Operations

Question 11.1, #4

4. Describe if any UM functions will be delegated. If any functions will be delegated, describe proposed ongoing monitoring strategies of the delegated entity.

Utilization Management Subcontractors and Staff Delegation and Monitoring (11.1.4)

Our affiliate, AIM, conducts UM leveraging its specialized expertise in specialty radiology, cardiology, medical oncology, radiation therapy, medical benefit drugs, and sleep medicine. Amerigroup's Iowa-based local leaders oversee and review AIM's UM services to verify performance and compliance. Health plan leadership holds Monthly Workgroup Meetings to formally review performance metrics and data obtained through our attendance at quarterly national Vendor Selection and Oversight Committee (VSOC) and Delegated Workgroup (DWG) meetings. Each Amerigroup affiliate health plan has voting members in the DWG, which is responsible for seeing that we follow established policies and procedures in accordance with State, federal, NCQA, and any other applicable regulatory and accreditation standards. The DWG has collaborative relationships with, and representation from, internal departments. As a governing body comprising local health plan representatives, the DWG will support corrective actions, as needed.

Question 11.1, #5

5. Describe the process for developing and updating practice guidelines.

Utilization Management Practice Guidelines (11.1.5)

Our utilization management procedures determine the necessity of care or services on a case-by-case basis in accordance with State and federal laws and regulations. Our process is grounded in nationally recognized, evidence-based criteria and guidelines. We are also acutely aware of and responsive to the differing needs and situation of each unique member. UM staff considers the severity of illness, presence of multiple conditions, and episode and member-specific variables when applying criteria to determine necessity of care or services. Our member-centric, holistic approach enables members to receive necessary care, support, and services within a safe setting that promotes optimal health and well-being. We have extensive experience working with state-defined medical necessity criteria in our local affiliate plans, and we are ready to work with DHS to implement any Iowa-specific criteria or process guidelines.

Our UM guidelines are developed and updated annually based on nationally accepted, evidence-based practices. We take medical, behavioral, social, and functional factors into account and will work with DHS to incorporate state-specific criteria.

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Medical Necessity Determination

For medical State plan benefits, UM nurses will review the members' conditions and compare to the appropriate medical necessity criteria. We will use nationally accepted, evidence-based medical necessity criteria.

For behavioral health State plan benefits and substance use disorder services, we will use Amerigroup Behavioral Health Medical Necessity Criteria and American Society of Addiction Medicine

(ASAM) Criteria, unless superseded by State or regulatory guidance. We will also develop psychosocial medical necessity criteria specific to the Iowa Initiative.

For EPSDT services for members under 21, we will comply with State requirements to provide any services that could correct or ameliorate physical or behavioral health.

For emergency services, we will not impose restrictions on coverage that are more restrictive than those permitted by the prudent layperson standard. This means we will not deny emergency services when a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

LTSS Determination

Our affiliates have 17 years of experience managing LTSS benefits and will adhere to Iowa's criteria and methodology regarding the reasonableness and volume of services selected for inclusion in the member-centered care plan by the member and community-based care coordinator. We know how to manage all LTSS services, beyond the standard medical services in the State health plan. We will integrate and manage a full range of LTSS for eligible members.

Amerigroup's affiliate health plans have vast experience conducting utilization management of LTSS across seven markets. We understand and adhere to the variations of LTSS review criteria across those markets as each state has its own criteria, guidelines, and rules against which LTSS authorization decisions are made.

For LTSS, we will not use medical necessity criteria; however, we apply functional necessity based on our assessments/reassessments. The provision of LTSS and related durable medical equipment will be determined and approved through the member-centered care planning process in consultation between the member, his or her family or caregiver, and the community-based care coordinator. Spending on covered services must fall within the budget cap. We plan to partner with Telligen on a consultative basis during the implementation period to understand the existing process and criteria for LTSS in Iowa to promote consistency and continuity of care through the transition.

Following our process of comprehensive functional assessment and development of a member-centered service plan with involvement of the member's interdisciplinary team, the community-based case manager coordinates submission of all required documentation for NF LOC (the Iowa Level of Care Certification for Facility form, supporting clinical documentation) to the UM reviewer.

We will not limit or reduce coverage unless supported by individualized determination of necessity based on the specific member situation. We will apply appropriate medical necessity criteria to physical and behavioral State health plan services based on individual member needs and a thorough assessment of specific services available within the local delivery system. For LTSS, ***we are experienced working with members and their families or caregivers to make decisions about services as part of the member-centered assessment and resulting care planning process.***

During periods of transition, we will not reduce or deny members continuing access to their providers, services, or care until we are able to conduct a full assessment and develop a care plan. During Contract implementation and transitional periods, we will honor prior authorizations and support members to continue accessing their current providers, care, and services to verify a seamless experience and continuity of care.

Special attention will be paid to identifying and authorizing services needed to support the member remaining in his or her home or in another community-based setting of his or her choice; services needed to participate in the community (employments, school, other); and any extended State plan services such

as additional therapies included in a waiver because the State plan's service is capped or designed in a different way than the waiver.

Our utilization management and case management staff will refer members to cost-effective alternative services when appropriate to meet the member's needs. We will also train providers to help direct members to the most cost-effective and appropriate option for their situation. For example, we encourage members to use urgent care instead of the emergency room if their condition is not an emergency through PCP consultations, a 24-hour Nurse HelpLine, and member materials. In addition, we may require providers to document attempts to use a more cost-effective drug or therapy before we authorize a more costly drug or therapy if there is reason to believe the lower cost option will meet the member's needs as well as or better than the higher-cost alternative. In addition to promoting value for the State, this helps assure the safety, health, and well-being of our members.

Updating Practice Guidelines

We update our UM guidelines annually using clinical best practice guidelines from professional organizations; up-to-date clinical research; and practicing, licensed, and board-certified physicians through our national Medical Policy and Technology Assessment Committee (MPTAC). MPTAC is an interdisciplinary group, including network physicians from various medical specialties, clinical practice environments, and geographic areas. The committee considers information from a variety of sources, including the results of electronic literature searches; independent technology evaluation programs; and materials published by professional associations such as the Blue Cross Blue Shield Association, technology assessment entities, appropriate government regulatory bodies, and national physician specialty societies and associations. The committee may also consider a service or procedure being reviewed, with supporting documentation, as a standard of care in the medical community. For topics that represent a significant change or are otherwise required by law or accreditation, we also seek input from academic medical centers and specialty societies from around the United States. For example, UM of substance abuse disorder services will use the most current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM), as published by the American Society of Addiction Medicine. Additionally, MPTAC has designated subcommittees for certain specialty topics such as hematology/oncology and behavioral health. For example, criteria for review of behavioral health issues are reviewed by the National Behavioral Health Clinical Advisory Committee, a subcommittee of MPTAC.

Our Iowa MAC will review and approve criteria and guidelines annually with input from the Iowa QM/QI Committee, which will include practitioners knowledgeable about local delivery systems. All newly approved criteria and guidelines will be approved by DHS and shared with providers at least 30 days prior to the implementation of the guidelines. Additionally, providers may access Amerigroup UM criteria at any time through our provider portal (we also provide them to members and potential members upon request). Clinical Practice Guidelines are reviewed and approved bi-annually by the MPTAC. The MPTAC serves as the official medical/clinical policy-making body of Amerigroup in development of clinical standards or review and adoption of nationally recognized standards to support evidence-based coverage policies.

Question 11.1, #6

6. Describe how your UM program will integrate with other functional units as appropriate and support the Quality Management and Improvement Program.

Utilization Management Care Coordination (11.1.6)

Amerigroup's UM program includes activities related to the delivery of care in a proactive, coordinated, collaborative manner. We work closely with other departments, our provider partners, community agencies, and other resources that enhance care coordination, discharge planning, and care coordination to meet the physical and behavioral healthcare needs of our members. For example, our UM program staff connect members to our disease management, care coordination, and complex care coordination programs, as appropriate. Through this collaboration, the UM program facilitates the delivery of quality, medically necessary care and services to eligible members in the most appropriate setting.



For example, our Provider Services and UM teams work together to make sure members have access to medically necessary care. When members require services that are not available within the contracted network of providers, UM and Provider Services coordinate to obtain single-case agreements with identified providers and/or attempt to contract the provider to join the network.

Our UM program is also integrated into a cross-functional workgroup referred to as the Network Strategy Workgroup. This group includes representatives from Provider Services, Medical Management (MM), Quality Management, Compliance, Community Outreach, Government Relations, and Finance. The purpose of this team is to provide insight and feedback to make sure that our network has the right number, mix, and geographic distribution of quality providers to meet the needs of our members.

Our UM protocols, systems, and processes promote collaboration across the organization. We provide examples of the types of coordination that regularly occur below.

- Amerigroup's UM staff coordinate closely with compliance when potential fraud, waste, and abuse are identified through utilization review activities. Our UM staff report these instances and fully participate in investigative reviews.
- When implementing our provider incentive program, UM staff work closely with other functional areas, such as Quality Management, Provider Relations, Financial Services, Legal, and Claims to track provider performance against established targets, promote performance improvement, and communicate with providers.
- Amerigroup's innovative, member-centered care model includes UM support for providers. Each provider has a designated UM nurse with whom to communicate to meet the needs of our members through activities such as care coordination, prior authorization, social support, or other necessary services.
- Through the MAC, we review utilization data and collaborate on initiatives to improve member access to appropriate services. These initiatives may include member or provider education and outreach, corrective actions, innovative program development, or clinical practice guideline changes.
- Our UM staff coordinate with quality management if UM activities identify a potential quality-of-care concern. When completing UM processes, our clinical staff identifies potential issues that may

indicate a risk to the member; they report those concerns to Quality Management and participate in the investigative process, as appropriate.

- Our UM program is embedded in our interdisciplinary care team, which integrates all aspects of physical, behavioral, oral, social, and LTSS services for members, as well as PCPs, hospitals and institutional providers, behavioral health providers, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), LTSS providers, and health homes. UM staff work side by side with the rest of the interdisciplinary team on the same systems with the same approach to care planning to facilitate holistic, integrated care coordination.

Integrating with the Quality Management and Improvement Program

Amerigroup's UM program is an integral part of our quality improvement and system change efforts. We collect and report relevant information to the Quality Management and Improvement (QM/QI) program for quality improvement activities. This includes identifying quality-of-care concerns, disproportionate utilization trends, adverse access patterns, and lack of continuity and coordination-of-care processes.

The UM program is integrated with quality improvement activities to capture utilization trends and/or patterns, and our data are compared to nationally recognized thresholds to alert us to over- and under-utilization. Potential areas reviewed for utilization trends include but are not limited to:

- Inpatient/emergency room utilization
- Selected procedures
- Referrals to specialists
- Ambulatory care
- Behavioral health services
- Access to preventive care

Our Medical Advisory Committee (MAC) is an integrating forum where representatives from UM, QM, Network Providers, and other departments review utilization and quality data generated through our UM program. Additionally, the MAC collaboratively establishes key performance and quality-of-care indicators and criteria that are incorporated into the UM program.

Our MAC or UM Committee provides another opportunity for integration between our UM and QM/QI programs. An interdisciplinary team reviews utilization data during MAC meetings. Where results fall outside of performance standards, we conduct a qualitative analysis used to design and implement interventions to eliminate any barriers to care to promote improved outcomes. One such intervention is the use of provider and member incentives to encourage and reward access to high-quality services that improve member health outcomes.

In addition to routine care coordination, Amerigroup designates a specific clinician or case manager to verify continuity of services for members who are in active case management and members with severely emotionally disturbed children, adults with serious mental illness, children with special healthcare needs, and women with high-risk pregnancies.



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Question 11.1, #7

7. Describe how the UM program will encourage health literacy and informed healthcare decision-making.

UM staff, as an embedded part of the interdisciplinary team, will play a key role in directing members to the wealth of educational programs we offer to promote health literacy. Our UM program also makes available a variety of settings of care, such as emergency room alternatives, and leverages these options to encourage informed healthcare decision-making.

Health literacy is the ability to obtain and understand health information and services and use those to make informed health-related decisions. Put simply, health-literate members are empowered and responsible members and are more likely to have better health outcomes. Amerigroup employs member education, outreach, and incentive programs to promote health literacy and encourage informed healthcare decision-making. Improving health literacy is a critical element of our holistic approach to healthcare and a key objective of our Cultural Competency program, embedded in all interactions with our members. As they interact with members throughout the care planning process, the UM team reminds members about the availability of educational materials and programs and educates members on how to employ informed healthcare decision-making. In addition, key messaging is incorporated into our phone system when members call Member Services or their case manager.

Amerigroup will focus on the health issues most prevalent to Iowa members. We will provide a range of member education tools and outreach programs to help promote health and wellness and appropriate care utilization. We will work to influence the behavior of our Iowa members building on the existing



programs that have proven successful in other states and implementing new strategies to further educate and motivate members in making healthy decisions. Our health education initiatives will include maternal and child health, preventive and general health, member engagement and empowerment, appropriate use of emergency services, community outreach and education, and substance use disorder prevention and treatment. Our UM team, as an embedded part of the interdisciplinary team, will play a key role in referring members to these programs. These programs are described in more detail in Section 8.7 and include initiatives around maternal and child health, preventive health and general health and wellness.

Additionally, our **mobile notification program, Txt4health**, gives members the option to receive text alerts containing health and wellness information and reminders. Since implementing this program our affiliate health plans have seen the following results:

- Over 185,000 members enrolled; only four percent opted out of receiving the texts
- Seventy-two percent of recipients responded that the texts helped them remember to go to the doctor
- Members who received texts about a certain program/phone number (Nurse HelpLine, coaching, etc.) were six times more likely to call the promoted phone number within 30 days of the text than non-recipients
- Members who received texts reminding them to get a screening/physical were three times more likely to get a physical exam within 90 days of the text than non-recipients

Furthermore, our **Healthy Rewards member incentive program** will reward members for



Our Healthy Rewards program will reward members for actively participating in defined preventive care initiatives, such as completing well-care visits, obtaining routine lab tests, participating in screenings, and attending follow-up appointments.

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actively participating in defined preventive care initiatives, such as completing well-care visits, obtaining routine lab tests, participating in screenings, and attending follow-up appointments. As members participate in these types of wellness activities, they earn points. Points can be converted to reward dollars loaded onto a prepaid Healthy Rewards card that the member can use to purchase health- and wellness-related items at stores and pharmacies that accept prepaid cards.

For pregnant women in particular, Amerigroup offers a program to encourage beginning prenatal care visits in the first trimester of pregnancy. The *Taking Care of Baby and Me*[®] program offers prenatal and postpartum care incentives aimed at promoting early intervention and prenatal care to decrease infant mortality and low birth weight and to enhance healthy birth outcomes. Prenatal and postpartum incentives may include the provision of maternity and child-related items and will be fulfilled via the Healthy Rewards card.

We also make *emergency room alternatives* available to members and support informed decision-making. LiveHealth Online will provide members a convenient alternative to visiting the emergency room. We will offer online physician visits for members with the ability to access secure online video streaming services. As we implement this option for Iowa members under the statewide Contract, we will fully comply with all State statutes, regulations, and rules on virtual healthcare services. Amerigroup also mails postcards to members that live in areas with urgent care clinics, where providers have walk-in hours or extended office hours, or where a new PCP becomes available, informing them of alternatives to the emergency room. We focus these mailings on areas with high emergency room utilization and send to all members when we identify a new provider with extended office hours.

Question 11.1, #8

8. Describe strategies to monitor member access to preventive care and strategies to increase member compliance with preventive care standards. Describe how you will identify and address barriers which may inhibit a member's ability to obtain preventive care.

Amerigroup is committed to connecting members to the preventive care services they need to improve their health outcomes and avoid inpatient care. Our UM staff assist providers in connecting members to primary care, preventive services, and specialty services. UM staff also work with providers to identify appropriate services that meet the member's needs, locate resources, and facilitate the referral process. Our goal is to afford members access to the most appropriate services to meet their needs and achieve positive health outcomes in the least restrictive setting.

We understand that our members' lives are complicated with barriers and social determinants that impact their ability to deal with their healthcare. To assist our members in dealing with those barriers, the plan will assess for social barriers ongoing from the time of initial screening upon enrollment. We will conduct an initial screening for those members in care coordination and routinely screen members during interactions with our National Customer Care Organization and our 24-hour Nurse HelpLine. Our providers and community partners also seek to identify psychosocial factors that may impact the member's participation in care during routine and ongoing interactions.

Our goal is to facilitate member access to the services they need by proactively identifying and addressing any issues that may impede the member from actively participating in treatment. To that end, Amerigroup deploys multiple strategies to identify and remove all barriers to member care, including:

- Conduct outreach calls to members who do not have well-child or adolescent well-care visits and assist with identifying a doctor in their area, scheduling the appointment, and arranging transportation

- Enhance provider communication by sending quarterly reports to PCPs indicating which members on their panel require preventive care visits

We also have a number of incentives and Value-Added Services to encourage member participation in preventive care measures. Our Healthy Rewards incentive program encourages preventive care by rewarding members with financial incentives for completing appropriate screenings, attending well-child visits and completing disease-specific online education modules. Additionally, as part of our Health and Wellness Value-Added Services Suite, Amerigroup will waive member copays for all physician office and psychologist office visits.

Question 11.1, #9

9. Describe your UM Committee, including proposed committee composition and tasks.

Utilization Management Committee (11.1.7)

The Medical Advisory Committee (MAC) serves as the Utilization Management (UM) Committee, and is responsible for the development and implementation of the UM program.

The Iowa UM Committee will be led by the local Medical Director and will consist of the Behavioral Health Team Leader, the Quality Management Manager, the Utilization Management Manager, the Long-Term Care Manager, six to ten fully credentialed and actively participating providers, and other specialty associates as determined by the Medical Director.

The tasks of the UM Committee are as follows:

- To assess levels and quality of care provided to members and recommend, evaluate, and monitor standards of care for members
- To provide advice and input to the corporate committee with oversight over developing and updating clinical practice guidelines
- To identify opportunities to improve services and clinical performance by establishing, reviewing/updating CPGs based on review of demographic and epidemiologic information to target high volume, high cost, high risk, problem prone conditions
- To conduct a peer review process in order to provide a systematic approach for the monitoring of quality and appropriateness of care
- To conduct a systematic review process for network maintenance through the credentialing/re-credentialing process
- To provide advice to the health plan administration in any aspect of the health plan policy or operation affecting network providers or members
- To provide oversight for the peer review and drug utilization review processes
- To monitor practice patterns in order to identify appropriateness of care, over and underutilization trends, and for improvement/risk prevention activities
- To review and provide input, based upon the characteristics of the local delivery system, and approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization
- To review and provide input for the following processes and procedures: credentialing / re-credentialing, clinically-oriented Quality Management policies and procedures, Utilization Management and Disease/Case management

Our UM Committee Organizational Structure can be seen in Figure 11.1-2.

Figure 11.1-2. Our UM Committee Organizational Structure Engages Local, Interdisciplinary Expertise



Question 11.1, #10

10. Describe any benefits which are proposed to require PCP referral and what services would be available on a self-referral process.

Amerigroup encourages members to be the CEO of their personal healthcare process. To that end, we educate members about benefits available to them. PCP visits, specialist visits, behavioral health, family planning, and other preventive services are available through self-referral.

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Amerigroup places great value on the ability of members to not only be involved in the management and coordination of their care, but to actively manage their personal healthcare process. To that end, we strive to make resources easily available to members and make members aware of these resources and how to receive the most benefit from them. This includes easy access to the member handbook, newsletters, our member website, and provider directory.

Visits to specialist are available through self-referral, but services may be subject to prior authorization requirements based on our medical necessity guidelines. Amerigroup will provide female members direct access to a women's health specialist as necessary to provide women's routine and preventive healthcare services.

Prior Authorization (11.2)

Question 11.2, #1

1. Describe policies and procedures for processing authorization requests including when consultation with the requesting provider will be utilized.

General (11.2.1)

As described in Section 11.1 (Utilization Management), Amerigroup is solely focused on serving the health care needs of those enrolled in public sector health care programs. We leverage a prior authorization program as part of our broader UM program in order to actively engage providers and ensure that our members are getting the level of care that will drive the best health outcomes and promote optimal safety and well-being.

Amerigroup's approach to prior authorization promotes the right care at the right time in the right place. We believe that prior authorization presents an opportunity to determine medical necessity and appropriateness of services, procedures, and equipment prospectively to ensure that the right care is given in the right place at the right time. Such prospective medical necessity determinations promote member safety through avoidance of unnecessary interventions that may impart risk to member health. It also affords the opportunity to determine whether the services, procedures, or equipment are a covered benefit for the member and whether the member can be directed to Network Providers. The use of Network Providers helps facilitate consistency in service delivery, confirm that providers rendering care are

Our prior authorization program actively engages providers and interdisciplinary team members to make sure members receive the level of care that will drive the best health outcomes and promote optimal safety and well-being.

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appropriately credentialed and delivering the highest quality of care, and allows such care to be delivered in a cost-effective manner

The goals of our prior authorization program are:

- To assure adequacy of service availability and accessibility to eligible members
- To maximize appropriate medical and behavioral health care and substance abuse services
- To resolve over- and under-utilization of medical and behavioral health care and substance abuse services



We processed more than 3.6M authorizations across all of our Medicare and Medicaid businesses in 2014.

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Through our affiliates, we have extensive a great deal of experience processing prior authorizations across all of our business lines. In 2014 alone, our affiliates processed more than 3.6 million prior authorization requests across all of our Medicaid and Medicare businesses. We process prior authorization requests in a timely manner to assure that our Members are receiving the right care at the right time. **Our Louisiana affiliate, for example, processed almost 100 percent of inpatient authorization requests within two business days, 94 percent of outpatient authorization requests in within two business days, and 100 percent of requests within 14 calendar days.**

Our policies and procedures incorporate our affiliates' years of experience across different states. We select the services that require authorization carefully limit the care and services that require prior authorization in order to minimize administrative barriers for physicians and other providers. We continuously reassess our prior authorization requirements to be consistent with recommended industry standards that are generally accepted by the provider community to benefit members.

A prior authorization clinician performs the following activities during the review process:

- Informs Case Managers of complicated admissions or members requiring care coordination
- Enters information into our core operations system
- Documents and provides authorization reference numbers to providers
- Promotes continuity of care between primary care providers (PCPs) and specialists
- Identifies potential quality of care, member safety, or fraud and abuse issues

We encourage member-centric consideration of medical necessity criteria and/or community standards of care, promoting proper care and member outcomes relative to each unique situation. Designed to be effective and provider-friendly, Amerigroup's prior authorization process promotes consultation between the treating provider and our Medicaid Medical Director in all cases in which medical necessity criteria are not met or when an alternate level of care appears more clinically effective.

To ease administrative burden on our providers and maximize efficiency, Amerigroup facilitates real-time authorizations for online and telephonic requests. Upon receipt, calls are automatically routed to Utilization Management (UM)

professionals who guide providers through the authorization process. We also provide the ability for providers to request authorization through the online provider web portal or by Rightfax. At any time, providers can check on the status of authorization through the provider portal or our telephonic voice portal.



Prior authorization presents an opportunity to determine medical necessity and appropriateness of services, procedures, and equipment to assure that the right care is given in the right place at the right time.

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Amerigroup attempts to avoid denial of service requests because of failure to meet medical necessity or other relevant criteria. The medical management clinicians work collaboratively with providers and facilities, discussing cases, asking for additional clinical information to clarify the need for the services, or finding an alternative service package that would better address the member's condition. If no further information or alternative service package can be identified and the Utilization Management Nurse Medical Manager cannot approve the request, then he/she will forward the request to an Iowa Medical Director for further review. Our goal is to develop a collaborative working relationship with providers so that they see us as a clinical resource rather than a roadblock or barrier to members receiving care.

UM Personnel

Local Amerigroup staff will be responsible for the decisions made regarding services for members in the Iowa plan. We train our staff to use policies and procedures as a guide; however, we consider each member situation on a case-by-case basis, taking into account medical, behavioral, and social factors to reach the best decision for each unique member and scenario.

The prior authorization program is primarily executed by Utilization Management staff specialized nurse coordinators and member and provider services staff. These staff members coordinate with other departments and staff as needed, such as care specialists for care coordination purposes. When necessary, our experienced local professionals will be supported by clinical staff at our corporate office. The Iowa Medical Director will also engage in prior authorization decisions and communication with providers as needed.

The following provides a brief description of the two main prior authorization staff roles:

- **Utilization Management Nurse Coordinator:** The Nurse Coordinator is responsible for day-to-day management of prior authorization activities. He/she manages member care, ensuring essential, effective, appropriate, and coordinated behavioral and physical health and social services.
- **Customer Care Representative II (CCR II)/Care Specialist:** The Customer Care Representative II/Care Specialist is responsible for responding to inquiries from members and practitioners to clarify benefits, providing member education and health referrals. Representatives document prior authorization requests and arrange for services as identified by the Nurse Coordinator and/or the Care Manager.

Employee training, including new employee onboarding training and ongoing training, is addressed in Question 11.2, #10.

Policies

We design our prior authorization policies to assure that members are treated in the most appropriate and most cost-effective setting compatible with medical necessity. We make medical necessity decisions according to the severity of the illness and/or the intensity of the services needed to contribute to an improved health status relative to the specific condition. We also use behavioral health guidelines, psychosocial criteria, and the LTSS member-centered planning process to inform decisions.

We require prior authorization for non-emergent inpatient admissions, partial hospitalization, residential treatment, and psychological testing. We conduct concurrent review for inpatient hospitalizations and partial hospital/acute outpatient care to assess member progress, timeliness of care, level of care, members' strengths and needs, and "super-utilization" indicators that impact members' transition from



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inpatient to outpatient care. We conduct these reviews telephonically. Our UM employees work with providers to gather clinical information to support the necessity for requested services and coordinate with facilities to begin transition planning and to determine members' needs for services and supports.

We educate our network providers about the covered services and benefits available to members through our comprehensive provider relations model, and we have significantly reduced the number of services that require prior authorization to promote access to care and ease of provider administration.

As required by State and federal regulations, we will not require notification or prior authorization for emergency medical/behavioral health or substance abuse services. Our provider manual and member handbook inform providers and members that involuntary detentions or commitments (96-hour detentions or court-ordered commitments) will not require prior authorization for inpatient days when the detention or commitment is in effect.



Prior Authorization Review Criteria

We will use nationally accepted, evidence-based criteria to promote appropriate utilization of covered services. We will implement criteria and guidelines that are objective and provide a rules-based system for screening proposed care and services based on member-specific, best practice processes and consistently match services to member needs. We will coordinate with DHS and local stakeholders to align with Iowa-specific criteria and processes.

- For **medical State plan benefits**, UM nurses will review the members' conditions and compare to the relevant medical necessity criteria. We will use nationally accepted, evidence-based medical necessity criteria, unless superseded by State requirements or regulatory guidance. We will also develop psychosocial medical necessity criteria
- For **behavioral health State plan benefits and substance use disorder services**, we will utilize Anthem Behavioral Health Medical Necessity Criteria and American Society of Addiction Medicine (ASAM) Criteria, unless superseded by State requirements or regulatory guidance
- For **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services** for members under 21, we will comply with State requirements to provide any services that could correct or ameliorate physical or behavioral health
- For **emergency services**, we will not impose restrictions on coverage that are more restrictive than those permitted by the prudent layperson standard. This means we will not deny emergency services when a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part
- For **Long Term Services and Supports (LTSS)**, we will not use medical necessity criteria; however, we apply functional necessity based on our assessments/reassessments. The provision of LTSS and related DME will be determined and approved through the member-centered care planning process in consultation between the member, their family or caregiver, and the Community-Based Care Coordinator. Spending on covered services must fall within the budget cap. We plan to partner with Telligen on a consultative basis during the implementation period to understand the existing process and criteria for LTSS in Iowa in order to promote consistency and continuity of care through the transition.

When developing an Individual Service Plan (ISP), Community Based Care Coordinators consider medical necessity criteria based on individual member needs and preferences, an assessment of the availability of services within the local delivery system, and treating provider service requests. The UM criteria's comprehensive range of level of care alternatives is sensitive to the differing and complex needs of children, adolescents, and young adults, as well as members with specialized health care needs. When using the criteria to match a level of care to the member's current condition, coordinators consider the severity of illness and multiple conditions, as well as episodic variables such as living situation and available supports. Field-based coordinators at select provider locations, such as Health Homes and high-volume PCPs, facilitate the gathering of information for determination of medical necessity as necessary. We realize that members who are medically fragile will require significant in home, private duty nurse utilization; therefore, we employ Community Based Care Coordinators with pediatric nursing experience in an intensive care setting to assist with their service coordination.

Procedure

Amerigroup has established procedures for applying clinical criteria based on the individual member's needs and the local delivery system for medical and behavioral health services. These procedures apply to pre-service, concurrent, and retrospective reviews.

Amerigroup UM nurses complete prior authorizations on a case-by-case basis. UM nurses are licensed professionals with training and experience in utilization management and clinical expertise in treatment for the member's condition. We verify eligibility and benefits in the claim payment system and our prior authorization clinicians UM nurses collect relevant clinical information and review it against the prior authorization guidelines to determine if the level of service requested meets medical necessity criteria. The UM nurse prior authorization clinician approves the services for situations that meet medical necessity criteria, and all results, including the reason(s) for decisions made and/or any alternative services approved in lieu of the original request, are documented and maintained in our prior authorization system. Clinical employees must consider the member circumstances, including:

- Age
- Comorbidities
- Complications
- Prior treatment
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable
- Capabilities of the local delivery system, such as the ability to provide medically necessary treatment and level of care

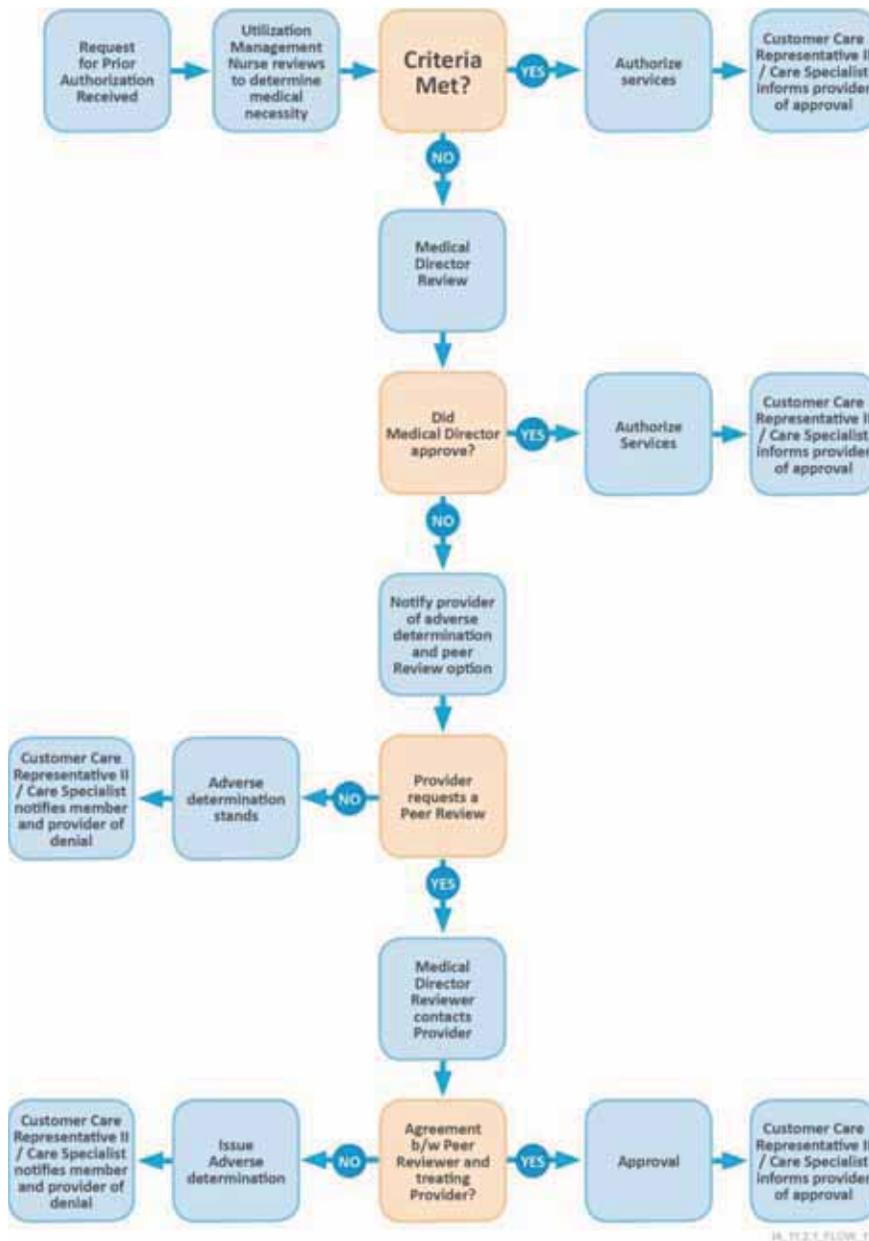
For medically necessary services, Amerigroup may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered. All medical necessity determinations are subject to member eligibility and benefit availability at the time of the delivery of service, including benefit limitations. We may approve services that are non-covered except as otherwise required or as directed by the State.

In circumstances where medical necessity or alignment with other criteria is in question, the clinician refers the case to our Iowa-licensed local Medical Director for review. The Medical Director offers the attending physician an opportunity to review and discuss the case, making every effort to find and agree on an acceptable service/care plan before making an adverse medical necessity determination.

If the Medical Director makes an adverse medical necessity determination, we communicate the decision to the provider verbally and via fax within one business day, followed by written notification to the provider and member. We always make prior authorization criteria available to providers and members upon request. Any denial or decision that the member or provider disagrees with can be appealed and will be reviewed by our professionals skilled with the relevant clinical expertise of the member's condition.

Figure 11.2-1 demonstrates the steps we take to review and complete a prior authorization request, including provider and member notification. We continuously evaluate our practices so that prior authorization achieves its intended purpose and is not an impediment to the timely delivery of medically necessary services. We will assist the member when the services require assessment or other requirements prior to the member accessing the care whenever necessary, such as scheduling appointments, arranging transportation, and providing a list of available providers to deliver the required services. We will approve the requested medically necessary services to make sure the member receives the right care in the right place at the right time without interruption or delay due to scheduling or other arrangements.

Figure 11.2-1. Our Prior Authorization Process Incorporates a Variety of Stakeholders to Ensure a Comprehensive Approach



Consulting with Provider Requesting

Amerigroup values our provider relationships, and we engage providers in collegial discussions about requests for service. Through this process we promote provider satisfaction and deliver value to the State by streamlining provider interaction. Our authorization process respects our providers' clinical judgment, incorporating their expertise into the decision-making process. Our Medical Director is available to providers to discuss specific requests. Providers may request these consultations during the authorization process.



The Medical Director offers the attending physician an opportunity to review and discuss the case, making every effort to find and agree on an acceptable service/care plan.

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Use of Board-Certified Consultants

We maintain policies and procedures for requesting board-certified medical or behavioral health consultations from board-certified specialists or subject matter experts individually or via Independent Review Organizations (IRO) to assist in making utilization management medical necessity determinations.

Requests for board-certified consultations may occur in, but are not limited to situations involving unusually complex cases when the facts are not clearly defined and there are alternative decisions that may be made based upon assessment of the clinical condition of the situation:

- Cases requiring special expertise in order to determine medical necessity and expertise is not readily available within the network of credentialed providers to provide a nonbiased and evidence-based review
- Situations where conflicts of interest are identified with the current potential reviewers or associations with network facilities
- Situations involving discordance between the treating provider and the health plan Medical Director or a behavioral health Medical Director about a treatment plan or a medical necessity appeal decision, such that an external objective opinion is warranted to attest credibility of the process.

When the local health plan Medical Director or behavioral health Medical Director determines that such a consultation is needed, a board-certified consultant is selected from a list of available consultants, or the contracted IRO is contacted.

- The health plan Medical Director or behavioral health Medical Director verifies that the consultant or contracted IRO has no known conflict of interest with the initial reviewer or parties involved with the particular case.
- The health plan maintains business associate agreements with all approved consultants and the contracted IRO, allowing for disclosure of Protected Health Information (PHI), or in the absence of such an agreement, the Health Care Management (HCM) staff obtains the required consent from the member as per policies and procedures related to disclosure of PHI.

Designated HCM staff notifies the consultant or the contracted IRO of the pending referral and any questions to be addressed and furnishes all necessary clinical information via an approved form of transmission to the external party.

Based on the medical information provided, the consultant or the contracted IRO will use the latest available knowledge to confirm the diagnosis, review the current treatment plan, define standards of care, and identify deviations from or adherences to standards of care and recommend a treatment plan.

Within a specified timeframe, the consultant or the contracted IRO provides the results of the consultation to the referring health plan Medical Director, behavioral health Medical Director, or designees.

The referring health plan Medical Director, behavioral health Medical Director, or designees review the report of the consultant or the contracted IRO and make a medical necessity determination, which is documented in the member's clinical record.

All applicable policies and procedures are followed in notifying the member and provider, as applicable, of the determination.

The health plan verifies through the credentialing and recredentialing process that the consultant is licensed and board-certified in one or more of the relevant specialties. The IRO performs verifications through their credentialing and recredentialing process that the consultant is licensed and board-certified in the relevant specialties.

- Corporate HCM – Clinical Operations staff maintains the national list of board-certified consultants or contracted IRO for each health plan on the HCMS SharePoint site.
- Designated HCM health plan and behavioral health staff notifies Clinical Operations of updates to their consultants or contracted IRO.

We acknowledge our policies and procedures for board-certified consultants are subject to State review and approval.

Denial

All decisions to deny service requests will be made by the Amerigroup Iowa Medical Director or another designated, qualified physician/practitioner. If the Medical Director or other practitioners within Amerigroup need additional expertise to make a decision about a service or condition, we will seek consultative review from additional professionals.

Amerigroup is particularly well-positioned in this regard due to our abundance of qualified medical personnel across our organization with a wide variety of expertise. Only in the most unusual circumstances will it be necessary to seek medical consultation regarding service requests outside of the Amerigroup medical staff. In those instances where this is necessary, we will contract with local, Iowa-licensed practitioners as much as possible.

We will deny services for members only if those services are not covered in the Iowa fee-for-service program or if the service requested does not meet medical necessity criteria. We will not deny any medically necessary treatment or services. If the requested services are covered under the fee-for-service program but are excluded from the Amerigroup Iowa contract, our Care Coordination staff will refer the member to the appropriate provider and will communicate with that provider to coordinate care with services that we are providing to the member.

Timelines for Review Decisions

Each type of authorization request has a specific timeframe for completion of the review process and communication to the provider and member as directed by the State.

Amerigroup's prior authorization employees conduct timely reviews to comply with industry, accreditation, and contract-specified timeframes. We review reports daily that track aging of open cases to set priorities and focus on those that require immediate action. The Medical Management Team reviews system-generated logs to identify and resolve potential barriers to timely case closure. They also monitor trended data in weekly or monthly reports to identify trends that may indicate problems with current processes or workload distribution.



Amerigroup is particularly well-positioned to address all denials in-house due to our abundance of qualified medical personnel with a wide variety of expertise.

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Table 11.2-1 specifies the timeframe Amerigroup will follow when making a decision and communicating the decision to the provider and member by type of request.

Table 11.2-1. We Will Comply with Timeframes Required for Prior Authorization/Certification Reviews

Type of Request	Decision/Notification Timeframe
Prior Authorization*	
Routine requests	Approval or denial of routine requests within 7 days
Emergency room staff request for non-emergency service	Approval or denial of non-emergency services within one hour of request
Urgent as determined by treating provider	Approval or denial within 24 hours of request
Requires additional information	Provider notification within 36 hours, which includes one working day following receipt of the request of service for any additional information
Additional information received	Approval or denial within 36 hours, which includes one working day of obtaining all necessary information
Initial Inpatient Admission*	
Initial review	Approval or denial within 36 hours, which includes one working day of obtaining all necessary information
Concurrent Review*	
Concurrent review	Approval or denial within one working day of obtaining all necessary information
Requires additional information	Provider notification within 36 hours, which includes one working day following receipt of the request of service for any additional information
Retrospective Review	
Retrospective review	Within 30 working days of receiving all necessary information

*Approval or denial will not exceed 14 calendar days following the receipt of additional information for a request for services requiring prior authorization and initial and concurrent reviews.

Concurrent Review

From the point of admission, our concurrent review nurses immediately begin planning for each member's discharge. They assess member progress and their expected needs at discharge (for example, the need for home health services or durable medical equipment); work with the facility to verify the medical necessity of continued stays; and coordinate discharge planning to facilitate a safe transition to the next level of care. Throughout concurrent review process, we verify that the right services are integrated, not duplicated, and are provided at the right time based on the member's changing needs. As necessary, the review nurses engage Medical Directors (including our Behavioral Health Medical Director) on cases in which medical necessity is in question.

Amerigroup concurrent reviewers may work onsite at high-volume facilities in our network to maintain collegial relationships with physicians, nurses, and administrative employees and promote strong local knowledge of available resources. Our Medical Directors talk to provider and facility employees every day and make themselves available for peer-to-peer discussions.

Discharge planning is also an essential part of concurrent review, ensuring that members are fully supported when they leave the hospital. Our organization does not employ utilization controls or other coverage limits to automatically place restrictions on length-of-stay for members requiring hospitalization or surgery, nor on length of service for outpatient levels of care. We base length of stay for a member's

request for hospitalization or surgery or for outpatient care on medical necessity rather than on arbitrary limits. Assigned HCM clinical employees manage additional coverage decisions when required for a member's care. The clinical review for these services specifies precertification for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the HCM clinical employee working with the hospital, PCP/attending physician, and/or other parties monitors and continually reviews the case to determine discharge readiness and to facilitate discharge planning. This helps to avoid a re-admission or another acute care episode.

The concurrent review clinician coordinates with the Member's PCP, attending physician, and the discharge planning personnel at the hospital to arrange services necessary to transition a member to a more appropriate level of care. When the member is discharged, the concurrent review clinician documents the plan in the Amerigroup authorization database for monitoring. If at any time we identify a potential quality issue through the review process, we refer it to our QM Department.

Amerigroup established a **stabilization program** to augment our UM team's discharge planning efforts and to prevent unnecessary re-admissions. Members who are at risk receive intensive outreach and individual coaching until they are stabilized at home or in a community setting. The program also targets members with behavioral health diagnoses. The goal of stabilization care is to reduce overall 30-day re-admission rates and to facilitate a smooth transition between inpatient settings and the home or other community settings by providing intensive, short-term support. For moderate- to high-risk members, a stabilization coach collaborates with the concurrent review clinician to work with the member or caregivers and, when appropriate, the hospital's discharge planning employees. The coach coordinates all necessary follow-up care, including community-based home care and personal care services, if included in the benefit package. The stabilization care coach is a resource to members and their families and caregivers by being available to provide information regarding post-discharge services.

The stabilization coach works directly with the member either on the telephone or in-person, depending on the risk level, to educate them about the transition and develop a written discharge plan with the member, their family, or other caregivers. The plan includes: (1) pre-transition visits, (2) follow-up care, (3) post-discharge check-in, (4) medication reconciliation, (5) red flag education, (6) disease-specific interventions, and (7) discharge plan reminders.

In addition to the stabilization coach, another tool available for members is our Value-Added Service post-discharge stabilization kit. The kit provides tips and tools for family members and caregivers to facilitate member education, maintain appointment attendance, help improve medication and treatment plan adherence and successfully help transition members from hospital to home



We base length of stay for a member's request for hospitalization or surgery, or for outpatient care, on medical necessity rather than on arbitrary limits.

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Question 11.2, #2

2. Describe mechanisms to ensure consistent application of review criteria for prior authorization decisions.

Mechanisms for Consistent Application of Review Criteria

Inter-Rater Reliability (IRR) testing is a formal auditing methodology performed annually by Amerigroup Corporate national Health Care Management (HCM) to assess the consistency and accuracy of employees in applying medical necessity criteria.

The IRR Program is designed to assess the consistency and adherence to corporate policy and process as related to utilization management practice within the corporation. Amerigroup strives to assure that members and practitioners receive fair and consistent treatment in the coordination and approval/adverse determination for payment of health care services. The knowledge of the guidelines and criteria used by Amerigroup's staff involved in these activities helps verify that the corporation is limiting its exposure to risk from both a medical and financial perspective. The impact of the IRR Program is intended to result in the following:

- Knowledge of nationally accepted, evidence-based criteria, Amerigroup Medical Policies, Amerigroup Behavioral Health Utilization Management Guidelines, American Society of Addiction Medicine, and Pharmacy criteria/guidelines
- Minimized variation in the application of the above guidelines
- Staff recognition of potentially avoidable or inappropriate utilization
- Identification of staff that need additional training
- Identification of training opportunities
- Identification of potential risk due to inconsistency in the application of guidelines

Question 11.2, #3

3. Describe processes for retrospective utilization monitoring for IDPH population services.

IDPH Prior Authorization (11.2.2)

We will not require prior authorization for any level of service for the IDPH population. However, we will conduct retrospective review of IDPH-funded service utilization to make sure clinical criteria have been applied accurately and consistently. We will utilize retrospective reviews to look for outlier utilization and use the data to further explore the situation with providers and IDPH.

UM clinicians will conduct retrospective reviews of medical records when members have received IDPH-funded services to assess medical necessity and appropriate application of our utilization management guidelines. We have a well-established process for retrospective review based on member medical necessity, level of care, inpatient/outpatient, elective/urgent/emergent status urgency of the service need, and timeliness of notification. We will adapt our process to IDPH service-specific issues as needed.

If Amerigroup-approved medical necessity criteria are not met, the case is referred to the appropriate Medical Director for review and determination. The Medical Director reviews the clinical information and determines if the admission, procedure, or service was medically appropriate. The member's claims record contains documentation of the retrospective review process and determination. When conducting retrospective reviews, determinations are based on the medical information available to the attending

physician or ordering provider at the time the medical care was provided. Providers may dispute the decisions/claims payment. Our dispute team will render decisions based on the same or new information given by the provider (e.g., new correspondence or updated medical records).

We also use retrospective review findings to conduct outreach to providers and to educate them on our policies. If, for example, we identify that a particular provider of IDPH services who is routinely rendering care that upon retrospective review meets criteria for a less restrictive/more cost-effective service or level of care, we will take that as an opportunity to reach out to the provider and discuss alternatives.

Along with retrospective review findings, we also deploy dedicated care managers, called Recovery Coaches, to focus solely on our members with SUD issues, especially those with high utilization of detoxification services and admission/readmission to inpatient settings. In 2013, one of our affiliate plans placed a special emphasis on discharge planning for these members., the 30-day SUD readmission rate decreased 2.8 percent, and the 90-day SUD readmissions rate decreased 5.3 percent from 2013 through year-to-date 2014.

In addition, we have the ability to develop reports that identify inappropriate drug utilization and/or inappropriate prescribing patterns in the following categories: Pain Management, Opioid Outliers, and Dedicated Provider Programs. Using the data, we develop a work plan for each prescriber that includes action to further investigate the data and to bring to the prescriber our concerns and to the proper authorities as required for corrective action. The data also allow us to recommend members for RCP. The report also allows us to identify specific members who are at risk for inappropriate drug utilization. These members are reviewed by the Amerigroup Recovery coach for possible enrollment into the SUD program.



In our affiliate health plans, they deploy dedicated care managers to focus solely on their members with SUD issues. This program has resulted in the 30-day SUD readmission rate decreasing 2.8% and the 90-day SUD readmissions rate decreasing 5.2% from 2013 through year to date 2014.

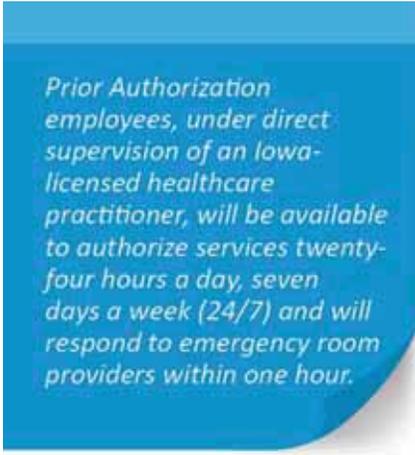
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Question 11.2, #4

4. Describe required staff qualifications for UM staff.

UM Staff Required Qualifications

Prior Authorization employees will be available to authorize services twenty-four hours a day, seven days a week (24/7). Employees will be directly supervised by an Iowa-licensed registered nurse, physician, or nurse practitioner. Our clinical associates who require licensure for employment based on Amerigroup's job descriptions go through a clinical peer review process (including a review of credentials and professional competence and conduct) at the time of hire and are subject to recertification every three years during the course of employment. In addition, background checks and drug screenings will also be conducted at hire. Prior authorization functions for behavioral health services are performed and/or supervised by a Behavioral Healthcare professional who is licensed in Iowa and who will collaborate with health care providers and members to promote quality member outcomes, optimize member benefits, and promote effective use of resources.



Prior Authorization employees, under direct supervision of an Iowa-licensed healthcare practitioner, will be available to authorize services twenty-four hours a day, seven days a week (24/7) and will respond to emergency room providers within one hour.

Staff will do the following:

- Facilitate medically appropriate, high quality, cost-effective care by assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out-of-network services, and appropriateness of treatment setting by using the applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs, or community resources
- Work with Medical Directors in interpreting appropriateness of care and accurate claims payment
- Conduct prior authorization, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to verify compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts
- Promote member access to medically necessary, quality care in a cost-effective setting according to the Contract
- Consult with clinical reviewers and/or the Medical Director to facilitate medically appropriate, high quality, cost-effective care throughout the medical management process
- Refer treatment plans/plan of care to clinical reviewers as required and do not issue non-certifications
- Facilitate accreditation by understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards

Education, Training, and Experience Qualifications

Prior Authorization employees require a current active, unrestricted nursing (RN) license to practice as a health professional within the scope of practice in applicable state(s) or territories of the United States with two years acute care clinical experience. Prior authorization functions for behavioral health services require a licensed behavioral health staff. Staff must have strong oral, written, interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Question 11.2, #5

5. Describe proposed utilization management clinical standards, including the use of any nationally recognized evidence based practices.

Proposed UM Clinical Standards

Amerigroup uses nationally recognized, evidence-based clinical standards. Although our medical policy governs the medical necessity of individual services and procedures, we always first consider federal and State law and Contract language when determining eligibility for coverage.

We involve actively practicing physicians to develop and adopt review criteria. Through our national Medical Policy and Technology Assessment Committee and local Quality Management and Improvement (QM/QI) Committee, we review and approve criteria annually. See Section 11.2.3 for additional detail.

The national Anthem Office of Medical Policy and Technological Assessment (OMPTA) developed policies and guidelines that serve as sources for making decisions about coverage. The development process relies upon thorough consideration of guidelines prepared by professional organizations such as the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, American Academy of Pediatrics, American Academy of Neurology, Association for Ambulatory Behavioral Healthcare, and others. In addition, we may also adopt national guidelines produced by health care organizations, such as individual medical and surgical societies, the National Institutes of Health, and the Centers for Disease Control and Prevention.

Guidance provided by authoritative agencies such as the Substance Abuse and Mental Health Services Administration and Agency for Healthcare Research and Quality are also consulted. Because the standard of care is constantly evolving, we research peer-reviewed medical literature to provide the most up-to-date perspective. We synthesize the information obtained into proposals for the medical necessity of various types of behavioral health services.

Proposed behavioral health policies and guidelines are sent to multiple academic centers for consideration by experts selected by each medical center. The proposed behavioral health policies and guidelines are sent to professional organizations, including those listed previously for feedback from consultants of the professional organizations' choice. The input from these external sources is synthesized into policies and guidelines that merit consideration for approval. No less than annually, a subcommittee of independent consultants (including primary care, psychiatry, psychology, and social work representatives) reviews the behavioral health policies and guidelines for approval. Because behavioral health care represents an integral aspect of the medical system that is critical to many other practitioners, the behavioral health subcommittee presents its decision to the Medical Policy and Technology Assessment Committee, a group of professionals representing a host of specialties that review the recommendations of the subcommittee and finalize decisions about implementation of the guidelines. Although the behavioral health policies and guidelines capture services relevant to the treatment of behavioral health disorders, each type of service receives member-centered consideration to be sensitive to the unique characteristics of each individual seeking care.

Question 11.2, #6

6. Describe how you will identify those services that will be reviewed for medical necessity determination. Provide a list of services for which prior authorization would be required.

Medical Necessity Determinations (11.2.3)

Our Medical Directors, UM supervisors, physician reviewers, and physician consultants work together to verify that day-to-day prior authorizations and other specialty prior authorization program decisions are based upon medical necessity, medical appropriateness, contract provisions, and covered benefits. Our process includes considering the unique needs of individual members such as cultural and linguistic needs and characteristics of the local delivery system, including the capacity and capabilities of the medical delivery system.



We consider the unique needs of individual members such as cultural and linguistic needs and characteristics of the local delivery system when making authorization decisions.

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Annual Review

The national Medical Operations Committee (MOC) performs annual prior authorization reduction review to verify that services are appropriately identified for medical necessity determination. We complete this review by analyzing utilization data such as:

- The top 100 procedures by volume and cost
- The top 50 denied and modified procedures
- Appropriateness reviews of all procedures that require prior authorization
- Procedures associated with specific medical policy or clinical guidelines that warrant medical review

Based on the annual review, recommendations may be made to revise the authorization requirements. All recommended changes, along with relevant data, are reviewed/approved by the Precert Change Committee. This committee is comprised of Corporate and Health Plan Medical Directors, along with senior management from Health Care Management. Once approved, recommendations are submitted to a multidisciplinary team for implementation. Written notices of changes are sent out to Network practitioners and providers per State guidelines. All authorization requirement changes are presented to the UM Committee and the Medical Advisory Committee. We distribute final revised versions of the Prior Authorization Lists to the provider network and to members via our website and changes to the member handbook and provider manual.

Services Requiring Prior Authorization

While most services do not require prior authorization in order to support access, the following major types of services are subject to prior authorization:

- Elective inpatient admission
- Specialty procedures (the organization does not require prior authorization for any emergency services, including specialty care, for treatment of any immediately life-threatening medical condition)
- Non-emergent services rendered by an out-of-network provider, with exception of covered EPSDT services, covered family planning services, and women's preventive health services, unless excluded by State or Federal requirements

Additionally, several behavioral health, substance abuse, activity therapies, mental health, housing, and community services require prior authorization.

Below is a short list of behavioral health services that require prior authorization. We have similar lists for all the categories mentioned above and will make sure to communicate these prior authorization requirements to providers as part of our provider education efforts.

Behavioral health services requiring prior authorization include:

- Initial, including cortical mapping, motor threshold determination, delivery and management
- Subsequent delivery and management, per session (predominant code)
- Subsequent motor threshold re-determination with delivery and management
- Electroconvulsive Therapy
- Psychological Testing
- Psychological Testing by Technician
- Psychological Testing by Computer
- Assessment of aphasia
- Developmental Testing Limited
- Developmental Testing Extended
- Neurobehavioral Status Exam
- Neuropsychological Testing
- Neuropsychological Testing by Technician
- Neuropsychological Testing by Computer
- Standardized cognitive performance testing
- Resource-intensive Behavioral Health services (e.g., inpatient care, residential care, etc.)

Medical Necessity of Mental Health Services (11.2.4)

We will develop and implement guidelines for determining the psychosocial necessity of clinical, rehabilitative, or supportive mental health services which meet all the following conditions:

- Are appropriate and necessary to the symptoms, diagnoses, or treatment of a mental health diagnosis
- Are provided for the diagnosis or direct care and treatment of a mental disorder
- Are within standards of good practice for mental health treatment
- Are required to meet the mental health needs of the member and not primarily for the convenience of the member, the provider, or the Contractor
- Are the most appropriate type of service which would reasonably meet the need of the member in the least costly manner

Our guidelines will comply with contract requirements and will take into consideration:

- The member's clinical history, including the impact of previous treatment and service interventions
- Services being provided concurrently by other delivery systems
- The potential for services/supports to avert the need for more intensive treatment
- The potential for services/supports to support the member to maintain functioning improvement attained through previous treatment
- Unique circumstances which may impact the accessibility or appropriateness of particular services for an individual member (e.g., availability of transportation, lack of natural supports including a place to live)
- The member's choice of provider or treatment location
- The member's family and natural supports and what is achievable by the family in the community

Our affiliates have experience with psychosocial criteria; for example, we use CASII in Nevada and know and are familiar with both LOCUS and CALOCUS. Our affiliates also have experience working with the State on state-specific psychosocial guidelines, for example, in Georgia.

We look forward to collaborating with State, provider experts, and potentially other MCOs to develop guidelines that make sense for Iowa consumers and providers. We wish to avoid "guideline fatigue" for providers and suggest the MCOs selected collaborate on one set of criteria for psychosocial guidelines.

Prior Authorization Requests (11.2.5)

Our Pharmacy Benefit Manager's (PBM's) prior authorization process complies with State and federal laws. We require prior authorization to verify medical necessity and assure compliance with the formulary and Preferred Drug List (PDL). Non-preferred drugs are subject to PDL prior authorization and may require the prescriber to submit documentation that shows trial and failure of preferred drugs. We do not require prior authorizations for non-preferred drugs that meet state exception criteria or are exempted by federal or State law. Both preferred and non-preferred drugs may require clinical prior authorization to confirm that therapies are clinically appropriate and prescribed in a manner that minimizes risks and maximizes therapeutic outcomes. In addition, specialty drugs (e.g., biological) require special handling and pose additional risk factors; therefore, they are also subject to prior authorization to mitigate these risks.

Policies and Procedures

Our PBM's prior authorization policies and procedures provide seamless processes for our providers. Providers can submit prior authorization requests online through our PBM provider portal, by calling the toll-free line or by fax or mail. Certified Pharmacy Technicians and Clinical Pharmacists review prior authorization requests to deliver a timely and accurate evaluation and decision. Our PBM embeds prior authorization policies and clinical protocols in the decision logic to give the prior authorization team real-time access to information about member eligibility and medication history, as well as formulary and PDL benefits, to enable a timely response. Our National Medicaid Division maintains oversight and audit of the PBM. We do not charge pharmacies for any costs related to prior authorization. Providers who request authorizations must provide medical necessity certification and justification. If the prescriber does not supply the necessary clinical information to render a decision, we fax a notice to the prescriber's office within two hours of the request that indicates the request was received and identifies the additional data needed. Established protocols based on clinical policies direct authorization decisions. Our PBM notifies the prescriber and the dispensing pharmacy of the decision within one hour and mails a letter to the member within 24 hours.

Procedure for Accessing a 72-hour Emergency Medication Supply

When a prescription is not filled when presented due to an authorization requirement, the pharmacy must contact the provider and dispense a 72-hour emergency supply if the provider is not available.

Amerigroup employees are trained to quickly facilitate this process. The pharmacist is trained to use professional judgment to confirm that dispensing the prescribed medication would not jeopardize the health or safety of the member and to enter an override code for billing purposes. Periodic written reminders to pharmacists promote ongoing compliance. Pharmacies identified as under- or over-utilizing the emergency fill are re-educated.

Policies and Procedures for Escalating Prior Authorization Requests Not Approved Within 24 Hours

Providers can identify a prior authorization request as urgent in order to escalate those they deem to be urgent, and we prioritize those requests. We have established PBM policies and procedures for prior authorization requests that cannot be approved within 24 hours. We take additional steps to obtain supporting clinical information from the prescriber. If the prescriber does not supply the documentation to support medical necessity within 24 hours, the request will be denied. The prescribing provider or member may appeal the denial.

Procedure for Transitioning Members to Preferred Drugs

Continuity of care and access to necessary medications are primary objectives of our Pharmaceutical Care Management Program. Breakdown in drug therapy can lead to reduced medication adherence and increase the risk of adverse outcomes. To mitigate potential lapses in care, a transition process provides coverage for members who are stabilized on drugs not included in the PDL. This process applies to new members transitioning into Amerigroup and members affected by formulary/PDL changes. Our transition process covers non-preferred drugs for the first 60 days or until the member's physician has completed the prior authorization process.

Procedure for Members Transitioning From Another Plan into Amerigroup

We look at available authorization and claims data to identify previously authorized medications. Evidence of paid claims for a non-preferred drug demonstrates that the drug was previously authorized. Our PBM accepts this evidence as proxy for an authorization and allows claims to process during the defined transition period without the need for an additional prior authorization. Members who receive non-preferred drugs continue on that medication during the transition period and up to the length of the existing authorization. When the prior authorization from the previous plan expires, the Pharmacy Department works with the prescriber to initiate a prior authorization and determine medical necessity for the non-preferred drugs.

Second Opinions

Our members have the right to ask for a second opinion about the use of any health care services. Second opinions, which are described in our member handbook, may be requested and obtained by members in situations where there is a question concerning the diagnosis or the options for surgery or other treatment of a health condition. The member is entitled to obtain a second opinion from a network provider or a non-network provider (if a network provider is not available). There is no cost to the member for obtaining a second opinion. At the member's choice, members may receive a third surgical opinion at no cost, provided by a third provider, if the second opinion fails to confirm the primary recommendation that a medical need exists for the specific surgical operation. This policy applies consistently to all member populations for all medical, behavioral, and LTSS services.



Other Prior Authorization Requirements

Amerigroup will comply with all Prior Authorization program requirements in the Scope of Work. Through our affiliate health plans in 19 other states, we have experience meeting similar requirements and will leverage existing policies, procedures, systems, and training to ensure compliance in Iowa from day one. This includes:

- Complying with all timeframes for determining prior authorization, communicating decisions to members and providers, and handling appeals as required by the contract
- Facilitating provider requests for authorization for primary and preventive care services and assisting the provider in providing appropriate referrals for specialty services by locating resources for appropriate referral
- Granting members with special needs, who are determined to need a course of treatment or regular care monitoring, the ability to directly access a specialist for treatment
- Providing female members direct access to self-refer to a women's health specialist within the network for routine and preventive health care services
- Meeting the requirements of the Newborn and Mothers Health Protection Act and not limit benefits for postpartum hospital stays per the contract or require a provider to obtain prior authorization for stays up to 48- or 96-hour periods
- Not requiring authorization for emergency services within or outside the network; and providing post-stabilization care services in accordance with the contract, as described in detail in Section 3.2.5

- Not requiring authorization or PCP referral for EPSDT screening services; see Section 3.2.7 for additional details
- Not requiring PCP referral to behavior health services; see Section 3.2.8 for additional details
- During transition of new members, honoring existing prior authorizations per contract requirements and continuing medically necessary covered services as outlined in Section 3.3

Question 11.2, #7

7. Describe your prior authorization request tracking system.

Tracking & Reporting (11.2.6)

PA Tracking Requirements (11.2.6.1)

Prior authorization tracking is an integral part of our information and reporting systems. Prior authorizations are entered in our Core Operating system, thus allowing Amerigroup to easily access both authorizations, provider information, reimbursement, claims payment, and much more in a single system. As per our policies and procedures, all correspondence and notes in the prior authorization tracking system will be signed and suffixed by clinical staff. The system tracks all users' input and with automated date and time stamping, allowing Amerigroup to easily audit and provide detailed reporting as needed. Access and functions are assigned to a specific job function (job roles and responsibilities), thus controlling access and administration rights by job function to ensure compliance. Additionally, our prior authorization documentation processes will require our employees to record the following information for each approval:

- Name and title of caller
- Date and time of call, fax, or online submission
- Prior authorization number
- Time to determination, from receipt
- Approval/denial count

Authorizations are assigned a tracking number and tied to the member and provider so that they can easily be matched to claims. The authorization system allows the UM team to enter notes and updates within the record. For example, if a member is hospitalized and clinical information is needed to make determinations, then the UM team can place the updates in the system and track the status of approvals or denials. Also, our tracking and reporting systems maintain a historical record of notes so that no one can override any information previously placed within the system.

Denials (11.2.6.2)

Amerigroup will maintain a record of prior authorization denials in accordance with Iowa State requirements. Please see prior sections for additional details on denial policies and procedures.

Question 11.2, #8

8. Provide sample notices of action as described in Section 11.2.7.

Notice of Actions for Services (11.2.7)

Notification Letters (11.2.7.1)

Amerigroup will comply with the State's requirements around providing notices of action for services within the mandated timeframe. Examples of provider and member authorization denial letters follow. Final letters will be approved by DHS prior to implementing within our process and system. Notice will comply with the language and formatting requirements designated in SOW Section 8.2.

Time Requirements for Notices (11.2.7.2)

In addition, Amerigroup will comply with all time requirements in the Scope of Work, including:

- Notifying members of standard decisions as quickly as possible, not to exceed 7 days or a 14-day extension if requested by the member or provider in order to collect more information to better serve the member
- Making expedited decisions and notification as quickly as possible and in no more than three days if the standard timeframe would jeopardize the member's life, health, or ability to maintain function. We understand that unless otherwise provided by law, if Amerigroup fails to respond to a member's prior authorization request within three business days of receiving all necessary documentation, the authorization is deemed to be granted and notice must be given
- Notifying members in writing on decisions to terminate, suspend, or reduce authorized services at least 10 days before the date of action; for cases of probable fraud, this window may be shortened to 5 days
- Amerigroup will give notice on the date of action for denial of payment

Question 11.2, #9

9. Indicate if your organization elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds.

Objection on Moral or Religious Grounds (11.2.8)

Amerigroup does not have any objections on the basis of moral or religious grounds to provide, reimburse or provide coverage of a counseling or referral service.

Question 11.2, #10

10. Describe your program for ongoing training regarding interpretation and application of the utilization management guidelines.

Ongoing Training on UM Guidelines

We are committed to providing appropriate, medically necessary covered services to our members with full consideration of individual member needs and preferences. To fulfill this commitment, we will provide appropriate training through our initial new hire clinical training program. Beginning with new hire training, Amerigroup will educate employees on our member-centered approach to UM, clinical best practices, and tools used for UM decision-making and provides training to foster positive relationships with providers.

To further support our employees in making appropriate clinical decisions, we will assign a preceptor to all new staff. Preceptors provide coaching, mentoring, and oversight to verify that new staff fully understand how to apply clinical practice guidelines.

Our UM employees will continually build their skills through Continuing Education Units required to maintain licensure. Through the production of job aids that provide a quick reference resource for employees and individual skill-building provided by managers, we maintain a continual improvement process for the competency and expertise of our staff. In 2013, for example, across our organization we targeted education on the tools and systems used within UM, such as our knowledge base system, our Member Grievance Tool, and the procedure for reviewing incoming requests.

Providing rigorous oversight of all clinical training activities promotes strong employee performance.

Organization-wide, Amerigroup's clinical compliance program addresses the following areas:

- Training for clinical employees
- Monitoring and auditing mechanisms
- Policies and/or procedures outlining corrective action plans for non-compliance
- Tracking to verify that targeted employees fulfilled the training expectations, on-going training, and improvement initiatives
- Tracking on-going evaluation expectations, such as inter-rater reliability assessments

Such efforts promote consistent adherence to federal and State contractual or regulatory compliance, as well as NCQA or other accrediting body compliance and support organizational initiatives.

General Expectation (12.1)

Amerigroup’s affiliate health plans administer healthcare benefits to more than 5.2 million members in state-sponsored programs across 19 states, giving us extensive experience in detecting and preventing fraud, waste and abuse, as well as recovering taxpayer dollars inappropriately spent on the administration of Medicaid programs. The increasingly complex Medicaid marketplace and interconnected programs require diligent monitoring and oversight to safeguard against fraud, waste and abuse. **Across our affiliate health plans operating state-sponsored health programs, our comprehensive approach to program integrity resulted in significant savings of over \$210 million dollars in calendar year 2014**

We have extensive experience implementing program integrity initiatives and processes and will bring the best practices we have developed over the years to Iowa. Program integrity at Amerigroup is defined as a set of initiatives, policies, procedures, systems, and best practices directed at the detection and prevention of fraud, waste and abuse. The key objectives of our program integrity initiatives are:

- Identification and implementation of system and oversight activities to reduce instances of fraudulent activities
- Increased use of advanced data analytics, expanding detection capabilities across a broader spectrum of clinical services
- Deployment of improved operational performance and metrics aimed at optimizing savings for the Iowa Initiative
- Combatting the diversion of funds that could otherwise be spent/applied to safeguarding the health and welfare of our members

As illustrated in Table 12.1-1, Amerigroup’s program integrity activities and responsibilities cross many functional areas with multiple departments working together against fraud, waste and abuse.

Table 12.1-1. Illustrates the Interdepartmental Program Integrity Structure at Amerigroup

Department	Relevant Role / Function
Healthcare Analytics <ul style="list-style-type: none"> • Program Integrity Team 	<ul style="list-style-type: none"> • Program Integrity Advanced Analytics • Program Integrity Strategy/Governance • Health Plan Relations • Data Mining Vendor Strategy • Cost-of-Care Initiative Monitoring
Customer Service Operations / Financial Operations <ul style="list-style-type: none"> • Cost Containment • Quality and Process Improvement 	<ul style="list-style-type: none"> • Issue Identification • Project Validation • Root Cause Fixes / Increased Accuracy • Provider Notification and Recovery • Coordination of Benefits/Credit Balance Vendor Management
Reimbursement Policy Management <ul style="list-style-type: none"> • Provider Billing Integrity • Medical Claim Review • Medical Policy & Medical Coding 	<ul style="list-style-type: none"> • Policy Development • Provider Education • Record Reviews/Audits • Clinical Support • Medical Director Leadership
Health Plan Services	<ul style="list-style-type: none"> • System Edits

Department	Relevant Role / Function
<ul style="list-style-type: none"> Code Editing Configuration 	<ul style="list-style-type: none"> System Configuration ClaimCheck / PAM /ClaimsXTen/iHealth
Compliance <ul style="list-style-type: none"> Medicaid SIU Medicare SIU 	<ul style="list-style-type: none"> Fraud & Abuse Investigation State / Law Enforcement / MEDIC Referrals Hotline / Referral / Lead Triage Regulatory Reporting
Pharmacy <ul style="list-style-type: none"> Member Lock-in Pharmacy Coordination of Benefits 	<ul style="list-style-type: none"> Outlier Rx medication use member management Pharmacy coordination of benefits vendors Pharmacy outlier claim review
Health Plan	<ul style="list-style-type: none"> Issue Identification Provider Relations Project Approvals

Amerigroup’s program integrity initiatives in Iowa will benefit from the policies and procedures developed by our affiliate Medicaid health plans. We will customize and implement a compliant program assuring that the Iowa Medicaid dollars entrusted to us are properly spent. To do so, we will work to ensure that the services provided to members are effective, efficient and safe, and that payments are made to legitimate providers for reasonable services provided to eligible members. Amerigroup will deploy experienced staff in Iowa who will use a variety of tools and processes to promptly investigate reports of suspected fraud and abuse by employees, subcontractors, providers, and others with whom we conduct business. Prior to implementing our comprehensive set of policies and procedures, we will submit them to the State for approval.

Program Integrity Plan (12.2)

Plan Contents (12.2.1)

Our Fraud, Waste and Abuse Compliance Plan includes a system of processes and controls to prevent, detect, report and implement corrective action for fraud, waste and abuse. Amerigroup’s best-in-class program and extensive program integrity experience positions us to fully deliver on this requirement. We understand that the Fraud Program Integrity Plan must include the following core elements:

- Written policies, procedures, and standards of conduct that articulate our organization’s commitment to comply with all applicable state and federal standards
- The guidance and fraud referral performance standards published by CMS in September 2008 entitled “CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit” (Amerigroup’s Program Integrity Officer will incorporate any other appropriate guidance and/or future CMS guidance into our written policies and procedures and training materials)
- Provision for a data system, resources, and staff to perform the fraud, abuse, and other compliance responsibilities including running algorithms on claims, analyzing data, performing predictive analytics, trending claims behavior and conducting provider and member profiling
- Designation of a Program Integrity Officer and a Compliance Committee accountable to senior management (our full-time Iowa Compliance Officer will meet with State audit and investigations representatives at the frequency required by DHS)

- Annual training and education for the Program Integrity Officer and other employees involved in program integrity work; trainings include instruction on the False Claims Act
- Effective lines of communication between the Program Integrity Officer and the organization's employees (Employees are able to report any suspected fraud and abuse activity directly to the Program Integrity Officer, the Compliance Officer or the Medicaid Special Investigations Unit)
- Enforcement of standards through well-publicized disciplinary guidelines
- Provision for internal monitoring and auditing
- Provision for prompt response to detected offenses and for development of corrective action initiatives
- Written standards for organizational conduct
- Inclusion of information on fraud and abuse identification and reporting in provider and member materials
- Program integrity-related goals, objectives, and planned activities for the upcoming year
- Compliance with 42 CFR 455, including timeframes for implementing and completion
- Coordination with DHS Program Integrity to remove incarcerated, deceased or incorrectly enrolled members or providers

The Program Integrity Plan will be updated annually, and as contractually required, submitted for review and approval. We will implement the plan as approved and will submit any changes to the State for approval prior to implementation. Functional managers throughout the organization in consultation with the Program Integrity Officer develop standard operating procedures for their respective units aligned with the goals and procedures outlined in the Plan. We have experience developing Program Integrity Plans across our affiliate health plans, and we will take the best practices from each of those in developing the Iowa Plan. Monthly, we will submit a Program Integrity activity report compliant with the minimum data elements, and will outline our program integrity-related activities and findings, as well as our progress in meeting Iowa specific program integrity-related goals and objectives. We welcome an opportunity to engage the State in discussions regarding additional reporting capabilities we could bring to the table.

Amerigroup Iowa will maintain a dedicated Program Integrity Officer at the health plan who will devote at least 90 percent of his/her time to the oversight and management of our local program integrity efforts. In addition to our Iowa Compliance Officer, our national Medicaid Compliance Officer will work with our Iowa Program Integrity leadership team to provide extensive and focused management on program integrity issues including education and training, risk identification and mitigation, and the development and oversight of corrective actions.

The Iowa-based Program Integrity Officer will be the primary liaison with the State and other parties as identified in the contract, including the State's program integrity vendor regarding our fraud, waste, and abuse activities. Our Program Integrity Officer will provide all required data in the timeframe and manner prescribed by the State, and will work with the vendor to foster ongoing communication and collaboration regarding program integrity issues impacting providers and members. Our extensive national experience and expertise will be available to the local Amerigroup Iowa team, and will allow us to implement a robust and fully functional program from day one with an emphasis on Iowa. We will be able to build upon and exceed the gains realized by the State's program integrity contractor over the last several years. We understand that a final Program Integrity plan, incorporating any changes requested by DHS, must be submitted within 30 days after the official submission of the draft plan, which will occur within 30 days of Contract execution. Please see Attachment 12.2-1 for our Draft Integrity Plan.

Question 12, #1

1. Describe your procedures for avoiding, detecting, and reporting suspected fraud and abuse to the State.

Policies, Procedures, and Standards of Conduct (12.2.1.1)

Through our National Medicaid Division, Amerigroup has written policies, procedures, and standards of conduct that outline our commitment to comply with all applicable state and federal standards which will be used to develop the Iowa program. We will incorporate the 2008 published standard entitled “CMS Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit”, as our affiliate health plans do in our other Medicaid state markets. Additionally, we will continuously review our policies and procedures and incorporate other appropriate guidance including State and/or future CMS standards into our written policies.

Avoiding Fraud, Waste and Abuse

Although recovering inappropriate provider reimbursement and referring suspected fraud and abuse to investigators is important, our philosophy is driven by prevention. Prepayment review is highly effective in stopping suspect claim payments. In addition to prepayment review, prevention tools and processes are included in Table 12.2-1.

Table 12.2-1. Prevention Tools and Processes

System	Activity Description
Mckesson Claim Check	Software that automatically and comprehensively audits codes before claims are paid. The system identifies the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesiology procedures identified by CPT®-4 and HCPCS codes
The Policy Administration Module	This module addresses claims editing based on published national reimbursement policies and national coding standards not currently available in ClaimCheck.
LexisNexis Healthcare Portal	A retrospective, rules-based system that detects anomalies in data, using thousands of statistics, rules, and patterns. These examinations track many different aspects of healthcare billing and payment activities and identify instances where values fall outside or in excess of norms
iHealth	A pre-payment solution in a real-time environment through a Facets interface – applies iHealth edits and payment policies to all professional claims and outpatient facility claims.
FICO Insurance Fraud Manager	Use of predictive models, pre- and post- payment, to score claims and providers for the likelihood of fraud and abuse and the level of financial risk.
Credentialing and Provider Profiling	Profiling includes review of the Office of Inspector General List of Excluded Individuals/Entities and Iowa Exclusion Database; license verification; and billing history check for fraud.
Quality Control and Utilization Management	Information from our Utilization, Quality, and Case Management Departments on member and provider over- and under-utilization

Detecting Fraud, Waste and Abuse

Although Amerigroup focuses heavily on prepayment activities, we use proactive, data analysis driven, post-payment review to identify erroneously billed claims and behaviors that cannot be detected by up-front edits. Our detection systems and resources include the following:

- EDIWatch, a retrospective, rules-based system that detects anomalies in data using thousands of statistics, algorithms, rules, and patterns; trend reports identify outliers and overutilization patterns
- State-based and national medical management staff available for training and analysis
- Facility site information
- Membership information
- Medical record reviews
- Field staff information
- Electronic Visit Verification (EVV) for HCBS
- Information databases, such as:
 - LexisNexis
 - Accurint for Insurance (Public Records)
 - CPT-Inquiry Services
 - National HealthCare Anti-Fraud Association Special Investigations Resource and Intelligence System

Amerigroup conducts clinical reviews prospectively through prior authorization of select services, point-of-dispensing reviews at network pharmacies, and during Case Manager contacts with members enrolled in case management. We refer suspicion of fraud, waste or abuse to our national Medicaid Special Investigations Unit or the Program Integrity Officer for investigation.

- Amerigroup's prior authorization process requires Utilization Management employees to comprehensively and continuously review case records and assess member needs.
- Case Managers confirm member's receipt of services as authorized in the member's care plan during contact with the member, family members or the member's legally appointed representative.
- We also conduct retrospective clinical reviews during the claims process and medication therapy management programs that address potential cases of provider and member fraud, waste, and abuse.

Reporting Fraud, Waste and Abuse

Amerigroup encourages and promotes multiple avenues for reporting suspected fraud, waste and abuse activities both internally and externally. Methods available for reporting include our toll-free number, the Corporate Compliance Hotline, our email address Medicaidfraud@amerigroup.com, or the fraud, waste and abuse reporting links on our website. Referrals may come from members, providers, employees, law enforcement agencies, or professional organizations. We notify members and providers of our fraud waste and abuse initiatives at enrollment and during contracting. We use newsletters to remind members and providers of the mechanisms to report suspicions of fraud, waste and abuse, as well as monthly tips to all our employees. Our analysts, tools, and referrals allow us to detect fraud, waste and abuse that we then categorize and prioritize for investigation based on the severity, financial impact, and quality of care impact.

Program Effectiveness and Implementing Best Practices Reporting

We routinely monitor and measure our compliance program, including fraud, waste and abuse to make sure that activities and initiatives are conducted in a manner and within a framework that supports an effective compliance plan. We also use these monitors and measures to validate that controls are in place to mitigate targeted compliance risks, including those that may arise in connection with operations areas across our health plan: medical management (utilization, case and care management); marketing and enrollment; payments from federal and state regulatory agencies; data submissions and other reporting; quality management; accreditation and access to care; complaints, appeals, and grievances; claims payment; relationships with providers and contractors; subcontractor oversight; and privacy of protected information.

The oversight and support from our national Medicaid Special Investigations (SIU) Unit will enable us to implement best practices developed from the experiences of all 19 affiliate health plans. As we identify new processes, tools, and best practices, we adjust our program accordingly. This collaboration also provides our local investigators with a backup network of experienced investigators to further support Iowa activities. Amerigroup's Medicaid SIU also collaborates internally with the Medicare and Commercial SIUs to obtain best practices across the entire company. We do not share protected health information; rather, we take advantage of best practices that will result in improved integrity for the Iowa Initiative..

Tools and Systems (12.2.1.2)

Prevention is at the heart of our approach to fraud, waste and abuse, and we demonstrate this through strict vetting practices, strong contract provisions, and significant investment in education and training. Amerigroup deploys state-of-the art detection tools and systems that are applied prior to claim payment; during post-payment claim review, data mining, and referral follow-up; and when monitoring new fraud schemes identified by various organizations. We will configure Iowa-specific algorithms, detection tools, and systems and will add to them proven data analytics from our markets and vast experience bringing a first class solution to Iowa.

Prohibited Affiliations and Exclusions

Amerigroup will adhere to all federal requirements found in 42 C.F.R 1002 and the Iowa Contract with respect to excluded or disbarred providers and employees. We screen entities against the following entities:

- Office of Inspector General List of Excluded Individuals/Entities
- State-specific Exclusion Database
- The System of Award Management
- Other applicable sites as may be determined by each state where we operate

Monthly protocols are in place to process exclusions and debarments that occur after the initial screening or credentialing and before mandatory periodic screenings or credentialing. We will report exclusion information discovered during screening with three business days to DHS and will include in the comprehensive listing as required by DHS.

Watch Lists

Amerigroup establishes “Watch Lists” based on recurrent themes our Medicaid SIU has identified through trending and analysis of our affiliates’ business across the country. The Watch Lists identify common schemes pervasive in all markets as well as aberrances not yet seen in certain states, giving us the opportunity to monitor issues that may appear in the future. We will use this expertise when we review Iowa claims data. Using advanced data analytics and the experience of our entire investigative team, we extract multiple data sets periodically and match them with paid claims across all of our Medicaid affiliate health plans. We search for local aberrances as well as national fraud trends.

Medical Record Requirements

The basis for the majority of fraud detection systems is the medical record. Amerigroup has policies and procedures to maintain, or require providers and contractors to maintain, an individual medical record for each member that meets the specifications outlined in Scope of Work (SOW) Section 15.6.

Investigating Fraud, Waste and Abuse Allegations

Our Iowa Program Integrity Officer has primary responsibility for the investigative process, serving as the primary contact for identified issues and leading all investigative efforts, in conjunction with the Medicaid SIU, for any potentially fraudulent or abusive claim or issue. When our investigators or other staff within the Medicaid SIU receives a referral for investigation, they enter it into the Case Information Management System database, where it is assigned a Medicaid SIU case or lead number. Our investigators follow a formal process for investigating all possible fraud and abuse, as outlined in Table 12.2-2.

Table 12.2-2. Investigators Follow a Formal Process to Evaluate Potential Fraud and Abuse

Step	Activities
Detection and Referral	In this stage, suspected fraud and abuse is detected and the Medicaid SIU is notified.
Initial Assessment	The primary goal of assessing the lead is to firmly establish predication and the need for additional investigation. The investigator reviews the information gathered to date and accumulates any additional information needed in the initial screening process.
Investigative Strategy	If the need for additional investigation is established, we create an investigative plan and assess case prioritization. During this vital stage, the logical and appropriate investigative measures are mapped out.
Information Gathering	The investigator uses all available, legal, and appropriate measures to gather information. At this time, data is analyzed, interviews are conducted, records are obtained and reviewed, and utilization histories are scrutinized. Investigations are in-depth and can include contract and credentialing reviews; licensure validation; data analysis; medical record audits; interviews with members, providers, and office staff; on-site office visits; Internet research; or collaboration with other health plans.
Evaluation of Evidence	All of the evidence that has been collected is evaluated to determine if there is reasonable evidence that fraud or abuse has occurred.
Determination of Action	At this point, the investigator, possibly in conjunction with legal counsel, must determine if and how to pursue with the case.
Civil/Criminal Proceedings	Finally, if appropriate, the investigator will meet with the attorney responsible for litigation of the case. Typically, this stage of the investigation is worked in tandem with the law enforcement agency prosecuting the case. The investigator often becomes the expert on the case, as he or she is familiar with all details and evidence, and assists with analysis, evidence gathering, and testimony, if requested.

The results of these investigations are shared with the Program Integrity Officer, the Program Integrity Committee, and other senior-level executives who review the findings to ensure they are aware of major findings and to also identify edits and potential policy changes to prevent future inappropriate payments.

The Program Integrity Officer and Medicaid SIU meet regularly to discuss matters of potential fraud, waste and abuse and preventive measures.

Determining and Implementing Corrective Actions

Once confirmed, Amerigroup, in partnership with the State Medicaid agency and Medicaid Fraud Control Unit (MFCU), takes appropriate action to address reports of potential fraud, waste, and abuse depending on the scope and severity of the situation. We design each corrective action plan specific to the provider and nature of allegation. In doing so, we tap into our knowledge of and experience with the local provider community, setting Amerigroup apart from other health plans that apply a rigid, inflexible approach.

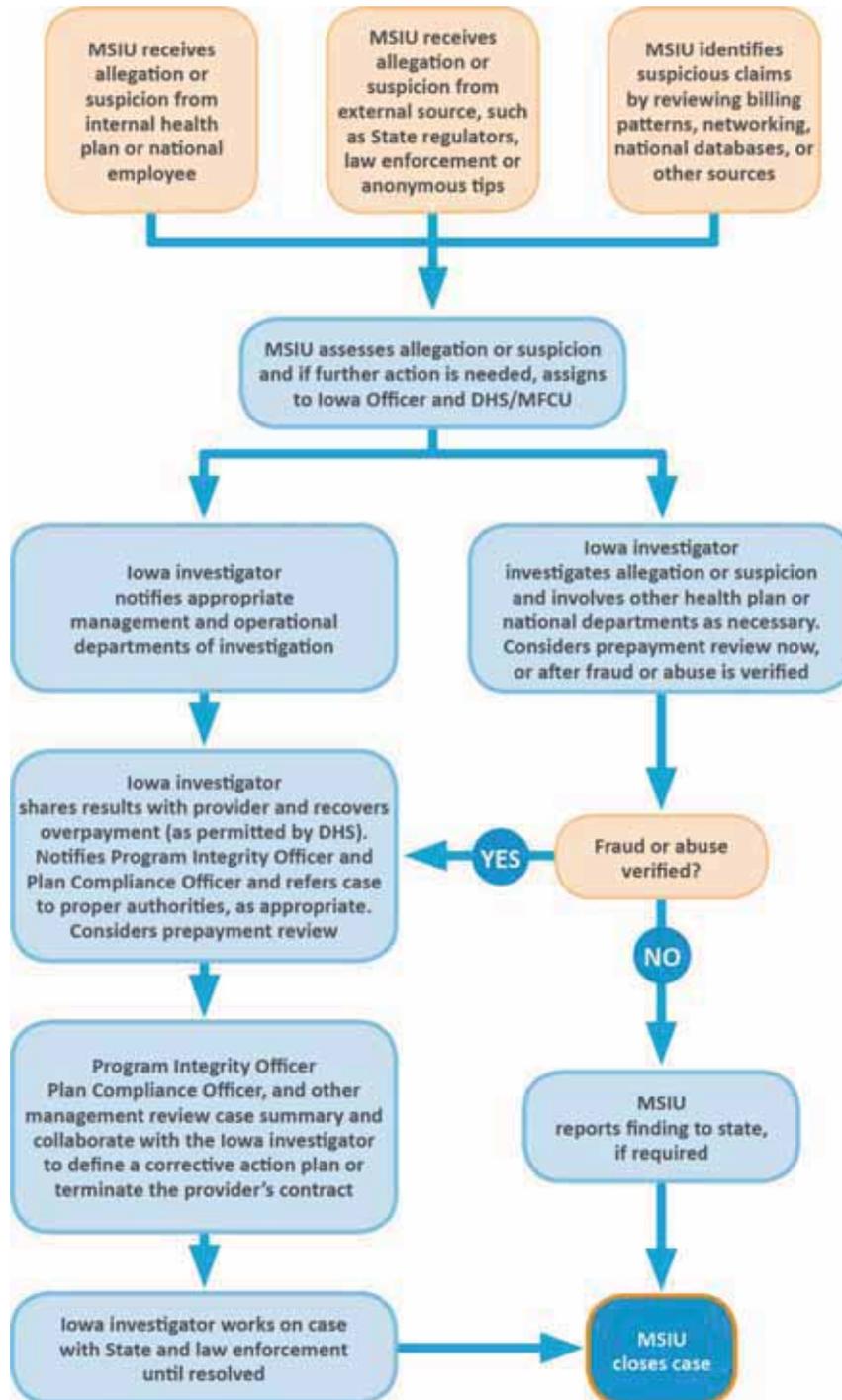
Based on the results of the investigation, we take appropriate action, which may include the following:

- **Provider letter.** Upon review by the Program Integrity Officer and Medicaid SIU management, we send certified letters to providers that document the findings and the need for improvement, and we request a timely response. We base further action on the provider's response or lack thereof.
- **Education.** Depending on the nature of the case, additional and targeted education may be directed at staff, providers, and members.
- **Medical record audits.** Our team, including clinicians, may review medical records to validate claims submissions.
- **Member lock-in.** Restricting a member to a single pharmacy and/or PCP to prevent duplicate and inappropriate drug therapies or assigning a member who sees multiple providers to a single primary care provider tends to result in reduced instances of fraud, waste, and abuse.
- **Prepayment review.** When billing issues are egregious or a provider fails to comply despite intervention, the provider may be placed on prepayment for further monitoring and evaluation. Certified Professional Coders within the Medicaid SIU review submitted medical records to verify that the services documented support the services billed on the claim forms.
- **Self Audits.** When aberrancies are detected Amerigroup may request that a provider conduct a self audit to identify billing errors and take corrective action to prevent future inappropriate payments.
- **Recoupment of overpayments.** Amerigroup may seek recoveries through either direct reimbursement by the provider to Amerigroup or through a recovery process.
- **Reporting the provider.** Amerigroup may report the provider to the appropriate legal or regulatory agency and medical board.
- **Corrective Action Plans.** Amerigroup prepares and requests providers sign a Corrective Action Plan, confirming the understanding of the changes they need to make to come into compliance.
- **Termination of the provider.** We may terminate from our network any providers who fail to comply with program policy and procedures or who violate the Contract in any way.

The Medical Director may also present a provider to our Peer Review Subcommittee for quality of care disciplinary action. Our ultimate goal is to educate providers, not penalize them, for aberrant practice patterns. We perform a follow-up review on these providers after six months and report any savings resulting from the action or education. When a situation arises that may lead to provider termination from our network, we terminate the provider if such a measure is in the best interest of our members and the State.

Figure 12.2-1 illustrates our process flow from allegations or suspicions through investigation and case closure.

Figure 12.2-1. Process Flow from Allegations or Suspicions through Investigation and Case Closure



Roles and Responsibilities of the Compliance Officer (12.2.1.3 - 12.2.1.13)

As previously indicated and in accordance with SOW Sections 12.2.1.3- 12.2.1.1.13 Amerigroup will designate an Iowa Compliance Officer, a Program Integrity Officer, and a Compliance Committee accountable to senior management. The Program Integrity Officer, the Medicaid SIU and other appropriate personnel will be available to meet with State audit and investigations representatives at the frequency required by DHS. Additionally the Amerigroup Program Integrity Officer will:

- Conduct initial and ongoing program integrity trainings for all employees in addition to the annual training that, at a minimum, will include instructions on the False Claims Act, as directed by CMS and written standards for organization
- Maintain effective lines of communications with employees and widely publicize disciplinary guidelines, detailing enforcement standards in a variety of ways, including employee trainings and provider orientations via our website and other documents
- Implement internal oversight activities to monitor and audit program integrity initiatives
- Implement policies and procedures to assure prompt response to detected offenses and the development of corrective action initiatives
- Coordinate with other business owners to assure that information regarding fraud and abuse identification and reporting is included in provider and member materials
- Include program integrity-related goals, objectives and planned activities for the upcoming year in the annual Program Integrity Plan
- Assure compliance with 42 CFR 455 including timeframes for implementing and completion
- Establish a process to coordinate with DHS Program Integrity to remove incarcerated, deceased, or incorrectly enrolled members or providers.

Required Fraud and Abuse Activities (12.3)

Question 12, #2

2. Provide examples of outcomes achieved in other states regarding program integrity efforts.

Activities (12.3.1)

In accordance with SOW Section 12.3, Amerigroup will deploy a team trained and experienced individuals to manage our fraud, waste, and abuse program both at the national and local plan level. Our teams comprise former law enforcement officers, former Medicaid regulators (federal and state level), and a wide variety of other experienced healthcare investigators. Our current Medicaid SIU Director is also an Accredited Healthcare Fraud Investigator, a Certified Fraud Examiner, and a certified Health Care Anti-Fraud Associate. This wide ranging and diverse set of expertise has allowed us to implement a best-in-class approach to detecting and reducing Medicaid fraud and positions us to be fully compliant with all required activities.

The Medicaid SIU is an internal proprietary function fully dedicated to the detection, prevention, and prosecution of fraud and abuse across Amerigroup and its affiliate health plans' state-sponsored programs. The unit is physically separate from the Claims and Operations Departments, administratively reporting to the national Medicaid Compliance Officer with dedicated investigation resources to each state health plan.

In calendar year 2014, our Medicaid SIU opened a total of 1,200 fraud, waste and abuse cases and identified over \$33,864,899.97 in suspected fraud, waste and abuse activities across our affiliate health plans. We recovered \$3,511,948.62 and avoided payments of \$25.4 million, resulting in net savings of \$28.9 million, which equates to a return on investment of approximately 9-1 as compared to the national average of 8-1.

The Medicaid SIU maintains strong working relationships across our national support functions and will extend that to local Iowa leadership, including the Program Integrity Officer, to effectively prevent, detect, investigate, and report fraud, waste and abuse. The Program Integrity Officer will work closely with the following staff, who lead our national efforts for fraud and abuse activities. There will be an Iowa dedicated investigator who will bring years of healthcare fraud investigation experience to bear for Iowa and build relationships within the DHS, MFCU, and other Managed Care Organizations.

Mary Beach has been a Director of the Medicaid SIU, since 2007. Ms. Beach brings over 30 years of healthcare fraud investigation experience and is an Accredited HealthCare Fraud Investigator, a Certified Fraud Examiner, and a Health Care Anti-Fraud Associate. She served on the Board of Directors for the National Health Care Anti-fraud Association and currently represents Amerigroup on the CMS Public Private Healthcare Fraud Prevention Partnership.

Bob Mays is also a Director of the Medicaid SIU. Mr. Mays has over 33 years of fraud investigation experience with many years of white collar crime investigations including healthcare fraud investigations in Medicaid and Medicare. He is an Accredited HealthCare Fraud Investigator, a Certified Fraud Examiner, and the recipient of the FBI Directors Award in 2008 for distinguished public service in healthcare fraud. He holds a Master's of Science degree in Public Administration. He serves on several committees and is a frequent instructor for the National Health Care Anti-fraud Association and currently represents our parent company, Anthem, on the CMS Public Private Healthcare Fraud Prevention Partnership.

Examples of Outcomes Achieved (12.3.1)

Below are examples of fraud, waste and abuse activities detected and pursued by some of our affiliate health plans. These examples highlight the experience we have in investigating Medicaid healthcare fraud in many Medicaid state programs and will leverage that experience for Iowa. These examples illustrate different methods of detection, degree of difficulty, types of investigations, and actions taken.

Home Health Services: This resulted from a member complaint that she had not seen her caregiver in several months. Initial review indicated that the provider had billed our affiliate health plan for services during the time period that the member had reported no services. The Medicaid SIU launched an investigation and requested the member's non-clinical, personal care records. The records were audited for appropriateness. The audit found the attendant timesheets for each of the four caregivers showed deficiencies. Dates were missing or changed, member signatures were vastly different from known samples, member and employee names were crossed through or changed, and signature lines were distorted. The Medicaid SIU identified an overpayment of \$7,883.95

- **How Detected:** Member Complaint
- **Action Taken:** Due to the significant findings of the initial audit, the Medicaid SIU extracted a sample from the attendant care agency's entire universe of claims. The provider's records were audited to determine if they were sufficiently detailed to substantiate the date, time, eligible recipient's name, level, and quantity of services. The Medicaid SIU also reviewed services billed on the basis of time units to determine if time spent with the eligible recipient was sufficiently documented. The results indicated inaccurate billing. Dates of service were denied as follows:
 - Inconsistent Signatures between Comparable Documents
 - No Documentation Submitted to Support the Requested Dates of Service

- No Personal Care Services Documented
- Altered Employee Signature Line & Inconsistent Markings
- Altered Dates on Signature Lines
- Copied Signatures and Dates
- No Personal Care Services Documented & Inconsistent Signatures

Once the audit was complete, an extrapolated overpayment of \$129,921.00 was identified. The Medicaid SIU recovered \$86,694.75 before the provider declared bankruptcy. The allegations were referred to the States Human Services Department and the Attorney General's Office, Medicaid Fraud Control Unit.

Home Health Services: Acting on a member complaint and proactive initiative, the Medicaid SIU investigated and substantiated allegations of services not rendered, time travel discrepancies, altered timesheets, and inconsistent or non-existent member/caregiver signatures for billed attendant care services. Two audits were performed. Records were requested from the home health agency to support billed visits and audited by the Medicaid SIU to determine appropriateness. Based upon the review, multiple dates of services were not supported by complete or accurate information.

- **How Detected:** Member complaint and retrospective claims audit
- **Action Taken:** Subsequent to members' complaint, the Medicaid SIU had already launched an investigation and discovered:
 - Inconsistent Signatures between Comparable Documents
 - Caregiver's Signature Missing
 - Inappropriate Markings Between Comparable Documents
 - Services Not Rendered
 - Incorrect Dates
 - Inconsistent Signature(s)/Caregiver and Member
 - Caregiver Signature Missing/Member "unable to sign"

An overpayment was calculated based on the audit results. The overpayment was \$80,236.38. The allegations were referred to the New Mexico Human Services Department and the Attorney General's Office, Medicaid Fraud Control Unit.

Physicians: In July of 2013, the Medicaid SIU was contacted by the New York city Human Resources Administration (HRA), Office of Investigations, Revenue, and Enforcement Administration; Bureau of Fraud Investigations. The HRA was conducting an ongoing fraud investigation and requested two Amerigroup Medicaid ID cards for an undercover operation. The Medicaid SIU worked in conjunction with the appropriate functional unit to create the "undercover" ID cards.

- **How Detected:** External Referral/Collaboration with a State Agency
- **Actions Taken:** Amerigroup created the cards and began authorizing services and making payments approximately every three to four months. The Medicaid SIU received requests from the HRA for medical and prescription claims for the two "undercover" IDs to track office visits and the associated prescription claims. In February 2014, HRA sent a request to the Medicaid SIU for copies of the checks sent to the providers who submitted claims using the "undercover" ID to the affiliate health plan. On February 3, 2015, the Medicaid SIU received a subpoena to appear in front of the Grand Jury and validate the Amerigroup claims and payment data. A Senior Investigator appeared before the Grand Jury on February 19, 2015. Arrests were made on April 1, 2015, and the press release indicated the providers were involved in a \$7 million fraud scheme. The Medicaid SIU will continue to work with the local District Attorney's office as this case moves forward. The Medicaid SIU will also verify if any of the other providers arrested are in the Amerigroup network and determine exposure. The Medicaid SIU will realize approximately \$1.4 million in costs of care savings associated with this investigation.

Home Health Agency: Acting on a referral the FBI, a multi jurisdictional task force launched an investigation regarding allegations of fraudulent billing by a home health agency for members served by one of our affiliate health plans

- **How Detected:** External Referral from Law Enforcement
- **Actions Taken:** As directed by the task forces, the health plan created a “fake” authorization for home health services for a member who was working undercover as an FBI informant. The provider used the “fake” authorization to bill Amerigroup for services not rendered, giving the FBI enough information to make an arrest. After the arrest, the FBI met with the local team to discuss ongoing collaboration and present commendations to two of our investigators for “outstanding work”.

Federally Qualified Health Center: Using data analytics, including EDIWatch, Amerigroup discovered that a provider submitted duplicate claims for clinic visits using an all-inclusive code, T1015. The duplicate billings were not immediately detected by the claims processing system because the provider used different place of service codes for the visits.

- **How Detected:** Proactive advanced data analytics
- **Actions Taken:** Referred the allegations to the State Medicaid agency and the MFCU. Amerigroup recovered all duplicate payments and the provider was placed on prepayment review whereby all claims were reviewed prior to payment. We shared results of the investigation with other MCOs in the marketplace.

Hospital: Using data analytics, an affiliate health plan discovered that a hospital provider submitted claims for identical services on the same dates of services for the same patient. The duplication of services was not immediately detected by the claims processing system because the provider used different identification numbers for each claim. Our affiliate determined that the provider was overpaid \$27,421.81.

- **How Detected:** Proactive advanced data analytics
- **Actions Taken:** Referred the allegations to the Medicaid agency and Amerigroup recouped the funds from all duplicate claims by offsetting future claims payments. We shared results of the investigation with other MCOs in the marketplace.

Ambulance/Behavioral Health: Using data analytics and cooperation from employees in one of our affiliate health plans, we identified a significant number of Basic Life Support ambulance services with no corresponding medical service claims. A review of transportation logs from a sample of ambulance providers identified common behavioral health provider destinations. During surveillance, Medicaid SIU investigators observed a number of questionable practices of up to five members transported in the same ambulance per ride, transportation provided in van then billed as ambulance services, and members being transported in an unsafe manner.

- **How Detected:** Referral from health plan, advanced data analytics, and members interviews
- **Actions Taken:** A total of 44 investigations were initiated and 11 ambulance providers and six behavioral health providers were terminated from the network. To date, 40 ambulance providers and six behavioral health providers have been referred to the state for credible allegations of fraud. This investigation is ongoing. Overpayment of approximately \$12 million has been identified and approximately \$12.3 million in inappropriate expenditures were avoided. We also contacted Adult Protective Services.

Psychologist: After receiving an allegation that a provider was billing under another provider's name, data mining revealed a provider in an affiliate health plan was billing psychotherapy services for members as young as 18 months. The data was sorted by name and revealed excessive billings for a core group of

about 17 members. Submitted claims indicated that some of these members were seen six days per week. The investigation found that the provider was unbundling group psychotherapy services and submitting claims for individual therapy sessions.

- **How Detected:** Allegation submitted via email
- **Actions Taken:** All identified overpayments were recovered. Notifications were made to the appropriate state agencies, and the provider was placed on prepayment review with all claims reviewed prior to payment.

Our parent company, Anthem, is represented on the National Health Care Anti-Fraud Association Membership Forum. In this capacity, Anthem has regular interaction with the NHCAA Law Enforcement Liaisons such as the National Association of Medicaid Fraud Control Units, U.S. Department of Health and Human Services, U.S. Department of Justice, National Association of Attorneys General, National Association of Insurance Commissioners, FBI/Office of Inspector General Fraud Task Forces, and other federal and state agencies and units. We are able to leverage these relationships, expertise, and contacts to implement and maintain a best-in-class program that incorporates all elements of an effective and result-oriented fraud, waste, and abuse program.

Question 12, #3

3. Describe methods for educating employees, network providers and members on fraud and abuse identification and reporting.

Fraud, Waste, and Abuse Trainings

Appropriate training is key to avoiding fraud, waste, and abuse. We educate our employees, providers, and members on signs of fraud and abuse and how to report suspected cases. Additionally, the Medicaid SIU publishes monthly tips, available on our website and in provider publications, on how to identify and report fraud, waste, and abuse. We use these same mechanisms to widely publicize our disciplinary guidelines and how we enforce standards.

Amerigroup provides each new employee with access to policies and procedures inclusive of fraud, waste and abuse protocols and the Code of Business Conduct and Ethics. The Code promotes compliance with legal obligations; provides guidelines on principles of ethical conduct adopted by Amerigroup; and offers guidance to employees, directors, affiliates, and some subcontractors' expectation regarding standards of lawful and ethical conduct. All employees are responsible for:

- Reviewing and acknowledging compliance with the Amerigroup Compliance Program upon joining the Company and annually thereafter
- Completing training session(s) covering the Compliance Program, the Standards of Ethical Business Conduct, and other compliance-related topics including program integrity
- Reading and understanding the requirements of our policies and procedures related to their day-to-day job responsibilities
- Reporting suspected incidents of non-compliance to a supervisor, manager, or the Plan's Compliance Officer, or directly to the Medicaid SIU through the use of the established hotlines

Amerigroup deploys a comprehensive and multipronged training program for employees, network providers, and members. We tailor our trainings to reflect the environment of our local plans and assure that state-specific requirements are highlighted.

Employee Training

Amerigroup educates all employees on the general definition of fraud, waste, and abuse through our New Employee Orientation Program that occurs within the first 30 days of employment and annually thereafter.

Training modules include:

- Standards of Ethical Business Conduct
- Privacy and Security
- HIPAA mandates
- CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks
- 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance
- Policies and procedures, including reporting requirements, for working with the State Medicaid agency

All employees are required to complete annual refresher training that addresses compliance generally, and includes specific modules on the identification, prevention, and reporting of fraud, waste, and abuse and other topics, including the False Claims Act, as directed by CMS.

Amerigroup further reinforces compliance with fraud and abuse standards through our online training program, which helps claims processors, member service representatives, medical review personnel, and other employees, identify patterns and trends indicating potential fraud. We use the term "red flags" to identify actions that may indicate the potential for fraud. Red flags may include:

- Pressure to adjudicate or process claims quickly
- Threats of legal action for delay in making payments
- Frequent telephone inquiries on claims status
- Assertive providers demanding same-day claim payment and special handling
- Charges submitted with no supporting documentation, such as X-rays or laboratory results
- An individual provider using a post office box as a return address
- Unusual charges for a service
- Unassigned bills that are normally assigned, such as large hospital or surgical bills
- Erasures or alterations
- Helping providers who abuse the system

We provide examples of fraud, waste, and abuse associated with healthcare as part of the educational process and will also include information on ***Iowa-specific Fraud, Waste and Abuse regulations***. Training reinforces that failure to comply with all policies and procedures, including the *Code of Conduct, applicable laws, and/or regulations, may result in corrective action up to and including termination or association with Amerigroup. In some instances, it may also involve civil or criminal sanctions.*

We periodically provide department-specific (Claims, Utilization Review, Quality Assurance) in-service training to Operational Departments by the Medicaid SIU. The training sessions will remind staff to constantly be aware of fraud, waste, and abuse indicators; provide tips and best practice guidelines; and reiterate the varied channels available to report suspicions of fraud, waste, and abuse.

Program Integrity Staff Training

In addition to corporate compliance training, Medicaid SIU employees annually must complete 40 hours of specialized fraud, waste, and abuse training through professional organizations including the National Health Care Association, Association of Certified Fraud Examiners, American Academy of Professional Coders, and the National Health Care Anti-fraud Association (NHCAA). The training can be either in-person or via audio conferences and webinars. It should be noted that several members of the Amerigroup Medicaid SIU management team are frequently invited to participate as instructors at some of these national trainings. The Directors of the Medicaid SIU, Bob Mays and Mary Beach, were both instructors at the March 2015 Investigator Boot Camp. Mary Beach conducted two training sessions at the 2014 Annual Training Conference and previously served on the Board of Directors for NHCAA. Both Directors currently serve on committees of the NHCAA and bring a wealth of networking capabilities as well as over 60 years of investigative experience to lead the Medicaid SIU.

Network Providers

Amerigroup Provider Relations Department employees provide fraud and abuse education to providers during orientation and in-service trainings and through the Provider Manual, e-mail alerts, newsletters, and our provider website. We advise providers and subcontractors of the consequences, including provider termination, of participating and/or contributing to fraud, waste, and abuse via our contractual agreements. We include fraud, waste, and abuse information in the Provider Manual and review it during provider orientation. We periodically include fraud, waste, and abuse training during in-person provider forums and webinar training sessions held during the lunch hour. These have proven to be a convenient and economical way to keep providers informed. We also use blast fax communications to update providers on important fraud, waste and abuse issues. The Provider Manual, quick reference cards, and blast faxes are always available to providers on our website.

Members

We educate members on our fraud, waste, and abuse program in a variety of ways and make sure our members know the channels available to report suspected incidents of fraud, waste, and abuse. We educate members through the following methods:

- **Member Handbook:** The Member Handbook includes an overview of what constitutes fraud, waste, and abuse and instructions on how to report suspected fraud, waste, and abuse activities
- **Member Newsletter:** We will include periodic articles on fraud, waste, and abuse in the member newsletter and will include contact information for reporting suspected fraud, waste, and abuse activities.
- **Explanation of Benefits:** As contractually required, we will provide members with an explanation of benefits monthly that summarizes services billed in the prior month. Members will be instructed to contact us if they believe that the services billed are not reflected of the services used.

Question 12, #4

4. Describe internal controls to ensure claims are submitted and payments are made properly.

Amerigroup uses several automated methods to assure claims are submitted and payments are made properly. Our core operations system audits claims throughout the claim processing cycle, applying program-specific processing rules and validating claim information against system data for members, providers, authorizations, and benefits prior to payment. These methods and systems allow us to validate the appropriateness of healthcare services and assure that billed services were actually provided to

members. Amerigroup will develop specific edits and algorithms for preventing, detecting, and investigating healthcare fraud, waste, and abuse for Iowa.

Pre-payment Review

We use McKesson Corporation's ClaimCheck[®] and the Integration Wizard[®] software to perform prepayment audits on submitted claims. ClaimCheck automatically and comprehensively audits codes before claims are paid. The system identifies the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesiology procedures identified by CPT[®]-4 and HCPCS codes. ClaimCheck's sophisticated clinical logic is based on clinical practice and reimbursement standards, along with the knowledge and judgment of medical experts. The system incorporates clinical coding sources including CPT-4, HCPCS, and ICD-9 Clinical Modification, American Medical Association and CMS guidelines as well as industry standards, medical policy, literature, and academic affiliations

In addition to ClaimCheck, we use a clinical Policy Administration Module, part of the Integration Wizard interface, which addresses claims editing based on published corporate reimbursement policies and national coding standards not currently available in ClaimCheck.

iHealth Technologies is a healthcare analytics company contracted to assist in identifying inappropriately paid claims. iHealth provides pre-payment solution in a real-time environment through a Facets interface. It is similar to McKesson's ClaimCheck with added functionality and flexibility. iHealth applies payment policy accurately and consistently allowing for accurate coding and payment. All professional claims and outpatient facility claims are reviewed during claims adjudication applying the iHealth edits and payment policies. In addition to ClaimCheck, iHealth is employed as a "final filter" before professional and outpatient facility claims are paid.

In addition to the automated prepayments checks the Medicaid SIU has a team of Certified Professional Coders (CPCs), who conduct pre-payment claims reviews. Based on findings from investigations, the Medicaid SIU may place a provider on pre-payment review. Providers placed on pre-payment review status are required to submit medical records with the submission of claims. The medical records are reviewed by a CPC. Should the records not support the services as billed, the claims are denied. Providers are provided information and education regarding documentation requirements and will remain on pre-payment review until the documentation submitted supports the services billed.

Post Payment Review

Amerigroup uses EDIWatch Intelligent Investigator,[™] which is a user-friendly, desktop fraud and abuse detection tool designed specifically for healthcare investigators, SIU management, and support staff. It is a retrospective, rules-based system that detects anomalies in data using thousands of statistics, rules, and patterns. These examinations track many different aspects of healthcare billing and payment activities and identify instances where values fall outside or in excess of norms. EDIWatch Intelligent Investigator rules are based on objective industry reference sets maintained by sources.

In accordance with continuing efforts to improve our processes, the Medicaid SIU recently launched a new project called the Data Analysis Work Group (DAWG). We believe that this enhanced capacity will significantly improve our post-payment review process. The DAWG focuses on proactive data analysis and its membership includes Directors of the Medicaid SIU, the technology manager, a senior data analyst, a coder, and several senior level investigators who have shown a propensity for enhanced data analysis. To date, the DAWG has identified two major projects that are in the initial stages of investigation with the potential for recouping millions of dollars in improperly billed/paid claims as well as avoiding payment of millions of dollars. Below is an overview of the tools used by this team:

- **Analysis and Review:** The group analyzes and discusses current and/or emerging fraud, waste, and abuse schemes occurring nationally and locally, and works to identify patterns that could be indicators of inappropriate billing and indicative of fraud, waste, and abuse trends.
- **Provider Patterns:** The proactive data analysis is performed at the provider level, searching for trends throughout the 19 state markets including trends by provider specialty. Once outlier occurrences are detected, they are assigned to investigators to open a case and conduct an investigation.
- **Tools:** The DAWG sifts through approximately 65 reports generated by EDIWatch as well as other intelligence data to identify aberrant providers billing patterns and inappropriately paid claims. The team also reviews "spike" reports from all 19 markets. The "spike" reports identify providers with significant changes in billing patterns from quarter to quarter, and allows us to quickly identify and investigate aberrant billing patterns using many variables, including provider specialty and geographic area.

Question 12, # 5

5. Describe methods for verifying whether services reimbursed were actually furnished to members as billed by providers.

In addition to the systematic and audits' process in place to detect fraud, waste, and abuse; we work with members, their caregivers, and authorized representatives to verify that services billed were actually provided. Methods deployed include:

- Amerigroup will generate monthly mailing to a random and statically valid sample of members for whom we paid claims in the prior month to verify if services were performed. We may oversample members receiving certain services or certain provider/provider types as a result of trends in the marketplace either nationally or locally. If a member reports that services were not rendered, the information will be forwarded to the Medicaid SIU for verification and further investigation.
- As contractually required and as previously indicated, we will send an explanation of benefits to members that, the EOB notification and will include a request for members to contact us if services billed are not reflective of the services received. All such contacts are routed to the Medicaid SIU for additional follow up.
- For members receiving long-term services and supports, the Community-Based Case Managers will confirm with the member receipt of services as authorized and documented in the member's care plan in our electronic case management system. As with the sample mailings, we may target certain services with higher prevalence of fraud, waste, and abuse activities such as home health services for more frequent and targeted reviews. The Community-Based Case Manager will check service delivery against authorized services and providers, and identify when additional information is needed during contact with the member, family, or the member's legally appointed representative. Cases of suspected fraud, waste, and abuse are routed to the Medicaid SIU for further investigation.

Reporting Fraud and Abuse (12.4)

Amerigroup's Medicaid SIU team has extensive experience reporting fraud or abuse activities to states. We will leverage our existing policies, procedures, and processes and make the modifications necessary to meet Iowa-specific requirements. Specifically, under the leadership of the Iowa Program Integrity Officer, we will report all possible fraud and abuse activities to the State, immediately launch an investigation, and within two days submit the results of our investigations to DHS. We will provide cumulative reports in the format and timeframes prescribed in our contractual agreement with the State and in compliance with all regulatory requirements. We will cooperate fully in any State reviews and/or investigations and subsequent legal actions. All corrective actions from the State or other authorized entities will be immediately implemented.

Coordination of Program Integrity Efforts (12.5)

Amerigroup understands the importance of and values open communication, coordination, and collaboration with other regulatory entities and the efficacy of coordination as we collectively work to reduce instances of fraud, waste and abuse. In each state where our affiliates operate, we establish strong partnerships with regulatory agencies, the Medicaid Fraud Control Unit (MFCU), and law enforcement. Additionally, our Medicaid SIU employees regularly participate in CMS-sponsored fraud, abuse, and waste outreach and education events to provide us with information and insight on the most current trends and tools in healthcare fraud prevention. We have found these to be very beneficial and anticipate an effective partnership in Iowa. Specifically, and in accordance with SOW Sections 12.5 -12.5.1.6, Amerigroup will implement and promote polices to:

- Include language that meets all relevant Contract, state, and federal requirements
- Make available the Iowa Program Integrity Officer, local investigators, and other team members as appropriate to meet monthly with the DHS Program Integrity Unit, Department of Public Health staff, and MFCU staff
- Upon request, provide originals or copies (at no charge) of any and all documentation or information to DHS, the MFCU, U.S. Department of Health and Human Services Office of the Inspector General or the U.S. Department of Justice and/or their designees in a timely manner and in the format requested. We will promote continued adherence to these requirements through our internal policies and procedures
- Within two working days report to the DHS Program Integrity and Medicaid Fraud Control Unit, and other appropriate legal authorities, any evidence indicating the possibility of fraud and abuse by a network provider network
- Annually, submit reports of all investigative activities and corrective actions taken, which will include all mandated data elements and will be submitted in the format and manner prescribed
- Hire and maintain an Iowa-based full-time Iowa Program Integrity Officer who will devote at least 90 percent of his or her time performing the duties and responsibilities as outlined (The Program Integrity Manager will have access to our entire claims and provider payment systems and other system and processes sufficient to meet DHS requirements. Our officer will be the primary liaison with Iowa's MFCU and/or the Office of the Attorney General.)
- As directed by the State, coordinate program integrity activities with other Managed Care Organizations.

Verification of Services Provided (12.6)

In accordance with CFR (a) 42 CFR 455.20, and as currently performed in our other affiliate health plans, Amerigroup will implement a process to verify with members whether services billed by providers were actually provided. A summary of the process follows.

- Monthly, we will randomly select a statically valid sampling of members for whom claims were paid in the prior month. It should be noted that our selected criteria excludes certain “sensitive services” such as any neonate services that resulted in a death.
- Selected members are sent a Member Verification of Services (MVS) letter with bold notification that “This Is Not a Bill”. We further explain that we are sending this information because we paid the identified providers for the service (s) listed under the “Procedure Description Column”. Members are informed that this is informational, and they do not have to do anything unless they did not receive the services listed. If the services listed were not received, they are instructed to contact our Member Services Department. All such calls are logged and /documented, and then routed to the Medicaid SIU for further review and/or investigation in accordance with their standardized protocols. The Medicaid SIU tracks the calls for inclusion in the mandated fraud allegations reports.
- The health plan operations team monitors the status of all MVS letters that were mailed to members and whether or not the mailing resulted in a call that was forwarded to the Medicaid SIU for investigation. This information will be made available to the State in the timeframes and format prescribed, and will include all required data elements.

Obligation to Suspend Payments to Providers (12.7-12.7.1.4)

Our affiliate health plans have implemented compliant Medicaid payment suspension processes in all of our Medicaid markets. We will modify our payment suspension polices and procedures to reflect Iowa-specific requirements. In accordance with SOW Sections 12.7, Amerigroup will suspend all payments to a provider after DHS determines that there is a credible allegation of fraud, unless we receive written directive from DHS, or any of its s authorized agents, not to suspend payments; or we are directed to initiate partial suspension. We will notify providers of the suspension and the reason(s) for the suspension. We will maintain a complete file of all materials related to payment suspensions for a minimum of five years. Additionally we will:

- Afford providers for whom payments have been suspended an opportunity to file a grievance (The provider notice of payment suspension will include information and instructions on the provider suspension grievance process.)
- Include in its provider agreements and/or provider manuals a requirement that providers must comply with Iowa Code 249A Subchapter II –Program Integrity
- Develop and implement a process for referring providers to DHS for sanctions as outlined under 441 IAC 79.2
- Update recoupment policies and procedures to reflect Iowa-specific requirements detailed in Section 12.7.1.4., which will include the requirement to not take any actions to recoup or withhold improperly paid funds or potential payments due to a provider when the issues, services, or the claim for the withhold meet one or more of the identified criteria (Department- and unit-specific standard operating procedures will clearly identify the prohibitions criteria and the Program Integrity Officer will

oversee the internal processes to assure compliance. We will assume responsibility for the external verifications with the IME Program, the State of Iowa, and we will review RAC recoveries prior to initiating any recoveries.)

Required Provider Ownership and Control Disclosures (12.8)

In accordance with SOW Section 12.8, Amerigroup will implement policies and procedures that are complaint with federal laws regarding required provider ownership and control disclosure as detailed in 42 CFR §§455.104, 105, and 106.

Contractor Reporting Obligations for Adverse Actions Taken on Provider Applications for Program Integrity Reasons 42 CFR §455.1002.3 (12.9)

Amerigroup's affiliates have extensive experience establishing a provider network that is adequate and fully compliant with established accreditation standards (NCQA) and federal and state requirements. Our enrollment processes obligate providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). All such disclosures will be immediately forwarded to DHS. Amerigroup will abide by DHS direction regarding admission of any such providers into the network. Specifically, the provider will not be permitted into the network if DHS or Amerigroup determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP; or if DHS or Amerigroup determines that the provider did not fully and accurately make any disclosure required pursuant to 42 CFR § 1001.1001(a)(1).

Termination of Providers (12.10)

In accordance with SOW Section 12.10 and as required by 42 CFR §455.416, Amerigroup will comply with contractual requirements for provider disenrollment and termination.

Enforcement of Iowa Medicaid Program Rules (12.11)

In accordance with SOW Section 12.11, Amerigroup will, by contract, notify providers of our extensive fraud, waste and abuse program. As good stewards of the State's resources, we will use all the tools at our disposal to vigorously pursue fraudulent activities. We will notify DHS of provider activities that may incur sanctions as noted under 441 IAC 79.2(249A).

Information Services & System (13.1)

Question 13.1, #1

1. Provide a general systems description and a systems diagram that describes how each component of your information system will support and interface to support program requirements.

Amerigroup Iowa's (Amerigroup) fully integrated Medicaid Management Information System (MMIS) complies with and will support SOW Section 13.1 requirements. Information systems are critically important to the effective management of clinical and healthcare services. Through our affiliate health plans, we have 24 years of experience managing state-sponsored health programs spanning 19 states, and more than 5.2 million members in programs such as Medicaid, CHIP, and coverage for the uninsured. As a result, we bring a structured, expertly operated, and well-maintained MMIS and best practices that will help deliver a successful Iowa implementation.

A secure state-of-the-art systems infrastructure and high systems reliability are key initiatives of Amerigroup. Our systems hardware and software architecture permits scalability of the technology platform to meet current and future capacity needs. Reliable, secure and easily accessible systems are critical to:

- Facilitating the delivery of quality care
- Providing a platform for utilizing data for better health outcomes
- Delivering the most efficient stewardship of taxpayer dollars in Medicaid service delivery
- Processing prompt payment to providers
- Communicating with members

We assess our architectural framework regularly – both hardware systems and applications software – to assure that they are flexible and scalable to meet future market needs. We maintain and test business continuity and disaster recovery plans to confirm our ability to provide continuous operation in the event of a disruption of any size, including a major disaster.

Medicaid Management Information System Description

Amerigroup's MMIS is built on a managed Medicaid model. We designed our systems to be configured and customized to meet the unique requirements of each state agency. Our integrated MMIS meets federal and state Medicaid requirements and it will support Amerigroup's Iowa operations. It will provide the functionality and capability to meet the processing requirements for the Iowa Initiative and the flexibility to customize to the program's unique needs.

A single, integrated system supports each of our affiliate health plans and accommodates market-specific needs and innovations. This model allows capabilities implemented for one affiliate to be leveraged for other health plan affiliates, which means that the Iowa Initiative can benefit when an enhanced capability is implemented for an affiliate health plan.

In support of the customers, we serve—state agencies, members, and providers—our national Information Systems Department management is fully integrated to support operations, including Claims, Case Management, Provider Data Management, Credentialing, Enrollment, Member and Provider Services, and Program Integrity. Integrating the management of these functions creates a collaborative environment that focuses on implementing technology tools to strengthen customer relationships and drive operational improvements. Our MMIS includes five essential integrated components:

- **Core Operations System**—The Core Operations System will serve as the system of record for all Iowa Initiative provider, member (including enrollment and eligibility), claims, and authorization data. All updates to this information will occur through the user interface or through application-specific data loads such as enrollment files received from the State. All other applications interfacing with the Core Operations System map to its data structures to enable consistency in naming, formatting, and validation and drive data quality and reliability.
- **Care Management System**—Our care management system is the system of record and the core of our clinical care management solution. Our care management system collects, organizes, and presents information enabling management and coordination of member care and supports and facilitates communications among participants of the member's care team. Member utilization data, such as claims history, authorization, immunization records, lab results, and care and disease management data is readily available in an organized format with tools for Care Managers to identify and manage members' needs.

Our Member 360 application consolidates and presents member data and information from various sources into a single record in a series of dashboards designed to deliver a holistic picture of an individual's utilization, Case Management services, and gaps in care. It includes information, such as member health risk assessments (HRAs), care plans, longitudinal health records, and clinical data. Through the provider facing Member 360 tools, providers can see their members' records via the Amerigroup self-service website, giving them simple, easy-to-access data and information to help engage members in their own health and well-being. Integrated data is displayed to make it easy for providers to act, assuring their members receive the services they need. This view enables any provider who treats our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve quality of care. The physician view will enable providers to understand, from a population health perspective, how members are doing and more importantly, get information to help them achieve better results. Member 360 integrates seamlessly with the Core Operations System and our care management system, among others.
- **Member and Provider Websites**—Amerigroup websites will deliver vital information and tools to our Iowa members, providers, and other stakeholders. Provider and member websites have public and secure self-service areas, and industry-standard web services and content management system technologies. Our websites comply with Section 508 of the Rehabilitation Act as well as the more stringent Web Content Accessibility Guidelines (WCAG) 2.0. Our interactive voice response system will deliver additional member and provider self-service tools.
 - Presented in English and Spanish, our member website will deliver information about Amerigroup, the Iowa Initiative program, and include self-service tools such as allowing members to submit questions, search for providers via an interactive online Provider Directory, and request an ID card.
 - Effective provider collaboration and support is critical to maintaining a partnership that can improve care coordination, operational efficiency, and improve member outcomes and health. The public pages of the provider website will contain information about our network and basic information and tools such as our Provider Manual and reimbursement policies. Our secure provider website enables providers and their authorized delegates to submit claims and prior authorization requests, view claims status and prior authorizations, access member eligibility data, view panel lists, update their own demographic information, and access Member 360. Amerigroup partners with Availity, a multi-payer portal, to maximize usability and administrative simplicity for our providers. Availity enables them to conduct transactions and exchange information with many payers through a common portal through a single sign-on.
- **Data Warehouses**— Our data warehouses support processes and functions within our MMIS. They are fed directly from the source (for example, the Core Operations System) to enable data quality,

control, and consistency. The data warehouses maximize our capacity for data analytics and afford the flexibility to produce targeted reporting to support state customers, business processes, and enhance provider and member support.

- **Supplemental Applications**—Our MMIS also includes numerous integrated surround applications that support the overall functionality of Medicaid managed care, including provider profiling, EPSDT, HEDIS, member ID cards, PCP assignment, credentialing, imaging and workflow, desktop integration for contact center efficiency, and workforce management. Dashboards/business intelligence analytical reporting and other supplemental applications maximize functionality, efficiency, security, and data analytics.

Through our affiliates, we already transact all of the interfaces identified by DHS in the RFP requirements with various state agencies and their agents, including incoming and outgoing enrollment and eligibility data, claims and encounters, provider data, third party liability, and specialized extracts as required. As shown in Figure 13.1-1, these existing capabilities will allow us to quickly implement the needed data interfaces with DHS systems, the Enrollment Broker, and other State agents.

A dedicated internal team of highly skilled and experienced technology professionals delivers MMIS support and is committed to providing solutions to best serve members, providers, and State agency customers. As detailed in Section 13.2, a set of business continuity and disaster recovery plans will allow us to deliver continuous operation in the event of a disaster.

We know technology can be a powerful tool that improves operations and delivers measurable impact to members and providers. We continually search for ways to apply existing and new technology to:

- Better understand and enable access to healthcare services and benefits for members
- Ease the operational burden on providers related to claims and authorizations
- Maintain a high level of member and provider satisfaction
- Improve the quality and efficiency of data collection
- Maximize the impact of performance improvement studies and results
- Provide measurable results to the state programs

The following diagrams illustrate our MMIS that will support the Iowa Initiative program. Figure 13.1-1 provides a conceptual overview diagram of our MMIS and shows the flow of information into our MMIS from DHS, members, and providers; the major functional processing components; and the flow of information sent from our MMIS to members, providers, and DHS.

Figure 13.1-2 illustrates the additional integrated applications that support the overall functionality of Medicaid operations, including workflows, business intelligence, analytical reporting, and other supplemental applications that maximize functionality, efficiency, security, and data analytics.

CONTAINS CONFIDENTIAL INFORMATION

Required Functions (13.1.1 – 13.1.19)

Amerigroup has a fully functioning MMIS that integrates member, provider, claim, authorization, and clinical information to deliver all of the required functions described in SOW 13.1.1 – 13.1.9.

Member Database and County of Legal Residency (13.1.1.1 – 13.1.1.2)

Our MMIS serves as the member database and maintains comprehensive information on member demographics and eligibility, using Medicaid state ID numbers – and capturing information on the county of legal residence – based on daily 834 files received from the State.

Comprehensive and accurate member data is critical to the support of a majority of the major operations functions, including claims processing, utilization management, and care management. Our MMIS will load and track eligibility begin and end dates and overall enrollment history (eligibility span) for every Iowa Initiative member, including utilization and expenditure detail for 1915(c) HCBS waiver members, long-term care recipients, and expenditures as required.

Clinical Information (13.1.1.3)

Amerigroup's MMIS will incorporate all of the clinical information captured in member clinical records, as described in Scope of Work (SOW) Section 13.1.13 Clinical Records. Our integrated systems collect and process data related to the member's experience including clinical information such as health assessments, immunizations, lab and pharmacy records, as well as provider, authorization and claims data. All of this data is aggregated within the MMIS, enabling us to provide data as needed—in real-time—and make it available to meet and exceed the reporting requirements for all of the states in which we do business.

Reporting (13.1.1.4)

In accordance with SOW requirement 13.1.1.4, Amerigroup will develop and implement reports as required by the key performance indicators identified to assess our performance as outlined in Section 6.2.3, Section 14, and Tables F1 and F2 in Exhibit F. We track most, if not all, of the data required for the identified performance measures today and are experienced at reporting on this data for the other states in which we do business.

We fully understand DHS' reporting requirements and the operational commitment necessary to meet them. Regulatory compliance is an essential part of our corporate culture, and we work continuously to meet reporting expectations and requirements. We will provide ongoing reports upon request and within the timeframes specified by DHS.

We have a very mature regulatory reporting process that starts with oversight from our Regulatory Services Department, includes identified business ownership and responsibility for each report, and is supported by the Enterprise Reporting team within our Information Systems Department as well as by the data within our MMIS and the reporting tools we have available. We develop and formalize the production of the recurring required reports. These reports follow our development lifecycle, which includes thorough testing as well as programmatic edits and controls to verify the completeness and accuracy of the data. Our operational systems provide a solid foundation for accurate reporting.

In order to meet timely and accurate delivery to the State, we will generate our reports a few days in advance and business owners will perform a quality review. This timing will allow any issues to be identified and resolved prior to the submission of the reports. Additionally, for those reports requiring data certification, this timing will support the reviews necessary for that process.

Claims Processing (13.1.1.5)

Today, our MMIS performs claims processing, authorizations, and payments for all of our markets. Claims processing and payment is an integral part of Amerigroup's Core Operations System and will be performed in accordance with SOW requirement 13.4. Amerigroup accepts paper and electronic claims. We scan paper claims into our document management system and transform them into electronic claim transactions. We receive electronic claims from clearinghouses and our secure provider website.

The claims editing and adjudication processes access a significant amount of data, including member eligibility, provider, prior authorizations, other health insurance information, and previously paid claims.

Processed claims data is input for provider reimbursement (via check or electronic funds transfer) and remittance advice generation (with multiple options for delivery, including paper, website, or HIPAA-compliant 835 data file). Providers can access claims status information directly through our secure provider website and our interactive voice response system. Please see our response to Sections 13.4 and 13.5 for more information on claims processing and claims auditing.

Medication Management (13.1.1.6)

Amerigroup's MMIS stores information about the services provided to our members through the claims submitted by their providers, including pharmacy data in support of Medication Therapy Management (MTM) activities, as described in Section 14.8.4 Pharmacy Reporting. In doing so, we comply with SOW requirement 13.1.1.6.

For example, our national healthcare analytics pharmacy team receives quarterly reports from MTM vendors and evaluates the effectiveness of the program on a semi-annual basis. Our experience with MTM programs in Texas, Kansas, and Louisiana indicates that these programs have resulted in improved outcomes. Some of these outcomes include dramatically improved medication adherence rates and improvement in gaps in care as well as overall safer, more effective medication regimens. Collaboration with providers who are willing to take action leads to healthier members and engaged providers.

Capitation Payment (13.1.1.7)

In accordance with SOW requirement 13.1.1.7, Amerigroup will document receipt and distribution of capitation payments as described in Section 13.3.1.2. Amerigroup has operational processes to reconcile the premium payments with member enrollment each month. Our process compares the 820 premium payment transaction files we receive from the State against member enrollment data provided on the State's 834 file and loaded into our Core Operations System. Each month, the system generates a billing file based on membership in the system. The data is triangulated with the 820 premium files and the raw 834 data. We will notify the State of any discrepancies within 30 days, as required in SOW 13.3.1.2.

Incurred Claims (13.1.1.8)

All clean claims for medical services are loaded into our MMIS. As claims progress through the adjudication cycle, their information is available in an unpaid status to support incurred but not reported tracking. As claims are paid, they become part of the reported set through the payment cycles and associated reporting.

Third Party Liability (13.1.1.9)

Amerigroup maintains data on Third Party Liability (TPL) payments and receipts within our MMIS and includes this data in our annual audited financial report in accordance with SOW Section 2.3.5 and 13.1.1.9. Amerigroup will share information regarding its members with third party payers as specified by DHS and in accordance with 42 CFR 438.208(b). Amerigroup collects and maintains current TPL data in other states today as identified in SOW Section 13.6 Third Party Processing Liability (TPL) Processing.

Further, we acknowledge that Amerigroup will identify, collect, and report third party liability coverage and collection information to the State, in accordance with SOW Section 13.6.3. As third party liability information is a component of capitation rate development, we agree to maintain records regarding third party liability collections and report these collections in the timeframe and format determined by DHS.

Claims Processing Timeliness (13.1.1.10)

Claims processing is part of our Core Operations System. Our claims processing system is configured to meet the requirements presented in Section 13.4.6, including claims payment timeliness standards and out-of-network provider filing limits. Amerigroup will use effective technology and experienced employees to consistently deliver prompt and accurate claims payment. We process large volumes of claims on a timely basis. In 2014, our national Medicaid Division processed more than 60.7 million Medicaid claims, paying 99.77 percent within 30 days. We are confident we can meet Iowa claims processing and payment requirements. We will meet performance targets and submit data and reports as described in Section 14.9.1 and Section 14.9.2.

Critical Incident Data (13.1.1.11)

In accordance with SOW 13.1.1.11, we will track and report critical incidents and unauthorized uses of restrictive interventions through care plan reviews and medical record audits. For example, Amerigroup's Quality of Care/Incident and Sentinel reporting includes date of incident, date reported, type of incident (critical incident/unauthorized use of restraint and seclusion), date of investigation, date of resolution, and outcome. Amerigroup will meet DHS' requirement to maintain critical incident data in our MMIS. As described in Section 10.4, information documented and reported on a critical incident may include, but is not limited to:

- Reporting party
- Member information
- Incident information
- Immediate resolution
- Physical injury/outcome
- Mental health outcome
- Law enforcement participation
- Abuse report
- Location
- Staff review
- Member review
- Equipment and supply review
- Environmental review
- Systemic resolution

Clinical Data (13.1.1.12)

Amerigroup maintains clinical and functional outcomes data to support quality activities and requirements with a combination of the Core Operations System, care management system, Data Warehouses, supplemental applications, and member and provider website components of our MMIS. Our Data Warehouses enable access and analysis of large amounts of data, including one dedicated to HEDIS. Please see our response to Question 13.1.3 for more information on the ways we use data and systems to support our Quality Management and Improvement (QM/QI) Program.

Grievance and Appeals (13.1.1.13)

The Core Operations System and supplemental applications components of our MMIS support our grievance and appeals processing. The Core Operations System is the authoritative host for information on grievances and appeals. We generate required letters and store supporting documentation in our document management system.

Amerigroup has the systems, processes, and resources in place to meet or exceed all grievance system requirements by maintaining documentation and data on clinical reviews, appeals, grievances and complaints and their outcomes, in accordance with SOW Sections 14.3.6 and 14.3.7, Member Grievances

Report, and Member Hearing and Appeals Report, respectively; and SOW Sections 8.15.5.1 and 8.15.5.2, Filing a Grievance or Appeal, and General Process for Appeals, respectively.

Our systems support ongoing tracking of all grievances and appeals via a daily report to designated grievance and appeals personnel of all open and unresolved cases in our system. We monitor status, track timeliness of resolutions, identify and quickly address patterns or concerns, and ultimately improve the quality of care provided to our members. Through this system, we are able to report on the data elements required by Iowa and are prepared to submit all required grievance and appeals information in the required format and timeframes stipulated by the State.

Aggregating and Analyzing Complaint, Grievance, and Appeals Data

Review and analysis of complaint, grievance, and appeals data is an integral part of Amerigroup's Quality Management program. In addition to preparing, reviewing, and submitting required reports to the DHS, our Quality Management Department will conduct a comprehensive review of complaint, grievance, and appeals data each quarter. The review will focus on identifying issues, problems, and trends for presentation to the Quality Management Committee.

Utilization Management (13.1.1.14)

In accordance with SOW Section 11 Utilization Management (UM), Amerigroup will maintain data on services requested, authorized, provided, and denied. We support utilization management requirements within the MMIS including the transition and continuity of care, prior authorization and pre-certification requirements, concurrent reviews, and reports that support utilization management activities and analyses. Some of the key UM requirements and the systems we use to meet them include:

- Prior authorization and pre-certification requirements supported within the Core Operations System
- Concurrent reviews
- Reports supporting utilization management activities and analyses generated primarily from our Data Warehouse with data fed from the Core Operations System
- Transition and continuity of care supported by the Data Warehouse

Our MMIS supports UM functions, such as clinical and concurrent reviews, through census reporting. Through an integrated process for the intake of authorizations, we will receive prior authorization requests from several sources, including the provider website, our custom-built FaxII application, and direct entry into the Core Operations System by our UM nurses. We load prior authorization requests into the Core Operations System and any attachments into our document management system.

We record UM decisions in our Core Operations System and share this information with providers. The prior authorization data is accessed during claims processing and used downstream in our care management system to support care coordination. Please see Section 11 for more information on the way we use systems and data to support our utilization management activities and meet DHS requirements.

Ad Hoc Reporting (13.1.1.15)

Amerigroup has experience meeting ad hoc reporting requirements. The accessibility of our data and availability of tools throughout the organization and within the Information Systems Department enables us to meet DHS' ad hoc reporting requests with a turnaround time averaging no more than five business days. In meeting any reporting request, we check to see if we have delivered something similar in the past that will give us an advantage in meeting the current request. Whether we have performed the request previously or not, our knowledgeable subject matter experts and technical staff bring their experience to bear to meet the reporting request.

Service Referrals (13.1.1.16)

In accordance with SOW requirement 13.1.1.16, Amerigroup will maintain data on member service referrals. Amerigroup can track referrals such as those from a PCP to the emergency room within our MMIS.

Service Specific Information (13.1.1.17)

Amerigroup is able to retrieve information specific to service type, including but not limited to behavioral health, Long-Term Services and Supports (LTSS), pharmacy, inpatient, and outpatient services through various data element indicators such as provider type and specialty, claim type, place of service, diagnosis and procedure codes. We maintain service-specific information through an integrated claims history; this information flows into our Data Warehouse from our Core Operations System and from our delegates. Additionally, we will augment our Data Warehouse with any claims history obtained from the State or Iowa Health Information Network. From the Data Warehouse, we are able to run reports and queries to analyze the services performed including procedures, physician type, behavioral health, and LTSS.

Age Specific Information (13.1.1.18)

In accordance with SOW requirement 13.1.1.18, Amerigroup will maintain data to generate member information by age. We maintain members' dates of birth as part of the demographics captured and received on daily 834 eligibility files and loaded into our MMIS. We take age information into account in innumerable ways; for example, EPSDT programs, reporting, system edits, and validations.

Encounter Data (13.1.1.19)

Amerigroup has a robust encounter management process focused on transmitting and receiving encounter data accurately, securely, and efficiently. The Encounter Management System (EMS) in our MMIS supports encounter data processing and submission. Our encounter data submission process relies on data from our Core Operations System such as member eligibility, provider, and adjudicated claims data, as well as from our data warehouse, which houses our subcontractor encounter claims in order to validate and deliver a comprehensive set of encounter data to the DHS.

Our national Encounter Management Department provides encounter data to all of our state-sponsored health plan affiliates in either HIPAA compliant ASC X12 837 and NCPDP formats or the state's proprietary format, depending on that state's requirements. The team has experience with multiple transmission standards and working with state-designated fiscal agents across our affiliate health plans. We will configure our encounter extract in accordance with DHS' specific requirements.

Processing encounter response files from the State is an important part of the encounter submission process. Information on rejected encounter records is updated in our EMS, and reviewed and remediated before resubmission in a subsequent file. Please see our response to Section 13.5 for additional detail.

We maintain data interfaces with our material subcontractors for pharmacy, vision, and transportation to exchange data in support of program requirements. Amerigroup sends regularly scheduled member eligibility data to each subcontractor to support member access to services. Amerigroup integrates encounter claim data we receive from our subcontractors into our data warehouse to support a variety of processes, including care coordination; encounter data submission; and fraud, waste, and abuse detection. We generate a series of operational reports against this subcontractor data to help us ensure that they are meeting program requirements.

General Systems Requirements (13.1.2)

Amerigroup's MMIS is capable of conforming to the general system requirements identified in SOW Section 13.1.2 including online access; online access to all major files and data elements within the information system; timely processing; daily file updates of member, provider, prior authorization, and claims to be processed; and weekly file updates of reference files and claim payments.

Our integrated MMIS is an online system with real-time user interfaces that enable access to our core data; for example, member, provider, claims management, and care management. There are many ways people may access the MMIS, including by VPN connection, or remotely via mobile technologies, to enable employees in the field to have online, real-time access to data.

Edits, Audits, and Error Tracking (13.1.2.1)

Amerigroup maintains comprehensive automated edits and audits to validate data and meet Contract requirements. Our MMIS tracks errors by type and frequency and maintains detailed audit trails.

Our state partners need the ability to monitor and audit the data, processing, and procedures of the implementation on a regular basis in order to confirm that we meet requirements. We encourage DHS to become active partners in our efforts to actively monitor all information system aspects of managed care operations in Iowa, including data exchanges, individual claims, and reports.

We maintain strict security policies and procedures to protect the personal data of our members and providers. We require anyone given access to the system to use a unique user identifier to gain access to workstations or systems. The access management function also restricts users by varying hierarchical levels of entry based upon system function.

Our MMIS maintains Audit Trails that track changes to source data. Whenever an authorized user makes a change to one of the database tables, the application automatically creates a history of the update transaction. The data is stored in an Audit Table with a before and after picture of the data being updated along with other identifying information, including:

- The unique log-on or terminal identification number of the person who made the change
- The subsystem used to generate the change
- The time and date of the change

Our MMIS is compliant with generally accepted accounting principles (GAAP) as well as the Sarbanes-Oxley Act (SOX).

System Controls and Balancing (13.1.2.2)

Amerigroup's MMIS has a system of controls and balances to make sure data input is accounted for—depending on how the data is received into our system—and outputs are validated. For instance, when loading our 834 enrollment files, we track to record count by checking load reports throughout processing, and we make sure all records are resolved by placing any member who cannot be loaded automatically due to a data issue into a work queue where they are manually addressed and re-queued to load once the issue is resolved. Additionally, we have a membership reconciliation database where we independently reconcile our 834 membership load against the data in our core system outside the actual enrollment processing to balance adds, terms, duplicates, etc.

We use work queues extensively to manage calls routed for resolution and follow-up, claims that do not auto-adjudicate and require manual intervention to process, care management workflow, and many other input items flowing throughout the organization. These queues allow us to track and manage work items so all are recorded and can be managed timely. Similarly, we validate outputs through various means, including manual review and validation for certification, error reports accounting for records that could not go on the report due to hitting data edits, and balancing against operational control totals.

Back-up of Processing and Transaction Files (13.1.2.3)

Question 13.1, #2

2. Describe data back-up processing plans including how data is stored at an off-site location.

In compliance with SOW Section 13.1.2.3, Amerigroup will comply with the following back-up timelines. For other states, we exceed these requirements:

- Twenty-four hour back-up of eligibility verification, enrollment/eligibility update process, and prior authorization processing
- Seventy-two hour back-up of claims processing
- Two-week back-up of all other processes

We have policies and procedures governing system backup, storage, and tracking. Our Infrastructure team manages the regular backups, the documentation and tracking of these backups, and their secure offsite storage. We perform daily, weekly, and monthly full backups to tape and additionally, for certain databases, we take incremental snapshots throughout the day, including those of our core operations system, which contains our member, authorization, and claims data. Tapes are stored offsite with Iron Mountain. Our procedures detail the rotation of tapes to and from Iron Mountain and the documentation and logging maintained to support tracking. In addition to these backups, we have the backups and off-site storage through our business continuity and recovery solutions in our alternate data centers and our high availability solutions.

Our Business Continuity Plans comprise a number of processes and strategies that enable us to maintain business operations and services to our members and providers.

Data Storage Off-site

Our Information Systems Department maintains backup and recovery plans for the types of events that could interrupt operations or cause a loss of data. We regularly back up systems and data and store copies of key files in secure off-site locations. Processes and procedures define steps for backing out transactions, restarting at certain checkpoints, or completely re-running programs.

The majority of the systems, applications, and technology that will support our Iowa program will operate out of data centers located in Virginia Beach and Richmond, Virginia, and each of these data centers have backup sites. Critical systems in Virginia Beach have replicated backups at the Dallas, Texas hot site. Critical production systems in Richmond have standby systems in St. Louis or at IBM Business Continuity and Resiliency Services in Sterling Forest, New York. We invest in the technology and equipment necessary to support our operational and business continuity needs.

In most cases, we maintain mirror images of files so that, if the hardware fails, a system can be automatically switched to operate from those databases. We maintain complete redundancy for all tiers of our Core Operations System, providing a high availability instance in addition to the production and disaster recovery instances.

This high availability solution is located in our primary data center in Virginia Beach, and if there is a non-disaster issue with our MMIS, we are able to switch to it. Likewise, we back up key hardware and communication lines that enable us to switch operations quickly from one piece of hardware to another.

Data Usage (13.1.3)

Question 13.1, #3

3. Describe how clinical data received will be used to manage Providers, assess care being provided to Members, identify new services and implement evidence-based practices.

Amerigroup will deploy a comprehensive, dynamic approach to data collection, evaluation, and analytics to determine how the implementation and operation of the Iowa Initiative will help the State achieve its access and quality-of-care goals. In accordance with SOW Section 13.1.3.1, we will use the data received to manage providers; assess member care including access to care, barriers to care, and quality of care; develop new services to improve access and program cost-effectiveness; and implement evidence-based best practices across the provider network.

For example, one of the most valuable supports we offer our providers is access to the wealth of data we have for our members who access healthcare services. To foster continuity of care and to reduce duplication of services and waste, we collaborate with our providers through sharing data through reports and a secure provider portal. The type of provider drives the type and amount of reporting and access we offer, with PCPs prioritized for information sharing. We facilitate information sharing and collaboration among all providers, offering technology that strengthens the role of the PCP and other providers involved in the care of our members. We offer our providers an array of data and resources such as:

- Interactive Provider website with links to a variety of resources, such as Amerigroup Patient and Medical Supports, Clinical Practice Guidelines, and Office Support. We recently migrated our provider claims and eligibility tools to **Availity**, a multi-payer portal that allows providers to use a single sign-on to access multiple payers. Providers can check eligibility, submit claims, and check claims status through Availity free of charge. Our website includes online copies of Provider Manuals, orientations, and training materials. After secure login, providers can access specific Amerigroup tools, including submitting prior authorization requests and retrieving panel listings.
- Reports to providers on their overall panel allow them to view their success at meeting certain quality measures. A HEDIS Quality Measurement Report Card enables us to engage in improvement discussions with the largest 50 provider groups.
- Preferred Provider Scorecard, a tool we developed to enable staff to implement member service referrals to high-quality providers—those with proven records of quality service and outcomes, such as annual quality audit scores, complaint counts, potential quality of care counts, and critical incident handling timeliness.

Managing Providers

We regularly review the ability of our contracted network to serve our members. We review providers' training, experience, and specialties, as documented in our credentialing files. To monitor service quality, we review quality of care concerns. Some measures allow us to monitor both access to care and quality of services. These measures include HEDIS Scores, administrative data review, grievance and appeals data, and feedback from the Provider Access, Availability, and Satisfaction Intervention Workgroup. We describe each of these below.

- **Routine phone calls** are placed to PCP offices once per year to collect data from the provider regarding appointment availability and hours of operation, including after-hours availability. We document provider responses in our data and analyze the data to confirm compliance, identify any potential quality improvement opportunities, and make sure accurate information is maintained in our data system and the Provider Directory.

- **Annual "Access to Care"** surveys allow us to assess provider compliance with appointment standards, wait time, and after-hours access.
- **Member Helpline** data identify potential compliance issues. For example, if we receive numerous calls regarding a specific provider's inaccessibility, we contact the provider and investigate the situation.
- **Quality of Care concerns** are reviewed and investigated as part of our Quality Management and Improvement Program (QMIP). We review the outcome of Quality of Care concerns, including Peer Review Committee actions, as part of our network monitoring activities.
- **HEDIS® Scores.** The HEDIS hybrid process allows Amerigroup many opportunities to monitor providers. Visits to the providers' offices allow our staff to monitor access and availability. We review medical records for documentation and access to care as well as quality of services.
- **Administrative data review** and annual comprehensive analysis of access and availability are conducted. The review includes analysis of administrative complaints, after-hours availability survey information, appointment access statistics, provider services helpline reports, GeoAccess reports, grievance and appeals data, and provider satisfaction survey results. In the analysis, we use results of telephone and mailed surveys, along with data from other departments, such as Provider Contracting and Database Administration, Operations, Medical Management, and Quality.
- **Grievance and appeals data** identify any trends at an individual provider level regarding adherence to contract requirements.
- **Provider Access, Availability, and Satisfaction Intervention Workgroup** reviews and analyzes the annual data reports, to identify barriers to adequate access, and to develop interventions to improve access and availability. The Quality Management and Improvement (QM/QI) Committee approves the annual analysis and recommendations from the Provider Access, Availability, and Satisfaction Intervention Workgroup and incorporates any changes into the provider contracting and training priorities as needed.

Any findings of provider noncompliance with access and availability standards may result in a variety of interventions, primarily focusing on assisting providers to improve their performance. Our assistance may include working with providers to extend their office hours or expand their practice.

Data-driven Monitoring to Assess Care

Using our integrated MMIS, the Iowa Initiative Program's Medical Director, Quality Management Manager, and Utilization Management Manager will have the ability to objectively and systematically monitor and evaluate member care and services, safety mechanisms and service delivery, including ongoing assessment of performance against program standards. We will assess the quality of care rendered to track members enrolled in the State's programs using provider, member, and stakeholder feedback and quantifiable data. We will employ these evaluation and improvement methods:

- Data-driven monitoring (service utilization, gaps in care)
- System outcomes data (HEDIS®, national core indicators)
- Member feedback
- Programmatic reviews
- Quality of care concerns
- Evidence-based practices

Using Evidence-based Practices to Improve Quality

Amerigroup will use nationally-recognized, evidenced-based guidelines and standards of care to improve member outcomes, minimize unnecessary costs, and gather data from our providers to evaluate their overall performance. We will disseminate clinical practice guidelines through our website and distribute hard copies on request from providers. We will also conduct annual reviews to evaluate provider compliance with clinical practice guidelines, and we will subsequently aggregate and share results with our providers to improve performance and with our committees to address barriers and opportunities. We continuously review this data and meet with members, providers, and stakeholders to discuss quality of care expectations, share data and best practices, collect feedback, and provide resources to improve accountability and quality of care. If providers do not accept accountability or meet quality-of-care expectations, we offer guidance and implement corrective action. If we identify issues related to the quality of care rendered by providers, we will notify DHS and furnish available information to facilitate performance improvement.

Taking Actions to Improve Access to Care

Amerigroup's integrated MMIS enables ongoing monitoring and trending processes that facilitate interventions in a timely manner to address any identified opportunities for improvement. Through our multi-disciplinary QM/QI Committee structure, Amerigroup will conduct routine analysis of these and other data elements to identify opportunities to improve member access to services and quality of care. We will incorporate performance data into our QM/QI Program to:

- Track and monitor performance and quality of care at the aggregate and individual provider and member level
- Identify opportunities for improvement
- Measure the successful implementation of interventions or corrective actions
- Evaluate our effectiveness in meeting our QAPI program goals

Our QM staff will work with providers to inform them on strategies to increase compliance with performance standards, adhere to best practices, and improve member health outcomes. We will also compare our annual and monthly performance measurement results to established minimum standards, NCQA percentiles, our own goals, and those specified by DHS.

Data Management (13.1.3.1)

Amerigroup uses the clinical data we receive to manage the care our members receive effectively. We agree to submit reports based on this data, in compliance with SOW Section 14 Performance Targets and Reporting Requirements. We actively seek out sources for data that we can use to better serve the needs of our members and providers. For example, if we receive immunization data from the State, we will integrate that data as well as any lab results data we may receive into our data warehouse and thus into the information we deliver to our care managers and providers through our care management system and Member 360 to support the care of our Iowa members.

Provider data is another integral part of the MMIS, and the Core Operations System is the authoritative host for provider demographic, network, and contracting data. In many states, we receive provider master files, which we use to identify new Medicaid Providers not currently in our network and support our recruiting efforts. If DHS provides such a file, we will integrate that data into our system and process as well. Additionally, Amerigroup will be in compliance with provider data submission requirements to DHS.

Our Core Operations System maintains comprehensive provider information, including demographic data, provider type, specialty codes, payment information, provider contract status, and affiliations. To support network analysis and our Provider Directory, our provider dataset includes information such as provider

capacity, locations, specialties, office hours, accessibility, and age/gender serviced. Once in the Core Operations System, provider data is available to other systems and processes, including member PCP assignment, claims processing and payment, utilization management (authorizations), and quality management (clinical service management). Provider data also feeds our Data Warehouse for reporting and analysis, including reporting that demonstrates compliance with member access standards.

Data Accessibility (13.1.3.2)

Amerigroup agrees to make data available to DHS and CMS as requested. In accordance with 42 CFR 438, subpart H, we will submit all data, including encounter claims, signed by Amerigroup's Financial Officer or authorized executive leadership attesting to the accuracy, truthfulness, and completeness of Amerigroup's data in the manner and timeframe requested by DHS. We are accustomed to making data available for our state partners including encounter data, regulatory reports, and other data TPL data provisioning requirements, provider provisioning requirements, and all others as required.

Amerigroup will Certify Data Provided to the State

Amerigroup acknowledges our understanding of the DHS requirement to certify data and documents submitted to the State. The certification will attest, based on the best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of documents and data submitted to the State.

Amerigroup will submit the certification concurrently with the certified data and document. Data will be certified by the Amerigroup Iowa CEO or his or her designee.

System Adaptability (13.1.4)

Amerigroup expects that technical requirements may change over the life of our contract. To that end, our MMIS not only maintains sufficient capability and capacity to meet and exceed DHS' requirements, but the system is also capable of adapting to new technical requirements established by the State.

With the support of our national Information Systems Department, Amerigroup will have the resources necessary to make modifications to the claims processing edits or expansion of MMIS capabilities.

Amerigroup assigns a Customer Account Manager (CAM) as the technical liaison and single technical point-of-contact for the State. This Customer Account Manager attends regular State meetings and provides an accountable conduit into Amerigroup for State technical personnel.

Our national Information Systems Department comprises highly skilled and dedicated technology professionals experienced in managed healthcare information technology and committed to delivering real solutions to State customers. Within the Department, the average tenure of an employee is more than seven years, and 35 percent have more than eight years with the company. The Iowa implementation – and subsequent modification support – will be performed by a team with significant experience adapting and configuring our MMIS to support State programs. Operating a single MMIS across our state-sponsored health plan affiliates provides many key benefits and features to include:

- Resources and technology investments that are focused on common integrated platforms
- The ability to leverage technology investments and enhancements for one state health plan to others
- A broad and deep knowledge base across business operations and technical employees
- Best practices that can be shared across our National Medicaid Division

Our Information Systems Department consistently seeks opportunities to enhance system performance, capabilities, and functionality and to conform to future federal or State standards. We identify system changes in a variety of ways, including those needed to support new requirements, correct an issue, or respond to changing business needs. Our defined Change Management process governs the development and testing of changes and deployment to production, and confirms that changes are appropriate and implemented correctly.

Amerigroup will respond to Iowa changes by successfully introducing the necessary modifications to production environments. We measure success as a balance of timeliness and completeness of change implementation with minimal disruption to systems, services, environment, or stakeholders, members, providers, and State agency staff. Our process also dictates that appropriate details of changes to information technology resources must be recorded, and those changes assessed, approved, implemented, and reviewed in a controlled and secure manner.

We tightly integrate our MMIS change management and production control operations processes with our Systems Development Life Cycle (SDLC) methodology. Besides the traditional waterfall SDLC, we also use iterative software development methods, allowing us to choose the best methodology for each situation. For system changes, we develop an implementation plan that includes a timeline, milestones, dependencies, and risks. Development follows a process that includes standards for requirements gathering, analysis, design, tests, and implementation.

Information System Plan (13.1.5)

Question 13.1, #4

4. Submit a draft Information Systems Plan as described in Section 13.1.5.

Amerigroup has included its draft Information Systems Plan as Attachment 13.1.5-1 for receiving, creating, accessing, storing, and transmitting health information data. It is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 160, 162 and 164 and the HIPAA Security Rule at 45 CFR 164.308). In accordance with SOW Section 13.1.5.1 – 13.1.5.7, Amerigroup will comply with the requirements pertaining to the Information Systems Plan including:

- Planning, developing, testing, and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets
- Concurrently using multiple versions of electronic transaction standards and code sets
- Registering and certifying new and existing trading partners
- Creating, maintaining, and distributing transaction companion guides for trading partners.
- Providing its proposed staffing plan for the electronic data interchange help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates
- Adhering to all HIPAA Privacy and Security Rules, state, and federal laws
- Applying the strategies used for our affiliate health plans for maintaining the most current information related to HIPAA mandates and defined or expected future compliance deadlines

We understand that a final plan, incorporating any changes requested by DHS, must be submitted within 30 days after the official submission of the draft plan, which will occur within 15 days of Contract execution.

Information System Staffing Model (13.1.6)

Question 13.1, #5

5. Describe your proposed information systems staffing model.

The Information Systems (IS) Department supports multiple disciplines, including programming, analysis, database management, website development, systems engineering, telecommunications, operations, network engineering, technical support, security, quality assurance, project management, and contract and financial management. Our IS employees are focused on the development, support, maintenance, and operation of our systems and infrastructure. In addition to being information technology professionals, IS employees are also experienced and knowledgeable in healthcare.

Our national Information Systems Department organizational structure is built on a model that centralizes common capabilities and infrastructure to minimize risk and improve economies of scale. The Department maintains some capabilities, such as application services, with a dedicated team centralized in individual business lines. For Iowa, this means that we perform key MMIS functions using a team of more than 1,200 technology professionals who are not only highly skilled in information technology, but also experienced in managed healthcare in the Medicaid environment.

This organizational structure sharpens our focus on the customers we serve—members, providers, and State agencies. We integrate Information Systems with our operations, including Claims, Care Management, Provider Data Management, Credentialing, Enrollment, and Member Services. By partnering technology and operations staff, we leverage the talents and experience of both while meeting Iowa requirements and delivering a cohesive solution.

Our national Vice President of Information Systems maintains direct responsibility for our National Medicaid Division's integrated, comprehensive managed Medicaid technology platform and monitors its integration with the enterprise-wide shared service areas, such as security and compliance.

Amerigroup will provide Iowa and its designees a primary technical point of contact to facilitate communication and assure timely response to all issues.

The differentiator for Amerigroup is the tight integration of this Department with our business operations departments. Our experience has demonstrated to us that complete coordination between the functions that the business units perform with the technology used to support them delivers the best value to our state partners. Our business operations staff works side-by-side with the Information Systems Department to define, test, and deliver a cohesive MMIS to support state Medicaid operations. Technology support for all health plans emanates from the corporate Information Systems team. Field Service Technicians located at each health plan provide onsite desktop and technology support.

We recognize the value of technology employees to smooth health plan operations. The Information Systems Department strives to hire experienced information technology professionals with a background in healthcare. We are also committed to employee retention and ongoing training.

Resources Monitoring System Performance

Amerigroup dedicates resources to staff the technical help desk to monitor system performance, identify and troubleshoot system issues, monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates. Our technical help desk includes staff through our systems and Infrastructure teams including associate help desk, data center, data base, and application focused associates, who perform proactive monitoring 24/7 for data center servers, systems, and applications. We use a broad suite of tools for system monitoring. For example, we use IBM Tivoli to monitor system availability and performance including:

- Resource monitoring, including alerts for server infrastructure and hardware (CPU, memory, disc)
- URL monitoring and synthetic transaction monitoring including alerts for web-enabled applications
- Up/down status of infrastructure devices via ping
- Network and voice (VoIP) monitoring
- Application log file monitoring
- Mainframe monitoring
- E2E application transaction monitoring
- In-depth J2EE monitoring

Our robust monitoring practices reduce the impact of outages by immediately alerting support team members when an application is experiencing degradation or the system becomes non-responsive. In addition, our help desk staff automatically performs corrective action, such as restarting a service or deleting a specified file to avoid an outage entirely and tracks performance over time to identify trends in outages or to predict the need for additional resources. We capture underlying data for at-a-glance dashboard fulfillment.

We use the Precise monitoring tool for our Commercial-off-the-Shelf (COTS) applications and Oracle and SQL Server database systems to identify less than optimally performing components and address potential Service Level Agreement (SLA) issues before they even occur. We have more than 1,200 custom alerts for monitoring our MMIS. Amerigroup uses scripts to look at event viewer data. We review data for any errors and make sure that we highlight any new errors. Our refined process sends only the alerts that are the most critical to our system performance.

Another tool, TeamQuest® Analyzer, offers reporting on service performance and predictive modeling for capacity planning in real-time, which allows for fast root-cause identification and resolutions should issues be detected and enables us to consistently meet IT SLAs. These tools are deployed in multi-system environments and incorporate business measurements along with related IT Infrastructure metrics.

To monitor network communications 24/7, including voice and video, Amerigroup uses NetQoS, which monitors WAN and VoIP performance by measuring up/down status, latency, and throughput. We have a converged, multi-purpose network upon which voice, video, and application traffic travels. It provides efficiencies that enable us to employ monitoring and management tools to judge network performance. We instrument the environment with these tools to monitor performance on the network for our most critical applications and services. In addition to NetQoS, we employ point solutions to monitor certain elements of the environment such as routers and Private Branch Exchange (PBX), our private telephone network server.

Because we maintain redundant operations for key functions, including care management, the call center, and claims offices, we can use telecommunications and networking technology to enable transparent transition among remote sites to re-route member and provider calls quickly and seamlessly to an unaffected worksite, if necessary.

Our Information Systems team is on-call to respond to alerts on any issues, such as when a circuit is down or system latency occurs. Latency has a big impact on network performance; therefore, checking IP latency is an important part of network monitoring and of any network performance test. The networking and telecom team meets daily to review the events of the night before to review alerts and performance site-by-site. We address any exceptions to expected performance at these meetings.

HIPAA Compliance (13.1.7)

Question 13.1, #6

6. Describe your plan for creating, accessing, transmitting, and storing health information data files and records in accordance with the Health Insurance Portability and Accountability Act's mandates.

Amerigroup understands the sensitive nature of the information we collect and maintain to conduct our business and the importance of securing this information to protect the privacy of our individual members and providers. Our Information Systems Plan, included as Attachment 13.1.5-1, governs and guides our compliance policies and procedures. We are compliant with HIPAA mandates and National Provider Identification (NPI) requirements, and we have policies, processes, and infrastructure to maintain continued compliance. ***Amerigroup will make system and operational enhancements necessary to comply with new or updated standards at no cost to DHS.***

We carefully monitor HIPAA, Health Information Technology for Economic and Clinical Health Act (HITECH), and other federal and state requirements to identify the impact that changes in electronic transactions and code sets have to our systems and operations. When system changes are required for our continued compliance, we create a project, define the scope, assign resources, and monitor progress toward compliance. Amerigroup works proactively with healthcare partners and state agencies to facilitate and support HIPAA-compliant formats and procedures.

We have detailed policies and procedures in place to govern privacy and security including administrative procedures and safeguards, physical safeguards, and technical safeguards. We have a Corporate Privacy Officer as well as a Corporate Security Officer and our privacy and security information is available to all associates through our Corporate Intranet, called WorkNet.

Creating, Accessing, Transmitting, and Storing Health Information

Storage and access of historical member, eligibility, claims, and encounter data in a manner that supports ongoing processing as well as reporting and auditing is key to effective operations. Amerigroup has policies and procedures in place and can meet or exceed DHS's requirements related to historical data maintenance and access. Amerigroup's Core Operations System will serve as the system of record for information, such as member demographics and eligibility, provider demographics, claims adjudication, and authorizations, with the Data Warehouse housing claims from delegated vendors.

Amerigroup's Records and Information Management (RIM) Policy governs the creation, receipt, use, access, security, privacy, reproduction, retention, preservation, and/or destruction of business records regardless of media or format (including electronic and paper). Each Amerigroup health plan establishes and maintains recordkeeping systems that comply with legal, regulatory, and contractual requirements. We will hold our Iowa management accountable for assuring that RIM policies and procedures are implemented at all levels of the office.

For Iowa, we will store all electronic data and documents for no less than seven years in our live systems. Amerigroup retains or archives all records that are part of our designated record set in accordance with state and federal laws and regulations. Our designated record set includes enrollment, payment, claims adjudication, and case or medical management records concerning a member, and such other records used to make a treatment or payment decision about a member. Our Privacy Officer, in collaboration with our Information Systems Department and the business owners, is responsible for assuring that we retain the designated record sets stored in an electronic format.

The business owners who create or handle paper records that are part of the designated record set file, maintain, and retrieve paper documents. According to our documented procedures, paper documents must

be archived according to a defined schedule and stored in an off-site storage facility operated by Iron Mountain. These documents are placed in archival boxes, labeled, catalogued, and stored in such a manner that they can be retrieved easily when needed. We destroy all data and documents according to established procedures once they are no longer required. Paper documents are shredded; electronic versions of files are deleted; and electronic media formats such as CDs, diskettes, or magnetic tape are forwarded to the Information Systems Department for proper disposal.

The Core Operations System maintains an audit history of data updates, including time and source of change. We maintain audit trail information for no less than 10 years, online for no less than six years, and then make the information available from archive.

EDI Transaction and ICD-10 Compliance

Amerigroup is compliant with the most recent versions of all of the EDI transactions and the national code sets as required by the State: We are 5010 compliant. We interface with a number of clearinghouses to support data exchange between Amerigroup and our providers.

We maintain industry-standard code sets (ICD, CPT, HCPCS, CDT/ADA, revenue, and NDC), and we have processes in place to monitor and maintain code sets to deliver timely and accurate updates. We load updated code sets into our MMIS with effective dates so that transactions reference the correct information.

Amerigroup is on track to meet the ICD-10 compliance date of October 1, 2015. Our core systems modifications are complete and we are testing internally and externally.

To comply with Iowa Medicaid NPI requirements, Amerigroup will apply enhanced edits and checks regarding Provider NPI attestation in our claims processing and encounter management systems. We describe this in more detail in Section 13.4.3.

Amerigroup is committed to physical security within our facilities and data and network security within our MMIS. We store health information within Amerigroup's MMIS. Access to workstations and systems requires the use of a unique user identifier with a complex password that must be changed at regular intervals. Our access management function limits access to systems, applications, and Data Warehouses to only those individuals who have a legitimate business need for the data. Role-based security limits update capabilities and access to application functionality based on job role and responsibilities and the sensitivity of the data stored. Reports and alerts highlight unsuccessful attempts to access systems and websites.

The Information Systems Department controls network access through usernames and passwords and two-factor authentication controls remote access. We control individual user level access to systems through Active Directory group membership, in addition to application, file, directory, and drive-level security. We manage and protect our network using industry-standard tools.

Privacy and Security

Amerigroup has been compliant with the HIPAA Privacy and Security Rules since 2003.

As a covered entity, Amerigroup Iowa maintains compliance with the provisions of the HIPAA Privacy Rule, including designation of national Privacy and Security Officers through our national Privacy and Security Offices. In addition, we maintain a national Member Privacy Unit who focus on the fulfillment of member privacy rights requests; investigate and resolve privacy incidents; and maintain Medicaid privacy procedures. We maintain an infrastructure designed to support on-going compliance requirements throughout the company, including the development and adoption of policies and procedures and annual training of all employees. Please see our response to Question 2.15 for a complete description of our adherence to the HIPAA Privacy and Security Rules.

Electronic Mail Encryption (13.1.8)

In accordance with SOW Section 13.1.8, Amerigroup affirms that we can support DHS' Tumbleweed software interface. We understand that DHS may send an email to Amerigroup and we will be able to access and respond to the email via a link to the Tumbleweed server. Likewise, Amerigroup may send an email to DHS containing confidential information, and it will be transmitted securely and made available via an HTTPS link. Amerigroup uses ZIXCorp Secure eMail, a secure email program that encrypts emails and attachments identified as potentially having Protected Health Information (described in Section 6.1.9). In either case, we are able to comply with the State's requirement for electronic mail encryption.

Interface with State Systems (13.1.9 – 13.1.9.3)

In accordance with SOW requirements 13.1.9 – 13.1.9.3 and 13.5, Amerigroup is capable of receiving, processing, and reporting data to and from the DHS Medicaid Management Information System, DHS Title XIX Eligibility System, and the Iowa Department of Public Health (IDPH) Data System.

Amerigroup's MMIS electronically receives information through a file transfer process. We have experience accessing and interfacing with other state data systems, and we are confident in our ability to access the State's IDPH system as requested. We will see to it that substance use disorder treatment services are accurately documented and reported as required.

All interfaces into our Core Operations System, such as eligibility/enrollment and claim loads, are developed under the Information Systems Department's SDLC standards and rigor. We will customize the loads to meet DHS requirements and apply appropriate front-end edits to make certain that data going into the Core Operations System is clean, accurate, and compliant.

Amerigroup has the capacity to submit encounter data to the State's MMIS in the manner and timeframe specified by DHS. In support of other state plans, we currently load and evaluate encounter response files to identify errors in encounter data submitted to State Fiscal Agents. We mark rejected records in our Encounter Management System for investigation and remediation.

Connecting our MMIS to DHS Systems

Electronic exchange of information is a critical component of the implementation of the Iowa Initiative. Interfacing with state systems is an Amerigroup core competency. We have extensive experience with implementing against similar state requirements using common interfaces, such as eligibility, encounter, and claims files; and we will collaborate with DHS to identify sources of key data and information that will allow us to provide the best care for members.

Timely access to member information can drive meaningful outreach and care coordination strategies and result in a greater opportunity to improve health outcomes and manage costs. We will leverage member data from all available sources, including DHS, its affiliate agencies, and the Iowa Health Information Network. We will work with all to determine a schedule that will deliver the most current information to our care managers and predictive modeling process.

Maintaining secure, ongoing data interfaces is a strength of Amerigroup's Information Systems Department team, which has more than two decades of experience exchanging data with ancillary vendors, state partners, and others, including enrollment brokers, fiscal agents, and intermediaries; external quality review organizations; and recovery audit contractors. We are 5010 compliant and currently support interfaces in the HIPAA standard X12 and NCPDP formats. Additionally, we support HL7 and many state-specific formats, among others. When establishing new data interfaces, we collaborate with the external entity to identify or confirm detailed data transmission requirements, and establish and test connectivity and exchanges. For each data feed, we coordinate the format, timing, and delivery mechanism with DHS or other external entity. Upon receipt, we validate data feeds for completeness and credibility, and then we load it into the production environment.

Data Exchanges – Method, Triggering and Frequency

Amerigroup accomplishes data exchange interoperability between our systems in one of three ways:

- **Web services-based interfaces mainly for real-time integration.** Asynchronous interfaces exist between all of our core systems. We are currently processing 7mm transactions per month between environments. We use SOAP/Web Services for smaller transactions where large batch file processes would be too cumbersome, inefficient, and slow. For instance, single member eligibility lookup can be accommodated in real time rather than awaiting a file up load, processing, and validation of the file and then sending back a response file.
- **Batch file-based interfaces using Extract/Transform/Load (ETL) tools.** Interfaces used to move data from our core systems to a reporting or Data Warehouse environment often use ETL. These interfaces are typically batch-based interfaces that run on a scheduled frequency based on business requirements (daily, weekly, or monthly, for example). Our enterprise scheduling software manages job control and scheduling for these interfaces. Interfaces are built using industry standard tools designed for moving and integrating large volumes of data quickly. These ETL tools allow for Metadata management and code re-use within the development process to ensure consistency of data-length, data types, and data format across systems.
- **Storage system-based data snapshots or replication.** These interfaces are mainly storage system or database system replication-based interfaces that are used to maintain a secondary online or near line copy of a production system for high availability or disaster recovery

Our data exchanges between key production systems fall into two main categories: third party integrations and custom built. For third party integrations, we rely on vendors to provide the integration between purchased products. Examples of these interfaces include core operations system to prospective payment system, core operations system to care management system, and core operations system to clinical editing software. These interfaces are typically real-time and web services based.

We use custom-built interfaces where our core systems have pre-built Application Program Interfaces and extensibility. These interfaces allow us to develop specific functionality to meet business needs when requirements are not met by standard system functionality.

Secure Connectivity

Our Information Systems Department has experience establishing appropriate protocols for connectivity and developing solutions that foster interoperability and conform to open systems architectural standards. While the majority of our data exchanges are performed using Secure File Transfer Protocol (SFTP), we also maintain data exchanges using Hypertext Transfer Protocol Secure (HTTPS) and Virtual Private Network (VPN). We are confident using multiple methods and we will continue to collaborate with DHS and other external entities to use the best method for each data exchange.

Amerigroup applies comprehensive system and process checks to monitor data integration and confirm that data is successfully imported and exported. Information Systems Department staff monitor data interfaces to address any transmission or data errors, and confirm successful processing.

Use of Common Identifier (13.1.10)

In accordance with SOW requirement 13.1.10, Amerigroup will use common identifiers, such as member identification numbers, to link databases and computer systems. Our MMIS stores all required member information, including any State-assigned member identification number, which may include Social Security numbers.

Unique Member IDs across Systems

Amerigroup assigns each member a unique number that allows us to track and manage the individual throughout all systems within our span of control, including our relationship with subcontractors. This

number stays with the member even as there are changes in eligibility categories and products. Our systems manage variation in the member's eligibility category and product eligibility through uniquely dated spans within the Core Operations System. In addition to tracking a member by this specific number, Amerigroup also maintains the member's state-assigned Medicaid ID, Social Security number, and Medicare number, if provided. Our understanding and experience with state-assigned identifiers extends to a custom built extension, State Assigned Member Identifier (SAMI), to our Core Operations System. In SAMI, we are able to track and associate multiple identifiers for a member beyond the single currently assigned Medicaid ID, when they exist.

Identification of Duplicate Member Records

During the automated load process, we compare several data elements, such as name, address, date of birth, and Social Security number, to identify potential duplicates. The system pends for review prior to loading to avoid creation of most duplicates. The enrollment team will work with DHS to make a final determination regarding the disposition of identified records and update member data accordingly.

We perform a secondary check for duplicate member records as part of a weekly enrollment data review. We review any duplicates identified during this process to determine if claims history is present for both member IDs. If both member IDs have claims history, we work with the Claims Department to determine which member ID to keep, and we move the claims. We also maintain a cross-reference that links the active member ID with the inactive one.

We understand and acknowledge that we are prohibited from publishing, distributing, or releasing Social Security numbers of members.

Electronic Case Management System (13.1.11)

Question 13.1, #7

7. Describe your proposed electronic case management system and all information which is tracked in such system.

Care Management System Supports Members

Our care management system integrates information and data to support community-based management activities and care coordination in compliance with the State's 1915(c) and 1915(i) HCBS waiver programs and the Law. Specifically, our MMIS is able to capture and track:

- Key dates and timeframes such as:
 - Enrollment date
 - Date of development of care plan
 - Date of care plan authorization
 - Date of initial service delivery
 - Date of level of care and needs reassessments
 - Dates of care plan updates
 - Enable notification of Community-Based Case Manager, Case Manager or Care Coordinator of care plan, assessment, and reassessment deadlines
 - The care plan
- All referrals
- Level of care assessment and reassessments
- Needs assessments and reassessments
- Service delivery against authorized services and providers

- Actions taken by the Community-Based Case Manager, Case Manager or Care Coordinator to address service gaps
- Case notes

We fully integrate our care management system into our MMIS. It collects, organizes, and presents information to enable management and coordination of member care and support and facilitate communications between the member and participants of the member's care team.

Member utilization data—such as claims history, authorization, immunization records, lab results, and care and disease management data, as well as UM data from our subcontractors, and external entities—are readily available in an organized format with tools for Care Coordinators to identify and manage members' needs.

Member 360 consolidates member data and information from various sources into a single record to deliver a holistic picture of the individual's utilization, Case Management services, and gaps in care. Member 360 includes information such as member health risk assessments, care plans, longitudinal health records, and clinical data. Member information is accessible through numerous dashboards. Please see Section 9 for a complete description of Amerigroup's Care Coordination Program.

Supporting Care Coordination and Management

Our care management system provides Case Managers with the information and tools they need to develop, maintain, and monitor care plans that support member-centered medical coordination. Specifically, the system:

- Consolidates all available member information from internal and external sources (such as DHS paid claims, if available) to present a comprehensive picture to help the Care Manager evaluate current health status and identify necessary services and outreach activities for the member or their providers (Available member data includes claims history, authorizations, lab results, immunizations, and demographic information.)
- Supports the Care Manager, the Medical Home Provider, and other interdisciplinary team participants in developing an appropriate care plan for the member; and it also allows the Care Manager to track and record individual interactions with each member
- Enables the Care Manager, in conjunction with other members of the interdisciplinary team, to:
 - Access available member information, including:
 - Demographic information
 - Initial Health Risk Assessments and Comprehensive Health Risk Assessments
 - Clinical conditions
 - Claims and authorization history
 - Medical Home Provider
 - Treating Providers
 - Prescriptions, including dosage and last refill date
 - Lab results
 - Access comprehensive clinical assessment instruments to evaluate member healthcare needs
 - Review and import evidence-based clinical guidelines into the care plan
 - Document the care plan, including short- and long-term goals, barriers, milestones, and interventions
 - Document progress toward meeting goals
 - Set follow-up reminders and interventions
 - Modify the care plan as necessary to improve member health outcomes

- Record interactions with members, their authorized representatives, or the provider in support of the care plan, including telephone calls, care coordination activities, clinical interventions and outcomes, education information, care coordination across providers, and referrals
- Deliver the care plan and information on interactions and services provided to the member to the interdisciplinary team

Our care management system is built on a series of screens that allow Care Managers to view and document all aspects of a member's health status and care plan. The amount of detail in the care plan may vary depending on the complexity of the member's condition, identified needs, and level of care coordination performed. Each care plan includes short- and long-term goals, interventions, and outcomes. The member's risk stratification results, results of screenings and assessments, engagement with the medical home provider, and preventive services are also included in the care plan.

Electronic Visit Verification System (13.1.12)

Question 13.1, #8

8. Indicate if an Electronic Visit Verification (EVV) System is proposed and what methodologies will be utilized to monitor Member receipt and utilization of HCBS.

Through our affiliates, Amerigroup has experience in implementing and monitoring HCBS services through an EVV in other states and working collaboratively with other MCOs. For services to have positive outcomes, we must be able to confirm that the services have been provided. To monitor member receipt of HCBS, Home Health Services, Hospice, and EPSDT utilization for Iowa, ***we recommend that all selected MCOs come together to select a single EVV vendor for the State's program. This approach will simplify implementation and reduce administrative burden for providers and personal care attendants/caregivers*** so that they only have a ***single consistent system*** to use. Within 30 days of the Contract award, DHS and the MCOs (and their IT teams) would meet and then reach out to EVV vendors to solicit presentations, and then select a single EVV. Through this process of collaboration the MCOs would identify, review system requirements, qualify and select a single EVV vendor to engage for this program.

Included in the final selection then the MCOs with the approval by DHS would define the methodologies utilized to monitor receipt and utilization of services.

- Select a vendor that offers telephone, mobile and computer based system to verify service visits occur and document the precise time service provisions begin and end.
- Verification is the key prior to paying claims and helping to guard against fraud and abuse while improving care delivery.
 - Authorization validation matches to visits prior to claims payment
- Alerts:
 - Identification of late/missed visit alerts through text, email and/or dashboard reports
 - Gives providers and/or Case Managers the necessary information to ensure emergency back up protocols can be activated in a timely manner
 - Instantly informs supervisors of missed visits, late visits, and other problem situations
- Comprehensive Reporting:
 - Reporting packages that include daily and date range reports
- Consumer Direction:
 - EVV would be made optional for individuals who have selected to enroll in the self directed program Consumer Choices Option

- Training for providers:
 - Training materials would be created for the EVV process for providers
 - MCOs would utilize the same training documents and process to provide consistency and administrative ease for providers as they transition from FFS to Managed Care
 - Providers can attend training sessions held by the EVV vendor in collaboration with the MCOs.
 - MCOs would make the materials available in their training sessions and online through our provider websites.

Amerigroup believes that the approach to selecting a single EVV is the ideal solution to aid providers as they transition from FFS to Managed Care. Amerigroup offers our experience to bring the MCOs and DHS together to select a single EVV vendor should we be one of the selected MCOs in Iowa.

Clinical Records (13.1.13)

Question 13.1, #9

9. Describe in detail how clinical records, as described in Section 13.1.13 will be maintained in your information system.

Amerigroup will maintain records relating to Iowa Initiative services and expenditures, including reports to DHS and source information used in preparation of these reports. The records will include financial statements, records relating to quality of care, clinical records, and prescription files. Our MMIS will store electronic data and a set of detailed policies and procedures that govern the maintenance of records across our entire operations. Amerigroup complies with 45 CFR 164.530(j)(2) and maintains records that disclose the extent of services provided to our members for seven years or for the duration of contested case proceedings, whichever is longer.

Amerigroup's MMIS Maintains Complete Information on Services Provided to our Members

Amerigroup's MMIS maintains a history of member claims processed for all services—medical, behavioral health, pharmacy, vision, and transportation. As described in our response to Question 13.1.1, Amerigroup's Core Operations System, as part of our MMIS, will serve as the system of record for all provider, member, claims, and authorization data. Our MMIS houses the information required to authorize and monitor services and provides the data necessary to perform quality assessments and other evaluation activities.

All updates to this information will occur through the user interface or through application-specific data loads. All other applications interfacing with the Core Operations System map to its data structures to enable consistency in naming, formatting, and validation and to drive data quality and reliability.

We understand that upon conclusion of the Contract, all clinical records generated by Amerigroup become the property of DHS. We also understand that, upon request, Amerigroup will transfer records to DHS at no additional cost.

Information Maintained in Clinical Records

Amerigroup will maintain and require that all providers and subcontractors maintain clinical and medical records in an updated, detailed, and organized manner in compliance with our established Clinical Records Policies and Procedures. Medical records serve as a blueprint for the providers and members in understanding the member's current healthcare needs, prior treatment plans, and short- and long-term healthcare objectives. These records are essential in ensuring that the member receives medically necessary services delivered within the highest standards of quality and timeliness. Amerigroup policies

assure that clinical records allow for effective and confidential member care and that medical records are compliant and reviewable for administrative, civil, and/or criminal investigations or prosecutions. We will comply with the requirements for maintaining clinical records as described in SOW requirements 13.1.13.1 – 13.1.13.11 Clinical Records, including but not limited to:

- We document member diagnoses and assessment scores in our care management system; diagnoses are also maintained in our Core Operations System.
- We determine and document members' level of functioning in our care management system.
- We store clinical services requested, services authorized, substituted, and provided in our Core Operations and care management systems.
- Documentation of services not authorized, the reasons for the non-authorization based on IAC citations, and substitutions offered to the member are documented by the Medical Director in the authorization decision. When substitutions are applicable, they rationale is documented in the MMIS. In addition, UM reports capture denials and the reason for the denial.
- Care Managers enter missed appointments and subsequent attempts to follow-up with the member as part of their case notes that are captured in our care management system.
- Care Managers follow up (and document this follow up) on members discharged from the ER without an admission for inpatient treatment and observation in our Core Operations Systems.
- We document joint treatment planning, clinical consultation, or other interaction(s) with the member or providers and/or funders providing services to the member, including the name(s) of people who are integral to member treatment planning and who access multiple services, in our care management system.
- We document any Medication Therapy Management by Amerigroup clinical staff in our care management system
- We capture assessment and determination of level at admission, continued service, and discharge criteria in our care management system.
- We track in our Core Operations System the discharge plan for each member discharged from 24-hour services reimbursed through Amerigroup, including the destination of the member upon discharge. The destination of the member upon discharge is tracked in the UM Notes field. Part of our normal discharge planning includes identifying the patient's destination. We start working on the discharge plan on Day One of the 24-hour services stay and document final destination upon discharge.

Documentation in the record will reflect the quality, appropriateness, and timeliness of services provided.

System Problem Resolution (13.1.14)

Question 13.1, #10

10. Submit system problem resolution plans and escalation procedures.

Amerigroup has included its plans for system problem resolution and escalation procedures as Attachment 13.1.10-1. In compliance with SOW Section 13.1.14, Amerigroup agrees to notify DHS immediately upon identification of network or software failures and sub-standard performance affecting our core operations, specifically members and providers. In addition, we agree to conduct triage with DHS to determine the appropriate severity level or deficiencies or defects and determine timelines for fixes.

Communication in the Event of a System Problem

Clear and immediate communication is vital when systems are unavailable. An Amerigroup-assigned Customer Account Manager will be responsible for communicating systems issues. In the event an issue arises, the Customer Account Manager will provide updates via phone and/or email of any core system availability issues.

We will notify DHS immediately upon discovery of a problem that may indicate network hardware or software failures and sub-standard performance, and that may jeopardize availability of critical functions. Communication will include triage with designated DHS representatives regarding the impact to critical path processes such as enrollment management and encounter submission.

Escalation Procedures (13.1.15)

Amerigroup has included its plans for system problem resolution and escalation procedures as Attachment 13.1.10-1. Amerigroup agrees to notify DHS and other stakeholders of any system problems not considered a "disaster" by definition (according to SOW Section 13.2.1) subject to DHS review and approval.

Release Management (13.1.16)

Question 13.1, #11

11. Submit sample release management plans.

In accordance with SOW requirement 13.1.16 Release Management, Amerigroup has included **Sample Release Management Plans** as Attachment 13.1.11-1. We will submit a final plan to the DHS within 30 days after the *first* submission of the plan, incorporating any changes requested by DHS, as requested. In doing so, we will execute, comply with, and provide the services set forth in the DHS-approved plan. We understand that any changes to the plan must be approved by DHS in advance and subsequent updates made to the current version of the plan.

Implementing System Changes and Maintenance

Systems changes are inevitable, whether necessary to correct a problem or to conform to future federal or DHS standards. At Amerigroup, proven Change Management processes enable our team to manage and coordinate change requests and releases to the production environment. This includes infrastructure, network, system components, protocols, configurations, hardware, and software related changes.

The Change Management Process is built upon the concept of a Change Control Board (CCB). There are two types of control boards in the process: the Change Advisory Board (CAB) and the Change Control Board (CCB). The CAB is a team of technologists that review, approve, monitor, schedule, and govern changes that occur in the production environment. They also assure that scheduled changes in a given maintenance window are compatible, mitigating risk as needed. The CCB is responsible for approving, reviewing, monitoring, and governing changes for all high risk and high impact requests for change.

We have a comprehensive set of policies and procedures that govern development and review of Change Notification Requests (CNRs) as part of the Release Management function. For high-risk and high-impact changes, the CCB is responsible for approving, reviewing, monitoring, and governing changes. System tools and strict procedures safeguard systems from unauthorized modifications.

Systems Changes and our Systems Development Life Cycle

Our information systems change management and version control processes are tightly integrated with our Systems Development Life Cycle methodology. For all system changes, the Information Systems Department follows formal change notification policies and procedures that include standards for

requirements gathering, analysis, design, tests, and implementation. Figure 13.1-3 depicts our Systems Development Life Cycle.

Figure 13.1-3. Amerigroup Systems Development Life Cycle



The Information Systems Department uses change management software during maintenance and implementation of all application software and documentation. Changes to documentation begin at the initiation of systems requirements and continue through testing. We use the updated documentation as a basis to train all employees affected by the change before deployment.

Our documented policies and procedures include all methodologies required to manage the life cycle of our applications and systems. We have procedures, templates, checklists, and processes that enable systems projects to move from a concept through requirements gathering, requirements tracking, systems design and development, complete systems testing, user training, documentation updates, and controlled deployment of new or changed source code. The processes are documented and repeatable. We monitor the processes and continuously look for process improvement activities.

DHS Notification of Systems Changes

Systems availability is critical to efficient operations in Iowa and we will schedule all system maintenance that results in systems unavailability during times that do not compromise critical business operations. Our usual practice is to schedule system down time on weekends. If we must schedule maintenance during normal systems operational hours, we will coordinate with DHS for scheduling and approval. Amerigroup is committed to compliance with SOW Section 13.1.16 Release Management. DHS will be notified at least thirty calendar days prior to the installation or implementation of minor software and hardware upgrades, modifications or replacements, and at least 90 days before major changes are made to these core processes:

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management

We will make sure that system changes or upgrades are accompanied by a plan that includes timelines, milestones, and testing to be completed prior to implementation and make sure that such plans are delivered to DHS upon request in the timeframe and manner specified by the State.

Environment Management (13.1.17)

As an implementation best practice, we have invested in multiple test environments that allow us to support simultaneous testing cycles and multiple initiatives. This allows a test environment to be available for follow-up and integrated testing while other specific testing is occurring in another environment. This testing environment will be available to support testing for the Iowa rollout. Thus, the environments for development, system testing, and User Acceptance Testing remain separate from the production environment. In fact, Amerigroup deploys many separate environments including Development, Training, Quality Assurance, and Production among others.

Rigorous testing of data exchanges is a critical component of our implementation plan. We understand that it is our obligation to demonstrate to DHS that data exchanges between the Fiscal Agent, Enrollment Broker, and Amerigroup systems are complete, accurate, and reliable.

Contingency and Continuity Planning (13.2)

Question 13.2, #1

1. Provide a detailed disaster recovery plan and contingency and continuity planning documents.

Continuity Planning (13.2.1)

Amerigroup Iowa (Amerigroup) will maintain a focus on effectively responding to disasters with minimal impact on all constituencies. Amerigroup's Business Continuity and Disaster Recovery plans will safeguard continuation of established services and systems and address our business processes, applications, and platforms. Each business unit, whether an individual health plan or a national support area (such as Claims, Provider Data Management, Information Technology, or Legal), develops and maintains a Business Continuity plan specific to the operational needs of its customers and stakeholders.

Amerigroup understands the importance of Disaster Recovery and Contingency/ Continuity Planning. Our affiliates successfully maintain and execute these plans in other states. Although we understand it is helpful to review potential plans, per our parent company, Anthem, policy we do not include our Disaster Recovery and Contingency/Continuity Planning documents in our proposals as we consider them company confidential. We strongly believe that we need to protect the detailed information our planning materials contain to avoid inappropriate use. However, despite this strict access control we are both willing and ready to provide DHS visibility into the documents upon request through an online meeting or during a site visit. While we are not providing actual planning documents, we do provide an explanation of our plans and planning methodology.

We maintain Business Continuity plans for operations and Disaster Recovery plans for our systems. Together, these plans represent a detailed blueprint of our preparation for and planned response to any emergency or business disruption. Plans are "scenario neutral" and focus on unavailable resources rather than the event that caused the loss. This approach allows us to respond to any event that disrupts access to necessary services or resources.

In our plans, a disaster includes both the day-to-day types of occurrences that could jeopardize processing integrity or temporarily disable or interrupt operations, as well as a catastrophic event such as a major weather event or natural disaster, human error, pandemic, malfunctioning hardware or electrical supply, major telecommunications outage, or computer virus, and includes any other kind of occurrence that severely inhibits the State's ability to conduct daily business or severely affects the required performance, functionality, efficiency, accessibility, reliability, or security of our system.

We design our Disaster Recovery plans to protect against data loss and provide recovery from major unplanned interruptions to computing services, including system infrastructure, data, and applications. Several other enterprise programs also enable maintenance of critical business functions:

- **The Safety Program** provides a guide for a safe workplace for employees, contractors, and visitors
- **The Emergency Management Program** specifies overall response, command, and control before, during, and after an incident or event causing a business disruption
- **The Business Continuity Program** documents the recovery strategy of critical business processes

Amerigroup's Business Continuity plans include access to a substantial workspace recovery capability using a combination of resources, including network redirection of work, national-owned worksite

recovery capacity, mobile recovery resources, and secure satellite connectivity for voice and data. Our Business Continuity Program aligns the business requirements of the operating units and the deliverables of support areas to meet stakeholder commitments following an unplanned event. Open communication is key in our continuity activities. We will work and coordinate with DHS and appropriate contractors to help assure a continuous delivery of services.

We believe that comprehensive Business Continuity and Disaster Recovery planning, coupled with continuous readiness, is an integral part of our responsibility as an employer, partner to DHS, and service provider to our members and providers.

Contingency Plans for Essential Business Functions

Technology tools enable our employees to seamlessly access necessary systems remotely to facilitate continuing operations for DHS. Through the use of our Citrix Access Gateway, employees can use critical applications securely from any location with Internet access. Regardless of the nature of the emergency, redundant operations will minimize disruption for our DHS members and providers.

Disaster Recovery Site

The disaster recovery site, or “hot site,” for our Virginia Beach data center is located in an AT&T Internet Data Center (IDC) in Dallas. The hot site includes equipment to support our most critical medical management and member/provider contract applications, including our core operations system, clinical criteria, Fax II/Rightfax, imaging and workflow document management, and call center workforce management. There is continuous real-time replication between the production data center in Virginia Beach and the hot site to keep critical applications in sync with production. The AT&T IDC facility is 142,000 gross square feet with 72,150 square feet of raised floor in the data center. It is a tier 3-4 data center with N+1 redundancy on all critical infrastructure systems.

The Dallas IDC provides a secure, reliable environment for the internal disaster recovery hot site. It also provides a very scalable environment with tremendous capacity for additional space, power, HVAC, UPS, and all other critical infrastructure components as our requirements increase over time.

General Responsibilities (13.2.2.1-13.2.2.5)

Strong leadership, timely notification, and activation of our Business Continuity and Disaster Recovery plans are critical to the management of any incident that disrupts normal business operations. Generally, the time frames for notification are based on the impact and severity of the incident and may vary from immediate to a few hours. After the initial assessment and according to the documented plan for recovery, notification is sent to key management and support areas to advise or engage staff as needed. The Amerigroup Health Plan Administrator or Director of Operations will notify DHS of an incident impacting our Iowa High Quality Healthcare Initiative operations. A number of emergency notification system (ENS) methods are available to support contact and notification between resources during an incident.

Notification of Members and Providers

Amerigroup knows that communicating promptly and effectively with our members and providers is critical in an emergency or service disruption. Consequently, our Business Continuity and Disaster Recovery plans include steps to notify members and/or providers depending on the type of event and what services are unavailable. Notification methods may include:

- **Member and Provider Websites** — In addition to maintaining ongoing emergency procedures on our website and in member and provider manuals, we may post alerts on our website notifying members and providers of a service disruption and how it impacts their ability to access services
- **Automated Calls, Text Messages, and Email Messages** — We can generate automated telephone calls, text messages, and emails to communicate information to our members and providers

- **Personal Calls** — Amerigroup employees may make personal telephone calls to vulnerable members, including those in case management
- **Call Center** — Our Member call center and Provider Helpline employees will provide up-to-date information to callers on how to continue accessing services
- **Local Media** — Local radio and television can be used to disseminate emergency information

Maintaining Member Access to Information and Services

Amerigroup is committed to maintaining member access to information and services in any emergency. We will use our Member call center, member website, and member self-service voice portal to provide information, and our Business Continuity and Disaster Recovery plans contain processes to maintain availability of these services before, during, and after an emergency or business disruption.

We will also mobilize our health plan employees, including case managers, member and provider services representatives, and other medical management employees, to assist members with access to information and services before and during a declared incident.

Helping assure data is safeguarded and accessible is a key element in our disaster recovery planning. We store copies of key files in secure off-site locations. We back up data files daily, as well as transactions, program libraries, job scripts, operations procedures, and systems documentation. Our technology tools enable our employees to seamlessly access necessary systems remotely to facilitate continuing operations for DHS.

Information systems employees are assigned to disaster recovery teams that are responsible for and have developed contingency plans to respond to worst-case scenarios. The disaster recovery teams take ownership of the recovery of business operations by reviewing all documentation, making recommendations, alerting the disaster recovery contingency planners of system changes and upgrades, and participating in the testing of the Disaster Recovery plans.

Amerigroup is committed to conducting annual exercises to test current versions of information system contingency and continuity plans. Annual exercises can be coordinated with the approval of DHS. Reports of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercises will be recorded and shared with DHS.

IS Contingency Planning and Execution (13.2.3)

Amerigroup is experienced and able to meet the State's needs in IS contingency planning and execution. Amerigroup agrees IS contingency planning will be developed in accordance with 45 CFR 164.308. Amerigroup contingency plans will include: (i) Data Backup plans; (ii) Disaster Recovery plans; and (iii) Emergency Mode of Operation plans. Application and Data Criticality Analysis and Testing and Revisions procedures will be addressed within the required contingency plans. Amerigroup agrees to be responsible for executing all activities needed to recover and restore operation of information systems, data, and software at an existing or alternate location under emergency conditions within 24 hours of identification or declaration of a disaster. Amerigroup agrees to protect against hardware, software, and human error. Further, we agree to maintain appropriate checkpoint and restart capabilities and other features necessary to help assure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery.

Backup Requirements (13.2.4)

Section 13.1.2.3 provides a robust description of our backup capabilities. Amerigroup not only meets, but also exceeds the State's backup requirements for safe storage and accessible data. As described in Section 13.1.2.3, Amerigroup agrees to maintain full and complete backup copies of data and software in accordance with the timelines. We will maintain a backup log to verify the backups were successfully run,

and a backup status report will be provided to DHS upon request. Amerigroup maintains off-site storage for our Virginia Beach data center backups in Richmond, Virginia. On the Contract end date or termination date, all DHS-related data will be returned to DHS.

Data Exchange (13.3)

Question 13.3, #1

1. Describe your process for verifying member eligibility data and reconciling capitation payments for each eligible member.

Member Enrollment Data (13.3.1)

Retrieve and Integrate Enrollment Data

Our National Medicaid Division manages eligibility (enrollment) files in the HIPAA X12 834 format, as well as other formats received from state customers for each of our affiliate health plans. Amerigroup Iowa (Amerigroup) will meet or exceed all DHS requirements for eligibility/enrollment processing. Recognizing that the enrollment process depends on the timely availability of accurate member data, we leverage technology to streamline the data exchange processes while facilitating transaction tracking and reporting.

The national Enrollment Operations Department's mission is to process accurate and timely membership data into our Core Operations System and maintain the data to respond to changes in status, primary care provider (PCP) assignment, and demographic information. We will establish scheduled FTP downloads across secure connections with DHS to enable timely receipt of the enrollment files. After successfully completing HIPAA compliance checks, DHS-specific data edits, and business rule validations, the enrollment process will create and/or update member records in the Core Operations System. The system pends Individual Benefit/Enrollment records with identified issues so that the complete records can be loaded. We review the pended records and, where possible, correct problems and trigger records for processing. When the issue cannot be immediately resolved, an analyst consults with functional operations staff to obtain the missing information necessary to process the enrollment record. At various checkpoints during the enrollment process, reports are generated to balance records processed and identify any member errors that need to be corrected and reprocessed to accomplish a complete load into the system.

We structure our enrollment load processes to achieve optimal processing time and accuracy. The process incorporates numerous technology efficiencies that facilitate timely access to member data. As an example, rather than reloading every record within the entire 834 weekly Benefit/Enrollment Reconciliation file, we process only member data that has been changed or added since the last file processed. This significantly reduces the number of transactions and time to process. Once processed in our system, we will transmit enrollment/benefit data to our subcontractors via X12 834 transactions.

Identification of Duplicate Member Records

The automated member enrollment load process compares several data elements, such as name, address, date of birth, and social security number, to identify potential duplicates. The system pends Individual Benefit/Enrollment records with identified issues but continues processing/loading the remaining records in the file. The enrollment team will work with the State to make a final determination regarding the disposition of possible duplicate records and update member data accordingly. A secondary check for duplicate member records occurs as part of a weekly enrollment reconciliation data review. Any duplicates identified during this review are resolved by merging the member records when claims history

is not present for both member IDs. If claims history is present for both member IDs, a link between the records is created.

Maintaining Audit Trails of Data Changes

Whenever a change is made to member information, a history of the update transaction is automatically created, including the time and source of the change. Audit trail data through our Core Operations System is available for inquiry and reporting. We maintain audit trail data online for the duration the State requires, but not less than six years. Once archived, audit trail data is available for recovery in 48 hours or less.

Assigning PCPs

Amerigroup's Medicaid Management Information System (MMIS) will meet the requirements for PCP auto-assignment. As part of enrollment file processing, Amerigroup will receive notification of a newly enrolled member. If the member enrollment data does not indicate a PCP has been chosen, the system will assign a PCP for the member. The PCP assignment will take into consideration a current member-provider relationship or existing provider relationships with family members, if the data is available. The system will also consider other factors such as the member's location or language preference and will determine the PCP's capacity to accept the member assignment. If a member is a dual member then the system will bypass and not assign them a PCP as dual members are not required to have a PCP. If the dual member calls and requests that we identify their PCP, then the call center will assign them to their selected PCP.

Within five days of auto-assignment, we will provide the member with PCP contact information, as well as information on the process to change PCPs. Please refer to Section 13.1 for further information on assigning PCPs.

Reconciling Enrollment to Capitation Payments

Amerigroup has additional operational processes to reconcile the premium payments with member enrollment each month. Our process compares the 820 premium payment transaction files we receive from the State against member enrollment data provided on the State 834 file and loaded into Facets. Each month, the system generates a billing file from 834 enrollment data and compares the data to the 820 premium files. Additionally, a member-to-member comparison looks for discrepancies that could be the result of the following:

- Members on the premium 820 file who are not in our MMIS
- Members in our MMIS who are not on the premium 820 file
- Members whose data differs between the premium 820 file and our MMIS

As in the monthly eligibility reconciliation, discrepancy reports receive careful review to identify the reason for the discrepancy. The Premium Reconciliation Manager and the Enrollment team collaborate with the Iowa Finance and Accounting team to investigate discrepancies. If we can resolve the discrepancy, we update the member files in our MMIS. If we cannot resolve a discrepancy, we will notify the State. Resolved discrepancies will be processed during the next reconciliation cycle and will, therefore, not appear on subsequent reports. The Enrollment team tracks the results of each monthly reconciliation and provides analysis and reporting information to the Finance and Accounting team.

Member Enrollment Data Exchange (13.3.1.1)

Amerigroup fully meets and exceeds the requirements for member enrollment data exchange. We will maintain stringent operational processes and controls to support the Iowa Initiative eligibility and enrollment data exchange requirements. We are HIPAA-compliant and capable of receiving 834 enrollment files within 24 hours of receipt. Our MMIS assigns each member a unique identifier that is

used on all member-specific materials and member-related processing. We cross-reference our assigned member ID to other numbers such as SSNs and State-assigned member numbers.

As we outlined in Section 13.3.1, our daily enrollment load process includes logic that identifies potential duplicate members. Our processes are proven and results focused, based on years of experience in multiple markets. We have succeeded in designing, testing, and deploying the enrollment and eligibility data exchange early in the implementation project plan. Having a tested data exchange accomplishes two key objectives: it serves as a needed prerequisite for claims, authorization, and encounter testing; and it positions us to begin processing actual 834 eligibility and enrollment files months before the start of operations to distribute materials and identification cards to our members.

Reconciliation Process (13.3.1.2)

As described in Section 13.3.1, we have a robust reconciliation process. Amerigroup uses the monthly 834 file to reconcile member eligibility records. Our process compares the State's 834 file to member eligibility data in our MMIS to identify the following:

- Members on the 834 file who are not in our MMIS
- Members in our MMIS who are not on the 834 file
- Members whose data differs between the 834 file and our MMIS

We carefully review discrepancy reports to identify the reason for the discrepancy and then take appropriate action. We will notify the State of any eligibility discrepancies within 10 days.

Provider Network Data (13.3.2)

Amerigroup agrees to submit provider network information to the State in the time frame and manner defined by the State. Amerigroup agrees to keep provider enrollment and disenrollment information up-to-date.

Claims Processing (13.4)

Question 13.4, #1

1. Describe your capability to process and pay provider claims as described in the RFP in compliance with State and Federal regulations.

Amerigroup Iowa (Amerigroup) is committed to adjudicating claims in a timely, accurate, and provider-friendly manner. All claims that pass initial edits and are accepted into our highly automated claims processing system, including adjustments, are considered clean claims. Each of our affiliate health plans is required to meet a specific percentage of claims payment within a designated time period based on individual state and program requirements, so overall claims operations are designed to facilitate claims aging and workflow management. We do not distinguish between in-network and out-of-network claims payment timeliness, and our claims payment timeliness reporting includes both paper and electronic clean claims.

Our core operations system generates daily, weekly, monthly, and ad hoc reports that allow leadership to gauge processing performance, identify problem areas, and monitor quality performance. These reports detail the number of pended claims by aging category and allow us to quickly react to any fluctuations in claims submission and pended volumes. By working pended claims in order of receipt, we can pay providers efficiently and achieve processing goals. We automatically post resolved claims to the next payment cycle. Our system completes adjudication cycles nightly. We perform two payment cycles each week.

While claims operations monitors performance against claims timeliness standards in each of our affiliate health plans, they also maintain internal standards that are often higher than state requirements. Claims

operations recognize that our primary goal is to adjudicate claims quickly and accurately so that providers can receive payment in a timely manner.

Amerigroup will require monthly reports from our subcontractors that provide detailed information on claims processing and performance, as well as quarterly reports that will include the number of claims received, paid, denied, pending, and adjusted and the number and percentage of claims paid within ranges of days. We meet quarterly with each subcontractor to review the subcontractor's performance and discuss any issues.

Question 13.4, #2

2. Describe your plan to monitor claims adjudication accuracy.

Monitoring Provider Claim Submissions

Amerigroup uses several methods to monitor provider compliance with our claims submission and billing procedures. We subject EDI claims to extensive format and syntax edits. We report and reject exceptions and respond to the provider via their clearinghouse. We closely monitor the number of rejections and initiate contact with any providers with unusually high rejection rates.

Once claims enter our claims processing systems, they are fully edited prior to the automated adjudication process. We may return claims with missing data to the provider and may deny claims that fail to meet program requirements for member and provider eligibility, benefit coverage, or medical policy. We report denied claims on a Claim Denial Notice back to the provider.

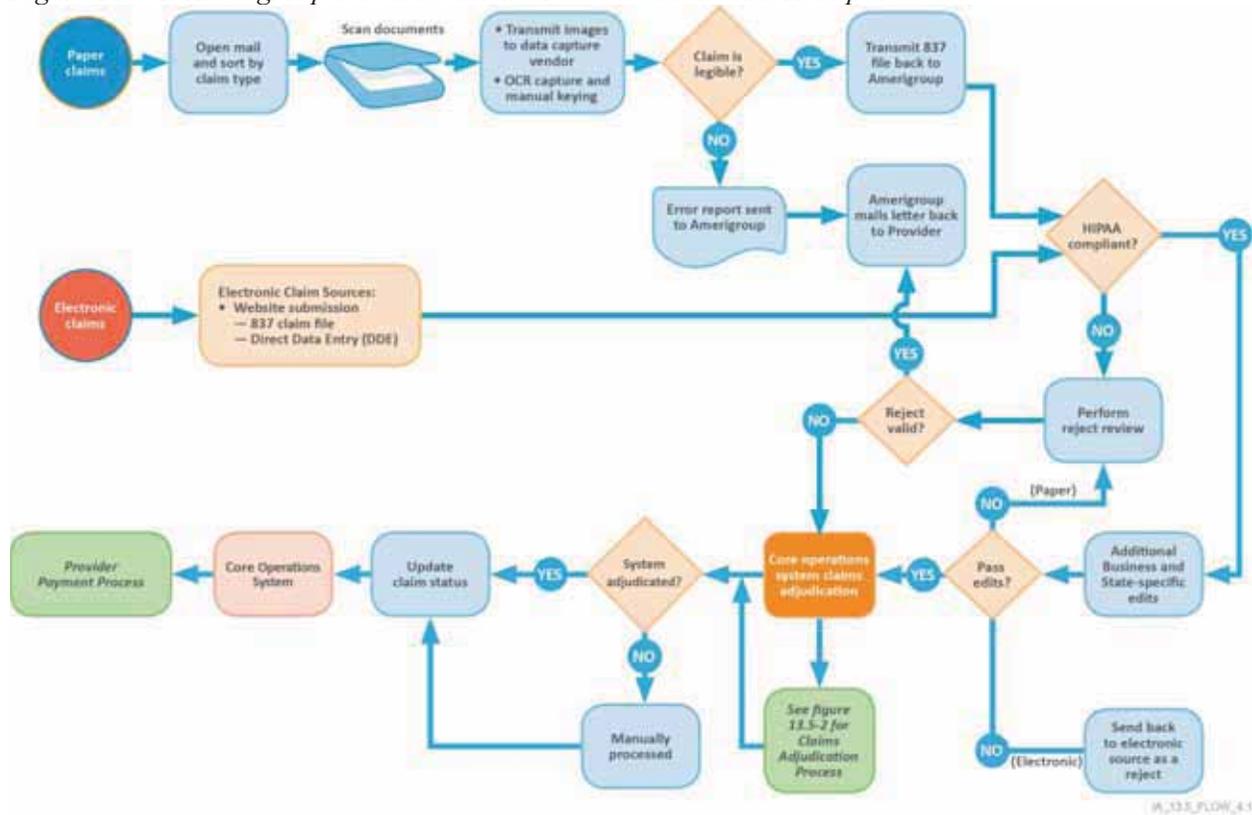
We continually monitor claims processing performance and compliance. Daily, weekly, monthly, and ad hoc reports allow management to monitor and measure processing performance, identify problem areas, and review quality. Reports list the number of pending claims by aging category and allow us to quickly react to any fluctuations in claims submission and volumes. By working pending claims in the order of receipt, we can pay providers efficiently and achieve processing goals.

Management reports summarize the number of denials by type of denial and provider, and, again, any unusually high number of denials for a particular provider will trigger follow-up action with that provider. When we identify common issues, we educate providers through our Network eUPDATE service or fax blasts and incorporate them into our Provider Manual.

Claims operations and management analyze claims reports for issues such as possible provider submission problems, system problems, or other areas of improvement. If, for example, we see a high number of claims pending for a specific reason, we will analyze the claims to determine if there is an appropriate intervention, including provider education, reviewing authorization rules, or modifying a system edit. ***A high volume of claims pending or denying for a specific provider will prompt additional review and often results in proactive outreach to the provider by Amerigroup Provider Services Staff.***

Figure 13.4-1 shows Amerigroup's overall claims process—from receipt to payment—with additional detail on the claims receipt process. The figure highlights where in the process that adjudication and payment activities, detailed on subsequent charts, occur.

Figure 13.4-1. Amerigroup's Overall Claims Process and Claims Receipt Process



Audit Trails and Claims Review Process

Amerigroup bases its claims processing practices on comprehensive policies and procedures that guide our professional audit staff as they monitor and audit claims to verify timeliness, accuracy, and integrity and evaluate claims processing for financial, payment, and statistical accuracy. We maintain an internal audit function independent of claims management. In the paragraphs below, we describe our process for sampling paid claims and our claims auditing process to verify claims payment accuracy.

Audit Trails

Amerigroup's claims processing system maintains audit trails to track changes of claims and claims-related data. When an authorized user makes a change, including adjustments to claim information, the application automatically creates an audit record with before and after images of the data, the time and date of the change, and the user and subsystem that made the change. Our systems maintain audit trail data online for a minimum of six years.

We maintain the audit trails in a separate database and can create audit reports using all or portions of the audit trail records. We use audit trail information to create comprehensive reports of system and user activity.

Additional Claims Payment Accuracy Processes

Amerigroup's claims will be subject to quality audits executed by our national Quality Process and Improvement Department. Claims quality audits are part of our quality assurance program and verify that we accurately process system adjudicated claims as well as manually adjudicated claims. Our claims auditing function is independent of claims management. To measure our overall performance on claims accurately, we will audit a random sample of claims each week. In addition, we perform specialized audits, including the following:

- **High-dollar audits**—Daily pre-payment audits of all high-dollar claims where the payment amount or the denied claims amount is over specific dollar thresholds
- **Individual focus audits**—Weekly audits on claims from each claims analyst and daily audits of claims during the new-hire training period to determine processing accuracy
- **Focus audits**—Targeted audits on specific claim types or surrounding processes to measure performance and remediate claims issues
- **Post-implementation audits on new markets/expansions**—Targeted audits on new or expanded markets to verify accuracy

The audit process includes a thorough end-to-end review (from receipt to final disposition) to verify our compliance with all federal, State, and internal requirements and any specifics in the provider agreements.

If the process finds errors, the audit is not closed until the claim is corrected and the correction is validated by the auditor. We examine root causes of errors to prevent future instances.

Additional Resources to Improve Claims Quality

Our national Claims Quality Steering Committee includes senior leadership from operational areas and meets monthly to review audit errors, discuss the root causes, and create action plans to address deficiencies. Based on our audit findings, we develop policy changes or edits to our claims processing system to mitigate future problems and improve our claims payment accuracy. We log all corrective actions identified by the Steering Committee and track them through completion in the action item log.

A dedicated national Quality Process Improvement team works on large projects to improve claims payment accuracy, increase auto adjudication rates, and bring efficiencies to internal processes. This team follows an established project methodology through five phases: initiation, planning, execution, control, and close. It also employs Six Sigma methodology when warranted.

Monthly Quality Framework meetings provide an opportunity to review manual claims audit data and create action plans to prevent future errors. Led by Regional Operations Experts, the meetings bring together the Director of Performance Enhancement, Process Improvement Business Analysts, and Claims Quality Managers. All actions initiated through these meetings are tracked by the Quality Process Improvement team.

Amerigroup will use effective technology and experienced employees to consistently deliver prompt and accurate claims payment. We have proven ability to process large volumes of claims on a timely basis; *in 2014, our national Medicaid Division processed more than 60.7 million Medicaid claims, paying 99.77 percent within 30 days.* Amerigroup is confident we can meet Iowa claims processing and payment requirements. The claims processing component of our MMIS fully integrates with all key systems (member, provider, prior authorization, encounter, third party liability, and case management) and accurately and efficiently adjudicates claims.

We will offer providers multiple options for claims submission, including electronic submission via Automated Clearing Houses or our provider website as well as paper claims submission. The claim adjudication process applies edits to all claims based on eligibility, provider status, medical necessity, type and quantity of benefits, pricing, authorization, and third party liability. Through the provider payment process, we receive the adjudicated claims from claim processing and create financial transactions to transfer the calculated funds to the provider, either by check or electronic fund transfer. Our national Quality Process and Improvement Department executes quality audits on all claims as part of our Quality Assurance Program and verifies that we accurately process adjudicated claims. Upon completion of the adjudication process, we offer flexible options and notification vehicles in paying providers, including:

- Electronic deposits directly to designated provider accounts
- Remittance advice statements that can be downloaded electronically and a remittance advice archive with HIPAA-compliant 835 data file compatible with most electronic billing software.

Amerigroup is confident that our claims processing capability will meet or exceed Iowa Initiative requirements. We believe that maintaining a single manual for our providers simplifies the process for those who deliver services across multiple programs. Claims submission procedures are minor and deal primarily with covered benefits and member eligibility requirements. Feedback from providers on our consolidated Provider Operations Manual is positive.

Our providers also have a single point of access for information via our website, Amerigroup.com, and single telephone numbers for our Customer Care Center and our EDI Solutions Center. We will maintain this policy as we implement programs and services for the Iowa Initiative.

Question 13.4, #3

3. Describe your provider claims submission process, including provider communications addressing the provider claims process.

Claims Submission Methods

Amerigroup has instituted fully operational and well-tested procedures to receive and process claims submitted by providers. We accept professional and institutional claims in electronic and paper formats. Electronic claims submission facilitates accurate, timely, and efficient claims processing. We work with a number of clearinghouses to enable providers to submit claims through EDI in HIPAA-compliant ANSI X12 file format. On our provider website, we also list information about web-based claims submission services that providers may choose to use. We recognize that the technology environments and needs of our providers vary, so Amerigroup supports a variety of electronic claims submission solutions.

Providers can find detailed information about submitting EDI transactions in the Provider Operations Manual posted on our provider website and by calling our EDI Solutions Center.

Our experience demonstrates that providers realize a number of benefits when they file claims electronically, including:

- Increased completeness of claims information submitted for adjudication
- Consistency in payment accuracy
- Better cash flow through faster payment turnaround

We actively encourage our network providers to submit claims electronically through:

- Distributing newsletters describing the benefits of EDI
- Posting information on the provider portion of our website
- Discussing EDI with providers as part of the initial contracting process
- Conducting targeted outreach to high-volume providers who continue to submit paper claims to identify any existing barriers that prevent them from submitting electronically and determine how those barriers can be removed

Providers can call our EDI Solutions Center for technical assistance in submitting electronic claims. We train our EDI Solutions Center staff to help providers with initial set up, with specific problems, and with the submission of individual batches or individual claims. When there are major changes, such as the implementation of 5010, our EDI Solutions Center plays a critical role in quickly addressing and resolving provider issues so claims processing is not interrupted or delayed.

Paper claims are scanned and converted to electronic X12 837 claims format throughout each production day. Once the claim is in electronic format, it can be auto adjudicated, which speeds processing, improves consistency, and reduces errors. On average, this cycle occurs within 48 hours of receipt, helping us process clean claims as quickly as possible. Once in the system, we subject paper claims to the same data validation protocols used for electronic claims. We may return paper claims with missing or invalid information to the provider with a "mail back" form enclosed. Once a provider responds, we enter the corrected information and complete the processing.

Regardless of whether a claim is submitted on paper or electronically, providers can access claims status information through Availity.com, a multi-payer portal, and our interactive voice response system.

Provider Communication

Amerigroup uses a variety of methods to communicate with providers about claims submission, including:

- **Provider website** – Using our provider website, providers can verify and update their enrollment data and access plan- and program-specific information, including information on claims submission and billing procedures, our newsletters, and bulletins.
- **Provider Operations Manual** – We post our Provider Operations Manual on our provider website for easy availability.
- **Provider bulletins** – We generally deliver provider bulletins through Amerigroup's Network eUPDATE email service and/or fax blast. We also post provider bulletins on our provider website, distribute them as handouts at Amerigroup workshops, and use them as an educational resource during visits by Provider Services Staff.
- **Training and education** – We educate providers on claims submission using either group seminars and webinars or one-on-one sessions in provider offices at their request. Our locally based Provider Services Staff work in the field and meet one-on-one with network providers and their office staff to educate and answer questions about a variety of topics, including claims submission.
- **Provider calls** – Specialized call center employees work with providers who contact Amerigroup with a question or concern about claims submissions, claims status, authorizations, or any other matter. Our IVR system is also available twenty-four hours a day, seven days a week (24/7) for claims status information.

Providers can call our EDI Solutions Center or our provider helpline for claims submission assistance. Amerigroup's EDI Solutions Center is a special technical support group that assists providers with electronic claims submission while our provider helpline can assist providers with a variety of issues, including:

- Enrolling with Amerigroup or updating enrollment information
- Checking claims status
- Clarifying the reasons for a particular claim denial or a specific payment amount
- Requesting claims submission and payment policies and procedures
- Determining how to request a reconsideration or adjustment
- Filing a grievance

We track the reason for a provider's call and whether or not the call was answered completely or a referral was required. We then use this information to improve provider communications. For common problems, we assess the best method for reaching providers with the information they need—newsletters, special workshops, website updates, and/or updates to our manuals—and take the appropriate action.

Question 13.4, #4

4. Describe policies and procedures for monitoring and auditing provider claim submissions, including strategies for addressing provider noncompliance; include any internal checks and balances, edits or audits you will conduct to verify and improve the timeliness, accuracy, and completeness of data submitted by providers.

Claims Processing Capability (13.4.1)

All Amerigroup claims are subject to periodic quality audits executed by our national Quality Management and Improvement department. Claims quality audits are part of Amerigroup's quality assurance program and verify that we accurately process system adjudicated claims as well as manually adjudicated claims. In addition, we perform specialized audits, including the following:

- **High-dollar audits**—Daily pre-payment audits of all high-dollar claims where the payment amount or the denied claims amount is over specific dollar thresholds
- **Individual focus audits**—Weekly audits on claims from each claims analyst and daily audits of claims during the new-hire training period to determine processing accuracy
- **Focus audits**—Targeted audits on specific claim types, or surrounding processes, to measure performance and remediate claims issues
- **Post-implementation audits on new markets/expansions**—Targeted audits on new or expanded markets to ensure accuracy

Our audit process includes a thorough end-to-end review (from receipt to final disposition) to confirm that we are in line with all federal, State, and internal requirements and with any specifics in the provider contracts. If errors are found, the audit is not closed until the claim is corrected and the correction is validated by the auditor. We work to determine root cause of errors so we can prevent future instances.

We record all audit results, including error sourcing and attribute testing results, and use the data to produce internal and external reports and ad hoc requests. Monthly dashboards present current, quarterly, and year-to-date performance to share with executive leadership and all internal departments involved in the claims process. We track error data over time to identify trends and maintain consistent performance. We conduct trend analyses by market as well as by broad and sub-error category.

To maintain the quality of the audit data, auditors present all identified errors to leadership for review. If the source department and auditor(s) disagree, we follow a formal escalation process. We also have a separate group of senior auditors who "audit the auditors." In addition, we evaluate all auditors quarterly based on key claim processes in a Measurement System Analysis. In this process, auditors review selected claims and compare results against the expert. This process identifies learning opportunities for our auditors and promotes knowledge sharing.

Monitoring Provider Claim Submissions

Amerigroup uses several methods to monitor provider compliance with our claims submission and billing procedures. We subject EDI claims to extensive format and syntax edits. We report and reject exceptions and respond to the provider via their clearinghouse. We closely monitor the number of rejections and initiate contact with any providers with unusually high rejection rates.

Once claims enter our claims processing systems, they are fully edited prior to the automated adjudication process. We may return claims with missing data to the provider, and we deny claims that fail to meet program requirements for member and provider eligibility, benefit coverage, or medical policy. We report denied claims on a Claim Denial Notice sent to the provider.

Amerigroup continually monitors claims processing performance and compliance. Daily, weekly, monthly, and ad hoc reports allow management to monitor and measure processing performance, identify problem areas, and review quality. Reports list the number of pended claims by aging category and allow us to quickly react to any fluctuations in claims submission and volumes. By working pended claims in the order of receipt, we can pay providers efficiently and achieve processing goals.

Management reports summarize the number of denials by type of denial and provider, and, again, any unusually high number of denials for a particular provider will trigger follow-up action with that provider. When we identify common issues, we educate providers through our Network eUPDATE service or fax blasts and incorporate them into our Provider Operations Manual, as indicated.

Claims operations and management analyze claims reports for issues such as possible provider submission problems, system problems, or other areas of improvement. If, for example, we see a high number of claims pending for a specific reason, we will analyze the claims to determine if there is an appropriate intervention, including provider education, reviewing authorization rules, or modifying a system edit. A high volume of claims pending or denying for a specific provider will prompt additional review and often results in proactive outreach to the provider by Amerigroup Provider Services Staff.

Question 13.4, #5

5. Describe your claims dispute procedures.

Claims Disputes (13.4.2)

We maintain robust, effective procedures for our provider complaint and appeal process, from receipt and tracking methods, to escalation processes and resolution timeframe requirements, to follow-up responsibilities. Our comprehensive provider complaint and appeal program includes specialized staff to manage complaints and appeals, systems to track and monitor resolution, tracking and trending of issues to improve processes for providers, and hands-on provider training.

Our provider complaint and appeal process is specific to providers and does not replace the member grievance system. When a provider submits a grievance or appeal on behalf of a member, the requirements of the member grievance system apply.

All disputes between Amerigroup and providers, both in-network and out-of-network providers, will be resolved via a provider payment dispute process that is currently operational in our 19 affiliate state-sponsored program health plans. If the payment dispute involves payment for covered services, we will not charge the member for any portion of the disputed amount.

We designed our Provider Payment Dispute procedure to afford providers access to a timely dispute process. If the provider is dissatisfied with the resolution of a dispute, the provider can file an appeal as outlined in the Provider Manual and can submit a written payment dispute to an address included in the manual. We require all disputes to be submitted within 12 months/365 days from the provider's receipt of the EOP. We will not penalize providers for filing a payment dispute.

We log all provider payment disputes into a reportable database. We maintain the provider claims payment dispute records for a minimum of seven years or in accordance with the respective state or federal laws, regulations, and/or contractual obligations.

See Section 6.1.6 for further information on our provider complaint and appeal process.

Compliance with State and Federal Claims Processing Regulations (13.4.3)

Amerigroup has instituted fully operational and well-tested procedures to receive and process claims submitted by providers. We accept professional and institutional claims in electronic and paper formats. Electronic claims submission facilitates accurate, timely, and efficient claims processing. On our provider website, we also list information about web-based claims submission services that providers may choose to use. We recognize that the technology environments and needs of our providers vary, so Amerigroup supports a variety of electronic claims submission solutions. Amerigroup agrees to comply with the requirements related to claims forms as set forth in Iowa Admin. Code 441 Chapter 80.2. Amerigroup fully complies with applicable federal regulations, including HIPAA regulations related to transactions and code sets and confidentiality and submission requirements for protected health information (PHI). Amerigroup agrees to require that all providers that submit claims have a national provider identifier (NPI) number and will be consistent with 45 CFR 162.410.

Out-of-Network Claims (13.4.4)

We are committed to adjudicating claims in a timely, accurate, and provider-friendly manner. All claims that pass initial edits and are accepted into our highly automated claims processing system, including adjustments, are considered clean claims. We require our affiliate health plans to meet a specific percentage of claims payment within a designated time period, so we design overall claims operations to facilitate claims aging and workflow management. We do not distinguish between in-network and out-of-network claims payment timeliness, and our claims payment timeliness reporting includes both paper and electronic clean claims.

Our core operations system generates daily, weekly, monthly, and ad hoc reports that allow leadership to gauge processing performance, identify problem areas, and monitor quality performance. These reports detail the number of pended claims by aging category and allow us to quickly react to any fluctuations in claims submission and pended volumes. By working pended claims in order of receipt, we can pay providers efficiently and achieve processing goals. We automatically post resolved claims to the next payment cycle and complete adjudication cycles nightly. Two payment cycles are performed each week.

While claims operations monitors performance against claims timeliness standards in each of our affiliate health plans, they also maintain internal standards that are often higher than state requirements. Our Claims Department recognizes that our primary goal is to adjudicate claims quickly and accurately so that providers can receive payment in a timely manner.

We will hold our subcontractors to DHS claims processing standards. We include language in our subcontractor agreements that clearly defines requirements for claims payment timeliness and accuracy. The agreements also specify fines and penalties that we will assess for noncompliance. Further, we require monthly reports from our subcontractors that provide detailed information on claims processing and performance, as well as quarterly reports that include the number of claims received, paid, denied, pended, and adjusted and the number and percentage of claims paid within ranges of days. We meet quarterly with each subcontractor to review the subcontractor's performance and discuss any issues.

Amerigroup will take proactive steps to maintain claims payment timeliness. As noted above, we enter paper claims into the system within 48 hours of receipt, and electronic claims are entered into the system the same day of receipt. Our active encouragement of providers to submit claims electronically is a critical factor in maintaining claims payment timeliness.

Question 13.4, #6

6. Describe proposed processes for collaborating with other program contracts to simplify claims submission and ease administrative burdens for providers.

Coordination among Contractors (13.4.5)

In the state-sponsored programs our affiliates administer in 19 states, it is our standard practice to coordinate with government organizations, providers, health plans, and community organizations to secure services and supports for each member. In Iowa, we will implement effective system-level policies that are important in promoting care coordination in our other programs, such as:

- We will designate staff to regularly meet with system partners and stakeholder organizations.
- We will invite community stakeholders to participate in our training programs and in quality improvement initiatives.
- We will seek opportunities to collaborate with other agencies on health-related initiatives such as strategic planning and strengthening community-based services or supports.

Amerigroup will offer providers three options for submitting electronic claims; we accept claims through:

- Three nationally recognized EDI clearinghouses
- Free of charge through our provider website, including:
- Submission of an 837 file
- Submission of claims entered on-line via Direct Data Entry (DDE)

Availity MPP is a multi-payer portal that will allow our Iowa providers to submit claims to a number of payers through a single sign-on. The Availity MPP offers providers a number of services, including claims submissions, claims status inquiries, claims appeal submission, and eligibility and benefit inquiries. See Section 13.1 for further information on Availity.

A dedicated Amerigroup toll-free hotline is available to answer specific questions related to electronic claims. The hotline employees can help providers with set-up questions and to resolve any submission issues or claim rejections. Provider services staff are also available via a toll-free number to assist providers with any questions or concerns.

Claims Payment Timeliness (13.4.6)

We will pay claims accurately and timely. We understand that timely and accurate payment to providers is critical to maintaining provider satisfaction. Amerigroup has a strong track record of meeting claims payment timeliness standards. Our highly automated claims adjudication process, which processes a high percentage of claims on the first pass, combined with careful attention by our claims operations team to pending claims aging reports leads to our quick, efficient, and consistent performance.

Amerigroup will negotiate payment rates and timeframes with providers mutually acceptable to both and in compliance with RSMo 376.383 and RSMo 376.384. We will also make timely payments to in-network and out-of-network providers subject to applicable conditions within other Section 13.1 requirements regardless of the arrangements between Amerigroup and the providers. Amerigroup is committed to adjudicating claims in an accurate, timely, and provider-friendly manner.

Our National Medicaid Division has extensive experience configuring varied negotiated provider payment rates in our claim payment system across our affiliates' health plans, and we will implement the payment rates as negotiated with providers for DHS.

Claims Reprocessing and Adjustments (13.4.7)

Amerigroup educates providers on how to submit corrected claims. Health Plan IRU teams review claims payments to providers. As they identify root cause issues or payment issues, Amerigroup works with configuration to correct the system and re-process claims and apply interest as applicable. Amerigroup will adjudicate 100 percent of all clean, provider-initiated adjustment requests within 10 business days of receipt. We will also reprocess all claims processed in error within 10 business days of identification of the error or upon a schedule approved by the State.

Member Financial Participation and Cost Sharing (13.4.8)

Question 13.4, #7

7. Propose ideas for handling Medicare crossover claims which reduce the administrative burden on providers.

Amerigroup brings vast experience in working with Medicaid plans where members have dual coverage. In these markets we have worked with the state to obtain the CMS claims files and pull them in daily for our members to process claims for providers. This reduces the administrative burden on the provider in having to submit a claim with a copy of an EOP from Medicare. Amerigroup would then process the claim and pay any co-insurance or deductible always applying lesser of rules and paying only up to the Iowa Medicaid allowable rates. For claims that are not on the files coming over from CMS or other third parties, then the provider would then submit a claim with the copy of the EOP. This happens rarely when Amerigroup is obtaining the CMS paid claims reports for our members.

Question 13.4, #8

8. Describe processes for notifying providers of a member's financial participation or cost sharing requirements.

Providers are sent an explanation of payment (EOP) statement with information explaining the dates of service, diagnosis code(s), charges, amount allowed, amount disallowed, co-pay (financial participation/cost sharing), and payment amount including applicable explanation codes.

In our Virginia affiliate, for duals members we send letters to providers notifying them that they are recognized as the provider with the most authorized HCBS services and will be required to file claims with the member's patient liability and it must be collected directly from the member. The provider bills their full charges and indicates the patient liability on the claims. We would pay the claim less the liability. If the provider fails to bill the liability then based on the information from the State enrollment files we deduct the amount from the provider's payment.

IDPH Prospective Reimbursement (13.4.9)

Question 13.4, #9

9. Describe processes for providing monthly prospective reimbursement to providers of IDPH funded services.

Amerigroup understands that the risk is borne at the provider versus Contractor level for IDPH funded services. We will provide prospective reimbursement each month to contracted IDPH funded substance use disorder network providers. We will pay the provider one-twelfth of its annual contract by the fifteenth day of the month of service. The provider must agree to accept the payments as payment in full for all services provided to clients beyond the client co-pay according to the standardized sliding fee scale. The provider will be required to serve all IDPH Participants who seek services, within capacity constraints, and to serve a minimum number of clients as defined in the contract. A portion of the payment may be withheld if penalties are assessed.

Audit (13.4.10)

Amerigroup agrees DHS reserves the right to perform a random sample audit of all claims. We will comply with the requirements of the audit and provide all requested documentation, including provider claims and encounter submissions in the form, manner, and timeframe requested by the State.

Encounter Claim Submission (13.5)

Question 13.5, #1

1. Describe your policies and procedures for supporting the encounter data reporting process, including:
 - a. A workflow of your encounter data submission process proposed...
 - b. Your operational plan to transmit encounter data to the State...

Encounter Submission Process

The Encounter Claim Submission process begins when a member visits his or her provider. Providers provide services for members and file claims with Amerigroup. The claim is then accepted and loaded into the adjudication system. When the claim is processed and finalized, the encounter process begins. After claims are received, in either paper or electronic form, claims operations and management analyze claims reports for issues such as possible provider submission problems, system problems, or other areas of improvement. If, for example, we see a high number of claims pending for a specific reason, we will analyze the claims to determine if there is an appropriate intervention, including provider education, reviewing authorization rules, or modifying a system edit. A high volume of claims pending or denying for a specific provider will prompt additional review and often results in proactive outreach to the provider by Amerigroup Provider Services Staff.

As shown in Figure 13.5-1, our encounter data process combines claims and claims adjustment data processed since the last submission with encounter claim data from our subcontractors and loads the data into our Encounter Management System (EMS). Controls validate that all retrieved claims and subcontractor encounter claim records load properly for subsequent processing.

Our EMS will edit and process all encounter records against DHS requirements. Business rules evaluate each claim or service line to validate that records meet state-specific processing requirements and confirm the presence and validity of all required data elements, including member and provider data; date of

service; diagnosis; procedure; and revenue codes, date of claim processing, and date of payment. Business rules will be invoked to validate that the encounter records meet Iowa-specific processing requirements.

We pend any claims or service lines that fail an edit or business rule without impacting remaining records. The Encounters Management Team reviews pended records and coordinates corrective action with the appropriate operational unit such as claims or provider data management. We involve subcontractor on errors in subcontractor encounter claims data. Management reports help monitor pended encounters and deliver timely remediation and submission. Corrected encounters are automatically included in the next submission.

We also validate member and product eligibility for the date of the encounter to confirm that all claims are appropriate to be submitted for the market. As with business rule remediation, we pend any encounters that fail compliance checks and submit them after remediation and resolution.

After all issues that can be resolved are addressed, we create a final encounter data file. To confirm compliance, we rerun the file through the HIPAA compliance software, as well as the member/product eligibility check before submission. To complete the submission process, we encrypt the file and place it on the Secure File Transfer Protocol (SFTP) server as designated by the DHS Fiscal Agent. We maintain comprehensive information on each encounter submission, including information on each claim submitted, including claim, line, type (original, adjustment, or void), file, path, and creation date.

Daily encounter aging reports allow the team to remediate encounter records that were pended during the encounter submission process. Employees work with operational departments to resolve issues. Remediated encounter records are included in the next weekly encounter data submission.

Our system compiles encounter records that pass all edits into a HIPAA-compliant X12 837 or National Council for Prescription Drug Programs (NCPDP) D.0 format and then runs the file through HIPAA Level 1-6 compliance and business rule checks. We verify that the encounter file meets format and content rules prior to submission. This is the same software that the DHS Fiscal Agent uses to evaluate the encounter files we submit. Editing our encounter files with a tool that mirrors the exact logic that the DHS Fiscal Agent uses enables us to submit the cleanest data possible and allows us to correct any problems before they become rejections. Please see Attachment 13.5-1 for our Encounter Claims Draft Plan.

Figure 13.5-1 illustrates the flow of the claims submission process *before* the encounter generation and submission process, and Figure 13.5-2 illustrates the flow of the claims submission process *after* the encounter generation and submission process

Figure 13.5-1 Claims Submission Process BEFORE Encounter Generation and Submission Process.

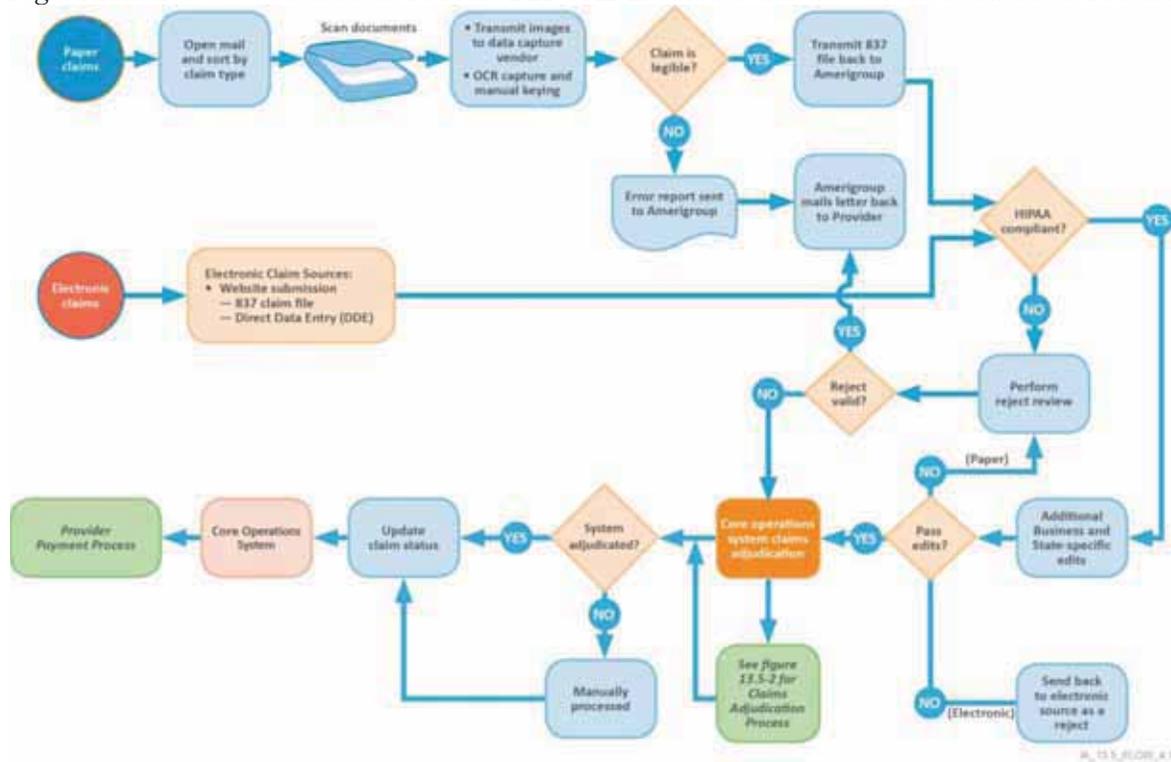
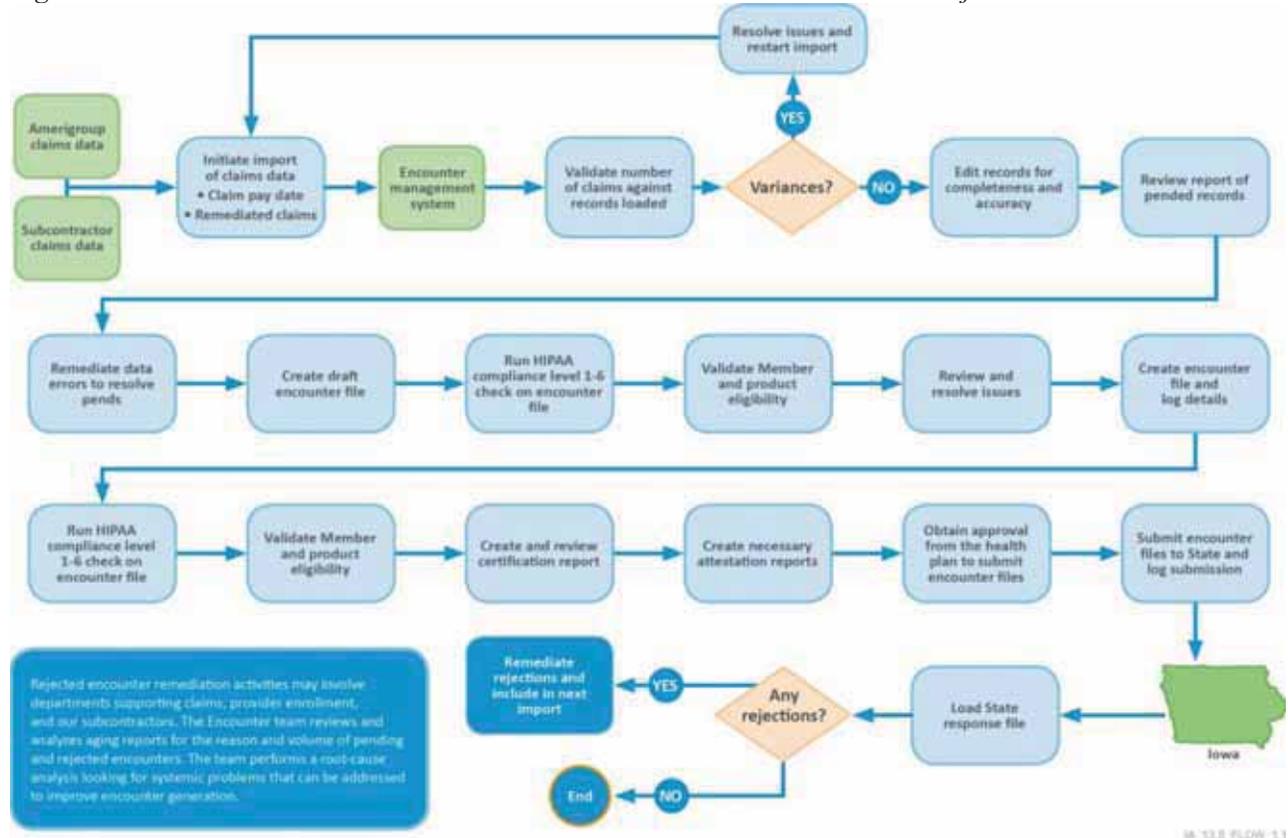


Figure 13.5-2. Encounter Generation and Submission Process AFTER Claims Adjudication



The encounter generation process begins with all the adjudicated claims data from our subcontractors and all the claims and claims adjustment data processed by the Core Operations System since the last submission of encounter records. Claims data is consolidated and stored in the EMS. Adjudicated claims include paid, denied, adjusted, and zero-paid claims. Amerigroup will submit a single 837P, a single 837I, and a single 837D encounter file to DHS containing all encounter data. This process provides consistency regardless of the source of the claim data or type of provider. We will hold subcontractors accountable for the timely and complete submission of encounter data and specify penalties for non-compliance.

The claim data import process includes checks that balance the number of claims contained in the imported files to the number of claims loaded into the EMS. If an imbalance is identified, we investigate and remediate the cause and rerun the load process.

System edits will check for completeness and accuracy, duplicate claims, and verification of provider data and apply business rules to validate that the encounter records meet DHS-specific processing requirements.

We will review and correct records that pend as a result of editing prior to the first creation (draft) of the encounter file. We process the draft encounter file through HIPAA compliance Level 1–6 checks and a process to validate member information. Prior to the next process steps, we identify and resolve any identified issues.

We then generate another iteration of the encounter file through HIPAA compliance Level 1–6 checks and the member validation process. Once the accuracy and completeness of the file have been determined, the certification report and other necessary reports are created. After health plan staff review and approve the encounter file and reports, the file will be submitted to the State.

Robust Claims and Encounter Processes

Amerigroup recognizes the critical value that accurate claims and encounter data bring to effective management of clinical and healthcare services information—and the systems, processes, and staffing necessary to maintain high standards.

We also know the importance of complete, accurate, and timely encounter records, and our results demonstrate our ability to meet DHS quality standards. We transmit encounter files once each week using SFTP and have never missed an encounter file submission deadline, even during major weather events.

After careful review of the Iowa High Quality Healthcare Initiative RFP, we are confident in our ability to meet and exceed the requirements for encounter data with our existing systems, policies, and procedures. The Encounter Management Team in our National Medicaid Division currently provides encounter data to all of our state-sponsored health plan affiliates in 19 states in either an ASC X12N 837 standard or the state's proprietary format, depending on the state's requirements. We are committed to complying with DHS requirements for encounter submission.

The Encounter Management Team has experience with multiple transmission standards and working with state-designated external agencies across our affiliate health plans. We understand the importance of transmitting and receiving encounter data accurately, securely, efficiently, and in accordance with the DHS schedule. Most encounter submissions in our affiliate health plans are transmitted using HTTPS or secure File Transfer Protocol (FTP), and the team is experienced using both methods. DHS will benefit from Amerigroup's tailored service: We will configure our encounter file in accordance with the specific requirements of the Iowa High Quality Healthcare Initiative as specified in 13.1.9.1.

Amerigroup understands and supports the State's need for accurate and timely encounter data to support many purposes such as federal reporting, rate setting, and risk adjustment, payment indication of delivery, services verification, managed care quality improvement activities, utilization patterns and access to care, hospital rate setting, and research studies. We will carefully review available documentation to create compatible encounter files that meet DHS requirements.

We void encounter claims when we discover data is not correct or not valid or when some element of the claims not identified as part of the original claim needs to be changed, unless noted otherwise. Our Encounter Management Team has experience with this requirement in other markets and has the systems and procedures to support the encounter void process.

We will consistently submit accurate, timely, and complete encounter data using dedicated staffing, a robust and proven EMS, and a tightly managed submission schedule. The Encounter Management team will include full-time business analyst staff trained specifically on DHS encounters who will partner with the Information Technology staff and functional departments to meet all encounter submission and reporting obligations.

Rejected Encounters

After the State has processed our encounter file submission, we will receive, process, and review the State response 837 Reject File. We understand the State will apply edits to the incoming encounter files to identify valid and invalid encounter records. We also understand that we will receive Adjudication Confirmation files generated by the State. These files will confirm those encounters that were successfully processed by the State. Additionally, we will receive a weekly Adjudication Rejection File containing those encounters that were initially accepted but were not successfully processed. If the State returns records to us for research and resolution, the Encounter Management Team will carefully review and research all rejections and remediate errors.

The Encounter Management Team uses daily encounter aging reports to identify the encounter records that were rejected during the most recent encounter submission process. Working with operational departments and subcontractors as appropriate, the Encounter Management Team will remediate the rejected encounter records. Remediated encounter records will be included in the next encounter data submission.

The Encounter Management Team aggregates rejected encounters to identify trends and perform root cause analysis and, if necessary, initiates changes to operational and system processes to increase the number of accepted encounter records. If analysis identifies a pattern of deficiencies for specific providers or subcontractors, we will work with the appropriate business function areas to identify and resolve issues.

Submission Acceptance Rate

We will maintain at least a 98 percent submission rate of all encounters submitted to DHS. We will also maintain an encounter acceptance rate of 98 percent as measured by the State agency.

Capitated Services

Amerigroup will contract with most of our providers on a fee-for-service basis, which inherently drives claims submission and quality results in encounter data. For those few arrangements in which we may have capitated provider reimbursement, we will require the provider to submit encounter data as zero-pay claims. Claims from capitated providers will process through our Core Operations System, will receive all the same edits and validations, and will become part of the overall claims data set extracted by the EMS for encounter submission.

Amerigroup understands that not including encounters for providers contracted though capitated reimbursement may result in a corrective action for the health plan.

Audit Process

We will implement policies and procedures to validate that encounter claims submissions are accurate. We agree DHS reserves the right to monitor encounter claims for accuracy against our internal criteria, as well as State and federal requirements. In addition, DHS may regularly monitor our accuracy by reviewing compliance with our internal policies and procedures for accurate encounter claims submissions and by random sample audits of claims. We understand and will comply with requirements

of these audits and provide all requested documentation, including applicable medical records and prior authorizations. We will submit a corrective action plan and will require non-compliance remedies for failure to comply with accuracy of these reporting requirements.

To evaluate claims payment accuracy, we will audit a random sample of Iowa claims each month. The sample will include claims from providers, including vision and non-emergency medical transportation; nursing facility claims; and home- and community-based waiver claims.

To further assess claims payment accuracy, we perform additional audits, including the following:

- **High-dollar Audits**—Daily pre-payment audits of all high-dollar claims where the payment amount or the denied claims amount is over specific dollar thresholds
- **Individual Focus Audits**—Weekly audits on five claims from each claims analyst to determine processing accuracy and daily audits of 10 claims during the new-hire training period (Results impact performance management and process improvement of manually processed claims.)
- **Focus Audits**—Targeted audits on specific claim types or surrounding processes to measure performance and remediate claims issues
- **Post-implementation Audits on New Markets/Expansions**—Targeted audits on new markets/expansions to ensure accuracy

Our audit process includes a thorough end-to-end review (from receipt to final disposition) to assure that we are in line with all federal, state, and internal requirements, and any specifics in the provider contracts. If errors are found, we do not close the audit until the claim is corrected and validated by the auditor. We work to determine root cause of errors so we can prevent future instances.

In the event we process a claim in error, we will give providers multiple avenues to pursue resolution:

- Call Provider Services. Dedicated employees trained to answer provider claim inquiries review the claim and either educate the provider on why the claim was processed correctly; immediately reprocess the claim for correct payment; or forward the claim for further research and resolution to the Internal Resolution Unit (IRU). The IRU is a team of expert claim reviewers dedicated to resolving claim inquiries by identifying and resolving the root cause of the error for correct payment or educating the provider on the accuracy of the claim's original payment.
- Call their assigned Provider Services Staff. The representative will submit the claim inquiry to the IRU for research and resolution.
- File a formal claim dispute. We maintain a department dedicated to researching and resolving claim disputes within 30 days of receipt.

Definition and Uses of Encounter Claims (13.5.1)

Amerigroup's encounter claim process will be maintained and geared to meet the State's requirements. We agree to submit an encounter claim to the State or its designee for every service rendered to a member for which Amerigroup has either paid or denied reimbursement. We agree the State shall primarily use encounter data to calculate the Amerigroup's future capitation rates, with alternative data sources utilized as appropriate to meet actuarial and federal standards. We acknowledge that encounter claims data will also be a source used to calculate any liquidated damages assessed to Amerigroup.

Reporting Submission Schedule (13.5.2)

Amerigroup agrees to submit encounter claims in an electronic format that adheres to the data specifications set forth by DHS and in any State or federally mandated electronic claims submission standards. We will submit encounters weekly (medical and pharmacy) if we are allowed. These submissions will include all claims finalized for the week prior or received by our subcontracted vendors the prior week. All remediable errors will be fixed within the timeframes required. We will provide the

State with all of the remedies available under the Contract, including liquidated damages, for failure to comply with these requirements. Further, we agree pharmacy encounter data must be submitted for adjudicated claims weekly in support of the IME's pharmacy drug rebate invoicing process identified in Section 3.6.2.11.

Amerigroup processes encounter claims weekly. We agree encounter data must be submitted by the 20th of the month subsequent to the month for which data are reflected, but will also be submitted weekly. We will finalize all corrections to the monthly encounter data submission within 45 days from the date the initial error report for the month is sent to Amerigroup or 59 days from the date the initial encounter data were due. Our error rate for encounter data will not exceed one percent.

Encounter Claims Policies (13.5.3)

Amerigroup will maintain policies and procedures that support encounter data reporting for the Iowa Initiative. These policies and procedures will reflect requirements listed in Section 13.5 and will address submission of encounter claims to DHS. Amerigroup agrees to submit our draft plan to the Agency within 30 days of Contract execution, and a final plan, incorporating any feedback from the Agency, within 60 days of the official submission of the plan. We will resubmit a work plan annually.

Accuracy of Encounter Claims (13.5.3.1)

Verifying Accurate Submission

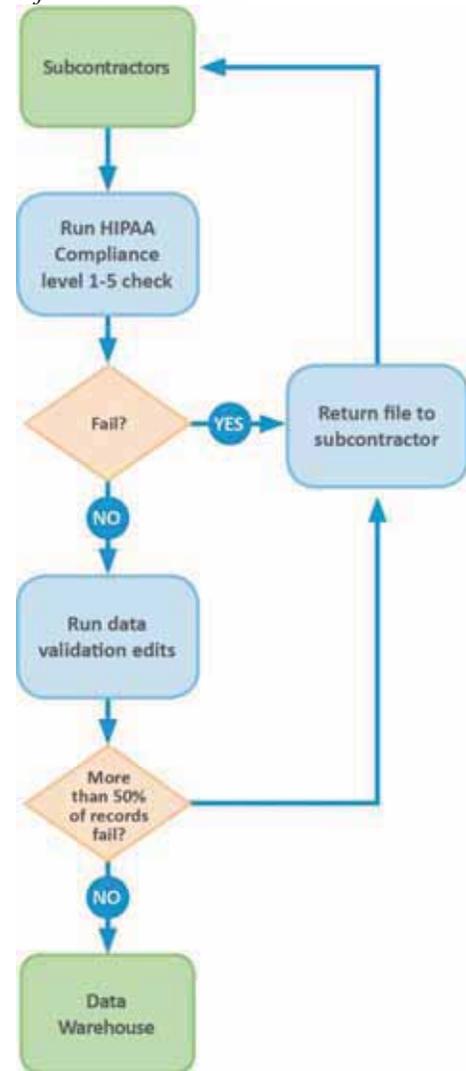
Amerigroup requires that our subcontractors submit encounter claim files in HIPAA-compliant X12 or NCPDP format and with the required data elements as specified in the Encounter Data Companion Guides. As shown in Figure 13.5-3, our encounter process includes several steps to verify the accuracy of subcontractor encounter claims files we receive.

First, we run HIPAA level 1-5 compliance checks. If any record in the file fails, we reject the submission and return the file to the subcontractor with the reason for the failure. Subcontractors typically submit a corrected file within 24-48 hours.

After passing the HIPAA compliance check, the file goes through a set of data validation edits, including checks for claims previously submitted, duplicates within the same file, and member eligibility. The process marks individual encounter claim records that fail validation edits as rejected and returns them to the subcontractor in a HIPAA-compliant file so they can initiate a correction/re-submit action. If more than 50 percent of individual encounter records fail, we reject the entire file, and we notify the subcontractor. We track rejected records to verify that subcontractors re-submit within 30 days.

We load subcontractor encounter claim records that pass validation edits into our data warehouse for inclusion in our weekly DHS encounter process.

Figure 13.5-3. Subcontractor Files are Subject to Validations



IA_13_FLOW_1.1

Our weekly encounter data process combines claims processed by Amerigroup with encounter data from our subcontractors and loads the data into our EMS for further processing. Edits confirm the presence of Critical Data Elements prior to submission to DHS's Fiscal Agent. Please see our response to Section 13.5 for more information on our process to submit encounter files to DHS.

We carefully review the response file we receive from the DHS Fiscal Agent and evaluate any rejected encounter records. We work with the subcontractor to resolve any rejected encounter claim records. As necessary, we perform a root cause analysis to understand the reason for the error and identify opportunities to mitigate future rejections.

Maintaining Timely, Accurate, and Complete Encounter Data

Our national Encounter Management Department manages our submission encounter data through dedicated staffing, a robust EMS, and a tightly managed submission schedule. The EMS is a critical component of our MMIS and is highly customizable to meet the encounter data requirements of each of our state partners. The EMS includes controls that allow the Encounter Management Team to closely monitor compliance with DHS requirements during the creation of each encounter data file.

We have established policies and procedures that will support encounter data submission for the Iowa Initiative. These policies and procedures reflect requirements in the Encounter Data Companion Guides and Contract compliance requirements. Our systems, strict processes, and tight controls allow us to deliver:

- **Timely Encounter Data.** Our submission schedule is designed to meet DHS submission requirements and includes adequate time for careful review and remediation of any errors.
- **Accurate Encounter Data.** We will edit incoming provider claims and encounter claims from our subcontractors for the presence and validity of required data elements, and we will apply business rule edits and HIPAA compliance checks prior to encounter data submission to DHS's Fiscal Agent. Business rule edits will verify that encounter records meet DHS requirements, including Critical Data Elements and other required fields, and allow us to maintain a low Encounter Error Rate.
- **Complete Encounter Data.** We will maintain strict controls throughout our operational environment to deliver complete encounters to DHS. Our encounter process captures all paid, denied, and adjusted claims, paper and electronic, and combines them with encounters from subcontractors into a complete submission.

Our experience demonstrates our ability to successfully meet DHS requirements for encounter data submission:

- **Timeliness.** Amerigroup has submitted weekly encounter files in a timely manner since we began operations
- **Accuracy.** Our current Encounter Error Rate is consistently one to two percent, significantly less than the five percent requirement across our affiliate health plans

The section below provides a brief overview of the process our national Encounter Management Team executes to deliver weekly encounter data files that meet program requirements.

Encounter Data Completeness (13.5.3.2)

Monthly Verifications of Encounter Completeness

Each month, we verify the completeness of our encounters using a process that mirrors the one used by the State's Recovery Audit Contractor, Myers and Stauffer. We execute this process for encounter claim data submitted by our subcontractors and for our own paid claims data. Understanding variances early will allow us to be proactive in investigating and resolving discrepancies and deliver complete encounter data to DHS.

Each month, we proactively verify the completeness of our encounter data using a process that mirrors the one used by Myers and Stauffer.

For our dental and vision subcontractors, we reconcile the encounter claim data received against the provider payments they report, and for our pharmacy subcontractor, we reconcile encounters against the invoice received. For our own paid claims data, we reconcile encounters against the same cash disbursement journal data we provide to Myers and Stauffer.

If discrepancies exist, the Encounter Management team performs a root cause analysis to determine the source of the problem. The discrepancy may be due to a number of factors, including rejected encounters, the cash disbursement journal data, or claims payment issues. The team will engage representatives from appropriate

departments to effect resolution. For discrepancies with subcontractor encounters, the Encounter Management Team will engage our national Vendor Contracts and Management and will collaborate with the subcontractor to determine the root cause of the problem and the best path to resolution.

Question 13.5, #2

2. Describe your experience and outcomes in submitting encounter data in other states.

Experience Submitting Encounter Data in Other States

Amerigroup has affiliates in 19 states covering more than 5.2 million members in state-sponsored programs. Across all markets, we submit more than 10.5 million encounters to our state partners each month. Our national experience allows us to leverage best practices across all of our state partners. Our experience demonstrates the strength of our system, process, and commitment.

Amerigroup’s affiliate health plans currently administer managed care services for beneficiaries of all populations included in the Iowa Initiative, providing our national encounters management organization with valuable experience to draw upon for the Iowa Initiative. Our national experience and outcomes submitting encounter data for our state-sponsored programs in other states demonstrates our commitment and our success. As we implement programs and services for the Iowa Initiative, we will leverage our experience in affiliate states serving a similar population to deliver timely, accurate, and complete encounter data.

Third Party Liability (TPL) Processing (13.6)

TPL Responsibility (13.6.1)

Question 13.6, #1

1. Describe your plans for coordinating benefits in order to maximize cost avoidance through the utilization of third-party coverage.

Plan to Coordinate Benefits and Maximize Cost Avoidance

Amerigroup Iowa (Amerigroup) recognizes the importance of a strong Third Party Liability (TPL) cost avoidance and recovery program in lowering costs. We maintain sound fiscal management practices by staffing a corporate Cost Containment (CC) Department responsible for a wide variety of programs, including identification of Other Health Insurance (OHI), cost avoidance through Coordination of Benefits (COB), overpayment/collections, and subrogation. We leverage experienced financial personnel,

technology, and automated applications, and consistent, replicable processes. Our Cost Containment Program focuses on:

- Cost avoidance through COB prior to claim payment
- Post-payment recovery after payment of a claim

We design our cost avoidance efforts so that Medicaid is the payer of last resort. Recovery efforts will bill liable third parties following our payment of a claim. Recovered funds will be applied to claim records and reflected in encounter files. ***Amerigroup will comply with all activities laid out in the Iowa Department of Human Services Medicaid TPL Action Plan.***

Our guiding principle is that **member access to medically necessary services is paramount**. Cost avoidance and recovery strategies prudently manage Medicaid funds with the least impact on providers and members. Further, our approach includes working with network and out-of-network providers to identify and resolve the root causes of inappropriate billing.

Our Cost Containment Program uses experienced employees, strategic vendors, and documented policies and procedures to maximize the identification and recovery of TPL. In our culture of continuous improvement, the CC Department regularly evaluates the program to:

- Accurately identify and maintain comprehensive OHI information on our members
- Increase the number of claims where OHI and TPL are identified prior to claims payment
- Raise the percentage of post-payment recoveries

In addition to our employees experienced and skilled in TPL/COB programs, we also have structured strategic partnerships with industry-leading vendors who specialize in key aspects of TPL/COB identification and recovery. These vendors assist our CC Department employees with:

- **COB Recovery** – Identifies OHI and recovers any payments associated with COB from the provider or directly from the primary carrier through Medicaid reclamation. OHI identification uses a repository that includes health information from more than 150 health insurance organizations, as well as telephonic and online verification tools to facilitate prompt confirmation
- **Subrogation** – Assists with TPL subrogation cases, including the initial identification of liable third parties, such as auto carriers, through final payment recovery/reimbursement and case closure
- **Credit Balance Recovery** – Conducts ongoing audits across our provider network to identify credit balances on a providers' accounts receivable

Amerigroup Seeks to Maximize Cost Avoidance

Amerigroup emphasizes and prefers prospective cost avoidance versus retrospective pay-and-chase whenever possible. Identifying OHI coverage and TPL prior to claims payment minimizes the need for more difficult and costly post-payment recoveries.

We employ a number of cost avoidance strategies, including capturing OHI data from all available sources, validating OHI leads, storing OHI information on a member's electronic record, and applying extensive edits in our claims processing system. We strive to maximize the identification of OHI and TPL and increase cost avoidance by:

- Capturing any available data regarding OHI, including receipt and processing of an electronic file from our state partners



- Dedicating staff to the daily review and update of potential OHI and TPL leads received from members and providers
Validating potential OHI leads with the primary carrier and information stored in the member's electronic record
- Reporting members identified as having Medicare or other coverage to our state partners
- Incorporating a series of edits into our claims processing system to identify alternate insurance information
- Suspending claims where OHI data is attached to the member record and triggering them for follow-up
- Automatically incorporating COB information into the claims adjudication process
- Evaluating root cause analysis and educating providers to reduce billing errors

While we will actively pursue legal avenues to recoup Medicaid monies, we carefully evaluate all cost avoidance strategies to assure that they do not prevent our members from receiving medically necessary services.

Identifying Other Health Insurance Information

Amerigroup stores in each member's electronic record any available data regarding alternate insurance carriers, such as a commercial health care insurer or HMO; TRICARE (the health care program for active duty service members, National Guard and Reserve members, retirees, their families and others); or an employer-administered Employee Retirement Income Security Act of 1974 (ERISA) plan. Sources for this information include state-identified OHI, Amerigroup's recovery vendor, providers indicating this information on or with claim submissions, and Amerigroup Provider Services or Member Services Representatives.

All potential OHI leads are submitted to a dedicated unit for validation. These employees conduct a daily review of all potential OHI and TPL leads received throughout the company from members, providers and others. The information is validated with the primary carrier; and if appropriate, it is added to the member's record on a COB tab. The COB tab includes the policy issuer and number, effective and termination dates, and last date verified. The tab also identifies the policy holder, which is important if the member is a child and the insurance coverage is through an absent parent. For members with such information noted in their record, COB is automatically incorporated into the claim adjudication process.

We regularly share member demographic data with our COB recovery vendor who uses the demographic data to search an extensive data repository of OHI information for any new, modified, or terminated coverage for members. The findings are reported at least monthly to the CC Department for validation and addition to the member's record on the COB tab.

Cost Avoidance is Integrated with Claims Adjudication

Amerigroup's claims processing system is fully integrated with our TPL process to:

- Capture OHI information contained on the claim
- Evaluate OHI information stored on the member's electronic record
- Suspend claims where OHI or TPL is indicated, unless the service is designated pay-and-chase

Our claims process effectively supports cost avoidance by automatically incorporating a series of edits that prospectively identify and correct potential overpayments based on current alternate insurance information housed in a member's medical record.

When alternate insurance is noted with the claim or we have alternate coverage information on file, the information is included on the COB tab of the member record. The record notes the policy issuer and

number, effective and termination dates, and last date verified. If OHI exists on the member record, COB is automatically evaluated during claims adjudication.

During adjudication, our claims processing system compares the submitted Dates of Service (DOS) to the effective and termination dates of the OHI coverage on the member record. If the claim DOS are within the OHI effective and termination dates, the claim is suspended for additional analyst review. If the analyst determines the claim is eligible for cost avoidance, they will coordinate the claim based upon our COB guidelines. For example, if an OHI source is identified and the required Explanation of Benefits (EOB) is not attached, we will notify the provider that it must be submitted to the appropriate third party for a determination of the OHI amount. If the required information is attached to the claim, the claim is suspended for additional analyst review prior to final adjudication. We use this information to assure the total benefits issued by the primary carrier and Amerigroup do not exceed Medicaid's allowed amount. In certain circumstances, such as claims for EPSDT/preventive services or when the primary coverage is held by an absent parent, we will pay the claim first and then pursue recovery.

Post-Payment Recovery Efforts are Captured in the Claim Record

Once we adjudicate claims and disburse payments, we analyze data to retrospectively identify opportunities for COB or TPL recoveries. We provide our recovery vendor with a monthly data file of all processed claims with associated member and provider data. They compare claims information against their data repository that contains health information from more than 150 health insurance organizations, identify the appropriate primary carrier, and bill them for payment.

When overpayments are identified, we gather all claims documentation and send written notification to the provider of the overpayment, furnishing supporting documentation. We offer providers the option of refunding the overpayment directly to Amerigroup or offsetting future payments by the overpayment amount. We wait a minimum of 45 days for the provider to respond to the written request. Once we receive confirmation, we adjust the individual claim record and configure the record to either accept a refund or withhold future payments up to the overpayment amount.

All reimbursements are directed to Amerigroup and recoveries are noted in the claims record for reporting to our state partners. When new OHI information is identified, it is incorporated into the member record to facilitate COB for future claims. See Figures 13.6-1 and 13.6-3 for an illustration of our process.

Figure 13.6-1. COB Verification

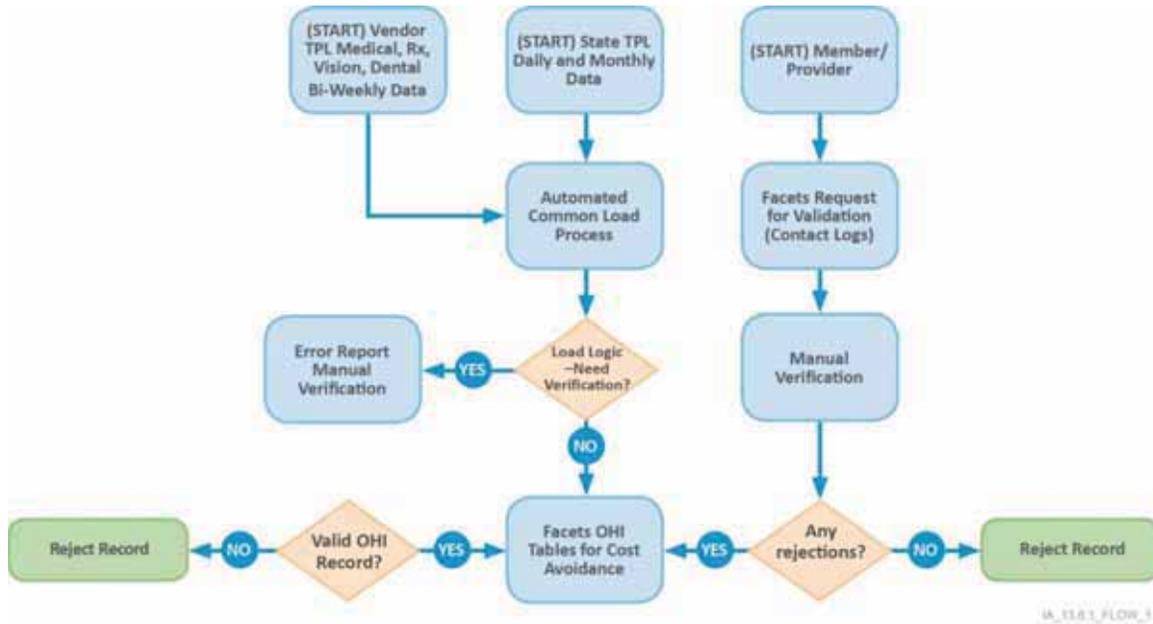
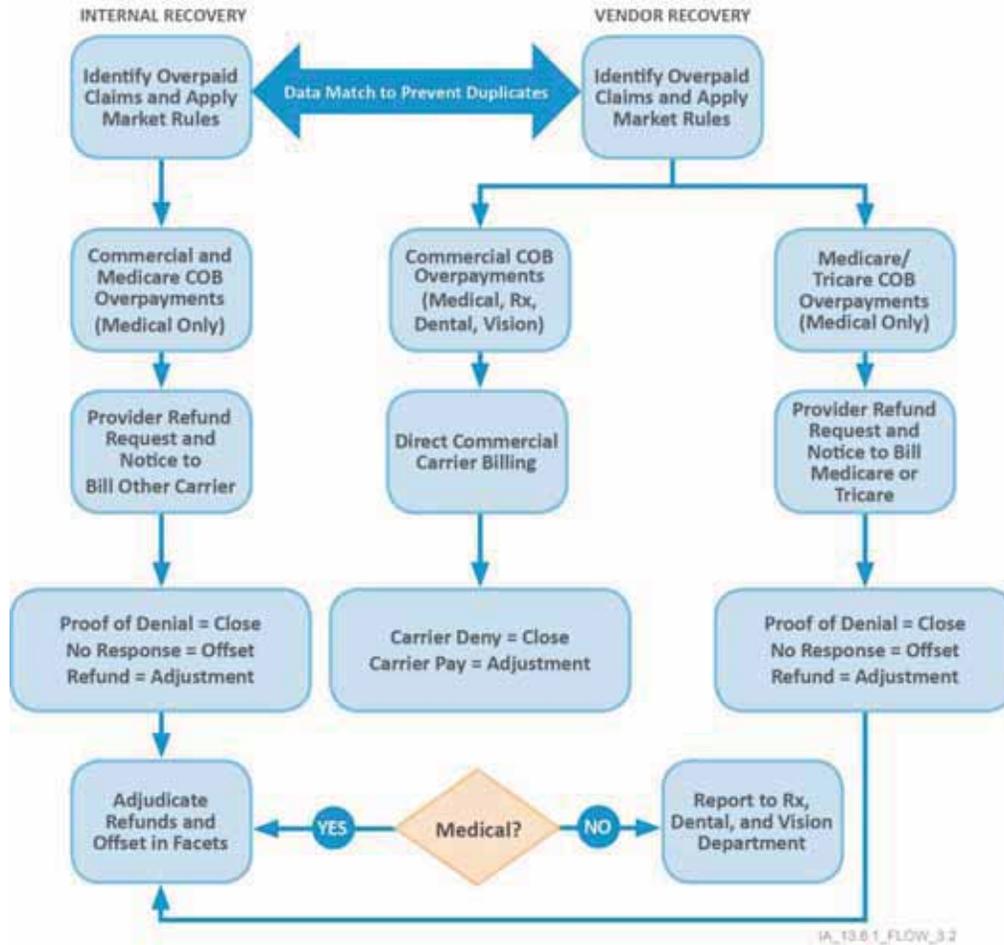


Figure 13.6-3. COB Post Payment Recovery Process



Question 13.6, #2

2. Describe your process for identifying, collecting, and reporting third-party liability coverage.

Process for Identifying, Collecting, and Reporting TPL Coverage

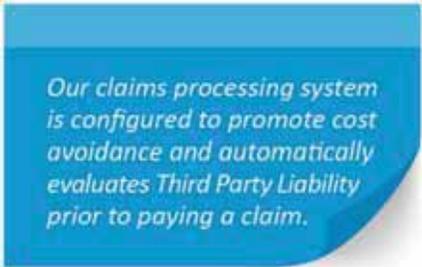
A key part of the claims adjudication process is TPL processing. The member's data is interrogated for the presence of an OHI. If no OHI is indicated, the claim resumes processing. If the member has an OHI or another insurer's EOB is attached to the claim, the claim is pended for further review. If the claims analyst review verifies the member has another insurer, the TPL guidelines are applied—cost avoidance, pay and chase, or other state exceptions. The claim then resumes processing.

A centralized Coordination of Benefits team validates all potential OHI leads. The team conducts research to validate other coverage, collects necessary detail, and takes appropriate actions to update member records so claims process appropriately. Once member data is updated, the Recovery team will identify any claims that were overpaid and initiate recovery actions.

During adjudication, our claims processing system compares the submitted dates of service to the effective and termination dates of the OHI coverage on the member's record. If OHI is found and the claim is submitted without evidence of being paid or rejected by the other insurer, the claim is denied and returned to the provider. The provider must submit claims to the primary payer first and then submit them to Amerigroup to coordinate any remaining balance, if applicable.

We will continue to coordinate benefits and payments with the health or casualty insurer for services authorized by Amerigroup but provided outside our network. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the enrollee or provider of service by Amerigroup will not prevent or unduly delay an enrollee from receiving medically necessary services.

As secondary payer, we will reimburse the provider the maximum allowable Medicaid benefit payment, less any amounts paid by other payers. We understand that Amerigroup is wholly responsible for any services we cover that are not covered by the other insurer. A centralized Coordination of Benefits team validates all potential OHI leads. The team conducts research to validate other coverage, collects necessary detail, and takes appropriate actions to update member records so claims process appropriately. Once member data is updated, the Recovery team will identify any claims that were overpaid and initiate recovery actions.



Our claims processing system is configured to promote cost avoidance and automatically evaluates Third Party Liability prior to paying a claim.

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During adjudication, our claims processing system compares the submitted dates of service to the effective and termination dates of the OHI coverage on the member's record. If OHI is found and the claim is submitted without evidence of being paid or rejected by the other insurer, the claim is denied and returned to the provider. The provider must submit claims to the primary payer first and then submit them to Amerigroup to coordinate any remaining balance, if applicable.

Post-payment TPL Identification and Recovery

Once we adjudicate claims and disburse payments, we analyze data retrospectively to identify opportunities for COB or TPL recoveries. Once a month, we send our paid claims, membership, and other data to our recovery vendor. Our recovery vendor identifies claims that have been paid by Amerigroup that are potentially the responsibility of another payer and sends letters to providers requesting refunds. We maintain a lock box where we instruct participating providers to direct their refunds. After 45 days, we receive a list of claims for our participating providers on which no refunds have been received. Amerigroup then takes the outstanding balances of the overpaid claims and establishes an account receivable for the provider. Our claims payment system offsets future claims against the outstanding

balances until the money has been recouped. Our recovery vendor pursues recoveries from nonparticipating providers.

Sources of TPL (13.6.1.1)

Amerigroup agrees applicable liable third parties can be held legally responsible for the payment of all or part of the medical costs of a member. We identify trauma and accident cases where funds expended can be recovered from liable third parties and recover the funds.

A claim submitted to Amerigroup for payment in which indicators suggest the service rendered is the result of an automobile, liability, or workers' compensation injury or illness may mean that another entity has primary responsibility for the cost of health care services. We will pay the provider for the service rendered and then evaluate claims data in accordance with diagnosis and trauma codes designated in the code of federal regulations. Specifically, we use the diagnosis codes identifying injury or poisoning in the range between 800 and 999.9 (excluding 994.6) in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and "E" codes (External Causes of Injury and Poisoning) in the range between E800 and E998. If we determine that pursuit of payment by another entity may be appropriate, we establish a case for further investigation and recovery of payments made.

TPL Data (13.6.1.2)

Amerigroup agrees to share information regarding members with other payers as specified by DHS and in accordance with 42 CFR 438.208(b). In the process of coordinating care, we protect each member's privacy in accordance with the confidentiality requirements stated in 45 CFR 160 and 164. We agree that DHS will provide information on member TPL that is collected at the time of Medicaid application and through ongoing TPL identification processes. We will report weekly any new TPL to DHS to retain in the TPL system. The information collected will contain the following:

- First and last name of the policyholder
- Social security number of the policyholder
- Full insurance company name
- Group number, if available
- Name of policyholder's employer (if known)
- Insurance carrier ID
- Type of policy and coverage

We will implement strategies and methodologies to assure the collection and maintenance of current TPL data, including recoveries from direct billing, disallowance projects, and yield management activities.

Cost Avoidance (13.6.2)

To avoid overpayment, the Amerigroup claims adjudication system incorporates a series of edits to prospectively identify and correct potential overpayments based on current alternate insurance information housed in a member's record on the COB tab. These edits also check for inappropriate coding of charges or bundling of services and incorrect coding of procedures on submitted claims. When a member has coverage with another primary carrier, incoming claims are automatically pended for review when loaded into our core operations system. From this review, the claim record is updated with primary carrier payment information.

During adjudication, our claim system's COB logic rules compare the submitted dates of service to the effective and termination dates of the other health insurance coverage on the member's file. If the dates of service on the claim are within the other health insurance effective and termination dates, the claim is suspended for additional analyst review according to our COB guidelines. If the claim reflects adjudication by the identified primary carrier and the required EOB documentation is attached, the analyst reviews the claim to assure that any copayment, coinsurance, or deductible amount required by the primary carrier is considered in determining any balance due to the provider and that the combined payments by the carrier and Amerigroup do not exceed allowable amounts. If the claim does not reflect

adjudication by the identified primary carrier or references payment, but the required EOB documentation is not attached, Amerigroup returns the claim to the submitting provider with instructions to bill the appropriate third party for payment adjudication and then re-submit a claim to Amerigroup if there is a balance owed. Claims/services appropriate for “pay and chase” are an exception. These claims are paid if other coverage criteria are met. See more about pay and chase below.

Provider Education (13.6.2.1)

Our provider education and training program is built on our experience working with provider communities through our affiliate health plans in 19 states. Through this experience, we have learned what types of training work best with different providers and what information they value most. Specific to billing requirements, we educate providers through:

- In-person and live webinars
- Online tutorials
- Our Provider Manual
- Newsletters and fax blast updates

Regular contact with our Provider Services Staff

Our Iowa-based Provider Relations Representatives have experience and understanding of provider office functions and challenges. They receive and review claims trending reports for their assigned providers and present individualized coaching on billing requirements to facilitate prompt payment.

Initial Education and Training

For new providers joining our network, Table 13.6-1 outlines our initial training topics on billing. A newly contracted provider completes initial training within 30 days of going on active status with our network. Qualified Amerigroup Provider Services Staff and leadership team members conduct the training. We post all materials from training sessions to our provider website.

Table 13.6-1. Billing-related Topics Covered in Initial Training

Topic	Provider Education
Eligibility Verification	<ul style="list-style-type: none"> • Enrollment and eligibility for the program • How to verify member eligibility
Covered Services and Cost Sharing	<ul style="list-style-type: none"> • Covered services • Prohibition against member cost-sharing
Claims Submission Guidelines and Processes	<ul style="list-style-type: none"> • Claims submission requirements and timeframes • Clean claim requirements • Electronic claims submission process • Electronic Funds Transfer (EFT) setup
Provider Payment Guidelines and Processes	<ul style="list-style-type: none"> • Reimbursement policies (policies are available on our provider website) • Payment cycles (Amerigroup runs twice weekly payment cycles) • Explanation of Payment (EOP) and Remittance Advice generation, content and timeframes (providers are given their choice of remittance options, including RAs in HIPAA-compliant 835, PDF, and HTML formats, as well as hard copy; and checks or EFT for payment) • Interest payments
Prior Authorization and Referrals	<ul style="list-style-type: none"> • Services requiring prior authorization and referral • Prior authorization and referral submission requirements and timeframes (Amerigroup provides real-time authorizations for telephonic and online requests from providers) • Use of evidence-based and nationally accepted clinical criteria • Decision timeframes • Demonstration of the look-up tool on our provider self-service • Website

Topic	Provider Education
Grievances, Appeals and Claims Disputes	<ul style="list-style-type: none"> • Provider complaint, grievance and appeal, and claims dispute processes and timeframes (phone, web, and mail submissions)
Provider Website	<ul style="list-style-type: none"> • How to access our self-service tools • How our site interacts with Availity.com, a multi-payer portal • A demonstration of each site’s and tool’s functionalities
Third Party Liability	<ul style="list-style-type: none"> • Overview of TPL Processing
Fraud and Abuse	<ul style="list-style-type: none"> • Prohibitions against fraud and abuse • Reporting and compliance • How to contact our Office of Business Ethics with concerns or questions

Customized Training for Specific Provider Types

We tailor our training to meet the needs of specific types of providers. For instance, we provide hospitals with a separate, comprehensive orientation session that includes policies, procedures, and formal agreements for communications between our Medical Management team and the hospital. We conduct ongoing Joint Operating Committee meetings with them to provide further education and address any operational issues. Amerigroup is prepared to educate new providers on The Iowa Initiative. We will work personally with them, explaining billing and authorization guidelines. We will closely track cycles of claims payments to these critical providers. While the claims may well be within DHS standards for cycle time, we follow-up internally as necessary to promote more rapid payment. This helps avoid disruption of services, and in particular, disruption of important relationships between members and provider staff that can be critical to avoiding acute inpatient hospitalizations or nursing facility admissions.

Our Provider Website

To simplify practice management, our provider website also supplements live training by allowing providers to review billing and claims payment information, including:

- Important billing news and administrative updates
- Claims submission and status
- Prior authorization requirements and requests status

Cost Avoidance Requirements (13.6.2.2)

If insurance coverage information is not available or if one of the cost avoidance exceptions described below exists, Amerigroup agrees to make the payment and make a claim against the third party, if it is determined that the third party is or may be liable. We will always make sure that cost avoidance efforts do not prevent a member from receiving medically necessary services in a timely manner.

Cost Avoidance Exceptions – Pay and Chase Activities (13.6.2.3)

Amerigroup agrees to first pay the provider and then coordinate with the liable third party. We will not require providers to bill the third party prior to Amerigroup in the following situations: (i) the claim is for prenatal care for a pregnant woman; (ii) the claim is for coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency and the provider of service has not received payment from the third party within 30 calendar days after the date of service; or (iii) the claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, we will actively seek reimbursement from responsible third parties and adjust claims accordingly.

Collection and Reporting (13.6.3)

Our Finance Department will track TPL collections and report these collections to DHS as required. We will track cases until each case is settled or closed and update claims history files to reflect subsequent recoveries or settlements.

Amerigroup agrees to identify, collect, and report third party liability coverage and collection information to the State. We will maintain records regarding third party liability collections and report these collections to DHS in the timeframe and format determined by DHS. We will retain all third party liability collections made on behalf of our members. We will not collect more than what has paid out for any claims with a liable third party. We will provide to the State or its designee information on members who have newly discovered health insurance, in the timeframe and manner required by DHS. We will provide members and providers instructions on how to update TPL information on file and shall provide mechanisms for reporting updates and changes.

We produce the following reports:

- Monthly amounts billed and collected, current and year-to-date
- Quarterly recoveries and unrecoverable amounts by carrier, type of coverage, and reason
- Quarterly TPL activity reports
- Internal reports used to investigate possible third-party liability when paid claims contain a TPL amount and no resource information is on file
- Monthly quality assurance sample verifying the accuracy of the TPL updated applied during the previous month
- Monthly pay-and-chase carrier bills

Other Insurance for IDPH Participants (13.6.4)

Amerigroup has a long-standing history of open communication and collaboration. We agree to work closely with the State and providers to develop policies regarding IDPH eligibility for persons with insurance coverage.

HIPP Program (13.6.5)

Question 13.6, #3

3. Describe your process to identify members with third party coverage who may be appropriate for enrollment in the Health Insurance Premium Payment (HIPP) program.

Amerigroup understands that Health Insurance Premium Payment (HIPP) program helps Medicaid-eligible individuals get insurance or keep insurance by reimbursing the cost of premiums when doing so is cost-effective for the State (meaning that it will cost the State less to reimburse all or a portion of a member's health insurance premium than for Medicaid to pay all of the costs). We identify members with third party coverage who may be appropriate for enrollment in the HIPP program through a variety of sources including State-identified OHI, our vendor partners, claim submissions, and our Provider Services or Member Services Representatives.

Amerigroup agrees to identify, collect, and report members with third party coverage who may be appropriate for enrollment in the HIPP program to the Agency in the timeframe and manner to be determined by the Agency. We acknowledge that the Agency maintains full and final authority for determining if an individual is eligible for HIPP.

Health Information Technology (13.7)

Amerigroup Iowa (Amerigroup) understands that Health Information Technology (HIT) and data sharing initiatives help drive fundamental changes that will transform healthcare delivery. We support DHS’s commitment to using HIT and data sharing to improve health status, achieve better health outcomes, improve service delivery, and maximize patient safety.

With 24 years of experience supporting publicly funded programs in 19 states and Amerigroup and our affiliate health plans have found that a critical success factor in effective care coordination is the appropriate and timely sharing of relevant clinical information. This includes the effective exchange of information between Amerigroup and our Network Providers and also between individual providers to optimize care coordination.

Question 13.7, #1

1. Describe your proposed healthcare information technology (HIT) and data sharing initiatives.

A major component of Amerigroup’s HIT and data sharing plan is to implement new methods for the efficient, secure, and timely exchange of pertinent and actionable health information with our providers for meaningful, impactful purposes, including to:

- **Supply vital information at the point of care** – Deliver relevant clinical information, including gaps in care, that directly impact provider interaction with members
- **Increase efficiency** – Give providers a complete view of a person’s medical history, even if the patient has had multiple sources of care; deliver clinical information that can help the provider avoid duplication of services; help providers intervene when prescriptions have not been filled or prescribed therapy has not been completed
- **Facilitate care coordination** – Foster collaboration between our care coordinators, interdisciplinary team, and Network Providers to improve member health outcomes; provide care coordinators and case managers with alerts to reach out when new actions are needed or when planned actions have not occurred
- **Improve quality** – Achieve sustainable improvements in the quality and coordination of care for members across all categories and benefits through robust analytics and actionable data that facilitate improved measurement of quality through outcomes data rather than through treatment
- We recognize that our HIT and data sharing initiatives must extend beyond our Network Providers. To meet DHS’s goals of improving quality-of-care and health outcomes and coordinating and integrating care, we also must share data and collaborate with our members and other Iowa stakeholders, including participants on the interdisciplinary team, health homes, transition specialists, and support coordinators, as well as DHS, the IHIN, and social services agencies.



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In this section, we first discuss Amerigroup’s vision for HIT and data sharing—a vision shared across our affiliate health plans. We follow this discussion with a description of the HIT and data sharing initiatives we propose for the Iowa Initiative.

National Vision Drives HIT and Data Sharing Initiatives

A cross-functional national team stays abreast of developments in HIT and Health Information Exchange (HIE) and supports Amerigroup and our affiliate health plans. This cross-functional team includes

representatives from a variety of functional areas impacted by HIT and HIE, including Case Management, Provider Collaboration, Provider Contracting, Health Care Analytics, and Information Technology. Team members monitor state HIE developments and meet with HIE representatives in each of our Medicaid markets to understand additional opportunities for data sharing. This team will take the necessary steps in the Participation Agreement application process upon notification of contract award.

Our straightforward approach to HIT and data sharing incorporates two main tenets:

- Deliver an enriched data set that combines administrative and clinical data and add value to providers, members, payers, and the State of Iowa
- Meet our providers where they are—at their level of technology adoption

With support from our parent company and affiliate health plans, we will continue to challenge ourselves to identify, investigate, and implement HIT and data sharing initiatives that can help us achieve increased efficiency and avoid duplication of services, while at the same time supporting the State’s goals for the Iowa Initiative of improving the quality of care and health outcomes for Medicaid and CHIP enrollees.

An Enriched Data Set Adds Value

Bidirectional data sharing to create, maintain, and deliver an enriched set of clinical and administrative data benefits all of the Iowa Initiative stakeholders and supports DHS’s goal to “integrate care and improve quality outcomes and efficiencies across the healthcare delivery system.” We can all play a role and work collaboratively to enrich the set of available data to drive better patient care, population health initiatives, and decision-making.

As shown in Figure 13.7-1, Amerigroup’s vision includes bidirectional data sharing between providers, Amerigroup, and the IHIN. Providers share clinical data with IHIN and Amerigroup. Amerigroup shares administrative data, as well as care plans and healthcare assessments, with providers and the IHIN. The IHIN can then share an enriched set of clinical and administrative data with providers and Amerigroup. Combining Amerigroup claims data with provider clinical data creates a wider and deeper set of member data that can drive better outcomes and help manage costs. Our goal is to support the IHIN as a primary aggregator of patient information. For providers who are not yet engaged with the IHIN, we will encourage participation and data sharing while at the same time serving as a conduit to deliver access to meaningful and actionable population management and member data.

As a payer, Amerigroup maintains a wealth of data and information about its members. We enrich our claims data with clinical data, including lab results, state immunization registry and provider Electronic Health Record (EHR) data. We use our clinical and administrative data sources to produce reports and analytics to monitor and manage the delivery of quality care for our providers and our state partners. The core mission is to provide member-centric data in an actionable format and distribute it in ways that encourage engagement. Amerigroup’s data will be strengthened with the clinical information we will obtain from the IHIN. Better data will allow us to derive more value from our analytical tools and processes, enable better care coordination and management, and help us drive better decision-making.

Collaboration and information-sharing between Amerigroup and our providers help improve operational processes, effectiveness of care, avoidance of duplication of services, member satisfaction, patient safety, prevention and wellness, chronic disease management and physician engagement. Our information-sharing technology vision and strategy help define our initiatives to enable all providers to take advantage of our analytics and data, especially small, rural practices.

Figure 13.7-1. Our Vision Includes Bidirectional Data Sharing





We Need to Meet Our Providers Where They Are

When it comes to HIT and data sharing, providers possess varying capabilities and have different workflow and logistical needs. We know that they are at different stages in their move to adopt EHRs and clinical data sharing. We use a tiered approach to data sharing that allows us to leverage the current capabilities of our Network Providers while supporting their move along a path to expanded, meaningful use of online clinical information and data sharing with the IHIN.

Amerigroup will deploy the technology and tools to meet providers at their level of technology adoption. All Iowa beneficiaries are entitled to benefit from the value that HIT can deliver—care coordination, prevention and wellness, and improved healthcare quality—regardless of whether the provider they choose has embraced EHR technology and HIE. We will support all providers by communicating with them in the manner that works within their practice:

- **Low Tech.** This provider is paper based and does not have an EHR but has Internet access and the ability to retrieve member information from Amerigroup through our secure provider website. We will implement programs to encourage low-tech providers to adopt EHRs and use of IHIN services (especially direct secure messaging), and we will connect them to resources, including the HIT Regional Extension Center (HITREC), for support.
- **Moderate Tech.** This provider has begun to adopt HIT. This provider may have an EHR and may be engaging with the IHIN on a limited basis but is not currently exchanging patient clinical data. The moderate-tech provider can benefit from our web-based tools for accessing population and member data to drive better health outcomes.
- **High Tech.** This provider has implemented extensive HIT capabilities within the provider's operations, has attested to meaningful use of the EHR, and is able to share patient clinical data in standard formats with HIE from the EHR. High-tech providers are ready to integrate data at the point of care—whether from the IHIN or Amerigroup—to augment their clinical data set.

Amerigroup will deliver a menu of HIT and information-exchange capabilities that enable and encourage electronic information-sharing in ways that can meet the needs of each of our providers. We understand that HIT adoption varies significantly across providers, and we consider it our responsibility to deliver consumable information to our providers at a level each can use.

However, we know the substantial benefits to healthcare delivery that providers can achieve by adopting EHR and fully integrating with the IHIN. Adopting the best practices of our affiliate health plans, Amerigroup will implement a plan to educate and encourage our providers to adopt a certified EHR and interface with the IHIN. This will increase the number of high-tech practices, while still providing value to our members by accommodating providers who remain low-tech and paper-based. We will leverage the IHIN's communication plan so that we can deliver a consistent message and educate providers on the benefits of the IHIN and the resources available, including Direct Secure Messaging (DSM) and how to use Query (patient look-up) to access patient information. And, more importantly, we will help providers determine how to integrate use of the IHIN into their practice workflow.

Amerigroup views HIT as a catalyst in our overall provider collaboration strategy—delivering additional methods for working with our providers to achieve the overall goal of improving the quality of healthcare delivery for all populations that will be served under the Iowa Initiative.

Proposed HIT and Data Sharing Initiatives

We know the value of technology. When applied correctly, it can be a powerful tool to improve efficiency and effectiveness of healthcare operations and to deliver measurable impact to members, providers, and the State. We focus our proposed HIT and data sharing initiatives on those that will be most impactful.

To support our Iowa programs and services, we will deploy several HIT and data sharing initiatives that will deliver tangible results toward the State's program goals that emphasize member choice, access, safety, independence, and responsibility. These initiatives capitalize on access to clinical and administrative data available from our providers and the IHIN and will include:

- **Integration with IHIN** that will allow Amerigroup to make use of the data and services available through the IHIN and, potentially, allow us to deliver our data to the IHIN to further enrich the available data set. We discuss our plans to interface with the IHIN in our response to question 2.
- **Accountable Care Organization (ACO) Provider Tool** that will deliver continued and consistent access to the population health tool already being used by Iowa ACO providers to support population health management
- **Population Health Management System** that will support providers who participate in one of our provider incentive programs and deliver actionable information to enhance the delivery of care they provide to our members and enhance their performance
- **Clinical Data Sharing and Collaboration Tools** that will give our providers, members, and other stakeholders electronic access to member health and care management information and support collaboration
- **Additional Information and Data Sharing Tools** that will support the needs of our providers, members, and other stakeholders to help reach DHS goals for the Iowa Initiative

ACO Provider Tool

Amerigroup will provide the 3M Treo Solutions Value Index Score (VIS) methodology and tools to offer our ACO providers a consistent measurement tool with a common measure set, including a dashboard and drill-down reporting. As discussed in Section 10.2, ***Amerigroup's intent is to build upon the VIS foundation that is already in place within the State to continue the positive trends in driving improvements in the cost and quality of care.***

We will collaborate with 3M and other Iowa VIS users, including Wellmark, to take full advantage of the existing VIS process so that our providers have information on their relative ranking in the Network, the strengths and weaknesses of their performance versus their peers, and actionable items such as member-level details and outliers to further improve quality care. After we have enough data and working experience with VIS, providers, and the State, we will develop enhanced approaches such as a mechanism to measure providers against any applicable State/national benchmarks so we can further improve Amerigroup HEDIS results and contribute to Iowa's State quality ranking.

In addition, we will work with 3M, in conjunction with Wellmark and other Iowa payers, to increase the value of the VIS product by incorporating feedback recently learned from the ACO community in Iowa, such as increased transparency and increased data sharing tempo. We strongly believe that payer alignment regarding the common use of the VIS dashboards and other reporting tools will allow providers to concentrate on improvement efforts to increase accountability, quality, and efficiency.

Population Health Management System

Providers participating in one of our incentive programs, as discussed in Section 10.3, will be able to review their performance and identify opportunities for improvement through our proprietary online reporting tool. This web-based, interactive tool will allow providers to see actionable, member-specific information to help identify members who need outreach and engagement or have care gaps that may

impact their performance. The tool includes alerts, icons, hover overs, drop downs, and drill-through to support population health management, including the ability to filter patient populations by key conditions, risk factors, gaps in care, and visit history. This tool not only gives providers real time information to help improve their performance as it relates to incentives, but most importantly it identifies opportunities to improve member health outcomes by specific disease state, such as diabetes, hypertension, smoking, etc. Accessible information for providers includes the following:

- **Care Opportunities:** This view identifies attributed members with gaps in care and provides alerts when the next clinical interventions are due. It also addresses pending gaps in care, looking forward 30 and 60 days and to the end of the calendar year, so that care planning can comprehensively cover future clinical due dates, address member needs, and help physicians practice medicine efficiently.
- **Hot Spotter:** Through a combination of claims and pharmacy data, we identify high-risk members who have impactable clinical opportunities and members who are at increased risk for hospital readmission. This helps providers identify members who will benefit most from care planning and increased care coordination.
- **Inpatient Census:** Through the Inpatient Census, PCPs can view information about members who are in the hospital to facilitate the PCP's active involvement in the discharge planning process beginning at the time of admission.
- **Emergency Room:** This view alerts providers to members who frequently use the emergency room and those who may have avoidable emergency room visits.
- **Medical Cost Performance:** If applicable, this view identifies opportunities to more efficiently manage the total cost of care for the provider's assigned members by displaying historical and current unit cost and utilization data across the full spectrum of medical costs.
- **Performance Score Card:** If applicable, the Performance Score Card provides a summary of physician performance against quality targets and includes historic measure rates for the baseline period, rolling measure rates, and performance benchmarks.

To help our providers use this information to improve quality, Amerigroup Provider Services Staff will work collaboratively with the practices to establish quality and cost-efficiency improvement action plans.

Clinical Data Sharing and Collaboration Tools

When it comes to data sharing and collaboration, Amerigroup believes that we need to deliver “the right tool for the right job.” The information, data sharing, and collaboration needs of our Care Coordinators and Case Managers are very different than our providers, members, and other stakeholders. To encourage widespread use, the tools must be tailored for the audience and give each consumer the information they need in a manner that supports understanding and action. We will deliver a suite of integrated data sharing and collaboration tools that allows us to extend our ability to coordinate with stakeholders beyond the Provider Network—including members, caregivers, and other agencies or service providers as shown in Figure 13.7-2.

Amerigroup Care Coordinators and Providers

Accessed through our secure provider website, Member 360 will give all of our providers, including ACOs, a single view that displays member data in an easy-to-navigate dashboard, including HEDIS care alerts, authorizations, prescriptions, and claims organized by type, such as inpatient, emergency room, behavioral health, and office visit. Providers can link from one of our population health management tools directly to Member 360 to see member-level detail. Member 360 will also serve as our primary method for sharing member care management information, including health risk assessments and the care plan, with providers on the interdisciplinary team. Please see Section 9.1.7 for screen shots of the Member 360 dashboard and longitudinal patient record.

Member 360 also organizes information into a timeline of clinical events representing a longitudinal patient record for the member across a number of domains, including diagnosis, providers, and medication history. Events are displayed as icons that show the intersection of “what and when.” In the diagnosis domain, events also indicate “where,” displaying a different icon for inpatient, emergency room, clinic/office, and home/hospice. Providers can access additional details of clinical events simply by placing their mouse over the icon or clicking to drill down.

The ability to view clinical events integrated into a timeline highlights opportunities for intervention from the provider, creating an easy “to do” list. The Member 360 view gives providers the ability to understand all aspects of the member's health, services, and utilization history, supporting the holistic management of the member's care and service needs. For example, they can easily find out whether members are taking their prescribed medication or visiting the emergency room frequently.

Members and Authorized Other Stakeholders

Amerigroup supports a holistic, person-centered approach to coordinating care and services. Working with their Care Coordinator, members create a care plan that guides the care and services that will help them achieve their goals.

An interdisciplinary team comprised of multiple stakeholders engaged in the member's life is critical to developing and delivering high-quality and accessible services and supports. Amerigroup will create and nurture an environment that promotes the involvement and engagement of a variety of individuals to support and enhance member health and well-being, including members and their families/caregivers, providers, and other stakeholders such as transition specialists and support coordinators.

Amerigroup will deliver an information-sharing and collaborative platform where interdisciplinary team participants can review and contribute to the care plan, as authorized by the member. The platform is operational today in several states serving members with disabilities and mental health and substance use conditions, including individuals with intellectual and developmental disabilities or those with a serious mental illness. Through our platform, we will strive to deliver the right information to each audience in a way that supports understanding, coordination, and action in the context of role-based authorization and access. Working together, we can support our Iowa members in directing a meaningful plan with their desired health and quality-of-life outcomes.

Additional Information and Data Sharing Tools

As discussed throughout our response to this RFP, Amerigroup will deliver a substantial array of information and data sharing tools to deliver relevant, actionable information to our Iowa members, providers, and other stakeholders. Some of the key tools include the following:

- **Mobile Tools for Field-based Case Managers.** CareCompass Mobile is fully integrated with our MMIS and will allow field-based LTSS Community-Based Case Managers to use guided tools to complete assessments, consent documents, and other critical forms while in the member's home.
- **Member Outreach and Engagement Tools.** Amerigroup will deliver a member website and mobile application that will deliver information and self-service tools that support member health and well-being. Key tools include an online provider directory (updated nightly), request or print an ID card function (or access through the mobile application), and a “Call Me!” feature with our Member Services call center information.
- **Provider Outreach and Engagement Tools.** Our provider website will deliver information and self-service tools to make it easy for providers to do business with Amerigroup. We support Availity, a multi-payer portal that allows providers to check eligibility, submit claims, and inquire on claims status for multiple payers from a single sign-on. Providers can access our population health and Member 360 clinical data sharing tools, as well as tools to submit requests for prior authorization. Our website also delivers easy access to educational information, including manuals, quick reference guides, and video-based tutorials and training documents.

Information on these capabilities and additional data sharing initiatives are discussed throughout our response to the RFP questions and Scope of Work requirements.

Question 13.7, #2

2. Describe how you propose to interface with the Iowa Health Information Exchange.

Amerigroup is excited to work with the Iowa Health Information Exchange, IHIN, to support Iowans and advance the Iowa e-Health mission to “to improve care, increase security, promote cost savings, streamline treatment, and reduce medical errors through the secure exchange of electronic health information.” ***We applaud the significant growth demonstrated by the steady increase in IHIN Participation Agreements and the use of DSM and Query. Amerigroup will actively support and participate in the IHIN, and we are committed to being an active proponent of the IHIN with our providers. Together, we can help the IHIN and DHS meet their goals.***

Our strategy in working with the IHIN is similar to our data sharing strategy with providers. We will work with the IHIN at their current level of interface and integration and move with them as they expand their service offerings. With state-sponsored affiliate health plans and commercial affiliates across the country, Amerigroup Information Technology professionals have gained valuable experience in working with more than 11 state, regional, and private HIEs and managing direct data exchange with a significant number of hospitals and large provider groups that Amerigroup will leverage to interface with the IHIN today and in the future.

Representatives from our national Information Technology and Provider and Clinical Analytics teams recently met with IHIN technical representatives to better understand the services, technology, and data sharing protocols in place today and on the IHIN's roadmap. This conversation helped confirm that we have the right tools and technology in place to interface with the IHIN.

Full IHIN Support and Engagement



As discussed earlier, Amerigroup believes that bidirectional data sharing with the IHIN will deliver the most value to them as well as to our members and providers. Also, it will enable us to more effectively manage The Iowa Initiative and help realize DHS's goals. Amerigroup will use IHIN services that are available at contract start to support our Iowa operations, pending the outcome of legislation to remove the barrier that restricts use of the IHIN to treatment purposes only. With IHIN we will evolve our interface as capabilities expand and are available to payers. We recognize the

enormous potential that accessing patient clinical data through the IHIN can bring, including access to:

- Lab and diagnostic test results to identify members who would benefit from disease management or care management based on current levels
- Medical record data that are more comprehensive and timely than our claims data, enabling us to improve our care management identification, outreach, and assessments
- Data for HEDIS measures that could reduce the number of necessary medical record reviews and improve data quality

Amerigroup also sees great value in the ability to receive admission, discharge, and transfer (ADT) data from the IHIN, and we are excited to see it on the IHIN's roadmap for later this year with the planned pilot for ACO providers. Several of our affiliate health plans are currently receiving, or will soon be receiving, near real-time feeds of ADT data from HIEs. Timely access to ADT data can support a number of our activities in Iowa, as discussed in our Utilization Management Program in Section 11.1.

We would appreciate the opportunity to participate in Iowa e-Health and IHIN work groups and strategy sessions to share ideas and help support common goals.

Our Technology Infrastructure and Tools are Ready

The Medicaid Management Information System (MMIS) that will support the Iowa Initiative is ready to interface with the IHIN. The technology platform that supports part of our care management and information sharing system, Member 360, also operates as the platform for seven state HIEs with robust capabilities and a proven track record. This platform gives our MMIS the technology infrastructure necessary to integrate with the IHIN. Our Medicaid affiliate in Tennessee is working closely with Informatics Corporation of America (ICA), giving our Information Technology team familiarity with the technology powering the IHIN.

Our MMIS is currently receiving real time ADT HL7 transactions from several HIEs. Interfaces use an internally developed HL7 engine that supports real-time SOAP/Https as well as batch interfaces based on FTP, both via secure connections. The engine supports transaction receipt (including delivering an acknowledgement to the HIE), validation, and routing to the care management subsystem to support care management, disease management, and utilization management activities, and to data warehouse and reporting environments. Prior to integrating with HIEs, our MMIS demonstrated the ability to exchange data with standalone health systems, delivering valuable feedback on the technology and impact on operational processes. Integration with HIEs increases the ability to scale across multiple health systems at a faster rate and with greater consistency.

To further demonstrate our capability and readiness to interface with IHIN, our MMIS is currently exchanging data with five HIEs and actively working to implement interfaces with an additional three by the end of the year. Outreach efforts are in progress with three additional state HIEs.

As early as July 2013, Grant Thornton concluded that our MMIS met the necessary standards and requirements during an HIE Readiness Assessment that was performed for one of our affiliate state-sponsored health plans. Grant Thornton awarded our MMIS the highest scores, evaluating HIE readiness across three dimensions: Functionality, Technical Infrastructure, and Governance, Operations, and Policy. Our MMIS capabilities related to HIE integration and data sharing have continued to grow in the last two years.

Question 13.7, #3

3. Describe HIT initiatives you have implemented in other states.

With Medicaid and commercial affiliates throughout the country, Amerigroup will capitalize on a substantial amount of HIT knowledge, experience, technology, best practices, and lessons learned. Sharing information about innovations that can positively impact the lives of our members is embedded in our organizational culture and consistently encouraged. In addition, our technology infrastructure enables us to leverage technology implemented for one health plan to affiliates, directly benefiting our programs as part of the Iowa Initiative. The following represent just a few of the initiatives implemented in other states that Amerigroup will leverage to support our Iowa members and providers.

Bi-Directional Data Sharing in Georgia

Our Georgia affiliate is working with the Georgia Health Information Network (GaHIN) to implement data exchanges to support their more than 353,000 state-sponsored program beneficiaries. It is the only MCO to be an approved member of the GaHIN. Care managers are actively using the GaHIN's web-based clinical viewer to access member health records to support their TANF and CHIP members, as well as children, youth, and young adults in foster care or receiving adoption assistance and select youth involved with the Department of Juvenile Justice. To further support health information exchange, they are working with GaHIN to establish bidirectional interoperability to *send* care plans and *receive* ADT data. Working with the GaHIN already provides enormous support to program operations by delivering easy access to member clinical data. Our affiliate expects to realize significant additional benefits through bidirectional data exchange, especially the ability to receive near real-time ADT notifications.

ADT Data Supports Maryland Clinical Initiatives

For more than three years, our affiliate health plan in Maryland has been receiving feeds of ADT data from Maryland's statewide HIE, the Chesapeake Regional Information System for our Patients (CRISP). CRISP receives data from all 42 Maryland hospitals, plus five hospitals in Washington D.C. and one in Delaware. The method CRISP uses to send ADT data and the health plan's processes to use the data have evolved—moving from a Microsoft Excel spreadsheet three years ago to today's near real-time HL7 data feed directly into our MMIS. As CRISP evolved, our affiliate modified its data exchange processes to adapt to the new method. Our affiliate has also improved how it integrates the information ADT data provides into care management processes and clinical initiatives to derive the most value.

Our affiliate receives approximately 1,000 ADT alerts each day for its more than 270,000 members. The system analyzes ADT data against high-priority clinical members and generates a set of email alerts to the member's PCP and individuals on the healthcare team. An alert also informs the hospital that the affiliate is monitoring the member's status and clinical condition.

Internally, our affiliate uses ADT data to support several clinical initiatives, including readmission reduction and discharge planning. Consistent access to timely ADT data enables the health plan to engage the member and initiate interventions much faster. The health plan is seeing positive outcomes in emergency room utilization and member PCP visit trends, documenting a 15.7-percent reduction in readmission rates for high-risk members across five Baltimore hospitals last year. Later this year, the health plan will begin using an online dashboard that will deliver additional capabilities to support the use of real-time ADT data.

Telemedicine for Rural Georgia Members

Our affiliate health plan in Georgia is improving the availability and provision of specialty services in rural and underserved parts of the State through telemedicine. In August 2011, it was the first MCO to partner with the Georgia Partnership for TeleHealth (GPT) to provide innovative solutions to expand access to healthcare services. Our affiliate increased access to services by:

- Equipping six rural and underserved counties with telemedicine presentation capabilities
- Enhancing access to specialty care for 20,000 to 30,000 Medicaid recipients
- Providing 1,200 children and adolescents in one rural county with on-site access to primary and specialty care by equipping school-based health centers with telemedicine capabilities
- Equipping six pediatric patient-centered medical home practices with on-site presentation capabilities, including same-day and next-day scheduling of behavioral healthcare appointments

Through telemedicine, our affiliate is improving the availability and provision of physical, behavioral, and dental health services, especially in rural and underserved parts of Georgia.

General (14.1)

Question 14, #1

1. Describe your plan to provide the reports described in the RFP, in the format required, and using templates that may be specified in the Reporting Manual and updated from time to time.

Performance Reporting Requirements

Through our affiliate health plans, Amerigroup Iowa (Amerigroup) has extensive experience producing reports to support state-sponsored health programs across 19 different states. Through our collective 24 years of participating in these programs, we have a proven track record for timely and accurate reporting. In addition to producing the required program reports for DHS and its designees, Amerigroup will continuously track and monitor current performance internally for a variety of care and service measures. We utilize these indicators to verify the effectiveness of services, assess provider performance and member outcomes, allowing us to assess the efficacy of programs and services and as applicable identify opportunities for improvement.

Amerigroup will capitalize on the national experience and resources of our affiliate state-sponsored health plans and leverage their established policies and procedures, mechanisms to expedite report development using the templates and format prescribed by DHS in its reporting manual, or if none is provided we will use a standard format from a similar market. Our oversight, monitoring and validation processes will assure that all financial and non financial performance data is accurate. For our local Iowa health plan, we will hire experienced individuals who understand managed health data, current data mining technology tools, and who will position us to meet the information and data analytics needs of DHS.

Amerigroup has carefully reviewed required reports within each reporting category, such as quality and LTSS, described in the RFP. We understand that the Reporting Manual will be provided following contract awards and it will provide the detailed reporting requirements and the full list of required reports. Due to our extensive experience with reporting in other states, we are confident in our ability to meet all Iowa reporting requirements and will comply with the requirements as specified by DHS, and will coordinate with DHS accordingly when updates and changes are needed to reporting formats or requirements. We will use the processes and tools summarized in Table 14.1-1 comply with reporting requirements and help promote high quality and accurate performance reporting.

Table 14.1-1. Summary of Processes and Tools Amerigroup Uses to Facilitate Accurate Reports and Data

Process/Tools	Summary Description	Benefits to the State
National Information Management Data Governance Process	Data governance is a set of formal management processes that include accountability, risk management, and quality control to assure important data assets are managed in accordance with best practices.	<ul style="list-style-type: none"> Assures consistency and quality of information of all data sources Supports a process to continually enhance resources with additional value-added data.
Business Intelligence Competency Center (BICC)	Supports the Information Management Data Governance Process Provides training, help desk, and real-time associate support.	<ul style="list-style-type: none"> Provides consistent training in reporting tools and techniques to assure accuracy in reports and data

Tab 3: Bidder’s Approach to Meeting the Scope of Work
14 Performance Targets and Reporting Requirements

Formal Software Development Life Cycle (SLDC)	Standardized tools and techniques to assure each report is developed through a consistent process that includes the capture and validation of all report requirements, quality testing, and business review and validation.	<ul style="list-style-type: none"> • Supports both routine and additional reports assuring accuracy • Uses a streamlined process for reports to reduce development time and assure high-quality data
Regulatory Services Report Tracking Database	Tracks reports, data owners, due dates, and record of submissions	<ul style="list-style-type: none"> • Managed and updated by our Regulatory Services Department and Regulatory Oversight Manager to be sure we meet our contractual requirements • Tracks thousands of reports across our affiliates’ state-sponsored programs in 19 states. • Generates reminders for business owners and responsible managers to facilitate timeliness of submission and provides scorecards for managers for monitoring and tracking performance
Enterprise Data Warehouse	Amerigroup focuses on providing quality data, refreshed daily and housed in our enterprise data warehouse as the core foundation of reporting and analytics.	<ul style="list-style-type: none"> • Facilitates consistency and quality of information of all data sources • Does not burden online transactional systems with queries to maintain its performance
Advanced Reporting	Gap In Care and Primary Medical Physician Data Sharing and other performance-based reports	<ul style="list-style-type: none"> • Improves member care by encouraging behavior changes • Reduces costs

Reporting Requirements, Audit Rights, Meeting with Agency (14.1.1-14.1.4)

In accordance with the Scope of Work requirements, Amerigroup will comply with all reporting requirements and as previously described we will utilize the policies and procedures, and oversight and monitoring activities in place across our affiliate health plans as a foundation to ensure that all submitted reports are accurate and in the format prescribed and using the templates provided by DHS. It is further understood that:

- DHS may audit self-reported data at any time and may require corrective action or other remedies as specified in Exhibit E, if Plans are non-compliant.
- Upon receipt of our reports DHS may schedule conference calls to discuss submitted data, if DHS identifies potential performance issues, we will formally respond in writing within the timeframe required and that failure to do so may cause DHS to consider the Contractor noncompliant and that DHS may implement corrective actions.
- DHS may require more frequent reporting at the beginning of the Contract to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of member and provider services.

Other Reporting and Changes (14.1.5)

Question 14, #2

2. Describe additional data/reports you are capable of providing that can help the State evaluate the success of the program.

Additional Data Reports

In keeping with our vision of creating the best health care value in the industry by making health care more affordable for our customer and providing access and guidance to the right care, we actively pursue program initiatives to deliver improved health outcomes for providers and members. We will use our extensive data analytics and reporting capabilities to work independently or in conjunction with the State to identify opportunities for improvement in health outcomes specific to goals of the Iowa Initiative. Our system contains a best practices library that represents state-of-the-art health care knowledge and clinical rules. The rule authoring tool allows easy configuration for specific programs, so that the reports generated are valid measure for each program. The Iowa Initiative will benefit from Amerigroup and its affiliates' extensive experience and expertise in collecting and reporting data for state-sponsored programs, and we will be able to draw upon our best in class analytic capacity from day one. We look forward to collaborating with DHS following distribution of the Reporting Manual to identify potential additional reports to enhance DHS' opportunity to review and assess the High Quality Healthcare Initiative's program effectiveness and performance.

Across our affiliates, we have an extensive history and proven record of accomplishment for generating compliant, timely, and accurate reports on a weekly, monthly, quarterly, and annual, basis for all of our state customers. Our reporting capabilities also allow us to quickly respond to any DHS request for ad hoc reports. We have the capability to use our extensive data analytics and reporting capabilities to work independently or in conjunction with DHS to identify opportunities for improvement in health outcomes and to report those improvements to DHS. Our system contains a best practices library that represents state-of-the-art health care knowledge and clinical rules. We have the capability to track specific measures for conditions prevalent among specific member populations and we have the capability to aggregate and/or compile the reports on a regular basis, and submit the data to the State, to facilitate an open line of communication about some of the common problems Iowa members face. We can demonstrate how the specific interventions we develop are able to improve health outcomes for our members.

We currently generate thousands of reports to meet the needs of our current state partners across all of our affiliates. Our dedicated health plan team, along with our Iowa Compliance Officer and Regulatory Oversight Manager, will use well-established and documented processes to confirm that all required reports are available to DHS and can make available other ad hoc reports as needed by DHS. We will work closely with DHS to make sure the required report content, formats, submission media, and timetables meet contract specifications, as well as providing additional data and/or ad hoc reports to assist DHS in evaluating the success of programs.

Representative examples of the types of reports our affiliates have recommended for other state programs, and may be beneficial to DHS, are included below.

Service Utilization Reports: We continuously monitor member service utilization in accordance with industry clinical standards and guidelines at the member, provider, and care coordinator levels. We use this data to alert care coordinators about member-specific gaps in care, and to monitor care coordinator and provider performance in engaging members in their care. We can track specific measures for conditions prevalent among specific member populations. We require each department to develop

interventions to provide services in accordance with the guidelines via comprehensive member and provider outreach activities. We share service utilization reports and identify gaps in services for HEDIS and other quality measures with all employees periodically, allowing proactive interventions aimed at improving service utilization and better clinical outcomes.

LTSS Reports: Amerigroup's affiliate health plans have worked collaboratively with a number of our states to provide LTSS reports that document outcomes for individuals residing in an institutional setting or receiving HCBS to demonstrate the effectiveness of our institutional diversion strategies and promotion of HCBS. Examples of report elements that we currently track, trend, and analyze include grievance and appeal data, members returning to the community, critical incidents, fall risk management, out-of-state placements and quality of care concern reports, provider/member satisfaction surveys, and utilization data, readmission to nursing facility or hospitals, employment metrics and many other elements related specifically to members participating in waivers and residing in institutional settings. Through the analysis of these reports we find opportunities at the member and systems level to improve quality and processes and, ultimately, outcomes for applicable members.

Ad-hoc Monitoring Reports: We have the capability to aggregate and/or compile reports on a regular basis and submit the data to the State to facilitate an open line of communication about some of the common problematic health outcomes Iowa members' face. We can demonstrate how the specific interventions we develop are able to improve specific health outcomes for our members.

For example, our Complex Care Management team is collaborating with our team in Advanced Analytics to develop a Complex Care Management report that will monitor program activity and help demonstrate program effectiveness. The report will include Care Management activity metrics, as well as utilization measures for members receiving Care Management.

In another example of our ad-hoc reporting capabilities, our Texas affiliate launched a HealthCare Disparities (HCD) program in 2012, with the purpose of reducing health disparities, which disproportionately affect our members. In 2013 the program evolved to what we currently call the Healthcare Disparities program 2.0. The ongoing goal of this program is to develop replicable models for preventing and managing diseases and ultimately, reduce health care disparities in underserved communities within the State. We developed racial/ethnicity reports and along with HEDIS data and the population assessment, we established program goals and identified components that would align with the Cultural Competency Plan and target our population's needs.

Question 14, #3

3. Describe your internal operational structure that will support the compilation of the performance data and reporting processes of the programs, including:
 - a. The qualifications and experience of the staff responsible for the production and delivery of performance data to the State.
 - b. The process for internal review and validation of data prior to submission to the State.

Internal Operational Structure and Report Tracking

Our national Regulatory Services Department, oversees all regulatory State and Federal reporting requirements. Our dedicated Iowa Regulatory Oversight Manager facilitates, monitors, and promotes an understanding of, and compliance with, the regulatory and contractual obligations.

Key factors that contribute to our proven success in submitting timely and accurate reports include:

- The central accountability of the Regulatory Oversight Manager
- Generation of reports in advance of the due date allowing time for internal review

- Execution of a thorough review by Business Owners who know the data and have ready access to resources to validate reports and, resolve identified issues
- A Data Warehouse designed for warehouse data extraction

Our Regulatory Oversight Manager will track the status of all reports required by DHS and other regulatory entities, as applicable. We use our report tracking database to document the contractual requirements of each report and identify the primary and secondary business owners responsible for reviewing for completeness and accuracy, and approving reports prior to submission. Assigned Business Owners will create a business requirements document for new reports and deliverables to drive necessary programming and report development.

The Regulatory Oversight Manager maintains the reporting tracking database and will generate reminders that go to the Business Operation Owners and responsible managers to alert them of upcoming reporting requirements. The Regulatory Oversight Manager will serve as our primary liaison with DHS for day-to-day contract management and oversight issues, will manage the submission of all required regulatory reporting, and will be our internal subject matter expert and resource regarding Amerigroup Iowa's contractual and regulatory obligations. Additionally, we will provide dedicated technical resources to support the Iowa Initiative from our national Business Relationship Management organization. This technical support resource works directly with Business Owners and their teams to assure that all regulatory and compliance requests are satisfied and delivered timely and efficiently.

Our reporting process automatically generates most reports according to a defined schedule; yet, we also have the capability to manually generate reports to fulfill off-schedule needs or to develop additional reports. An integrated enterprise scheduler allows data center operations to schedule, execute, and monitor the system processes required to generate each requisite report according to the defined schedule, which allows us to incorporate schedule changes easily. Our Business Owners prepare and generate all reports requiring manual data collection, aggregation, and analysis. These Business Owners thoroughly understand the data sources, data elements, relationships between data, and the contractual reporting requirements. They are also in the best position to collect data and verify report accuracy.

We design our operational processes with reporting in mind to make sure we are capturing correct, complete data for reporting and our systems allow us to configure data collection, analysis, and reporting that will accommodate the specific Iowa reporting category requirements. For example, we will assign a Quality business owner to develop and design the Quality Management reports format. All reports and changes will be implemented and systems tested to verify reports are complete and accurate prior to final report production. After program launch, our Quality report business owner will take responsibility for producing the Quality Management reports and delivering them to the Regulatory Oversight Manager, who tracks all reports through a Regulatory Reporting Grid and compiles and submits the reports to DHS in accordance with contract requirements.

We have a prescribed escalation process that is implemented if a report is at risk of being late, inaccurate, or incomplete. In this rare instance, the Regulatory Oversight Manager, in collaboration with the local Iowa Plan Compliance Officer, will alert the Executive Director of the potential risk, and will contact the responsible Business Owner to report the issue and discuss the corrective action plan. The appropriate escalation level and resolution process is determined based on the level of risk. At a minimum, we notify key stakeholders of the risk to help assure that all necessary resources are promptly engaged to eliminate any barriers to timely, accurate, or complete delivery.

If the report requires certification, the Regulatory Oversight Manager will complete the Data Certification form and forward the report and the form to the Plans Executive Director (or designee) for review and signature. Once the certification is signed, the Regulatory Oversight Manager will submit the report to DHS. After we submit each plan, report, or data file; the Regulatory Oversight Manager updates the

Reporting Tracking Database to indicate that the report has been submitted, along with the date of submission. The database automatically generates the due date for the next monthly, quarterly, or annual report. These processes help to assure that all reports, and data extracts are reviewed and verified *before* we send them to the State.

Qualifications and Experience

Our reporting process and structure of quality control are key elements to producing accurate and timely reports and data to our State partners. We will leverage the expertise and qualifications from both our national experts and affiliate health plans managing similar populations. As previously indicated the Iowa Regulatory Oversight manager with support from business owners, data analytics, and Compliance Officer manages and monitors the submission of all reports to DHS. He/she will work closely with the identified primary and secondary business owners, defined as senior level staff within the organization that have the specific expertise and accountability to be able to prepare, assess, and review and validate the accuracy of each regulatory report. Our qualifications include:

- Ability to capitalize on national experience of our affiliate health plans operating state-sponsored health programs across 19 states in leveraging reporting capabilities that enable us to expedite new report deployment
- Applying consistent edits to incoming data and carefully monitored processing to promote data accuracy
- Designated Iowa reporting and data analytics employees who are supported by our national team
- Experienced employees responsible for report preparation who understand the data, managed health care, technology tools, and the information and data analytics needs of internal and external stakeholders
- Tools available for reporting and data analytics throughout the organization to format, aggregate, and report data

Table 14.1-2 summarizes our approach to making sure each category of reports we submit are accurate and provided timely.

Table 14.1-2. Summary of Approach and Qualifications by Report Category

Reporting Category	Description of Approach and Qualifications
Financial	<ul style="list-style-type: none"> • Financial report business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s financial performance will be identified • The business owners will work closely with our national Information Technology department, national accounting and finance teams, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our finance business owner, who has complete understanding of the program data and reviews finance reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS and/or DOI in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required financial reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.

<p>Member Services</p>	<ul style="list-style-type: none"> • Member Services business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring member services’ performance and activities will be identified • The business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our Member Services Manager, who has complete understanding of the program data and reviews member services reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required member services reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS..
<p>Provider Network</p>	<ul style="list-style-type: none"> • Our Iowa-based Provider Services team will be the functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s network access and adequacy, provider helpline, and other provider related activity reports; An assigned account manager will be responsible for monitoring all subcontractor reports • The Provider Services’ business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch, our Provider Services Manager, who has complete understanding of the program data and reviews Provider Services reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required Provider Services reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.
<p>Quality Management</p>	<ul style="list-style-type: none"> • Quality management business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s quality management activities will be identified • The quality management business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our Quality Management business owners, who have complete understanding of the program data and reviews quality management reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required quality management reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.

<p>LTSS</p>	<ul style="list-style-type: none"> • LTSS report business owners who are functional subject matter experts with knowledge of the LTSS reports and specific data elements will be identified • The LTSS business owners will work closely with our national Information Technology department and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production. • After program launch our LTSS business owner, who has complete understanding of the program data and reviews LTSS reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required LTSS reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS to assist DHS in evaluating the success of the LTSS program.
<p>Quality of Life</p>	<ul style="list-style-type: none"> • Quality of life report business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s related quality of life activities will be identified • The quality of life report business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our quality of life report business owner, who has complete understanding of the program data and reviews the reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required quality of life related reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.
<p>Utilization Reports</p>	<ul style="list-style-type: none"> • Utilization report business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s utilization activities and performance will be identified • The utilization report business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our utilization report business owners, who have complete understanding of the program data and reviews utilization activity reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required utilization reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS. s
<p>Claims</p>	<ul style="list-style-type: none"> • Claims report business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s claims processing performance will be identified • The claims report business owners will work closely with our national Information Technology department and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our claims reporting business owners, who have complete understanding of the program data and reviews claims activity reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required claims reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.

<p>CMS Reporting</p>	<ul style="list-style-type: none"> • We will identify report business owners who are functional subject matter experts with knowledge of the requested data or content for any CMS required reporting • The identified business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch the identified business owners, who have complete understanding of the program data and reviews CMS reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required reports for CMS are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.
<p>IDPH Reporting</p>	<ul style="list-style-type: none"> • IDPH report business owners who are functional subject matter experts with knowledge of, and responsibility for monitoring the health plan’s IDPH service delivery and activities will be identified. • The IDPH report business owners will work closely with our national Information Technology department, and other reporting analysts to define clear and consistent methodologies for developing each report in accordance with State guidelines, and for testing prior to production, as applicable. • After program launch our IDPH report business owners, who have complete understanding of the program data and reviews IDPH reports for completeness and accuracy will be responsible for delivering final reports to the Regulatory Oversight Manager for compilation and submission to DHS in accordance with contract requirements. • Amerigroup’s Compliance Officer and Regulatory Oversight Manager will confirm that all required IDPH reports are available to DHS and will coordinate with business owners to make available other ad-hoc reports as needed by DHS.

Internal Review and Validation Process

Amerigroup’s Regulatory Oversight Manager is central to the quality control of our reporting, including submitting accurate data to DHS within contractual timelines. As described above, our Regulatory Reporting database will document the regulatory and contractual requirements and identify accountable Business Owners for each report, the due date to DHS, and an interim due date to allow time for review.

We generate reports in advance of DHS’ submission deadline to allow adequate time for a thorough review. Business Owners and health plan leadership are responsible for reviewing reports for completeness and accuracy prior to submitting the report to DHS. Business Owners use a number of different methods to confirm the quality of reports. They compare the report to previous reports to identify changes in trends. They also compare them against other reports for the same time period to verify that data track across reports that include similar data elements. They consider events that have occurred during the reporting period that could affect the data. Business owners work with our IT department when necessary to immediately address any errors prior to the report being submitted to the State or makes updates for future reporting.

Following their review, Business Owners submit approved reports to the Regulatory Oversight Manager to review for compliance with DHS’ requirements, before submitting timely reports to DHS. Accountability for timely report submission and accuracy remains at the senior level of the organization. Senior management reviews a quarterly reporting scorecard to monitor performance against both internal and DHS reporting timelines.

These factors to our affiliates' proven success in submitting timely and accurate reports to our state customers:

- The **central accountability** of the Regulatory Oversight Manager
- **Generation of reports in advance** of the due date allowing time for internal review
- **Execution of a thorough review** by Business Owners who know the data and with ready access to resources to research and resolve identified issues
- **A Report card** developed for senior leadership to monitor performance
- **A Data Warehouse** designed for data extraction

The designated Regulatory Oversight Manager will remain the accountable and centralized point of contact for the reporting and communications process. We subject each plan, report, or data submission to extensive review and validation before certifying the product for submission. We do this because we understand how critical it is to get it right. DHS and others—including entities acting on behalf of the State,—need correct information to carry out their responsibilities properly.

We understand the requirements, and we plan the aspects of reporting to be measured (including key quality characteristics and key process variables). Furthermore, we create and run reports, measure the process, check the results, and take action to correct problems. Those actions may be process improvements to achieve higher performance levels or other quality initiatives to detect and correct the systemic cause of errors.

Section 14, # 4

4. Please provide any available Medicaid HEDIS scores in states in which you operate

Our dedicated national HEDIS Data Management teams oversee the HEDIS data processes and we work closely with our state partners across all of our affiliate health plans to meet or exceed each State's performance targets. Annual HEDIS rates are analyzed against national benchmarks and state performance targets to identify opportunities to improve clinical care and service.

We have included the Summary Sheets for each of our affiliate annual HEDIS reports as Attachment 3.2.7.5-3.

Section 14, # 5

5. Provide a copy of your most recent external quality review report for the Medicaid contract that had the largest number of enrollees as of the RFP release date

Amerigroup's affiliate, Amerigroup Texas, Inc., (Amerigroup Texas) holds a contract with the Texas Human Health and Services Commission for the State's Medicaid managed care program as an MCO in numerous service areas across the state. This contract had the largest number enrollees, as of the RFP release date, across Amerigroup and its affiliate health plans operating Medicaid contracts.

We have included the Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization (EQRO) Report as Attachment 3.2.7.5-1.

Financial Reports & Performance Targets (14.2)

Amerigroup Iowa (Amerigroup) will submit all required reports in DHS-specified formats and timeframes. Our established processes and flexible infrastructure will make sure that required financial data and reports covering all Amerigroup operational areas in Iowa – from Contract award, throughout implementation, and after program launch – are complete, accurate, and on time.

Through our affiliate health plans operating state-sponsored programs in 19 states, Amerigroup has extensive experience meeting the financial data reporting requirements of our state partners. In our Kansas affiliate plan, for example, Amerigroup submitted 1,307 required reports in 2014 – 99.7 percent of them were submitted on time, as scheduled. Following established processes across our National Medicaid Division, our Iowa Regulatory Oversight Manager will coordinate and monitor compliance with all DHS reporting requirements, including submission schedule, format, and certification/attestation.

We understand that DHS requires regular financial reports to assess its stability and ability to provide efficient, cost-effective services to members. And the more precise and complete those reports, the better. As Iowa launches its High Quality Healthcare Initiative, we offer our assistance in providing, developing, and customizing any new templates or reporting processes DHS may need or want. We welcome the opportunity to collaborate with our state partners..

In April 2014, for instance, the Kentucky Department for Medicaid Services (DMS) requested assistance from our Kentucky affiliate health plan, as well as the other Medicaid MCOs in the State, in revising their reporting processes and templates. The DMS goal was to not only make its reporting process more efficient, but also determine what data elements they truly needed. We all came together, reviewed the current reports, then provided requested feedback and suggestions. DMS was very grateful and has spent much time reviewing that information.

In February 2015, DMS began jointly meeting with the MCOs to discuss proposed changes. Those meetings included discussion of proposed template changes, as well as the creation of new reports and future deactivation of current reports. The meetings provided an opportunity for our Kentucky health plan and the other MCOs to collaborate with DMS to revise reporting and enable it to receive the most complete, relevant data.

Third Party Liability Collections (14.2.1)

Amerigroup agrees to report all third party liability collections to the State in the timeframe and format determined by DHS. We maintain records of all money collected from third party resources on behalf of all members, as well as certify that all third party collections are identified and used as a source of revenue. These records will be available for Status audit and review as needed.

Iowa Insurance Division Reporting (14.2.2)

Amerigroup will comply with all reporting requirements at Iowa Admin. Code r. 191-40.14(514B), and will copy DHS on all required filings with the Iowa Insurance Division. We will annually (on or before the first day of March) file with the Commissioner of Insurance a report verified by at least two of its principal officers and covering the preceding calendar year. We will provide this information on the form designated by the National Association of Insurance Commissioners (NAIC) and will complete it using statutory accounting practices. Further, we recognize the Commissioner of Insurance may request additional reports and information. We will provide the requested information in a timely manner.

Annual Independent Audit (14.2.3)

Amerigroup understands and will comply with all requirements specified in Scope of Work (SOW) Section 2.3.5. We will submit an annual audited financial report comprising our financial activities under the Contract within six months of the end of each calendar year. In accordance with NAIC Statutory Accounting Principles, an independent Certified Public Accountant – chosen from a list of three we will provide DHS – will prepare the report, and we will cover the cost of the audit.

Physician Incentive Plan Disclosure (14.2.4)

Amerigroup agrees to submit information on physician incentive plans, as prescribed by DHS, with sufficient detail to permit DHS to determine compliance with 42 CFR 422.208 and 42 CFR 422.210. Our affiliate health plans currently provide similar reports for our state-sponsored health programs in 19 other states and are accustomed to providing the detail required. We will leverage our flexible data systems to customize our existing reports to include all DHS-required elements.

Insurance Premium Notice (14.2.5)

Amerigroup agrees to submit certificates of required insurance no less than 30 calendar days prior to the policy renewal effective date.

Reinsurance (14.2.6)

Amerigroup will provide to the State a summary of our self-insurance plan, which will meet all requirements set forth in Section 2.3.2. As applicable, we will report to the State, in the manner dictated by DHS, all health care claims costs paid by our self-insurance after meeting the reinsurance attachment point.

Medical Loss Ratio (14.2.7)

Amerigroup agrees to maintain, at a minimum, a medical loss ratio of 85 percent, in compliance with SOW Section 14.2.7.

Member Services Reports & Performance Targets (14.3)

Amerigroup Iowa (Amerigroup) will submit reports to DHS in accordance with the terms of the Reporting Manual. Reports will include and are not limited to reports described in Sections 14.3.1 through 14.3.9. We understand that DHS may request additional reports prior to and following project go live. Amerigroup is accustomed to receiving such requests and prepared to work with the State to expeditiously provide these additional reports in the desired format.

Initial Health Risk Screenings (14.3.1)

As part of our comprehensive approach to identifying and addressing the needs of our Iowa members, Amerigroup will complete and report on initial health risk screenings as defined in Scope of Work Section 14.3.1. We know that early engagement with our Iowa members will help promote the appropriate use of health care services and will result in better outcomes. The initial screening is our first opportunity to identify immediate physical health, behavioral health, and/or LTSS needs that require expedited appointments with providers, as well as to identify members for disease management, complex case management, behavior health, care coordination, or other programs and services. We have established processes to conduct initial health risk screenings for new members, members who have not been enrolled in the prior twelve months, and members for whom there is a reasonable belief they are pregnant. We provide a variety of time-tested approaches to encourage participation and engagement and provide members the opportunity to obtain assistance if needed to complete the screening. We describe

our processes to complete initial health risk screenings within the required timeframe and our outreach and follow-up methods to make sure members receive these screenings in Section 9.1.1.

Comprehensive Health Risk Assessments (14.3.2)

Amerigroup will complete comprehensive health risk assessments in the timeframe mutually agreed upon by DHS and Amerigroup during Contract negotiations. As we fully describe in Section 9.1.2, we use several avenues for our members to receive a comprehensive Health Risk Assessment (HRA):

- When a member is **identified in the initial screening process** as having a special health care need or when there is a need to follow up on problem areas identified in the initial screening
- When members are identified for additional care coordination needs through **subsequent reassessments** as members' needs evolve over time
- When **referred for care coordination** (we accept referrals from all sources, including providers, self-referrals, caregivers or family members, and community-based organizations)
- When **analysis of claims** reveals a major change in status (such as a hospital admission, new diagnosis, change in ability to perform activities, etc.)

Care Plan Development (14.3.3)

Amerigroup will support care plan development for 100 percent of members identified through comprehensive health risk assessments and as otherwise defined in Scope of Work Section 14.3.3. Our interdisciplinary teams work together to develop person-centered care plans that address members' needs and goals in a holistic, fully integrated way.

Member Helpline Performance Report (14.3.4)

Amerigroup will meet all call center standards as specified in 14.3.4. Our affiliates operating state-sponsored health programs' experience typically exceed state call center performance expectations and we are confident we can bring superior performance to the Iowa Initiative by leveraging these processes. We will generate regular reports to monitor that we maintain service levels for incoming provider calls at or above DHS' expected rate and using DHS' defined formulas. We use multiple call status reports at a variety of frequencies, ranging from every 15 minutes to quarterly, that detail our compliance with performance standards. Our reports show trends for call volume, average speed of answer, and abandonment rate. We evaluate existing processes for our call center and make necessary adjustments to meet or exceed all service levels and requirements to improve the quality of service offered by our Member Service Representatives.

We maintain operating protocols that promote consistent achievement of our service standards. Our Workforce Management team conducts real-time monitoring of the call center's telephony metrics, using a variety of technology tools and custom reports. When call volume increases beyond the capacity of our scheduled Member Service Representatives, we expand the call answering queue to include designated back-up Member Service Representatives who may be located in any of our six call centers. This approach enables us to optimize staff efficiency while capably meeting performance standards.

Additionally, our workload balancing application helps to ensure that our scheduled staff can meet the forecasted needs. An added benefit of being able to move calls between our multiple call centers is that we react quickly during natural disasters. For example, inclement weather during the winter of 2015 forced the closure of Amerigroup call centers in New York, Virginia, Kansas, and Tennessee. We were able to immediately shift calls to our other call center sites and maintain service levels.

Member Enrollment and Disenrollment (14.3.5)

Amerigroup will report member enrollment and disenrollment information as defined in Scope of Work Section 14.3.5.

Member Grievances Report (14.3.6)

Amerigroup will resolve 100 percent of grievances within 30 calendar days of receipt or within three business days of receipt for expedited services. In addition, we will maintain and report to the State a member grievance log that includes the current state of all grievances.

Our member grievance system is supported by robust information systems, whose tracking and reporting capabilities, together with clearly delineated policies and procedures and appropriate timelines, help us facilitate a timely review and response to member inquiries, grievances, and appeals. Our systems support on-going tracking of all grievances and appeals via a daily report notifying the Complaint, Grievance, and Appeal Coordinator of all open and unresolved cases in our system. We maintain and track all inquiries, grievances and appeals to monitor status, track timeliness of resolutions, to identify and quickly address patterns or concerns, and to ultimately improve the quality of care provided to our members. Grievances, whether received verbally or in writing, are tracked in our core operating transaction system. This system will provide a separate log for Iowa Initiative members. Through this system, we track grievance data elements that including:

- Date received and date of decision (resolution)
- Identification of the individual filing the grievance (reported through a drop-down box indicating member, provider, or person acting on behalf of the member)
- Identification of Amerigroup employee recording the complaint
- Nature of problem
- Disposition
- Corrective action required

Grievances received in writing, other correspondence, and hard-copy information are electronically imaged and can be easily accessed through our system. We will work with DHS to develop an agreed upon timeframe and format to submit a log sheet for all inquiries, grievances, and appeals.

Other Monitoring Processes and Reporting Requirements

Amerigroup closely monitors grievance and appeal volumes, and daily aging reports will help us achieve timely resolution within State requirements. We use our member grievance and appeals processes to identify, assess, and address specific areas of member concern and dissatisfaction. These issues can include problems with Amerigroup or its employees or with providers who serve members.

Review and analysis of inquiry, grievance, and appeal data is an integral part of Amerigroup's Quality Management program. In addition to preparing, reviewing, and submitting required reports to the State, our Quality Management Department conducts a comprehensive review of inquiry, grievance, and appeal data each quarter. It focuses on identifying issues, problems, and trends for presentation to the Quality Improvement Committee. The primary report generated for review aggregates inquiry, grievance, and appeal data across a number of key dimensions, including type of inquiry or grievance, appeal action, and disposition. All report data is aggregated to protect member privacy. We also perform a root-cause analysis to identify drivers of increased inquiries, grievances, and appeals, as well as any specific trends in the types of issues received. We analyze results for review discussion and development of action plans for improvement, including member or provider education, and examining internal processes and/or development of a formal internal improvement initiative.

Member Hearing and Appeals Report (14.3.7)

Amerigroup will resolve 100 percent of appeals within 45 calendar days of receipt or within three business days of receipt for expedited appeals. In addition, Amerigroup will acknowledge 100 percent of appeals within three business days. We will maintain and report to the State a member appeal log that includes current status of all appeals.

Appeals are also recorded and tracked through our system that includes a recognized industry-leading application in business process management, business rules, and customer relationship management. Through this system, we maintain and track appeal data elements. Our technology is an enterprise solution for managing Medicaid appeals, reducing many of the manual and human processes that go along with it and thereby reducing error and increasing timeliness and efficiency. The application interfaces with our other systems, providing real-time access to member and provider information, including membership, eligibility, service, and claim payment details.

Our application also has the capability to track an appeal by member, provider, authorization, and/or claim, as well as act as the central repository for all segments of the appeal, regardless of whether it is related to benefit coverage. Our application also enables us to configure member notifications in other languages to accommodate diverse language needs and generates notifications based on State-required timeframes as well.

The filing date in our system will correspond to the verbal submission, when an appeal is initially filed verbally. The written and signed appeal request and other related correspondence and hard-copy information are electronically imaged and also accessible through our system and application. All required elements are obtained and tracked for appeals, and our system will provide a separate log for Iowa Initiative members.

Summary CAHPS Survey (14.3.8)

Annually, Amerigroup assesses member satisfaction through the Consumer Assessment of Health Plans Survey® (CAHPS) administered by an independent third-party vendor. It gathers data on member satisfaction with access, availability, and quality of services. We assess year-over-year improvements in survey results and compare our performance to that of the industry overall. The results provide us with valuable benchmark information and point us to those areas where we can focus for improvement. We are accustomed to provide survey results to State oversight agencies and will provide DHS our survey results from the independent CAHPS survey.

Member Website Utilization Report (14.3.9)

Amerigroup will track and report to the State member website utilization data, including EOB and quality information hits.

Member PCP Assignment Reports (14.3.10)

Amerigroup will provide a PCP Assignment Report in a format and frequency dictated by the State.

Provider Network Reports & Performance Targets (14.4)

Network Geographic Access Reports for Providers (14.4.1)

Amerigroup will leverage the best practices of its affiliate health plans operating state-sponsored health programs across 19 states and will continuously review network adequacy to proactively monitor access for our members. We will provide network adequacy reports to DHS upon request. Amerigroup will

demonstrate access for 100 percent of members by generating GeoAccess[®] reports for network adequacy according to the mileage requirements set forth in Exhibit B or additional network adequacy standards developed by DHS. We understand that DHS may request more frequent Network Geographic Access Assessment reporting at the beginning of the Contract.

Our Iowa-based Provider Services team will be responsible for generating and analyzing network access reports. The Provider Services Manager will be monitor these reports to validate network adequacy compliance.

GeoAccess offers reporting features that evaluate network adequacy for physical and geographic access that include the following:

- **Geographic Overview Maps:** Displays PCP and specialty care provider locations by geographic area.
- **Provider and Member Location Maps:** Plots members and providers of any or all specialty/specialties—or combinations of both; these maps overlay the provider network against the membership base with the appropriate radius encompassing each provider to identify geographic coverage in a particular area.
- **Member Accessibility Summary:** Provides an overview of the entire analysis displayed in a given report. It details the number and percentage of members with and without access to a PCP, as well as to key specialists (for example, number and percent of members with and without access to a gastroenterologist).
- **Access Comparison:** Provides a graph that demonstrates the point at which the percentage of members attains compliant status with the specified provider type and defined access standard.
- **Accessibility Detail:** Presents counts of members with and without access to care under the defined access standards. It provides the total number of members, providers, and a member-to-provider ratio for the demographic or geographic area analyzed. The report also provides a detailed analysis of a member's choice of up to five providers and the average distance to achieve that access.

If the network adequacy standards are met but our members' needs could be better served by a provider outside our network, Provider Services staff provides outreach to the identified provider(s) to discuss participation in our network. If a deficiency occurs, we immediately act to remedy the situation in accordance with our established policies and procedures. To address any deficiencies in our provider network, our Provider Services team develops action plans that identify staffing, responsibilities, resources, and a timeline to correct the situation.

24-Hour Availability Audit (14.4.2)

Amerigroup will require 100 percent of our network primary care providers to be available twenty-four hours-a-day, seven days-a-week (24/7)—using appropriate after-hours call services—by complying with Iowa after-hours standards, and will audit providers for compliance to this standard. We educate providers on this requirement and contractually obligate them to adhere to the standards. Our Provider Services Manager is responsible for oversight and analysis of provider audits around access and availability. Amerigroup routinely uses an independent audit firm to perform regular surveys that monitor provider availability. Amerigroup follows the detailed process outlined previously in Section 14.1 to validate the survey results to maintain 100 percent compliance with 24-hour availability.

When we identify a provider who is out of compliance with appointment standards, our employees visit the provider and present a letter requesting a corrective action plan. We will continue to monitor compliance and re-survey the provider after 90 days to verify compliance. Ultimately, we will remove any provider who fails to meet access standards from our network.

Provider Credentialing Report (14.4.3)

Amerigroup will provide DHS with a report on the timeliness and effectiveness of our provider credentialing processes, to include reporting on the following standards: (i) 90 percent within 30 calendar days; and (ii) 100 percent within 45 calendar days. We will adhere to DHS' defined time frames, tracking the start time when Amerigroup receives all necessary credentialing materials from the provider. Completion time ends when written communication is mailed or faxed to the provider notifying the provider of Amerigroup's decision.

Our Provider Services Manager analyzes credentialing timeliness reports to determine compliance. The Provider Services Manager and the Provider Services team follow defined processes that enable Amerigroup to fully credential providers in a timely manner. Amerigroup follows the internal review and validation process outlined in Section 14.1.

Subcontractor Compliance Report (14.4.4)

Amerigroup will conduct quarterly formal reviews of all subcontractors and provide summary reports in the prescribed format to DHS of all key findings and applicable corrective actions if implemented.

Every Amerigroup subcontractor is assigned an Account Manager who is responsible for receiving monthly, quarterly, and annual subcontractor data reports that our internal subject matter experts (SMEs) review further.

We assign an Amerigroup Account Manager from our National Provider Services Organization to any subcontractor who provides services to more than one Amerigroup affiliate. The National Provider Services Organization, comprised of 11 staff, has successfully managed subcontractor oversight in Amerigroup's affiliate plans and will bring that same expertise to our Iowa operations.

For our local Iowa subcontractors, the Account Manager function will be the responsibility of a health plan manager with the appropriate expertise to monitor that subcontractor's performance (for example, the Provider Services Manager would be Account Manager for a delegated Network Development subcontractor). If a subcontractor does not provide these reports in a timely fashion, or a deficiency is detected by either the Health Plan SME or the Account Manager, it is the Account Manager's responsibility to communicate such deficiencies to the subcontractor and initiate a corrective action plan.

The Account Manager is responsible for coordinating the formal, quarterly reviews for Iowa and then providing a summary report of the findings and any corrective action plans to various oversight committees including, but not limited to, the local Vendor Compliance Workgroup, which is a collaborative effort between Amerigroup's compliance, quality, and functional leadership.

Provider Helpline Performance Report (14.4.5)

Prompt response to incoming provider calls is very important to Amerigroup. Amerigroup will generate regular reports to monitor that we maintain service levels for incoming provider calls at or above DHS' expected rate and using DHS' defined formulas.

Our Provider Services Manager will analyze and validate service-level reports for provider calls. The Provider Services Manager and Provider Services team works closely with helpline leadership to review the results of provider service levels and will take appropriate actions to maintain required levels.

Amerigroup uses multiple call status reports at a variety of frequencies that range from every 15 minutes to quarterly and that detail our compliance with performance standards. Our reports show trends for call volume, average speed of answer, and abandonment rate. We evaluate existing processes for our provider helpline and make necessary adjustments to meet or exceed all service levels and requirements to improve the quality of service offered by our Provider Services staff.

We maintain operating protocols that promote consistent achievement of our service standards. Our Workforce Management team conducts real-time monitoring of the helpline's telephony metrics, using a variety of technology tools and custom reports. When call volume increases beyond the capacity of our scheduled Provider Services staff, we expand the call answering queue to include designated back-up from the Member Services and Provider Services staff who may be located in any of our six call centers. This approach enables us to optimize staff efficiency while capably meeting performance standards.. An added benefit of being able to move calls between our multiple helplines is that we can react quickly during severe storms or power outages to maintain optimal service levels for our members.

We will submit reports to DHS at the frequency specified in their Reporting Manual.

QM Reports & Performance Targets (14.5)

Amerigroup Iowa's (Amerigroup) Quality Management program reports provide the data which allows us the opportunity to identify ways to improve member satisfaction, enhance appropriate member access to services, level of care, quality and use of program services. Our QM reports objectively and systematically monitor and evaluate the quality, appropriateness, accessibility, and availability of safe and equitable medical, social, and behavioral health care and services. These reports will assist DHS in monitoring our quality management program and improvement activities. We will provide reports in the format prescribed by DHS in its Reporting Manual or if none prescribed, in a standard format used in similar markets.

QM/QI Program Work Plan (14.5.1)

Through our affiliate health plans, we have extensive experience developing and implementing Quality Management and Improvement Program Work Plans developed in support of state-sponsored health programs across 19 different states. Our work plans reflect the efficiencies and priority required to effectively manage quality programs. Through these plans we establish quality improvement strategies and use comprehensive quality tools, resources, and quality improvement processes to accomplish the QM/QI program goals. We monitor, measure, and report the outcomes of clinical care and services, by analyzing clinical and service performance indicators and health care outcomes, and identify and act on opportunities for improvement. The QM/QI program incorporates health promotion as well as performance monitoring in order to positively impact and improve the quality of care and services delivered to members.

The annual QM/QI Work Plan identifies specific activities and projects to be undertaken and the performance measures to be evaluated throughout the year. Work Plan activities align with contractual accreditation, and/or regulatory requirements and identify goals for improving the delivery of health care

benefits and services including a timeline with target dates and measurements to accomplish the goals. Attachment 14.5.1-1 Work Plan, provides a copy of our initial draft QM/QI Program plan and we will incorporate DHS requested changes and submit an official draft plan within 15 days of Contract execution and will execute and adhere to the plan as approved by DHS. Our work plan will include our proposed strategy to align with the SIM project, including specific detail for the value based purchasing requirements.

Please refer to Section 10.1.2 QM/QI Program Requirements and 10.2.5 State Innovation Model (SIM), for a complete description and additional detail of our QM/QI work plan. As requested, Amerigroup will provide the QM/QI work plan, prospectively each year, with quarterly updates and a final evaluation of the prior year, for DHS approval.

QM/QI Committee Meeting Minutes (14.5.2)

Drawing on regular, written minutes and reports from the Quality Management and Improvement Committee that list actions taken and improvements made, Amerigroup will identify needed enhancements to the operational QM/QI Program and Work Plan based on their review of the findings and issues of concern. These activities will be documented in Committee meeting minutes in sufficient detail to demonstrate that action was taken and will be provided in the reporting cycle following the meeting. A copy of the written minutes signed and dated will be available on-file and for review upon DHS or its designee request.

Care Coordination Report (14.5.3)

Amerigroup will submit care coordination reports summarizing all members engaged in our care coordination programs including active participation, member contacts, disenrollment and outcomes. Through our affiliates, we have experience providing these reports for each of our other state programs and closely track the member participation rates and outcomes; always looking for opportunities to provide members with the most effective resources and solution for the delivery of their medical, social, and behavioral health care service needs. For example, we have developed a "Care Opportunities Report"; which identifies attributed members with gaps in care and provides alerts when the next clinical interventions are due. The report also addresses pending gaps in care, looking forward 30 and 60 days, so that care planning can comprehensively cover future clinical due dates, addresses members needs and help physicians practice medicine more efficiently. We can adapt to report changes that the State may require and provide the flexibility to incorporate enhancements and changes when requested. Please refer to Section 9 Care Coordination for additional information on our care coordination reports and program.

HEDIS Report (14.5.4)

Amerigroup's dedicated national HEDIS Data Management teams oversee the HEDIS data processes to verify that our quality metrics accurately reflect our performance. We work closely with our State partners across all of our affiliate health plans to meet or exceed the baseline performance targets. We analyze the annual HEDIS rates against national benchmarks and state performance targets to identify opportunities to improve clinical care and service. We will conduct an annual HEDIS audit survey and submit the final audit report along with the audited data provided to NCQA.

Quarterly Health Outcomes and Clinical Reports (14.5.5)

Amerigroup will work with DHS and comply with DHS established quarterly clinical reports and baseline rates for monitoring health care services use and quality outcomes. We will provide reports for the priority areas as directed by DHS. The data and reports are a valuable resource which we use to effectively change and positively impact member behavior, approach and outcomes.

Behavioral Health (14.5.5.1)

Through our affiliate health plans, Amerigroup has extensive experience producing behavioral health reports and as a result we have implemented a variety of care management initiatives that have contributed to reductions in behavioral health readmissions and achieved cost savings while enhancing quality and positive outcomes for members. We will provide the following behavioral health reports as outlined by DHS: Follow-up after inpatient hospitalization for mental illness; Readmission rates for psychiatric hospitalizations; Anti-depression medication management; Follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication; Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; Adherence to antipsychotic medications; Number and percentage of members receiving mental health services; Number and percent of members receiving substance use disorder services; Foster children by a common identifier, age diagnosis, prescribed medication; and Foster children who are on 2 or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern. We will provide these reports in the format prescribed by DHS in its Reporting Manual or if none prescribed, in a standard format used in similar markets.

Children's Health (14.5.5.2)

Amerigroup's advanced EPSDT Datamart is designed to capture, store, and analyze internal and external data to monitor each member's compliance with the EPSDT periodicity schedule. The EPSDT Datamart provides a mechanism for tracking EPSDT screenings, well-child visits, adolescent well-care visits, childhood immunization status, adolescent immunization status, foster children that receive EPSDT screenings and developmental screening for children age 0-3, diagnoses, and treatment for our members. Our affiliate health plans have produced these reports in our other state programs and Amerigroup will provide these children's health reports as required by DHS. In addition to claims and authorizations, we capture data from many available sources, including state registries, pharmacy, lab vendors, medical record reviews, member assessments, and member care plans; therefore, providing the opportunity for additional reporting if requested by DHS. We use this data and the reports to identify opportunities to improve member participation and take appropriate action to support positive member outcomes.

Prenatal and Birth Outcomes (14.5.5.3)

Amerigroup will provide reports for prenatal and birth outcomes identifying the number of infants born between 34 and 36 weeks; percentage of deliveries that received recommended prenatal and postpartum visits; cesarean rate and frequency of ongoing prenatal care. As we evaluate the results of these reports we look for opportunities to enhance or implement new initiatives and conduct additional outreach and member education all in support of positively impacting prenatal and birth outcomes.

Chronic Condition Management (14.5.5.4)

Through our affiliate health plans, Amerigroup has extensive experience and dedicated programs supporting and coordinating care for members with chronic conditions. We continuously monitor and track these programs to measure our effectiveness of services for our members with chronic conditions and take appropriate action when needed. We will collect data and provide reports to support improvements and measure the effectiveness of the services delivered to members with chronic conditions such as diabetes; cardiovascular; HIV/AIDS; COPD; asthma; chronic kidney disease and other chronic condition prevalent among our members.

Hospitalization and ER (14.5.5.5)

We have extensive experience and provide hospitalization and ER reports currently in each of our affiliate health plans and will provide DHS required reporting including potentially preventable admissions; hospital readmission rates; potentially preventable ER visits and emergency room diversion. We use these reports to monitor readmissions by provider and provider type. We identify members who have frequent

readmissions and the inpatient provider who admitted the member. We use this information to target outreach to providers and members to identify the reasons for readmission and determine which admissions were potentially avoidable. We review the member's clinical conditions that led to admission and identify any contributors to readmission, including break down in inpatient, outpatient, or health plan processes. We may also identify a need for new initiatives during this analysis; which we can then implement to help avoid preventable hospital admissions, readmissions and ER visits. Please refer to Section 10.5 Provider Preventable Conditions for specific information demonstrating our process for avoiding payment for provider preventable conditions.

Adult Preventive Care (14.5.5.6)

Amerigroup will collect and develop reports to measure adult preventive care services to include cervical cancer screening; breast cancer screening; colorectal cancer screening and adult access to preventive/ambulatory health services.

For example through our provider collaboration model we orient providers toward timely delivery of preventive services for all members. Our providers will receive valuable reports such as the Monthly Potential Missed Care Opportunities Report identifying members who have not yet had a test, screening, or visit for various quality-of-care indicators. This report may prompt a provider to reach out to a member because of a missed breast cancer screening, cervical cancer screening or other preventive care services and increase the potential of closing this gap for the member.

LTSS Reports & Performance Targets (14.6)

Amerigroup Iowa (Amerigroup) will work collaboratively with the State of Iowa to develop reports that provide meaningful outcomes data for individuals residing in institutional settings or receiving HCBS. We track and report on several operational areas in LTSS to assure we are meeting our member's needs, such as: Assessment and Reassessment Completions, Care Plan updates and review dates, Medicaid redetermination dates, Staffing ratios for HCBS and nursing home, and New and Termed Provider reports.

Amerigroup's affiliate health plans have worked collaboratively with a number of our states to provide LTSS reports that document outcomes for individuals residing in an institutional setting or receiving HCBS. These reports demonstrate the effectiveness of our institutional diversion strategies and promotion of HCBS.

Examples of report elements that we currently track, trend, and analyze include grievance and appeal data, members returning to the community, critical incidents, fall risk management, out-of-state placements and quality of care concern reports, provider/member satisfaction surveys, and utilization data, readmission to nursing facility or hospitals, employment metrics and many other elements related specifically to members participating in waivers and residing in institutional settings. Through the analysis of these reports we find opportunities at the member and systems level to improve quality and processes and, ultimately, outcomes for applicable members. ***For example, in our New York health plan our member satisfaction survey results demonstrated a 96 percent overall satisfaction with the performance of the plan; 98 percent satisfaction with performance of care managers and 98 percent satisfaction with home care aide and personal care workers.*** In addition, in 2014 in Kansas, our affiliate health plan, we accomplished 100 nursing facility member re-integrations into the community and 640 nursing facility and ICF diversions.

Please refer to Section 4.3.12.4 Diversion Strategies for our implementation plan and proposed strategy for our comprehensive institutional diversion program and promotion of the provision of HCBS.

Nursing Facilities Admission Rates, Nursing Facility Days of Care (14.6.1 – 14.6.2)

Amerigroup will document the nursing facility, ICF/ID, and PMIC admission rate. We will collaboratively develop and provide reports that document nursing facility, ICF/ID and PMIC days per thousand used by eligible members. We will work with DHS, as baseline rates are established and deploy strategies that have proven successful in other markets to decrease the number of nursing facility, ICF/ID and PMIC days per thousand used by eligible members.

Amerigroup provides real solutions to meet our member's preference to remain in their own homes and communities through our comprehensive care coordination program and strategies. Amerigroup's approach builds upon principles of trust, collaboration, and understanding to engage members in the coordination of health, long-term supports, Value-Added Services and community services in creative solutions that support community-based alternatives to institutional settings of care. The elements of our approach include timely assessments, referrals, and member education regarding available services and benefits, and effective collaborative service planning. We also conduct intensive follow-up to ensure that at-risk members wishing to remain in a community setting are able to do so.

Return to Community (14.6.3)

Amerigroup's affiliates currently produces LTSS reports in each state program where we provide long term care services, including a return to community report, which documents the percentage of members who return to the community following nursing facility, ICF/ID and PMIC admission. We will collaborate with DHS as they establish both the report format and baseline rates, and we will implement our plan and strategies to increase the number of members returning to the community.

ICF/ID and PMIC Report (14.6.4)

Amerigroup will provide the reports necessary to document measures for ICF/ID and PMIC services as identified by DHS. We will collaborate with DHS and can adapt to program changes and work to incorporate measures as required.

Fall Risk Management (14.6.5)

Amerigroup will provide the report necessary to document the percentage of members in long-term care at risk for falling who are seen by a practitioner and receive fall risk intervention. Through experience with our affiliate health plans we have used fall risk management reports to take extra precaution for members at increased risk for falling and promote the most effective interventions and increase practitioner and member awareness. For our LTSS members, community-based case managers routinely observe the member's environment for potential health and safety issues related to falls, and discuss with the member available interventions and incorporate the most appropriate interventions into the member's care plan.

Hospital Admission after Nursing Facility Discharge (14.6.6)

Amerigroup will provide reports documenting the percentage of members discharged from a nursing facility who had a hospital admission within 30 days. We will collaborate with DHS as baseline rates are established and develop a strategy to demonstrate a decrease in the hospital admission rate following a member's nursing facility discharge.

Self-direction (14.6.7)

Amerigroup fully supports self-directed care. Through our affiliate health plans, we have extensive experience in educating our members with regard to this option. Numerous states that we are engaged in require some form of reporting as well as tracking or outcomes related to increasing the number of consumers selecting self-directed options. *In these states, our affiliates work closely with our state partners and have developed comprehensive policies and procedures that guide member education and election and implementation of self-direction.* We provide reports to identify the number of members who are self-directing their HCBS and use these reports to monitor member progress in self-directed services. In support of the State's HCBS transition plan goals, of increasing member self-direction, we will promote and look for opportunities for self-direction with our members.

Please refer to Section 4.4.8 Self-Direction for our proposed strategy for implementing the Consumer Choices Option to include monitoring and reporting.

Timeliness of Level of Care, Timeliness of Needs Assessment and Reassessment (14.6.8 – 14.6.9)

Amerigroup and our health plan affiliates has well-established, reliable, and efficient processes for tracking and reporting timeliness of level of care, assessments and reassessments to our state partners. Our innovative CareCompass technology and robust reporting systems reduce administrative burden and create efficiencies by automating the transfer of information. Our enabling technologies coupled with our well-defined policies and procedures and dedicated care coordination staff provides the consistency and efficiency required to meet the State timelines. For example, a 2013 annual quality survey in our Tennessee health plan reviewing a sample of member files revealed a 100 percent compliance score for timeliness of reassessments and reporting level of care changes to the State for determination.

We will complete one hundred percent of level of care reassessments within twelve months of the previous assessment and fully cooperate with a DHS audit; which we are confident will demonstrate our accuracy and appropriate application of criteria. We will report the timeframes for completion of needs assessments and reassessments for the 1915(c) HCBS waiver members and collaborate with DHS to establish a mutually agreeable timeframe during contract negotiations, for completion of these needs assessments.

Care Plan and Case Notes Audit (14.6.10)

Amerigroup will collaborate with DHS as they determine compliance by auditing the 1915(c) HCBS waiver care plans and case notes. Amerigroup and our affiliate health plans have experience complying with audits as *demonstrated in the results of our LTSS EQRO audits showing a ninety percent or greater compliance rate.*

Our member care plans and case notes will demonstrate our compliance with (i) timely completion; (ii) a care plan addressing the member's assessed health and safety risks and personal goals; (iii) member signature on the care plan; (iv) all providers are listed on the care plan; (v) all funding sources are listed on the care plan; (vi) plan for supports available to the member in the event of an emergency are documented; (vii) provision of services as delineated in the care plan; (viii) discussion of advanced directives with members; (ix) percentage of new members starting ongoing services within the required timeframe; (x) member and/or guardian participation in care plan development; and (xi) number and percentage of in-person visits that were on time, late or missed, as required by DHS.

Critical Incident Reporting (14.6.11)

We will regularly track and trend critical incident data and coordinate necessary oversight, performance improvement strategies, and ongoing monitoring as part of our ongoing commitment to improve quality of care and reduce occurrences of critical incidents. Amerigroup will provide the reports necessary to

document the number, percent, and frequency of critical incidents in the required timeframes. We will collaborate with DHS and other Iowa stakeholders and MCOs on critical incidents prevention activities and risk management strategies to promote health and safety with evidence-based policies and procedures.

Please refer to Section 10.4 Critical Incidents for additional detail of our plan to report on and identify trends, patterns, and areas for improvement, including our strategy for reducing the occurrence of critical incidents and improving the quality of care delivered to members.

Out of State Placements (14.6.12)

Through our health plan affiliates, Amerigroup has experience tracking out of state placements for our LTSS members and will track and collect the data required that provides the information and number of members receiving out of state placements and providers for adults and children for the Iowa program. We use this report to help identify options for member placement and assist with the most appropriate placement for our member's needs.

Quality of Life Reports and Performance Targets (14.7)

Amerigroup Iowa (Amerigroup) will provide data and reports in support of DHS's goals of measuring the quality of life for members and developing performance targets. We can coordinate with DHS for the measurement areas to include increased life expectancy, number and percentage of members who gain and maintain competitive employment, number and percentage of members engaged in volunteer work, satisfaction and reduction in homelessness, and other quality of life indicators as needed. When DHS determines a member survey is needed, we will conduct the survey to measure key experience and quality of life indicators using best practices for reaching populations with special health care needs. We have experience surveying a multitude of populations, including those with special needs. We have extensive experience meeting the needs and driving improvements in services and programs for special populations through collaborations with members and stakeholder.

For example, in our affiliate health plans we currently serve almost 31,000 individuals with intellectual/developmental disabilities (I/DD). We bring experience coordinating the full array of services needed to support individuals with I/DD, including self-direction, individual supports, employment supports, community activities, and supportive home care. Through monitoring and tracking these individuals, we make sure we understand the member's experience and satisfaction to continuously evaluate and support the most optimum quality of life outcomes for the members.

In addition, in our New York plan we developed a First Episode Psychosis Program where we conduct a member assessment that asks member's specific questions to help understand their quality of life and better address barriers and challenges they are facing. Questions that address their environment-housing and community; occupational-employment; emotional health and social-sense of connection to family, friends and community group.

Amerigroup has always been committed to providing quality health care services and supports to allow the best opportunity for people of all races, ethnic backgrounds, and religions and to those who are aging, have disabilities or special needs, or are homeless to reach their maximum potential and achieve the highest quality of life. We have done so in a way that recognizes and respects members' needs and preferences, values each individual's worth, and protects and preserves each individual's dignity. This is at the heart of who we are.

Utilization Reports & Performance Targets (14.8)

For 24 years, Amerigroup Iowa's (Amerigroup) affiliate health plans have provided appropriate care and services to over 5.2 million state-sponsored health program members across 19 states while achieving ongoing improvements in utilization management and quality outcomes. Through our affiliate health plans, we have extensive experience providing utilization reports and data which allows us the opportunity to identify ways to enhance appropriate member access to services, level of care, and use of program services in the most efficient manner possible. We facilitate provider access to reports, data, and information and systems that ease the administrative burden of review and support the most effective delivery of services.

We will submit our utilization reports which provides the data to assist DHS in monitoring program utilization trends and assess our stability and continued ability to offer health care services to members. We will provide reports in the format prescribed by DHS in its Reporting Manual or if none prescribed, in a standard format used in similar markets.

Program Integrity Plan (14.8.1)

Amerigroup's local Iowa Compliance Officer, accountable to our senior management, maintains responsibility, in conjunction with our national Medicaid Special Investigations Unit (MSIU), to develop and implement our Program Integrity Plan. Through quarterly reporting we provide DHS an outline of our key activities, findings and progress in meeting our stated goals and objectives. This report also includes the quarterly recoupment totals including the recoupment actions and receivables. Our Compliance Officer is responsible for communicating information about fraud, waste, and abuse across all functional areas and with system stakeholders. Changes to the Program Integrity Plan will be presented to DHS for approval.

We are quite familiar with these reports and take all reports of potential fraud and abuse very seriously. Our national Medicaid Special Investigation Unit (MSIU) staff addresses all allegations referred by company personnel, members, health care providers, vendors, subcontractors, and other external entities. The MSIU submits a monthly activity report of all investigative activities to the health plan leadership team as noted in our Program Integrity Plan. This report includes internal monitoring and auditing activities, review of fraud and abuse activities, corrective action plans and outcomes. We use this information in developing and incorporating changes and updates to our Program Integrity Plan.

Please refer to Section 12.2 Program Integrity Plan for additional information on our Program Integrity Plan that will be submitted annually, along with updates for DHS approval.

Prior Authorization Report (14.8.2)

We will make decisions within seven calendar days of the request for the service on 100 percent of the authorization requests with the exception of the requirement for an expedited decision which will be made within three business days of the authorization request. Decisions for pharmacy prior authorizations will be made within 24-hours of the request for service. In accordance with our tracking requirements, as referenced in Section 11.2.6.1 PA Tracking Requirements, quarterly prior authorization reports will include a summary of prior authorization approvals, pending requests and denials from the end of the previous reporting period.

Pharmacy Rebate Reporting (14.8.3)

As specified in Section 3.2.6 in accordance with Section 1927(b) of the Social Security Act and amended by Section 2501(c) of PPACA we will provide utilization information on covered drugs in the quarterly

rebate invoices to drug manufacturers and in the quarterly utilization reports to CMS. We will work with our PBM, Express Scripts to meet all pharmacy-related reporting requirements accurately and promptly. Our PBM provides claims and rebate data, which is used to create customized reports to meet Iowa requirements and goals. In addition, we have policies and procedures in place to support the transmission of pharmacy encounter data. Through our internal data warehouses, we pull encounter data from all systems representing all covered services, which enables us to report on the full spectrum of care provided and report to DHS as required.

Pharmacy Reporting (14.8.4)

We will provide Iowa pharmacy program reporting in the format or templates requested by DHS. We will work with our PBM, Express Scripts to meet all pharmacy-related reporting requirements accurately and promptly to include: Performance of the Pharmacy help desk; prior authorization performance; prior authorization turnaround times; number of claims submitted as a 72-hour emergency supply; denials; pharmacy network access; grievance and appeals and medication therapy management initiatives. Our PBM provides claims and rebate data, which will be used to create reports to meet Iowa requirements and goals. In addition, we have policies and procedures in place to support the transmission of pharmacy encounter data. Through our internal data warehouse, we pull encounter data from all systems representing all covered services, which enables us to report on the full spectrum of care provided.

Amerigroup's access to pharmacy and medical claims data affords us a unique opportunity to closely monitor all prescription drugs that members may be currently taking and providers are currently prescribing, which assists with identifying and engaging high utilizers, inappropriate prescription drug usage, and candidates for disease management, care management, training, and education. Our experience with our various programs and tools will enable us to not only trend our member and provider habits in under- and over-utilization, but also to act upon the information using technology and outreach.

Claims Reports & Performance Targets (14.9)

Amerigroup Iowa (Amerigroup) has a solid track record of delivering accurate and timely data reports. Amerigroup agrees to submit claims processing and adjudication data. We will identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. We will meet performance targets described below and will submit the data and reports described in Section 14.9.1 and Section 14.9.2.

Adjudicated Claims Summary, Claims Aging Summary and Claims Lag Report (14.9.1)

All adjudicated claims, both paid and denied, receive a specific explanation code informing the provider of the level of payment or corrective action required to complete the claim. We report this information to the provider on subsequent notifications that accompany the claim payment or denial.

Amerigroup agrees to pay or deny 90 percent of clean claims within 20 calendar days of receipt, 99 percent of clean claims within 60 calendar days of receipt and 100 percent of claims within 90 calendar days of receipt.

Claims Denials Reasons (14.9.2)

If a claim does not pass the adjudication edits, it is denied. Claims that require further information from the provider or a third party are also denied. We notify the provider of the issue, and after receipt of the

requested information, the claim is processed as an adjustment. Amerigroup agrees to report the top 10 most common reasons for claim denial.

CMS Reporting (14.10)

Amerigroup Iowa (Amerigroup) agrees to comply with the requirement to provide data to CMS and the State in support of federal waiver requirements in the manner and timeframe specified by the requesting agency. Such provision of data will include cases in which we identify Health and Wellness Plan or HCBS waiver members that may have other health coverage. In such cases, we will make a referral to the DHS Health Insurance Prepayment Unit (HIPP), providing the HIPP unit with the individual's Medicaid SID number and the name of the employer through which the individual has health insurance or may have insurance coverage available.

IDPH Reporting (14.11)

Reports Supporting Substance Abuse Prevention and Treatment Block Grant

Amerigroup Iowa (Amerigroup) will submit reports to IDPH as required supporting the Substance Abuse Prevention and Treatment Block Grant and other reporting as determined by IDPH. Through our affiliate health plans, we have experience in other states meeting all block grant reporting requirements. We typically include this information as a standard component of our routine monthly submissions to the State. For example, in several States our encounter files are used as a data source from which the State extracts information that is submitted as part of the block grant reporting requirements. We will work with Iowa to provide all data needed in the form, format, and timeframe required.

Please refer to Section 10.2.6 Substance Abuse Prevention and Treatment Block Grant for additional information regarding Amerigroup's support of IDPH.

Contractor's Termination Duties (15.1)

Question 15.1, #1

1. Describe your plan to complete the duties outlined in Section 15 in the event of contract termination or expiration.

Plan to Complete Duties in Event of Contract Termination or Expiration

In the event of contract termination, our focus is on the needs of the member, with particular attention to continuity of care. *We take transitions seriously and execute them with integrity and quality. We do the right thing, and we do it well. Our organization has never had a state-sponsored contract terminated for performance.* If the transition is a result of implementing a turnover plan, we follow a prescribed process to minimize disruption of services for the member, support the needs of the State, and assure complete and accurate data transmission to the appropriate parties involved. Our plan to complete the duties outlined in Section 15 includes the formation of a Transition Project Team consisting of:

- A Steering Committee
- A Transition Liaison
- Our national Implementation Management Office (IMO) staff
- Use of a Project Management Lifecycle
- Development of a Transition Plan
- Use of a quality oversight process, including a Risk Mitigation Plan

Amerigroup Iowa will be supported by our National Medicaid Division and resources throughout transition and post-transition. In the event of Contract termination or completion, we will maintain health plan capabilities and meet all obligations through a combination of Amerigroup Iowa staff and national capabilities.

Transition Project Team

The Transition Project Team will use established tools and procedures to help ensure completion of all required transition and post-transition activities while helping members and providers transition to another managed care contractor. The Transition Project Team will develop a written Transition Plan which addresses the key components outlined in Section 15, an example of which is provided in Subsection 15.1.2.

Transition Steering Committee

Central to a successful transition will be the formation of an Amerigroup Iowa Transition Steering Committee that includes the health plan's senior leadership. They will oversee the project team and termination process, including completion of milestones and deliverables specified by the Agency. The Transition Steering Committee will:

- Guide decisions
- Resolve issues or barriers
- Facilitate on-time execution of the Transition Plan
- Maintain compliance
- Maintain quality of care during transition

Transition Liaison

As specified in Section 15.1.1.3 of the RFP, we will appoint a Transition Liaison who will serve as the central point of contact with the Agency throughout the transition period and post-transition. The Liaison will be a member of the health plan’s leadership team whose experience and existing working relationship with key Agency staff will help ensure an orderly transition. The Transition Liaison will be responsible for day-to-day oversight of transition activities, including ensuring records are provided to the Agency in the format and timeframe required and for addressing post-transition concerns. He or she will work closely with the Agency until transition is determined complete by the State. The Transition Liaison will be supported by the Transition Steering Committee and the IMO, which identifies responsible business owners and required records, develops a project management plan and retrieves, collects, and tracks all records that must be submitted to the Agency. The IMO documents transmission completion and closeout.

Implementation Management Office

Our national Implementation Management Office (IMO) is charged with coordinating turnover planning and implementation, in partnership with the key department leadership at the health plan, and our national Technology Services Department. IMO is led by a certified Project Management Professional (PMP) with more than 20 years of health insurance industry experience. IMO staff are seasoned subject matter experts representing all areas of health plan operations who work closely with our local health plan leaders and other key personnel. IMO employs formal project management practices to help ensure projects are completed on time and in compliance with specified requirements. IMO will use a formal Project Management Lifecycle and Risk Mitigation Plan to guide completion of transition activities.



An example of a Project Management Lifecycle is depicted in Figure 15.1-1.

Figure 15.1-1. Amerigroup’s Formal Life Cycle for Project Management of Plan Transition Activities



Risk Mitigation

The IMO employs a formal risk management process in accordance with PMI’s global standard for project risk management. The project Risk Management Plan is used specifically for capturing and managing those things that are not necessarily known or given but might occur, and if they did, would present a risk to the project’s successful execution. The identification of project risks and their associated mitigation and/or contingency plans can and should occur at any point in the project lifecycle where they present themselves. Once the requirements and the schedule of task for the project are defined, it is advisable to gather the project team and facilitate a risk planning conversation to validate all risks captured to date, identify any risks not previously documented, and complete the Risk Management Plan with the input and consensus of the team. As the project progresses, it is the responsibility of the Project Lead to monitor the plan, regularly review it with the team, continually assess the risks, ensure the mitigation plans are progressing as planned, and communicate the need to invoke contingency plans as necessary.

The development and execution of the Requirements Matrix Document, the MS Project Schedule, and the Risk Management Plan are the foundational deliverables of the IMO team and the place where the discipline of project management adds considerable value in delivering what is required and promised by the source documentation. Expert project execution leads to smooth implementation and excellent operational performance, which is why our customers selected us in the first place.

Our Risk Management template is displayed in Figure 15.1-2.

Figure 15.1-2. Our Risk Management Template Provides a Formal Structure for Rapid Identification and Resolution of Any Threats to Completion of Required Transition Activities

Risk #	Functional Category	Description of Potential Risk	Deliverables or Operations at Risk	Prob Scale			Impact Scale	Total Risk	Who Monitors	Indicators to Monitor for the Risk	Actions to Recover from Risk (Contingency Plan)	Contingency Plan Execution Date	Contingency Plan Authorized By	Who Activates Recovery Plan
				1 (L)	2 (H)	3 (H)								
1														
2														

Question 15.1, #2

2. Provide a general end-of-contract transition plan which addresses the key components outlined in Section 15.

Written Transition Plan

The Transition Project Team will develop a written Transition Plan that specifies the activities to be carried out through completion all of the health plan’s obligations. Amerigroup will submit the Transition Plan to the Agency for approval within 60 days of Contract execution and comply with all other requirements as specified in Scope of Work Section 15.1.1.4.

Table 15.1-1 provides a general end-of-contract Transition Plan which addresses the key components outlined in Section 15 and that will be finalized with DHS following contract award.

Table 15.1-1. Our General End-of-contract Transition Plan Will Include the Following Activities

Organizational Area	Activity	Responsible Staff
Compliance	<ul style="list-style-type: none"> • Provide a written Transition Plan for the State’s approval. • Revise and resubmit that plan to DHS on a regular basis. 	Transition Steering Committee
Regulatory	<ul style="list-style-type: none"> • Provide required records to DHS or its designated entity in the format and within the timeframes required by the State as specified in Section 15.1.1.5 of the RFP or as otherwise directed by DHS • Supply program information to, any successor program contractors as specified by DHS • Submit required reporting as specified in Section 15.1.1.10 of the RFP or as otherwise directed by DHS <ul style="list-style-type: none"> ➢ Review regulatory and internal reporting requirements and update reporting grids/attestations ➢ Identify and track completion of required close-out reporting and activities including: <ul style="list-style-type: none"> ▪ Progress report every 30 days ▪ Information on all Iowa Health and Wellness Plan members’ completion of Healthy Behaviors Program requirements ▪ Performance data • Complete Turnover Results report documenting successful completion of Turnover tasks 	Regulatory Oversight Manager
Quality Management	<ul style="list-style-type: none"> • Submit performance data, including self-reported audited HEDIS® and CAHPS data and any other data specified by the Agency to the Agency or its designated entity • Participate in the External Quality Review, as required by 42 CFR 438, Subpart E, for the final year of the Contract. 	Quality Management Manager
Financial Management	<ul style="list-style-type: none"> • Maintain required fidelity bonds and insurance as specified in the Contract until all obligations of the Contract have been fulfilled. • Continue to pay claims as specified in Sections 15.1.1.13 through 15 for services rendered through the day of termination or expiration of the Contract including those previously denied but subsequently approved upon appeal or State fair hearing • Submit encounter data as specified in Section 15.2.2.16 • Report any capitation or other overpayments as specified in Section 15.1.1.22 	Claims Administrator and CFO
Grievance and Appeals	<ul style="list-style-type: none"> • Continue to resolve member grievances and appeals for dates of service prior to the day of Contract expiration or termination as specified in Section 15.1.1.11 	Grievance and Appeals Manager
Health Care Management Services	<ul style="list-style-type: none"> • Arrange for the orderly transfer of patient care and patient records to members’ new providers in conjunction with Health Care Management (Case Management, Disease Management and Utilization Management) • Complete HCM staff turnover training • Review and approve Prior Authorization and Case Management data transfer file 	Utilization Management Manager Behavioral Health Manager Case Management Manager Long Term Care Manager

Organizational Area	Activity	Responsible Staff
	<ul style="list-style-type: none"> ● Develop Transition of Care Plans for members enrolled in CM/DM, or in a residential or long-term care setting, or during a period of treatment including acute treatment, to help ensure continuity of care ● Authorize continued treatment for members for whom a change of providers could be harmful for up to forty-five (45) calendar days from the Contract Termination Date or until the members can be transferred to another program contractor, whichever is longer. ● Coordinate continuation of care for members undergoing treatment of an acute condition 	
Member Services	<ul style="list-style-type: none"> ● Develop member notification materials about Contract termination (as described below) and provide to the Agency for approval in advance of distribution. <ul style="list-style-type: none"> ➢ Complete Member Services Representative staff turnover training ➢ Design and implement call center turnover communication protocols ➢ Make National Call Center available for member calls during turnover timeframe 	Member Services Manager
Provider Relations and Communications	<ul style="list-style-type: none"> ● Develop provider notification materials about Contract termination (as described below) and provide to the Agency for approval in advance of distribution. ● Notify all providers about the Contract termination and the process by which members will continue to receive medical care. <ul style="list-style-type: none"> ➢ Complete Provider Relations turnover training ➢ Design and implement call center turnover communication protocols ➢ Make National Call Center available for provider calls during turnover timeframe 	Provider Services Manager
National Service Administration	<ul style="list-style-type: none"> ● Transfer mail and phone for post-turnover support ● Complete office space planning and closure 	Corporate Real Estate Manager
Information Systems	<ul style="list-style-type: none"> ● Prepare data dictionary, data mapping, and testing for file and data transfers ● Determine recipients of records/data files (the Agency, another contractor, or other entity) ● Identify record/file format (data mapping/data dictionary) and transfer method ● Generate and test data files ● Generate and execute data transfers 	Management Information Systems Manager
Legal	<ul style="list-style-type: none"> ● Complete contract terminations or amendments 	Legal Services Manager
Vendor Management	<ul style="list-style-type: none"> ● Identify and coordinate needed the Agency/ subsequent subcontractor training 	Vendor Account Manager

We will fully cooperate with DHS, its employees, agents, and independent contractors during the transition period to provide a seamless transition with minimal disruption for our members and providers.

Amerigroup Iowa understands the vital importance of continuing to serve or arrange for provision of services to members for up to forty-five (45) calendar days from the Contract Termination Date or until the members can be transferred to another program contractor, whichever is longer. Our continuity of care processes and experience supporting continuity of care for members with a range of needs and living or receiving services in a variety of settings are described in Section 3.3 of our proposal. Two key aspects of supporting successful continuity of care are 1) Comprehensive staff training and communication during the transition process; and 2) Provision of vital information to program contractors to whom the member will be transferred.

Turnover Training and Communication

A primary objective during transition is to give staff sufficient training so that providers, members, their families, or legally appointed guardians do not need to make multiple requests for the same information. We focus on:

- Timely and comprehensive Turnover Training for Amerigroup staff
- Timely and frequent communication with our members and their families/guardians, network providers, and other partners to apprise them of transition activities and status
- Direct support of members, families, and guardians throughout transition

Prior to transition, Amerigroup staff who interact with members or providers will be required to participate in extensive training to thoroughly understand transition implementation to support continuity of care for members and minimal disruption for members and providers.

Provision of Vital Information

We will provide vital information to the managed care contractor selected by the member or his or her family following the member's transition or at the time specified by DHS. We maintain a range of information that is vital to the receiving contractor to support continuity of care, including open authorizations for hospitalization, surgery, procedures, demographic information, provider and facility information, and diagnosis and procedure codes. This information is easily extracted and exportable using HIPPA compliant methods.

The following high-level list summarizes the optimal transition information that we provide to support a member's transition to another managed care contractor. We are prepared to work collegially with DHS and other managed care contractors to identify and agree upon a file transfer method for communicating data.

- Open Authorizations—Details on any service or benefit authorizations for covered services (including HIPAA-compliant 278 Files)
- Average Daily Census—Daily (Monday to Friday) summary-level statistics of members admitted to each facility
- Detail Daily Census—List of inpatient admissions including behavioral health admissions
- Pregnant Women Listing—List of pregnant women who are due to deliver
- Case Management listing—List of members who are currently in case management and their care plans or those who have been identified as potential candidates for case management and have not yet been contacted
- Disease Management Listing—List of members who are currently enrolled in a Disease Management program
- Recent/Planned Transplant Listing—List of members who have had a transplant within the past three months or have a transplant planned for the future
- Children with Special Health Care Needs—List of children with special healthcare needs
- Member PCP Listing—List of members with their current assigned PCPs
- Members Receiving LTSS and Type of LTSS

We will comply with all duties and obligations incurred prior to the actual termination date of the Contract, including maintaining sufficient staffing across departments to help ensure completion of all required functions, including but not limited to claims payment, care coordination, and support for members and providers as they transition to another managed care contractor. In addition, we will take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Contract to coverage under any new arrangement developed by DHS.

Experience (3.2.5.1)

The bidder shall provide the following information regarding the organization's experience:

A program of the magnitude and scope of Iowa's High Quality Healthcare Initiative, encompassing multiple high-risk and special needs populations, requires a managed care organization with proven success launching and operating similarly comprehensive, complex programs and working with a wide range of stakeholders.

Amerigroup Iowa (Amerigroup) will leverage the experience of its ultimate parent organization, Anthem, Inc. (Anthem), and its affiliate health plans to bring Iowa 24 years of publicly-funded program experience, providing a fully integrated approach to physical and behavioral healthcare across the nation. We will draw on their experience effectively implementing and managing administratively complex programs serving populations with diverse health needs that span the spectrum of care, such as Long-Term Services and Supports (LTSS), Foster Care, Aged, Blind, and Disabled (ABD), and Substance Use Disorder. Currently, our affiliate health plans provide healthcare services to more than 5.2 million members in state-sponsored programs across 19 states as shown in Figure 3.2.5-1.

Figure 3.2.5-1. Amerigroup's Affiliate Health Plans Have Extensive Publicly-Funded Program Experience



3.2.5.1.1 Experience Launching New Programs

3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP.

Amerigroup is one of the few managed care organizations with the experience, capacity, infrastructure, and proven processes to tackle a program the size and complexity of the Iowa Initiative. Our ability to successfully implement complex new programs while seamlessly transitioning new members and providers into our operations is one of our core competencies. But while our broad experience, deep resources, and extensive infrastructure provide the foundation, we treat each implementation as unique. We use each state's specifications to configure our technology systems and operations to meet residents' particular healthcare needs.

Over the past 24 years, our organization has successfully implemented more than 100 public-sector healthcare programs, service area expansions, and program enhancements, including three new health plans between February 2012 and January 2013. During that 15-month period, our affiliates managed the start-up of Medicaid health plans in Kansas, Louisiana, and Washington that comprised more than 256,000 new members. They completed these implementations without any disruption in service. In fact, the call center abandonment rate during those 15 months was just 1.04 percent.



In our collective history of state sponsored program implementations, none of our affiliate health plans have ever missed an operational start date.

In our collective history of Medicaid program implementations, ***none of our affiliate health plans have ever missed an operational start date.***

That proven experience will support our commitment to bringing DHS an efficient, fully integrated program that puts Iowa members first. It will serve the full continuum of their physical, behavioral, and special healthcare needs, including Long Term Services and Supports (LTSS); Aged, Blind, and Disabled (ABD); and foster care. Amerigroup's whole-person approach and strong care coordination are a natural complement to the breadth and scope of the Iowa program. We emphasize choice, independence, engagement, and personal responsibility in all aspects of member care, including our Value-Added Services and member incentive programs.

Regardless of age, ability, or need, we will emphasize care connections – our healthcare management programs will connect our Iowa members with the right providers to get the right care and services at the right time. Through our affiliated health plans in 19 other states, our organization delivers member access to care through recruitment, development, and maintenance of robust provider networks that reflect our members' diversity, geographic location, and preferences. Our quality initiatives and provider collaboration programs incorporate monitoring and oversight of patient safety measures. For instance, our parent company created the strengths-based National Advisory Board (NAB), which promotes services and supports models to foster independent living, choice, recovery, and quality of life for people who are aging or have disabilities.

Healthcare is local – each market poses different needs and conditions. We know that program delivery must be tailored to the particular needs and assets of its members. We understand the challenges faced by low-income and underserved individuals in each of the 19 states our affiliate health plans currently serve and have designed each of our programs to specifically address these challenges. We have the knowledge, support, and commitment to meet the particular healthcare needs of Iowa's residents with compassionate, high quality care.

Our best-in-class programs successfully manage all populations and services referenced in this RFP in a capitated environment across multiple states. ***Our affiliates' experience with populations requiring specialized services include:***

- Rendering fully integrated physical and behavioral healthcare, as well as LTSS, to Medicaid populations across 8 states
- Serving more than 168,000 dual eligible members in 11 states
- Implementing Home and Community-Based Services, training, and employment services for individuals with intellectual or developmental disabilities (IDD) in Kansas
- Administering Indiana's Hoosier Indiana Plan (HIP) 2.0, an ACA Medicaid expansion alternative comprising 19 different benefit packages
- Managing behavioral healthcare and services in-house in 16 states, including crisis services and outpatient therapy for families and children, intensive psychiatric rehabilitation, and peer support.

Our affiliates have also implemented a number of programs where individuals transitioned directly to managed care from Fee-for-Service (FFS), comparable to Iowa's objective for its High Quality Healthcare Initiative, including:

- Our Kansas affiliate collaborated with the State to launch a significant redesign of its Medicaid program, which launched in 2013. The new program includes the full range of populations and services, including LTSS, waiver programs, individuals with ID/DD, and members of all ages with disabilities.
- We participated in Louisiana's 2012 move from FFS to managed care, which included TANF, CHIP, and ABD populations.
- We worked with Georgia to launch managed care for its foster care population in 2014.
- We worked with Tennessee to roll out their TN CHOICES program, which transitioned HCBS waiver services to MCOs instead of FFS.

Effective Care Integration and Coordination

In each of the 19 states Amerigroup's affiliates serve, our integrated care approach and systems deliver superior quality through superior coordination because we do not subcontract any part of our care model. We manage the physical/behavioral, LTSS, and special healthcare needs of our members at the same place, at the same time, and with the same people. Our network includes specialized clinicians, clinical practices, and guidelines that address the unique physical, behavioral health, and social support needs of each of our members, aiming for reduced fragmentation of care and improved member outcomes. This gives us superior control and enables a seamless experience for both members and providers.

Our care coordination approach, developed and refined through our years of experience providing services to Medicaid, CHIP, LTSS, and special needs populations, addresses the needs of:

- Expectant mothers
- Young children
- HCBS waiver populations
- Hospital inpatients and those transitioning place of service
- Persons in nursing homes
- Persons with behavioral health needs
- Children and youth with special health care needs
- Other persons with chronic care or complex care needs

Innovative Integration Strategies for Specialized Populations

Amerigroup has developed innovative care management strategies for our members who have specialized physical, behavioral, or social challenges. Our affiliate health plans' interdisciplinary teams support their specialized populations with these strategies, including:

- ***PC INSITE*** integrates behavioral health capabilities into primary care clinics for universal depression and substance use disorder screening, enabling us to provide treatment, monitor, and follow-up with members
- ***CareMore Model*** improves coordination of care for members with complex or chronic disease management needs
- ***Community Mental Health Center Primary Care*** integrates behavioral and medical healthcare for members with Serious Mental Illness (SMI) through community mental healthcare partnerships
- ***Autism Services and Supports*** deploy Autism Specialists to delivered integrated care
- ***Intellectual and Developmental Disability(IDD) Services Program*** coordinates health plan staff and relevant community partners to execute fully integrated IDD care
- ***Prescription Opiate Use Interventions*** take a multi-faceted approach to reducing prescription opiate abuse

Amerigroup's Case Managers and Care Coordinators meet with members to develop individualized service plans that span the delivery systems of physical, behavioral health and LTSS to address their barriers, maximize their independence, and facilitate the care they need. That individualized, member-centric foundation actively engages individuals in their healthcare decisions and addresses their biopsychosocial strengths and needs by rendering the right quality care, services, and supports in the right place and at the right time. It is the cornerstone of the seamless experience both members and providers receive from Amerigroup.

For instance, starting October 1, 2015, our affiliate health plan in New York will be one of the few selected to administer a comprehensive and innovative program – the Health and Recovery Plan (HARP) – that supports members with severe mental illness. It seamlessly integrates the disparate physical health, behavioral health, and social services available to members and coordinates them to provide a meaningful, outcomes-focused system of care.

That integration of physical/behavioral healthcare and LTSS, shown in Figure 3.2.5-2, is a core value of our organization. Our affiliates' experience in other states has shown integration is the most efficient, cost-effective care model and has enabled us to develop best practices and refine our infrastructure, processes, tools, and approach to best serve the special needs of all state sponsored health program populations.

Figure 3.2.5-2. Amerigroup Affiliates Integrate Physical Health/Behavioral Health and LTSS in State Programs

State	Membership	Medical Health	Behavioral Health	LTSS	Pharmacy	Substance Use Disorder
CA	1,081,270	•	•	•	•	
FL	361,277	•	•	•	•	•
GA	352,860	•	•		•	•
IN	244,753	•	•		•	•
KS	130,158	•	•	•	•	•
KY	60,148	•	•		•	•
LA	133,131	•			•	
MA	261,152	•	•		•	•
MD	18,961	•			•	
NV	180,656	•	•		•	•
NJ	214,992	•	•	•	•	•
NY	464,530	•	•	•	•	•
SC	83,393	•	•		•	•
TN	222,134	•	•	•		•
TX	811,511	•	•	•	•	•
WA	129,180	•	•		•	•
WV	88,546	•			•	
WI	79,378	•	•			•
VA	272,004	•	•		•	•

Provider Networks

Amerigroup’s integrated care coordination begins with recruitment, development, and maintenance of a robust provider network. Our affiliate health plans are recognized for building network solutions, including LTSS providers and community based resources and for rural areas similar to Iowa’s, that support the needs of our state partners’ most vulnerable citizens – respecting their cultural and linguistic needs while providing them geographic accessibility. Our provider network development and management are based on the experience our organization has gained over 24 years, collaborating with providers, community leaders, and advocacy groups and listening to our members’ and families’ descriptions of the challenges they face.

We develop our networks to meet or exceed state requirements and include specialized providers, clinical practices, and guidelines that address our members’ unique healthcare and social support needs, reduce fragmentation of care, and improve their outcomes. Dedicated, regionally based staffs support our networks, enabling providers to transform member-centered care by developing their care coordination and member engagement skills.

Our national network development team, which will build Iowa’s network, has developed 12 different state Medicaid networks over the past 36 months. Most recently in Kentucky, Tennessee, and Virginia, we contracted with more than 72,000 providers to meet or exceed each state’s requirements as shown in Table 3.2.5-1.

Table 3.2.5-1. Rapid Network Development in Kentucky, Tennessee, and Virginia

Provider Types	Kentucky	Tennessee	Virginia
Primary Care	5,672	2,167	7,765
Behavioral Health	2,452	1,348	5,783
Specialists	23,176	5,068	14,202
LTSS	985	763	1,352
Urgent Care	482	246	51
Hospitals	113	52	74
Nursing Facilities	10	166	159
FQHC/RHC	207	101	87
TOTALS	33,097	9,911	29,473

In Iowa, we are currently partnering with Wellmark, which is helping us develop deep relationships with its existing Accountable Care Organization (ACO) providers, comprising more than 2,000 primary care providers.

Provider Incentives

Effective providers are the backbone of all our networks. They have the ability to touch every one of our members in a way that can alter the course of our members’ lives. Our goal is to provide the tools, support, and incentives to our providers to help them deliver optimal care and at the same time maintain practice viability. To promote that, Amerigroup’s affiliates have implemented a shared savings program in their state sponsored programs that incentivizes providers. With our support, providers cost-effectively manage the medical cost of members by reducing unnecessary expenses like non-emergent emergency room use, focusing on care coordination for those most at risk for high utilization, and effectively coordinating needed specialty care. Providers who effectively manage the quality and efficiency of care for their assigned members will receive rewards in the form of a shared savings payment.

Care Coordination

Our integrated care coordination model provides access, efficiency, and effectiveness in the system of care by supporting the following activities:

- Identification of members with potential or actual care coordination needs through early screening, comprehensive assessments, and periodic reassessments
- Stratification of risk level for each member based on a multi-faceted consideration of available information
- Placement of members into care coordination programs based on needs assessment
- Development of an integrated care plan that addresses physical/behavioral health and LTSS needs for members as they transition across all settings
- Reciprocal referrals and information sharing
- Formation of an interdisciplinary team to support members, provide consistency and continuity of contact with a familiar support system, as well as the expertise of a broader team of specialists as their needs evolve over time
- Care coordination support to improve member access to needed services, including scheduling appointments; arranging transportation; conducting appointment reminder calls; following up to verify service initiation, member progress, and appropriate service adjustments and incorporation into the care plan
- Ongoing evaluation of our care coordination program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and performance improvement

- Emphasis on disease prevention, chronic condition management, and increasing member compliance with recommended treatment protocols
- Member education to enhance understanding of healthcare conditions and prescribed treatment
- Member empowerment

In addition, Amerigroup supports the development of Health Homes (HHs), Patient-Centered Medical Homes (PCMHs), Primary Care Case Management (PCCM), and other models that facilitate strong care coordination and improved care access on a systems level. Our efforts have resulted in improvements in provider compliance with evidence-based clinical practice guidelines and a reduction in avoidable, unnecessary inpatient admissions and emergency room visits, including measured improvements in the quality of health care delivery. *In Maryland, for instance, our affiliate health plan realized a 22 percent decrease in 30 day readmission rates among a population of more than 6,000 members with PCMH, 10 percent for patients with diabetes, and 77 percent for persons with chronic asthma.*

Program Results

Amerigroup's affiliate health plans have successfully administered state programs that meet and exceed quality targets established in their contracts, as well as those identified internally as important to the quality of our service delivery system. Our commitment to member care is demonstrated in the positive outcomes our programs have achieved.

- Our Indiana affiliate has successfully achieved the 90th percentile for three consecutive years on the HEDIS[®] post-discharge follow up for a mental illness within seven days, demonstrating our ability to effectively manage and coordinate appropriate care following a mental illness discharge from the hospital.
- Our Texas affiliate implemented programs that resulted in a 38 percent increase in community-based adult day care services, a 32 percent increase in personal assistance while demonstrating improved health outcomes, and a 38 percent reduction in inpatient stays for targeted ABD members.
- Our Texas and Maryland affiliate health plans exceeded the 75th percentile for HEDIS measures related to pharmacotherapy management for COPD exacerbation.

A Focus on Community-Driven Prevention

Amerigroup's approach to comprehensive care coordination provides members the right care in the right setting at the right time. We know that what happens in the community can impact a person's health as much as what happens in the doctor's office or hospital. That knowledge has driven our affiliate health plans to develop programs and services that meet the particular needs of residents in the 19 states we serve.

Telemedicine/Telepsychiatry Services

Limited access to medical or behavioral healthcare in rural areas is a challenge many members face. To address that, our affiliate health plans provide members with a variety of telemedicine and telepsychiatry services that enable them to receive physical and behavioral health services from qualified providers in centers set up near their homes.

To increase the availability of behavioral health services where access is limited, such as Iowa's rural areas, we provide psychiatric services through telepsychiatry modeled after a best practice from our Georgia affiliate health plan. It enables members to receive those services in their primary provider's office from board-certified psychiatrists who are out of the area.

In Iowa, we will work with the substantial telehealth services currently in place in Iowa, such as those provided by the University of Iowa, and partner with providers to expand existing services as needed to meet the needs of our members.

- **Breakthrough Technologies:** We will partner with Breakthrough, a telehealth platform for behavioral health, and will be exploring other methods to deliver one-on-one consultations with board-certified clinicians either through personal computers or at kiosks installed at strategic community locations.
- **LiveHealth Online:** Several of Amerigroup's affiliate health plans provide their members access to physical and behavioral health consultation 24 hours a day, 7 days a week through our LiveHealth Online program, which we will offer in Iowa as well. When members call the Nurse HelpLine with certain non-emergent conditions, they will be connected to a physician for a web-based consultation when appropriate based on their condition and ability to access video streaming capabilities. These web-based consultations occur with board-certified, Iowa-licensed doctors who conduct a brief assessment, provide diagnosis, and recommend treatment—all of which will broaden member access to care, especially after-hours. Members also have access to our Behavioral Health Services Hotline through a single toll-free Member call center. Callers who do not speak English or Spanish are provided free, immediate translation services in more than 200 languages through a language line. Interpreters are available to join a call 24/7 and also support members calling from a provider's office.

Healthy Families

Obesity is a growing issue throughout the country, particularly among low-income residents. In response, Amerigroup has developed its Healthy Families program. This six-month program helps children and adolescents make lifestyle changes, such as healthier eating and increased physical activity. Healthy Families, which is operational in our Kansas, Florida, Washington, Louisiana, and Kentucky health plans, combines a family focus with nurse coaching to address youth obesity risk factors. So far, the program has realized a 57 percent increase in fruit and vegetable intake, 42 percent increase in activity level, and 30 percent decrease in screen time. We intend to implement Health Families in Iowa as a Value-Added Service.

Healthy Rewards

Another way Amerigroup encourages members to take responsibility for their own health is our Healthy Rewards program. It is a comprehensive member incentive program designed to encourage members to seek preventive services and screenings and manage their chronic conditions. Incentives provide a tool to engage members in self-management and personal responsibility. Since January 2013, our Kansas affiliate has had an established platform supporting program administration (card issuance and financial management of incentive accounts), and our Louisiana and Texas affiliates are in the process of implementing it. That platform enables us to tailor Healthy Rewards to address the unique needs of our state customers and members. We also have proven tracking and analytic tools and data experts who conduct ongoing assessment of the program's impact. Its flexible platform will enable us to easily modify program design to reflect Iowa's needs and impact member behaviors.

While Healthy Rewards has undergone only one HEDIS cycle in Kansas, there are early indications that members enrolled in the program are more successful in attaining important health screenings than those who are not.

HomeConnect

Amerigroup's affiliate health plans know from experience that avoidable hospital readmissions are primarily driven by a lack of follow-up care, with the greatest risk occurring in the first 48 hours post-hospitalization. To address this, we developed our HomeConnect program to engage members before discharge and create a transition plan with appropriate follow-up care. In addition, we reconnect members with their PCP for face-to-face interactions during the inpatient stay and improved access after discharge to follow-up care.

The Home Connect Program comprises the following interventions to support the member's seamless transition into the community. Interventions include:

- Discharge planning
- Daily Census Reports
- Educational letters to members
- Care Coordinator engagement with members during their inpatient stay
- Member visits, including transitional facility and bridge-on-discharge visits
- Provider outreach during admission and verification of follow up post-discharge
- Member outreach calls within one business day of discharge
- Stabilization care management
- Readmission rounds
- Facility feedback presentations to share performance data with high-volume providers

Amerigroup understands the unique challenges members can face when transitioning back home from a hospital stay. As a complement to our HomeConnect Program, we will also offer post-discharge stabilization kits and home-delivered meals to eligible members as Value-Added Services. The discharge kit provides tools for family members and caregivers to successfully help transition members from hospital to home, aid in recovery, and help decrease the chances for readmission. The meal program provides nutritious home-delivered meals, which allows members to focus more on recovery rather than proper nutrition, shopping, or finding a caregiver to prepare them.

Quality Management and Improvement

Amerigroup's affiliate health plans maintain comprehensive quality programs that span all functional areas – physical and behavioral health, LTSS, member safety, and community health – and include ongoing initiatives to strengthen integration. For example, our Tennessee affiliate developed a program striving to improve screening rates for members with cardiovascular disease and LTSS. In its first year, this program boosted low-density lipoprotein (LDL) screening rates by more than 120 percent.

Another example – In 2014, in New Jersey, our Quality Management program initiatives generated the following improvements for our members:

- Increased their customer service ranking from the 25th to the 90th percentile
- Increased their “Getting Care Quickly” ranking from the 25th to the 75th percentile
- Increased their “Health Plan Overall” ranking from 25th to 50th percentile

As further evidence of our organization's commitment to quality, the National Committee for Quality Assurance (NCQA) includes seven Amerigroup affiliate health plans in its list of the Top 100 Medicaid health plans in the country. Other key achievements across our affiliate health plans include:

- 51 NCQA-accreditation certificates in 13 states
- Exceeding the NCQA 90th percentile on critical performance measures, such as timeliness of postpartum care, appropriate medication use for members with asthma, post-discharge follow-up for individuals hospitalized for mental illness, breast cancer screening, HbA1c screening, and adult BMI assessment

Protecting Our Members

Protecting member safety is a hallmark of Amerigroup's organization-wide Quality Assessment and Performance Improvement (QAPI) program. Our affiliate health plans currently maintain a number of

patient safety initiatives, including processes for reviewing all potential Quality of Care issues. We supplement these efforts and expand our capabilities by capitalizing on the increasing abundance of available performance data to collaborate with our network providers to improve patient safety initiatives.

Additionally, our national Quality Management team has instituted a National Patient Safety Committee that provides strategic direction to our local health plans, including policies and procedures related to healthcare-associated infections, medical errors, preventable serious adverse events, and unnecessary and ineffective performance. This cross-functional committee comprises national and local health plan staffs, including Medical Directors. It will collaborate with our Iowa team to develop recommendations to improve patient safety throughout the program; establish patient safety standards, benchmarks and programs; and continually assess our patient safety and refine our programs based on benchmarked performance. This approach reinforces the Amerigroup organization's commitment to protecting the safety of the people we serve.

Program Integrity

Amerigroup and our affiliates have one of the most proactive regulatory compliance programs in the industry. We maintain a robust system of processes and controls to prevent, identify, and mitigate potential fraud, waste, and abuse risks. Our organizational commitment to compliance and to establishing a culture that encourages our employees to embrace this commitment is reflected in one of our company's core values: being trustworthy.

Last year, across the 19 states where we operate state-sponsored programs, our affiliate health plans opened a total of 1,200 suspected fraud, waste, and abuse cases totaling \$33.8 million. We recovered \$3.5 million and avoided payments of \$25.4 million for a net savings of \$28.9 million. That corresponds to a Return-On-Investment of approximately 9-1, as compared to the national average of 8-1.

We provide an overview on each of our contracts over the past five years in Tab 6, Q3.2.7.4 Contract Lists.

References (3.2.5.1.4)

3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment. Persons who are currently employed by the State, or who have been employed by the State in the past 5 years, are not eligible to be references.

We provide five reference letters from state agencies (listed below) with whom our affiliated companies hold current managed care contracts for services similar to those sought in this RFP.

- Kansas Department of Health and Environment
- Louisiana Department of Health & Hospitals
- New York State Department of Health
- Tennessee Bureau of TennCare
- Virginia Department of Medical Assistance Services

The Reference Letters and accompanying Questionnaires completed by each reference are included in Attachment 3.2.5-1.

Experience Managing Subcontractors (3.2.5.1.5)

3.2.5.1.5 Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

Amerigroup's mission is to operate a community-focused managed care company that responds to the physical, behavioral, and LTSS needs, improves outcomes, and offers choice, access, safety, and independence to Iowa's residents.

As a new DHS partner, we will leverage the deep organizational expertise administering state-sponsored programs of our affiliate health plans and our parent company, Anthem, Inc. (Anthem). All have in-depth experience and proven track records of subcontractor management, as well as the development and maintenance of a robust network of delegated vendors. Our affiliate health plans successfully manage various vision, non-emergency transportation, and physical/behavioral health vendors across multiple states. We believe that a primary reason for our success is that we have continually refined our vendor oversight and selection process over 24 years. We believe in a best practice approach, and constantly strive to find ever more efficient ways to hold our delegated vendors accountable, help them remain solvent, and meet all contractual and performance expectations, while delivering high-quality services and access to care.

One of our core competencies is the ability to successfully implement complex new programs, including those involving broad scale changes across a delivery system, in a manner that smoothly transitions members, providers, and stakeholders and avoids disruption to care.

Amerigroup has stringent requirements for selecting and overseeing subcontractors that perform delegated activities, including administrative functions we choose to delegate. We leverage centralized national resources and processes to obtain and manage the services of high-quality subcontractors. Our selection and management process assigns responsibilities in a way that drives authority to the appropriate organizational level and creates a system of checks and balances.

Monitoring and Evaluating Subcontractors

At the **local level**, Amerigroup's Vendor Compliance Workgroup (VCW) and Quality Management and Improvement (QM/QI) Committee will work together to see that subcontractors comply with all applicable requirements and expectations. Our goal is to promptly identify and mitigate potential risks. Our Plan Compliance Officer (PCO) heads this workgroup that includes Department Leads and Account Managers for subcontractors that also serve our affiliate health plans. This will be the cornerstone of our local subcontractor oversight program that includes:

- **Monthly Workgroup Meetings** with health plan leadership to review subcontractor performance metrics and data obtained through our attendance at quarterly Vendor Selection and Oversight (VSOC) and Delegated Workgroup (DWG) meetings. Examples of reviews include vendor rosters to identify adequacy of service coverage and access; call center reports to monitor call volume and resolution; customer complaint reports to identify quality and compliance issues; and claims payment reports to monitor payment accuracy, timeliness, and service utilization.
- **Quarterly Meetings with Subcontractors** to discuss performance against Contract provisions and customer expectations. If we identify performance issues, we work closely with the subcontractor to investigate each case, then take appropriate steps to quickly resolve the issue and prevent recurrence.

Each quarter, we will review service-level standards and management reports, such as claims processing timeliness and accuracy; Member call center and Provider Helpline statistics; and Fraud, Waste, and Abuse program activity and results.

For subcontractors that also serve our affiliate health plans, Amerigroup will leverage the following *national oversight* functions and governance structures to select, monitor, and regulate subcontractor activities and performance:

- The national **Quality Improvement and Compliance Committees** meet quarterly and are responsible for reporting any quality- or compliance-related issues to Amerigroup's local committees (including the Quality Management, Compliance, and Medical Advisory Committees).
- **Vendor Selection and Oversight Committee (VSOC)** has primary responsibility for overseeing subcontractors that serve multiple health plans. It is responsible for their compliance with state, federal, NCQA, CMS, and state program requirements, standards and expectations, and any other applicable regulatory or accreditation standards. VSOC reports to the national Quality Improvement Committee.
- **Joint Operations Committee (JOC) meetings** blend local and national oversight functions. Amerigroup's Quality Management staff, as well as key affiliate health plan personnel and staff, attend quarterly JOC meetings to discuss subcontractors' performance across markets and present issues and concerns to the DWG. Local Medical Advisory and QM/QI Committees receive a summary of each JOC meeting.
- **DWG reports to VSOC monthly.** Amerigroup affiliate health plans have voting members in the DWG. It is responsible for seeing that we follow established policies and procedures in accordance with State, federal, National Committee for Quality Assurance (NCQA), and any other applicable regulatory and accreditation standards. The DWG has collaborative relationships with, and representation from, internal departments. As a governing body comprising local health plan representatives, it also reviews results of the annual state program audits and supports corrective actions, as needed.

Compliance Audits for Subcontractors

Amerigroup will continuously monitor its subcontractors to verify compliance with its standards and requirements, State and federal laws and regulations, and applicable NCQA standards. Amerigroup retains full legal responsibility for all subcontractor performance and activities under a contract.

Amerigroup's Iowa-based VCW and QM/QI Committee will audit our delegated subcontractors' performance through quarterly reports specific to the types of services they provide, such as transportation access and service quality indicator reports, and vision services utilization reports. These reports will enable us to promptly identify and address issues as soon as they arise.

Managing Subcontractors Through Regular Reporting

Amerigroup will monitor its delegated subcontractors' performance through quarterly reports specific to their provided services. Examples of general reports include subcontractor rosters to identify adequacy of service coverage and access; call center reports to monitor volume and resolution of member calls; member complaint reports to identify quality and compliance issues; and claims payment reports to monitor payment accuracy, timeliness, and service utilization. Subcontractor-specific reports include transportation access and service quality indicator reports and vision services utilization reports.

Iowa's local health plan leaders will oversee delegated subcontractors' performance, regularly review their performance reports, and monitor member grievances and appeals. If we identify any subcontractor that is not meeting established goals, we will address the issues through a formal written Corrective Action Plan (CAP) and work closely with the vendor to investigate and take appropriate steps to promptly resolve them. For example, our Louisiana affiliate health plan's transportation subcontractor was placed under a CAP in October 2012, when Amerigroup noticed an uptick in the number of member complaints. They worked with the subcontractor to improve customer service through increased training for customer service representatives, a revised call script that included warm transfers to Amerigroup, unannounced

rides to promote compliance with vehicle and driver standards, and warnings and terminations to drivers who did not adhere to these standards. That subcontractor has shown marked improvement since.

Amerigroup will track and document progress on corrective action every 30 days until all items are addressed and the CAP is closed. Our Quality Improvement and Compliance Committees also track and monitor all active CAPs.

This proven material subcontractor oversight program and these methods will promote service quality and consistency for all Iowa members covered by this program.

For more on our selection and management of subcontractors, please see Tab 4, 2.2 Subcontractors.

Personnel (3.2.5.2)

The bidder shall provide the following information regarding personnel:

Tables of Organization (3.2.5.2.1)

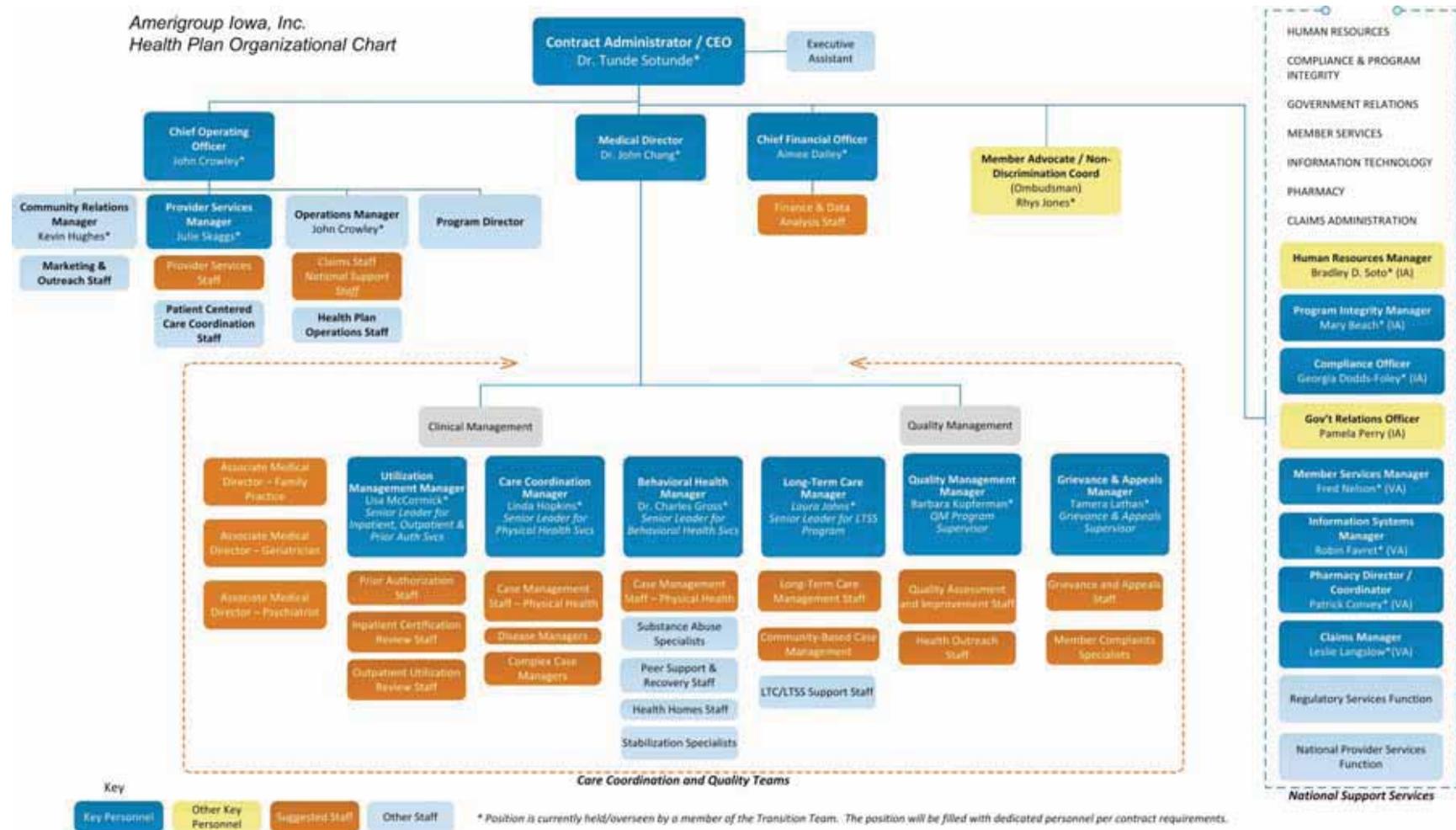
Illustrate the lines of authority in two tables:

- One showing overall operations
- One showing staff who will provide services under the RFP

The tables below provide information regarding the lines of authority and staffing levels for Amerigroup operations in Iowa. The organizational structure of Amerigroup Iowa (Amerigroup) is fully detailed in Sections 2.8 and 2.9.

Our local staff has ready access to collaborate and share best practices, not only with one another but with our national support services teams without compromising local authority and control of health plan operations. Figure 3.2.5-3 illustrates the local health plan organizational model.

Figure 3.2.5-3. Health Plan Organizational Chart



Amerigroup will hire talented, qualified employees to fill positions to meet the requirements of the contract in addition to dedicated national support services positions to further support Iowa operations. We continually evaluate and adjust our staffing to maintain and exceed quality service for our members. Table 3.2.5-2 outlines our anticipated staffing levels based on current membership assumptions and projections for the Iowa Initiative. We anticipate hiring 552 employees – 346 employees who will be locally based and an additional 206 who will be located elsewhere in Amerigroup's national support facilities. We will continually adjust based on membership volume and/or type.

Table 3.2.5-2. Staffing Levels for Amerigroup Iowa

Position	Location	Staffing Level
Executive and Executive Support		7.0
Contract Administrator/Chief Executive Officer (CEO)	Iowa	1.0
Chief Operating Officer	Iowa	1.0
Government Relations Officer	Iowa	1.0
Ombudsman	Iowa	1.0
Program Director	Iowa	1.0
Support Staff	Iowa	2.0
Accounting and Finance		11.0
Chief Financial Officer	Iowa	1.0
Manager Finance	Iowa	1.0
Finance Analysts	Iowa	4.0
Actuarial & Accounting Services	Out of State	5.0
Medical Directors		3.0
Medical Director	Iowa	1.0
Associate Medical Director	Iowa	2.0
Clinical Leadership		4.0
Care Management Manager	Iowa	1.0
Utilization Management Manager	Iowa	1.0
Behavioral Health Manager	Iowa	1.0
Clinical Administrative Support	Iowa	1.0
Care Management		57.0
Care Management Team Leader/Supervisor	Iowa	9.0
Physical Health Support Staff, including Disease Management	Iowa	8.0
Community-Based Physical Healthcare Managers	Iowa	40.0
Disease Management Staff	Out of State	4.0
Behavioral Health		56.0
Behavioral Health Team Leader/Supervisor	Iowa	2.0
Community-Based Behavioral Healthcare Managers	Iowa	18.0
Behavioral Health Peer Support & Recovery Staff	Iowa	4.0
Employment Outreach Specialist	Iowa	2.0
Substance Abuse Utilization Management Staff	Iowa	4.0
Behavioral Health Support Staff	Iowa	14.0
	Out of State	12.0
Prior Authorization & Concurrent Review		36.0
Prior Authorization & Concurrent Review Team Leader/Supervisor	Iowa	1.0
Prior Authorization & Concurrent Review Nurses	Iowa	16.0
	Out of State	4.0
Prior Authorization & Concurrent Review Support Staff	Iowa	15.0
Long-Term Care		131.0
Long Term Care Manager	Iowa	1.0
Long-Term Care Team Leader/Supervisor	Iowa	11.0

Position	Location	Staffing Level
Community-Based Long-Term Care Managers	Iowa	114.0
Long-Term Care Support Staff	Iowa	5.0
Quality Management		27.0
Grievance & Appeals Manager	Iowa	1.0
Quality Management Manager	Iowa	1.0
Quality Management Team Leader/Supervisor	Iowa	1.0
Quality Improvement Nurses	Iowa	11.0
Quality Management Support Staff	Iowa	5.0
Grievance & Appeals Staff	Iowa	3.0
Member Complaints Staff	Iowa	2.0
Quality Management Program Analysis Staff	Out of State	3.0
Compliance		7.0
Compliance Officer	Iowa	1.0
Compliance Support Staff	Iowa	2.0
Regulatory Services Staff	Iowa	1.0
	Out of State	3.0
Provider Services		41.0
Provider Services Manager	Iowa	1.0
Provider Services Team Leader/Supervisor	Iowa	2.0
Provider Services Staff	Iowa	11.0
	Out of State	8.0
Member-Centered Care Coordination Staff	Iowa	1.0
Provider Services Hotline Staff	Out of State	18.0
Claims Processing		68.0
Claims Administrator	Out of State	1.0
Claims Administration Team Leader/Supervisor	Out of State	2.0
Claims Staff	Out of State	65.0
Community Health Outreach		6.0
Community Health Outreach Staff	Iowa	6.0
Marketing and Outreach		9.0
Community Relations/Engagement Manager	Iowa	1.0
Tribal Liaison	Iowa	1.0
Community Relations Staff	Iowa	5.0
Marketing Communications Support Staff	Out of State	2.0
Member Services		24.0
Member Services Manager	Out of State	1.0
Member Services Staff	Out of State	23.0
Operations		18.0
Operations Manager	Iowa	1.0
Operations Team Leader/Supervisor	Iowa	1.0
Claims Resolution Staff	Iowa	6.0
Operations Support Staff	Out of State	9.0
Program Director	Iowa	1.0
Human Resources		4.0
Human Resources Manager	Iowa	1.0
Human Resources Support Staff	Out of State	3.0
Program Integrity		3.0
Program Integrity Manager	Iowa	1.0
Program Integrity Support Staff	Iowa	2.0
Pharmacy		11.0
Pharmacy Director/Coordinator	Out of State	1.0
Pharmacy Services Staff	Out of State	10.0

Position	Location	Staffing Level
Information Systems		26.0
Information Systems Manager	Out of State	1.0
Information Systems Support Staff	Out of State	24.0
Information Systems Technician	Iowa	1.0
TOTAL		552.0
	Iowa-Based Employees	346.0
	Out of State Employees	206.0

Names and Credentials of Key Corporate Personnel (3.2.5.2.2)

- Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project.
- Include names of the current board of directors, or names of all partners, as applicable.
- See Attachment 3.2.7.3-1: Scope of Work Section 2.9.3 for details for requirements for submitting information and resumes for key personnel who will be involved in executing this contract.

Amerigroup is a wholly owned subsidiary of Amerigroup Corporation. Amerigroup Corporation is a wholly owned subsidiary of ATH Holding Company, LLC (ATH). ATH is a wholly owned subsidiary of Anthem, Inc. (Anthem).

Provided in Table 3.2.5-3 are the names, addresses, and positions of the Officers and Directors who will be responsible for the conduct of the affairs of Amerigroup Iowa, Inc. Dr. Sotunde will be serving as the interim Contract Administrator within this project. The other board members will be providing general project oversight but will not be playing a direct role in project activities.

Table 3.2.5-3. Owners and Executives of Amerigroup

	Address	Official Position
Sotunde, Tunde	303 Perimeter Center North Suite 400 Atlanta, GA 30346	President and Director
Beck, Carter	120 Monument Circle Indianapolis, IN 46204	Director
Kelaghan, Cathy	120 Monument Circle Indianapolis, IN 46204	Director
Kiefer, Kathy	120 Monument Circle Indianapolis, IN 46204	Secretary
Kretschmer, Robert David	120 Monument Circle Indianapolis, IN 46204	Treasurer
Young, Jack	120 Monument Circle Indianapolis, IN 46204	Assistant Secretary
Noble, Rick	120 Monument Circle Indianapolis, IN 46204	Assistant

Information About Key Project Personnel (3.2.5.2.3)

Provide name and a general description of proposed Key Personnel as set forth in Section 2.9.3 of RFP Attachment 3.2.7.3-1, Scope of Work. Include the qualifications, number of years of experience in their field, and the proposed location from which the position shall be based. Provide resumes for each of these Key Personnel behind Tab 6 of the Bid Proposal. If the key staff person is not yet identified, state so in the response to this subsection.

In preparing to implement operations in Iowa, Amerigroup has identified a seasoned Transition Team with extensive Medicaid experience and a deep understanding of the needs of Medicaid members. The Transition Team will be responsible for overseeing initial operation of the Contract, which will include hiring highly qualified Iowa-based staff to initially fill the roles of the Contract Administrator, Medical Director, Chief Financial Officer, Compliance Officer, Pharmacy Director, Grievance and Appeals Manager, Quality Management Manager, Utilization Management Manager, Behavioral Health Manager, Member Services Manager, Provider Services Manager, Information Systems Manager, Claims Administrator, Care Coordination Manager, Program Integrity Manager, and Long-term Care Manager.

The Transition Team members will be responsible for overseeing initial operations of the contract, which includes hiring highly qualified, Iowa-based staff to fill these key roles, and will have ultimate accountability and responsibility for the success of Iowa health plan on a go-forward basis, as well as being able to easily step in on an interim basis (having knowledge of the Iowa operating landscape without any disruption to members, providers, and other stakeholders) in the event of a Key Personnel vacancy at any point during the life of the contract. More information regarding our organization's well-documented history of successful large-scale Medicaid plan implementations can be found in Section 1.1.

Our affiliates' vast experience in successfully operating Medicaid plans across the country, such as Tennessee, Kansas, and Texas, provides a roadmap for our future programs. We benefit from lessons learned that show us what is needed to be successful in the states where we operate. Amerigroup understands the staffing needs for successful Medicaid operations in Iowa. In addition to the aforementioned Key Personnel, Amerigroup will be hiring individuals for the Additional Key Personnel for the following position: Government Relations Officer, Human Resources Manager, Community Relations Manager, and Member Advocate/Non-Discrimination Manager (Ombudsman).

Table 3.2.5-4 provides the name, description, qualifications, and number of years of experience of Key and Additional Key Personnel. Full resumes for each of these individuals are provided behind Tab 6. All positions listed below will be located in Iowa, except for the Claims Administrator, Information Systems Manager, Pharmacy Director and Member Services Manager.

Table 3.2.5-4. Amerigroup Key Personnel

Name of Key Personnel	Title & Location of the Position	Scope of Work Requirement Met	Experience and Qualifications
Tunde Sotunde, MD	Contract Administrator/CEO Iowa	2.9.3.1	Dr. Sotunde currently serves as President of the North Region Medicaid Business, which includes the NY, NJ, MD, IN, and WI health plans. Prior to this role, he was President/CEO of Amerigroup Georgia. Dr. Sotunde is a pediatrician by training with extensive senior leadership experience in managed care spanning over a decade. He is a strong advocate of ensuring access to healthcare for vulnerable populations. Dr. Sotunde kept an active medical practice throughout most of his career, including providing pro bono pediatric services to the underserved, most recently with the Mercy Children's Clinic in Franklin, Tennessee. Dr. Sotunde holds an MBA from the University of Memphis, received his Doctor of Medicine

Name of Key Personnel	Title & Location of the Position	Scope of Work Requirement Met	Experience and Qualifications
John Crowley	Chief Operating Officer (COO) Iowa	2.9.3.17*	from the University of Ibadan in Nigeria, and completed his residency at the Howard University Pediatric Residency program. John currently serves as Staff Vice President of Medicaid Provider Networks since 2014 with a solid track record in successful network development, operations management, and, execution, including extensive experience in government programs for more than 20 years. John holds a Master's degree in Economics from the University of South Carolina.
John Chang, MD	Medical Director Iowa	2.9.3.2	Dr. Chang is currently Staff Vice President and Chief Medical Officer for the Medicaid business since 2014. He is a seasoned professional with over 11 years' experience in integrated healthcare delivery and strategic health plan management. Dr. Chang received his MBA from the University of Michigan and received his Doctor of Medicine from Hahnemann University School of Medicine.
Aimee Dailey	Chief Financial Officer Iowa	2.9.3.3	Aimee is Vice President of Medicaid Finance for Anthem's Government Business Division since 2013. She is a Certified Public Accountant with over 20 years of experience in progressively complex environments and has diverse experience in corporate finance, accounting, public company financial reporting, audit, management, and administration. Aimee holds a Bachelor's degree in Commerce from the University of Virginia.
Georgia Dodds-Foley	Compliance Officer Iowa	2.9.3.4	Georgia serves as Vice President and Medicaid Compliance Officer for Anthem's Government Business Division since 2011. A seasoned healthcare professional with 25 years' experience in the legal and compliance arena, Georgia brings extensive executive leadership experience in Medicaid and Medicare managed care. She received her Juris Doctor from the University of Pittsburgh School of Law.
Pamela Perry	Government Relations Officer Iowa	Addition to Key Personnel Requirement	Pamela serves as Regional Vice President of Government Affairs Officer for Anthem's Government Business Division since 2003. A seasoned professional with over 20 years of government relations experience, Pamela brings extensive leadership experience in managed care. She received her Master of Public Administration and Public Finance degree from the University of Georgia.
Patrick Convey	Pharmacy Director Out of State	2.9.3.5	Patrick is Staff Vice President of Pharmacy Sales and Account Management for Anthem's Medicaid business since 2013. A seasoned professional with over 20 years of healthcare experience in customer service, account management, business planning, and strategic initiatives, Patrick brings significant senior pharmacy leadership experience in Medicaid managed care. He received his Doctorate of Pharmacy from the University of Southern California School of Pharmacy.
Bradley D. Soto	Human Resources Manager Iowa	Addition to Key Personnel Requirement	Brad is Director of Human Resources for Anthem's North Region Medicaid business. In this role, he is responsible for human resources strategy and execution across the NY, NJ, MD, IN, and WI health plans, as well as for the Medicaid National Provider Networks, Business Development, and Product Development organizations. Prior to his current position, he served within the company as Director of Human Resources for the HealthPlus Amerigroup New York health plan. Brad brings over 10 years of human resources experience within managed care and operations. He received his Master's degree in University Personnel Administration from New York University.

Name of Key Personnel	Title & Location of the Position	Scope of Work Requirement Met	Experience and Qualifications
Tamera Lathan	Grievance & Appeals Manager Iowa	2.9.3.6	Tamera is Director of Grievances and Appeals within Clinical Quality Management for Anthem's Government Business Division since 2012. She is a seasoned healthcare professional with over 17 years of experience in the commercial, government, and specialty managed care industry. Tamera brings extensive grievance and appeals leadership experience of Medicaid managed care. She holds an MBA from the University of Phoenix.
Barbara Kupferman	Quality Management Manager Iowa	2.9.3.7	Barbara currently serves as Staff Vice President of Medicaid Quality Management. Prior, she served as Director of Quality Management for HealthPlus Amerigroup New York. A seasoned RN professional with over 15 years of healthcare experience in quality management, program development, and implementation, Barbara brings significant quality program senior leadership experience in managed care. She holds a Master's degree in Healthcare Administration from St. Joseph's College of Maine.
Lisa McCormick	Utilization Management Manager Iowa	2.9.3.8	Lisa is Director of Healthcare Programs within Anthem's Clinical Operations group since 2004. A seasoned RN professional with over 25 years of healthcare experience in clinical and network operations, Lisa brings extensive senior leadership experience in managed care. She received her AASN from Thomas Nelson Community College in Virginia.
Charles Gross, PhD	Behavioral Health Manager Iowa	2.9.3.9	Dr. Gross currently serves as Vice President of Behavioral Health since 2014. A seasoned psychologist and healthcare leader with over 25 years of experience in commercial, Medicaid, and Medicare managed care, including all EAP and MBHO models, staff models, integrated, carve-out and carve-in models, and sub-capitated arrangements with an emphasis on behavioral health in various roles – Dr. Gross brings extensive behavioral health clinical leadership experience in managed care. Dr. Gross holds a PhD in Clinical Psychology from Yeshiva University.
Fred Nelson	Member Services Manager Out of State	2.9.3.10	Fred is Director of National Customer Care within Anthem's Government Business Division since 2011. A seasoned professional with over 35 years of business experience in Customer Service and Quality Measurement and Analysis – Fred brings extensive senior leadership experience in the member services and call center environments. He holds an Associate's degree from Suffolk County Community College of New York.
Julie Skaggs	Provider Services Manager Iowa	2.9.3.11	Julie serves as Director of Health Plan Support and National Provider Relations since 2002. A seasoned professional with over 20 years of healthcare experience in building and enhancing provider networks, managing network operations, exceeding financial targets, formulation of health plan policy, and the development of health plan accreditation programs – Julie brings extensive leadership experience in managed care. Julie attended the University of Texas.
Robin Favret	Information Systems Manager Out of State	2.9.3.12	Robin is currently Director of Business Relationship Management for Anthem's Government Business Division since 2012. A seasoned professional with 30 years of healthcare experience in Customer Service Account Management, Service Operations, and various other roles – Robin brings significant leadership experience in managed care. She holds a Bachelor of Science degree in Business Administration from Old Dominion University.

Name of Key Personnel	Title & Location of the Position	Scope of Work Requirement Met	Experience and Qualifications
Leslie Langslow	Claims Administrator Out of State	2.9.3.13	Leslie serves as Director of Claims for Anthem' Government Business Division since 2007. A seasoned professional with over 25 years of Medicaid and Medicare claims and appeals experience – Leslie brings extensive leadership experience in managed care. Attended Old Dominion University of Virginia.
Linda Hopkins	Care Coordination Manager Iowa	2.9.3.14	Linda is currently Staff Vice President of Healthcare Management Services since 2014. A highly seasoned professional with over 25 years of healthcare experience in Medical Cost Management, Provider Network Management, Consumer Outreach and Clinical Evaluation, and Health Management Operations within Medicaid – Linda brings extensive senior leadership experience in managed care. She received her MBA from the College of William and Mary.
Mary Beach	Program Integrity Manager Iowa	2.9.3.15	Mary serves as Director of the Medicaid Special Investigations Unit since 2007. A highly seasoned professional with over 25 years of healthcare experience in healthcare fraud, investigations, customer reimbursement, and auditing within Medicaid, she brings extensive leadership experience in managed care. She received her Bachelor of Science degree from Indiana University.
Laura Johns	Long-Term Care Manager Iowa	2.9.3.16	Laura is currently Anthem's Director of Health Services/Long-Term Services and Supports for the Government Business Division since 2014. A seasoned professional with over 30 years' experience in staff management, case management, long-term care, home and community-based waivers, assessment/evaluation, regulatory compliance, staff training, program development, and performance/quality improvement, Laura brings extensive leadership experience in managed care. She holds a Master's degree in Psychology from Stephen F. Austin State University in Texas.
Kevin Hughes	Community Relations Manager Iowa	Addition to Key Personnel Requirement	Kevin serves as Staff Vice President of Medicaid Marketing Operations and Retention for Anthem's Government Business Division since 2007. A seasoned professional with over 25 years of strategic and tactical experience in member and community engagement and operations management, Kevin brings extensive senior leadership experience in managed care. He received his Bachelor of Science degree in Business Administration from Old Dominion University.
Rhys Jones	Member Advocate/Non-Discrimination Manager (Ombudsman) Iowa	Addition to Key Personnel Requirement	Rhys is Senior Director of Medicaid Business Development for Anthem's Government Business Division since 2014. A seasoned professional with over 20 years of healthcare industry experience in Medicare, Medicaid, and commercial health plans, Medicare/Medicaid integration and dual eligible programs; long-term care, services and supports; Big Four healthcare consulting, hospital and outpatient care settings, Rhys brings extensive member and local advocacy knowledge to the healthcare industry. He holds a Master's degree in Public Health, Health Policy, and Administration from the University of California.

** The COO will have a direct line of sight to and accountability for how our plan's healthcare delivery system functions and flexes due to programmatic changes and transformation efforts. This role or their designee (the Program Director) will serve as the primary point of contact for delivery system reform activities.*

In addition, in Table 3.2.5-5 we provide job descriptions for the Additional Key Staff Positions.

Table 3.2.5-5. Job Descriptions for Additional Key Staff Positions

Title of Additional Key Personnel Role	Location of the Position	Experience and Qualifications
Government Relations Officer	Iowa	<p>Responsible to develop and implement strategies to advocate enterprise and large State-specific legislative and regulatory positions in the most complex legislative and/or regulatory environments, directing and overseeing the resolution of most highly complex, varied, and sensitive political issues within the region and may have federal or multi-state responsibility. This includes the following specific responsibilities: Serve as the lead business owner for the rate-setting process with State regulators; establish and implement proactive strategies to bring new products or extensions of current products to market; monitor market databases and product review to analyze opportunities. Represent Amerigroup and its specific businesses in advocacy efforts. Establish and maintain strong relationships with legislators, regulators, other policymakers, and their staff that will support membership growth. Develop strategies for utilizing PAC and/or corporate political contributions. Partner with internal organizational stakeholders to inform and support business planning processes and proactively raise and address issues of concern. Make internal and external written and oral presentations on behalf of Amerigroup. Develop coalitions and target grassroots capabilities. Manage budgets and issues of importance to the enterprise. Serve as a leader in trade associations and other advocacy organizations. Generally work with legislative sessions of 6 months or longer and/or in the most complex legislative and/or regulatory environments. A Bachelor's degree in a related field required; 10 years of legislative, regulatory, political, public affairs, or industry experience; or any combination of education and experience that would provide an equivalent background. MS preferred. In-depth knowledge of the Medicaid business, including products and regulatory issues, and knowledge of future trends in the delivery and financing of healthcare services in the public sector managed care environment required.</p>
Human Resources Manager	Iowa	<p>Responsible for providing expert HR support to assigned business clients and build relationships with business and/or local leaders to link HR strategy to short- and long-range policy and operational issues and lead the tactical implementation. This includes the following specific responsibilities: Implement short-term and long-term HR programs with emphasis on succession planning, leadership selection, leadership development/ deployment, and large-scale talent transformational change. Coach and counsel business unit leadership on how to achieve business results through effective people strategies. Review data analytics to develop and implement corrective action plans. Provide competitive, labor, and legislative intelligence on local environment to HR and business partners. Research and manage complex and highly sensitive associate relations issues and termination issues, legal and compliance issues, and investigations, and take appropriate actions; and provide coaching and counseling to managers and associates. Advise clients on organizational and team effectiveness. Partner with Talent Acquisition to develop recruitment strategies that deliver the best available talent for required roles to meet organizational objectives. Partner with compensation to develop pay-leveling strategies that create competitiveness, internal equity, and career mobility. Ensure enterprise plans requiring client coordination are well implemented (salary planning, stock award allocation, performance management) and achieve maximum value. Conduct exit interviews and reporting. Assist with new hire orientation. <i>A Bachelor's degree required; 5-8 years of human resources experience; or any combination of education and experience that would provide an equivalent background. HR designation preferred (PHR or SPHR).</i></p>

Title of Additional Key Personnel Role	Location of the Position	Experience and Qualifications
Community Relations/Engagement Manager	Iowa	<p>Integrate member outreach strategies through alternative sources, such as faith-based organizations and other initiatives. Develop and execute strategies to enhance member outreach and engagement efforts. Develop objectives, policies, and programs for activities to accomplish objectives. Strategically plan and execute strategies, outreach and education activities for products to extend and increase membership growth and marketing. Develop short and long-term strategic directives, plans, campaigns, and programs to meet goals; review department performance in relation to established goals, implementing changes to effect improvement or react to a change in the organization or industry. Develop and maintain favorable relationships with key decision-makers and influencers in the community. Direct and coordinate activities of the community relations and member outreach and marketing operations in accomplishing outreach activities, and periodically evaluate and report results. Ensure compliance with state and municipal laws, rules, and guidelines for marketing and outreach; organize and direct training and orientation for all associates. Direct outreach planning and activities, which include maintaining favorable relations with members, analysis of competitive products and outreach techniques, consumer research, marketing legislation, outreach budget, and goals. Make recommendations to appropriate functions to achieve product modifications or improvements derived from market research, technical service work or marketing feedback. Identify and implement activities/services that promote member attendance and participation, member retention and growth, member health education and promotion. Develop education materials which address the cultural and educational diversity of membership. In partnership with Marketing Communications, responsible for identifying appropriate media opportunities and developing media relationships to assist in developing brand recognition. Participate in appropriate Board(s) and or committee(s) which will assist in the development of brand recognition. Perform other duties as requested or assigned. <i>Bachelor's Degree in Marketing, Business Administration or similar field required. Master's Degree in Business, Health Care Administration or a similar field preferred. 10 years of sales, marketing or healthcare experience with 5 years of experience in a supervisory role.</i></p>
Member Advocate / Non-Discrimination Coordinator (Ombudsman)	Iowa	<p>Responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that members have access to covered services and non-covered services. This includes the following specific responsibilities: Responsible for interacting with DHS equivalent ombudsman staff and submitting reports to DHS. Develop and execute statewide ombudsman strategy for the Iowa Initiative program through strategic planning, collaborations, and strategic alliances. Improve understanding of local advocacy organizations, philosophies, stakeholders, legislators, and providers that interact with or influence members and policy. Serve as an informal information resource, communication channel, complaint handler, facilitator, consultant, and practitioner for dispute resolution. Seek fair/equitable solutions to member/provider problems. Recommend dispute resolution processes to address and manage conflicts; recommend policy and procedural changes. Bring issues to health plan executive leadership to address care delivery improvement efforts and promote effective relationships/communication between members and providers. Build and develop partnerships that are in concert with the company's overall strategy to improve our collaboration within the local communities served by Amerigroup. A Bachelor's degree required. Seven years related experience, or any combination of education and experience that would provide an equivalent background. Proven track record of developing programs and services for vulnerable member populations.</p>

Reserved (3.2.5.3)

The State has marked this requirement as "Reserved" in the RFP.

Termination, Litigation, and Investigation (3.2.5.4)

Bid Proposals must indicate whether any of the following conditions have been applicable to the bidder, or a holding company, parent company, subsidiary, or intermediary company of the bidder during the past five (5) years that relate to services contemplated by this RFP unless otherwise noted. If any of the following conditions [listed in RFP Section 3.2.5.4] are applicable, then the bidder shall state the details of the occurrence. If none of these conditions is applicable to the bidder, the bidder shall so indicate.

Note: Failure to disclose information about the matters in this section may result in rejection of the Bid Proposal or in termination of any subsequent contract. The subject matter in the sixth unnumbered bullet of this subsection is a continuing disclosure requirement. Any such matter commencing after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, shall be disclosed in a timely manner in a written statement to the Agency. For purposes of this subsection, timely means within thirty (30) days from the date of conviction, regardless of appeal rights.

Amerigroup Iowa (Amerigroup) is a wholly owned subsidiary of our ultimate parent company, Anthem, Inc. As part of a national insurance company holding system, Amerigroup has several intermediary parent companies including ATH Holding Company, LLC and Amerigroup Corporation. Additionally, Anthem, Inc. has over 150 subsidiaries, which include licensed and operational health plans that operate across the country. For the purposes of this response, we use the term “Anthem” to refer to our parent company and all affiliate companies (inclusive of ATH Holding Company, LLC and Amerigroup Corporation).

Contract Termination

Amerigroup and Anthem have *never* had a federal or state-sponsored health program contract involuntarily terminated for performance and have not voluntarily terminated such contract in the last five consecutive full calendar years. Anthem's health plan subsidiaries currently hold more than 75 contracts nationwide serving more than 5.2 million members through state-sponsored health care programs.

Amerigroup's affiliate health plan in Maryland, Amerigroup Maryland, Inc., entered into an agreement by mutual consent with the Centers for Medicare and Medicaid Services (CMS) to terminate their Medicare Advantage Prescription Drug Plan (contract H5896) on January 1, 2015. There were no members enrolled in the plan when the request was made to CMS on September 3, 2014, nor when the termination was effected. Nishamarie Sherry with the Department of Health and Human Services, CMS, located at 7500 Security Boulevard, Baltimore, Maryland 21244, telephone 410-786-1189, assisted with the agreement.

Defaults and Notices of Default

Amerigroup and Anthem (inclusive of Anthem's subsidiary health plans) have *never* been subject to default or received notice of default or failure to perform a contract under a federal or state-sponsored health program contract.

From time to time, in the regular course of business, Amerigroup's affiliate health plans have received notices, sanctions, and other regulatory actions related to the numerous and rigorous requirements of any public program contract. We provide information about these actions in Attachment 3.2.7.4.2-2, Affiliate Regulatory Actions and Sanctions. None of these health plan affiliates operating federal or state-sponsored health programs will provide services for the Iowa Initiative program.

Damages, Penalties, Disincentives and Withholds

Amerigroup has never had any damages, penalties, disincentives assessed, payments withheld, or anything of value traded or given up under any of its contracts. With respect to Anthem (inclusive of Anthem's subsidiary health plans), in 11 of our markets, our affiliate health plans are subject to performance-based incentive payments and disincentive withholds under state-sponsored health program contracts. We provide information about these payments and withholds in Attachment 3.2.7.4.2-2. As noted above, information regarding notices, sanctions, and other regulatory actions for our affiliate health plans is included in Attachment 3.2.7.4.2-2.

Pending or Threatened Litigation and Other Matters

We provide information regarding any material current pending or threatened litigation, administrative or regulatory proceedings, or similar matters related to the subject matter of services sought in this RFP against Amerigroup and Anthem (inclusive of Anthem's subsidiaries), in attachment 3.2.5.4-1.

Irregularities

During the past five years, no irregularities have been discovered in any accounts maintained by Amerigroup or Anthem (inclusive of Anthem's subsidiaries) on behalf of others by an independent, state, and/or regulatory auditor in an Auditor's report.

Child or Dependent Adult Abuse Reports

No officer, primary partner, or staff providing services of Amerigroup or Anthem (inclusive of Anthem's subsidiaries) who will be involved with providing the services sought in this RFP have ever had a child or dependent adult abuse report, or been convicted of a felony. We engage in an extremely robust background screening process for all employees and those who perform work for us on a contract basis. Specifically, we conduct an in-depth criminal background check at the federal, state, and local county levels, as well as abide by all OFCCP requirements to verify that any individuals we hire meet stringent criteria related to providing services to our government-contracted business. Our screening process also includes adherence to Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994, which prohibits any individual with certain felony convictions from working in the business of insurance without a waiver from the respective state regulatory body.

Amerigroup also has in place an extensive screening process for providers, which occurs during the credentialing process. That process adheres to all CMS requirements related to education, experience, licensure history, and work experience post-schooling. Our process also includes verification of credentials against the Office of the Inspector General's exclusion database.

With respect to owners of Amerigroup as noted above, Amerigroup and our intermediary parent companies are under common ownership of their ultimate parent company, Anthem, Inc. Shares of Anthem, Inc. are publicly traded on the New York Stock Exchange (NYSE) under the symbol ANTM. As such, Anthem, Inc. common stock may be acquired in the ordinary course of business through open market purchases, and information on whether any person or entity acquiring Anthem, Inc.'s stock has ever had a founded child, dependent adult abuse report, or been convicted of a felony, is not available.

Similarly, to the best of our knowledge, no owner, officer, primary partner or staff providing services of any subcontractor who may be involved with providing services sought in this RFP have ever had a founded child, dependent abuse report, or been convicted of a felony, and we will require review of this information through our subcontract agreements. We will also mandate our subcontractors to comply with the ongoing disclosure requirement of this RFP, and timely disclose any manner commencing after the submission of the Bid Proposal and/or execution of the contract.

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Attachment 1.1-1 Letters of Support includes the following components:

- Attachment 1.1-1a Iowa Alzheimer's Association
- Attachment 1.1-1b Community Health Charities
- Attachment 1.1-1c UT Health
- Attachment 1.1-1d Thomas Suehs
- Attachment 1.1-1e Kansas Lt Governor
- Attachment 1.1-1f Wellmark
- Attachment 1.1-1g Julianne Beckett

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Chapter Headquarters
1730 28th St
West Des Moines, IA 50266
p 515.440.2722
f 515.440.6385

Burlington
1000 N Roosevelt Ave, Ste 8
Burlington, IA 52601
p 319.208.0271
f 319.208.0888

Dubuque
5900 Saratoga Plaza, Ste 11
Dubuque, IA 52002
p 563.589.0030
f 563.588.4523

Fort Dodge
822 Central Ave, Ste 310
Fort Dodge, IA 50501
p 515.478.3117
f 515.576.2737

Quad Cities
2208 E 52nd St, Ste B
Davenport, IA 52807
p 563.324.1022
f 563.324.6267

Sioux City
201 Pierce Street, Ste 110
PO Box 3716
Sioux City, IA 51101-3716
p 712.279.5802
f 712.277.8076

April 9, 2015

Tunde Sotunde, M.D.
Northeast Regional Vice President
Amerigroup Iowa
5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266

Dear Dr. Sotunde:

On behalf of the Alzheimer's Association, Greater Iowa Chapter I am writing to express support for Amerigroup's proposal to the Iowa High Quality Healthcare Initiative.

An estimated 63,000 Iowans have Alzheimer's and it is the six leading cause of death in the state. One of nine people age 65 and older have Alzheimer's and nearly half of those 85 and older are affected. Total payments for health care, long term care and hospice are estimated to be \$226 billion in the U.S., including \$113 billion paid by Medicare and \$41 paid by Medicaid.

Although there is no known way to prevent, treat or cure Alzheimer's disease, community based services and support alleviate the burden for the individual with the disease and improve the resilience of their caregivers. The Alzheimer's Association provides a variety of services and supports through its six locations in Iowa. Our programs target caregivers and individuals in all stages of the disease and include education, information, referral, support groups and care consultation.

The Alzheimer's Association will collaborate with Amerigroup to provide training about Alzheimer's and dementia so that health care providers can deliver appropriate information, support and referrals. We will offer the full range of services and supports across the state to complement care coordination activities and improve health outcomes for enrollees and their caregivers.

Thank you for the opportunity to collaborate to improve the health of Iowans with Alzheimer's and their caregivers.

Sincerely,

A handwritten signature in black ink that reads "Carol L. Sipfle".

Carol L. Sipfle
Executive Director

www.alz.org/greateriowa
24/7 Helpline 800.272.3900
Join Us On: [facebook/greateriowaalz](https://www.facebook.com/greateriowaalz)

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Tunde Sotunde, M.D.
Northeast Regional Vice President
Amerigroup Iowa
5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266

April 6, 2015

Dear Dr. Sotunde:

I am excited to learn that Amerigroup plans to submit a proposal in response to the Iowa Department of Human Services' procurement for the Iowa High Quality Healthcare Initiative. I am happy to offer this letter in support of that endeavor. I appreciated learning more about Amerigroup's work in managed Medicaid and long term services and supports, and I believe that your company has the experience required to deliver needed services to improve the lives of those served by our Medicaid program.

We represent more than 30 voluntary health organizations that offer programs and initiatives that serve citizens of the state of Iowa, who are eligible or may become eligible for Medicaid. Your support and partnership, will help us to expand programs that will equip us to better serve our communities. I'm impressed with Amerigroup's early investment in better understanding the populations you seek to serve in Iowa. I think that Amerigroup's experience in long term services and resources will make a significant contribution to improving the lives of Iowans who participate in the State's Medicaid program.

On behalf of Community Health Charities, and the 32 organizations that we serve, thank you for your interest in and support of our work. I look forward to continuing to create a meaningful partnership with Amerigroup in serving our most vulnerable citizens.

Sincerely,

Jessica Reiter-Flax
Executive Director
Community Health Charities of Iowa

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April 14, 2015

Tunde S. Sotunde, MD
President, Medicaid North Region
Amerigroup Corporation
303 Perimeter Center N, Suite 400
Atlanta, GA 30346

RE: Letter of Reference on Behalf of Amerigroup Corporation

To Whom It May Concern:

In response to the request for proposal by the Department of Human Services for the State's High Quality Healthcare Initiative, I am writing today to share my experience with Amerigroup's performance in and commitment to coordinating healthcare and Long-Term Services and Supports (LTSS) for older adults and individuals with disabilities.

In 2007, Amerigroup and a culturally diverse group of community advocates, health care experts and academics launched a first for the healthcare industry: the National Advisory Board (NAB) on Improving Health Care Services for Seniors and People with Disabilities. The NAB is dedicated to providing guidance and policy recommendations for improving programs and services for older adults and individuals with disabilities.

As a Board, we are people with disabilities; children of aging parents; parents of children and adults with disabilities; and allies of people with disabilities. The NAB represents millions of Americans with disabilities and older adults and their family members who have struggled with the complexities of our fragmented health care system. Each of us brings a personal perspective to the subject of LTSS because each of us has lived experience.

In 2009 the NAB published the *Declaration for Independence* which outlined Six Foundational Principles we assert as necessary for ensuring the equal rights and opportunities of older adults and individuals with disabilities. We believe the modernized health care infrastructure required to meet the needs of older adults and individuals with disabilities will come about only once these Six Principles are fully and broadly realized. Amerigroup shares this perspective and has committed to these Six Principles in practice as well as in principle.

In addition to supporting our work, Amerigroup has sought and leveraged our collective experience, perspective and guidance to develop more effective programs and better serve its members. This type of collaboration has enabled Amerigroup to coordinate person-centered, high quality and

Dr. Tunde S. Sotunde

April 14, 2015

Page 2 –

integrated healthcare and LTSS programs for the members and families it serves, as well as its state Medicaid and provider partners. It has extended beyond Amerigroup's coordination of health care and LTSS; it is a cultural competency embraced by their associates and incorporated in its business practices.

Thank you for the opportunity to share my experience with and support for Amerigroup. If you should have any questions or would like additional information about the NAB, please feel free to contact me directly. My direct telephone number is (713) 797-7124, or you may contact me by email to lfrieden@bcm.edu. I also invite you to learn more about the NAB at www.declarationforindependence.com.

Sincerely yours,



Lex Frieden, Professor
Director, ILRU at TIRR Memorial Hermann
Convener, National Advisory Board on Improving Health
Care Services for Seniors and People with Disabilities

Cc: Merrill A. Friedman, senior director, Disability Policy Engagement

April 28, 2015

The Honorable Terry Branstad
State Capitol, 1007 E. Grand Avenue
Des Moines, IA 50319

Dear Governor Branstad,

Please accept this letter of support and reference in regard to your recent decision to implement a Medicaid managed care system in the State of Iowa. I commend your decision; managed care has been a very successful tool in managing and containing cost in the Texas Medicaid program. Texas was one of the first states to implement managed care for Medicaid. I have been involved in this initiative from the beginning in 1998. This experience included my role as Executive Director of one of the largest health care trade associations in the country, Texas Health Care Association, as well as my capacity as both Deputy Executive Commissioner and Executive Commissioner (2009-2012), appointed by Governor Rick Perry, for the Texas Health and Human Services Commission.

During my term as Executive Commissioner, I found the health plans a valuable resource in the successful integration of managed care. Since retiring from state government in 2012, I have been working with various states and managed care companies to implement managed care while protecting and maximizing federal funding. I have participated in managed care discussions in West Virginia, North Carolina, South Carolina, Louisiana, and California.

Amerigroup is one of the managed care companies I have been advising. Amerigroup was instrumental in pilot testing the early stages of managed care and assisted in designing the system to improve quality and efficiency. Amerigroup worked hand-in-hand with the provider community and consumer advocates to facilitate understanding and acceptance of managed care. Equally important, Amerigroup took the feedback it received to heart in its own operational approach and its provider and member relations. Amerigroup further worked with the State of Texas in efforts to maximize federal funds such as through the creation of alternatives for various federal Upper Payment Limit (UPL) programs, and Amerigroup continues to help the State maximize available funds today through innovative network access improvement projects created in partnership with numerous medical schools and hospitals throughout the State.

The transition to managed care is not complex, but is an intense process requiring entities to work together to achieve common goals with the primary emphasis on serving the needy citizens of the state. If I can be of assistance to you or your staff please do not hesitate to contact me.

Sincerely,



Thomas M. Suehs
1122 Colorado Suite 102
Austin, Texas 78701
T: (512) 431-7553
E: thomas.suehs@suehs.net1

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Capitol Building
Room 252-South
Topeka, KS 66612

Phone: (785) 296-2213
Fax: (785) 296-5669
lt.governor@ks.gov

Jeff Colyer, M.D., Lieutenant Governor

Sam Brownback, Governor

April 6, 2015

The Honorable Terry Branstad
State Capitol, 1007 E. Grand Ave.
Des Moines, IA 50319

Dear Governor Branstad:

Congratulations on your plans to move Iowa Medicaid to a managed care system. In Kansas, we launched KanCare in January 2013. Since that time, KanCare continues to successfully deliver whole-person, integrated and managed care to more than 360,000 consumers across our state.

Our goal for KanCare is to improve overall health outcomes while slowing the rate of cost growth over time. This has been accomplished through the coordination and delivery of care and services by providing the right care, in the right amount, in the right setting and at the right time. The focus of our program is on ensuring that consumers receive the preventive services and screenings they need and ongoing help managing chronic conditions.

One of the keys to our success has been our working relationship with our managed care organizations. One of those partners is Amerigroup Kansas. Just a few of their 2014 achievements include:

- Achieved a clean claims turnaround time of 6.5 days;
- Assisted 600 people to exercise their preference to live in a community setting rather than a nursing facility;
- Assisted 119 people to move from a nursing facility back into the community;
- Assisted 68 people to transition into employment;
- Engaged our Waiver waiting list members in face-to-face assessment to ensure their well-being and offer assistance and support.

We appreciate that Amerigroup has a dedicated Kansas-based team deployed in communities across the state and the collaborative manner in which they work with the administration and our agency leaders. The Amerigroup leadership and staff are considered trusted partners in delivering managed care to our Kansas consumers.

We sincerely believe you would find the Amerigroup team to be an asset to Iowa as you implement your new managed care program.

Yours,

A handwritten signature in cursive script that reads "Jeff Colyer".

Jeff Colyer, M.D.
Lieutenant Governor

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An Independent Licensee of the Blue Cross and
Blue Shield Association

April 27, 2015

Charles M. Palmer, Director
Iowa Department of Human Services
1305 E. Walnut
Des Moines, IA 50319

Dear Director Palmer:

On behalf of Wellmark, I am writing in support of Amerigroup's proposal to participate in the Iowa High Quality Healthcare Initiative.

We at Wellmark have become closely acquainted with Amerigroup over the last few months, and are thoroughly impressed with their leadership in meeting the needs of Medicaid beneficiaries, their providers, and caregivers. Amerigroup currently serves nearly 5.2 million Medicaid members, including nearly 1 million in specialized populations, in 19 States.

Amerigroup has developed a unique expertise in serving Medicaid members with complex medical, behavioral, and social service needs. With over 24 years in the business, they have the experience to manage a large, complex, multi-population Medicaid program as is intended for Iowans through the Initiative. For example, in a 15 month period, they implemented three Medicaid health plans representing more than 256,000 new members in Kansas, Louisiana and Washington.

In addition, Amerigroup shares the State and Wellmark's commitment to work in innovative ways to transform health care and improve the health of Iowans. Evidence of this commitment is the high level of support and interest Amerigroup has shown in continuing the ACO and State Innovation Model Grant initiatives pioneered by Wellmark in Iowa. We believe that Amerigroup will be an accountable, innovative partner with the Iowa Medicaid Enterprise as the Initiative is implemented and as it matures.

Sincerely yours,

Laura Jackson
Executive Vice President
Health Care Innovation and Business Development

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April 30, 2015

Tunde Sotunde, M.D.
President, Medicaid North Region
Amerigroup Iowa, Inc.
5550 Wild Rose Lane, Suite 400
West Des Moines, IA 50266

RE: Support for Amerigroup to Serve Iowans under the Iowa High Quality Healthcare Initiative

Dear Dr. Sotunde:

My name is Julianne Beckett and my daughter Katie was the first Medicaid home and community-based waiver person in the country. I have been working for the University of Iowa, retiring last August, since June of 1984 in the capacity of parent partner with the Title V program.

I am excited to learn that Amerigroup Iowa, Inc., plans to submit a proposal in response to the procurement for the Iowa High Quality Healthcare Initiative. I am pleased to offer this letter in support of that endeavor. I have appreciated learning more about the impressive Medicaid capabilities of the Amerigroup family of companies, and I believe that your company will deliver needed innovations to improve the lives of those served by our Medicaid program.

As we have discussed, our programs/initiatives serve citizens of the state who are eligible or may become eligible for Medicaid. Your support for our families and family organizations will help us to expand (program/initiative), which will equip us to better serve our community, especially those with disabling conditions. I am impressed with Amerigroup Iowa's early investment in better understanding the new populations you seek to serve in Iowa. I believe that your innovations (child obesity, prenatal care, asthma, etc.) will make a significant contribution to improving the lives of Iowans who participate in the State's Medicaid program. I view this as an opportunity to advance coordinated and meaningful access to long-term services and supports and promote community-based, self-directed and person-centered services and supports for Iowans with disabilities and their families.

From all of us serving people on Medicaid, we thank you for your interest and support of our work. I look forward to continuing to create a meaningful partnership with Amerigroup Iowa in serving our most vulnerable citizens.

Sincerely,



Julianne Beckett
Advocate for Children with Disabilities

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/18/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER 1-818-539-2300 Arthur J. Gallagher & Co. Insurance Brokers of California, Inc. License #0726293 505 North Brand Boulevard, Suite 600 Glendale, CA 91203-3944	CONTACT NAME: Robin Johnston
	PHONE (A/C, No, Ext): 818-539-1354 FAX (A/C, No): 818-539-1654 E-MAIL ADDRESS: Robin.Johnston@ajg.com
INSURED Anthem, Inc. And Its Subsidiaries 2015 Staples Mill Road Mail Drop VA2001-N350 Richmond, VA 23230	INSURER(S) AFFORDING COVERAGE INSURER A: ACE AMER INS CO NAIC # 22667
	INSURER B: Great American Ins Co of NY NAIC # 22136
	INSURER C: AMERICAN ZURICH INS CO NAIC # 40142
	INSURER D: Zurich American Ins Co NAIC # 16535
	INSURER E: ZURICH AMER INS CO NAIC # 16535
	INSURER F:

COVERAGES CERTIFICATE NUMBER: 42410108 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC			HDO G27333849	05/01/14	05/01/15	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 2,000,000 MED EXP (Any one person) \$ 25,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 5,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS			ISA H08820740	05/01/14	05/01/15	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			UMB 8635190	05/01/14	05/01/15	EACH OCCURRENCE \$ 25,000,000 AGGREGATE \$ 25,000,000 \$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N			WC9299269-14 (Deductible)	01/01/15	01/01/16	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER
D	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N		N/A	EWS5347154-10 (OH Excess)	01/01/15	01/01/16	E.L. EACH ACCIDENT \$ 1,000,000
E	If yes, describe under DESCRIPTION OF OPERATIONS below			WC9376766-13 (Retro)	01/01/15	01/01/16	E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 Subject to policy terms, conditions and exclusions.

CERTIFICATE HOLDER Evidence of Insurance	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE

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WELLINC-03 BOLDENJA

CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)
 2/13/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Willis of Virginia, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 37230-5191	CONTACT NAME: certificates@willis.com PHONE (A/C, No, Ext): (877) 945-7378 FAX (A/C, No): (888) 467-2378 E-MAIL ADDRESS: <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: none;">INSURER(S) AFFORDING COVERAGE</td> <td style="text-align: center; border: none;">NAIC #</td> </tr> <tr> <td style="border: none;">INSURER A : ACE American Insurance Company</td> <td style="border: none;">22667</td> </tr> <tr> <td style="border: none;">INSURER B : Lexington Insurance Company</td> <td style="border: none;">19437</td> </tr> <tr> <td style="border: none;">INSURER C :</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">INSURER D :</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">INSURER E :</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">INSURER F :</td> <td style="border: none;"></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : ACE American Insurance Company	22667	INSURER B : Lexington Insurance Company	19437	INSURER C :		INSURER D :		INSURER E :		INSURER F :	
INSURER(S) AFFORDING COVERAGE	NAIC #														
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INSURER B : Lexington Insurance Company	19437														
INSURER C :															
INSURER D :															
INSURER E :															
INSURER F :															
INSURED Anthem, Inc. 120 Monument Circle Indianapolis, IN 46204															

COVERAGES**CERTIFICATE NUMBER:****REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N	N / A				<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Managed Care E&O			MSP G21816097 009	01/31/2015	01/31/2016	20,000,000
B	Sec. & Privacy Liab			01-940-11-43	01/31/2014	03/31/2015	See Attached

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

THIS CERTIFICATE VOIDS AND REPLACES THE PREVIOUSLY ISSUED CERTIFICATE DATED: 2/4/2015
 See attached for \$10,000,000 xs \$15,000,000 Security and Privacy Liability

Managed Care E&O Retentions
\$10,000,000 SIR - Each Claim
\$50,000,000 SIR- Class Action

CERTIFICATE HOLDER**CANCELLATION**

Evidence of Coverage	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE
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ADDITIONAL COVERAGE SCHEDULE

COVERAGE	LIMITS
POLICY TYPE: Cyber Security Liability CARRIER: Lexington Insurance Company POLICY TERM: 01/31/2014 – 03/31/2015 POLICY NUMBER: 01-940-11-43	Security & Privacy Liability \$10,000,000 X SIR
POLICY TYPE: Excess Security & Privacy Liability CARRIER: Lloyd's POLICY TERM: 01/31/2014 – 03/31/2015 POLICY NUMBER: MEDTE1300490/340-02	Security & Privacy Liability Insurance \$15,000,000 x \$10,000,000



EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY)
05/02/2014

THIS EVIDENCE OF COMMERCIAL PROPERTY INSURANCE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE ADDITIONAL INTEREST NAMED BELOW. THIS EVIDENCE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS EVIDENCE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE ADDITIONAL INTEREST.

PRODUCER NAME, CONTACT PERSON AND ADDRESS Robin Johnston Arthur J. Gallagher & Co. Insurance Brokers of California, Inc. License #0726293 505 North Brand Boulevard, Suite 600 Glendale, CA 91203-3944		PHONE (A/C. No. Ext): 1-818-539-2300	COMPANY NAME AND ADDRESS Lexington Ins Co		NAIC NO: 19437
FAX (A/C. No.):		E-MAIL ADDRESS: robin_johnston@ajg.com		IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH	
CODE:		SUB CODE:		POLICY TYPE	
AGENCY CUSTOMER ID #:		LOAN NUMBER		POLICY NUMBER 020412806	
NAMED INSURED AND ADDRESS WellPoint, Inc. And Its Subsidiaries 2015 Staples Mill Road Mail Drop VA2001-N350 Richmond, VA 23230		EFFECTIVE DATE 05/01/14	EXPIRATION DATE 05/01/15	<input type="checkbox"/> CONTINUED UNTIL TERMINATED IF CHECKED	
ADDITIONAL NAMED INSURED(S)		THIS REPLACES PRIOR EVIDENCE DATED:			

PROPERTY INFORMATION (Use REMARKS on page 2, if more space is required) BUILDING OR BUSINESS PERSONAL PROPERTY

LOCATION/DESCRIPTION

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS EVIDENCE OF PROPERTY INSURANCE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

COVERAGE INFORMATION PERILS INSURED BASIC BROAD SPECIAL

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: \$ 25,000,000		DED: \$100,000	
	YES	NO	N/A
<input checked="" type="checkbox"/> BUSINESS INCOME <input checked="" type="checkbox"/> RENTAL VALUE	x		
BLANKET COVERAGE	x		If YES, LIMIT: Included <input checked="" type="checkbox"/> Actual Loss Sustained; # of months:
TERRORISM COVERAGE	x		Attach Disclosure Notice / DEC
IS THERE A TERRORISM-SPECIFIC EXCLUSION?		x	
IS DOMESTIC TERRORISM EXCLUDED?		x	
LIMITED FUNGUS COVERAGE		x	If YES, LIMIT: DED:
FUNGUS EXCLUSION (If "YES", specify organization's form used)	x		
REPLACEMENT COST	x		
AGREED VALUE	x		
COINSURANCE		x	If YES, %
EQUIPMENT BREAKDOWN (If Applicable)		x	If YES, LIMIT: DED:
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	x		
- Demolition Costs	x		If YES, LIMIT: Included DED:
- Incr. Cost of Construction	x		If YES, LIMIT: Included DED:
EARTH MOVEMENT (If Applicable)	x		If YES, LIMIT: Included DED: **
FLOOD (If Applicable)	x		If YES, LIMIT: Included DED: **
WIND / HAIL (If Subject to Different Provisions)	x		If YES, LIMIT: DED:
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS		x	

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ADDITIONAL INTEREST

<input type="checkbox"/> MORTGAGE <input type="checkbox"/> CONTRACT OF SALE	LENDER SERVICING AGENT NAME AND ADDRESS AUTHORIZED REPRESENTATIVE <i>Robin Johnson</i>
<input type="checkbox"/> LENDERS LOSS PAYABLE	
NAME AND ADDRESS Evidence of Insurance Only	

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Attachment 3.2.5-1 Reference Letters includes the following components:

- 3.2.5-1a Kansas Reference Letter
- 3.2.5-1b Louisiana Reference Letter
- 3.2.5-1c New York Reference Letter
- 3.2.5-1d Tennessee Reference Letter
- 3.2.5-1e Virginia Reference Letter

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Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Suite 900 N
Topeka, Kansas 66612-1220



Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov

Susan Mosier, MD, Secretary
Michael Randol, Director

Department of Health & Environment

Sam Brownback, Governor

April 21, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: Reference Letter for Amerigroup for Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009)

Dear Ms. Lindgren:

Please accept this letter of recommendation regarding Amerigroup Iowa, Inc., which is submitting a proposal in response to the State of Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009).

Since 2013, the State of Kansas Department of Health and Environment has worked with Amerigroup Iowa's affiliate company Amerigroup Kansas, Inc., to administer the KanCare program – covering nearly all Kansas Medicaid members' physical health, behavioral health, HCBS, NF, NEMT, dental and pharmacy services. Under the KanCare contract, Amerigroup Kansas currently serves over 130,000 Medicaid members statewide, as one of our three KanCare MCOs.

Throughout the readiness process, launch, early implementation and operation, Amerigroup has been a strong and responsive partner with us on the KanCare program. They proactively learned the Kansas system, providers, members, advocates and other stakeholders. They put together a strong and capable team of leadership and management staff, including both local people experienced in the service areas and national support staff experienced in managed care operations. They are always solution-focused and responsive, extremely well organized with strong administrative staff and processes, and consistently good communicators and collaborators. They are achieving strong clinical and personal outcomes for our Medicaid members.

Enclosed with this letter, I am including a Reference Questionnaire that provides additional information about Amerigroup's performance in Kansas. Please contact me if you have any questions or would like to discuss further. My contact information follows:

Elizabeth Phelps, MPA, JD
Program Finance and Informatics – PSE III
Kansas Department of Health and Environment
Division of Health Care Finance
900 SW Jackson – 10th Floor
Topeka, KS 66612-1220
Phone: (785) 296-4552
EPhelps@kdheks.gov

Sincerely,

Elizabeth Phelps

REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: AMERIGROUP KANSAS, INC.*

Amerigroup Iowa, Inc. intends to submit a proposal to the Iowa Department of Human Services (DHS) in response to the Request for Proposal (RFP) for High Quality Healthcare Initiative (RFP #MED-16-009). This Questionnaire supplements the Reference Letter submitted on behalf of Amerigroup.

- (1) Please provide the following information about the individual completing this reference questionnaire on behalf of Amerigroup.

NAME:	Elizabeth Phelps
TITLE:	Program Finance & Informatics – Public Service Exec. III
TELEPHONE #	(785) 296-4552
E-MAIL ADDRESS:	EPhelps@kdheks.gov
SIGNATURE:	

- (2) What services does the reference subject provide to your organization?

Comprehensive Medicaid managed care organization, managing nearly all Kansas Medicaid members' physical health, behavioral health, HCBS, NF, NEMT, dental and pharmacy services. Also provide value added benefits and in lieu of services designed to effectively and efficiently meet members' needs with preventative or right-sized services.

- (3) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				x

- (4) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

Yes, consistently.

*Referenced subject is an affiliate of Amerigroup Iowa, Inc. (Amerigroup), the bidding entity.

REFERENCE QUESTIONNAIRE — Page 2

(5) How satisfied are you with the reference subject’s ability to perform based on your expectations and according to the contractual arrangements?

Highly. They take care to know and implement the terms of our contract to our expectations, and beyond. They get after issues promptly; raise questions until they are clear on our position, vision and expectations; and they are responsive both to us and to the providers/members they serve. They take good care of our members that pick them for managed care services, and they take good care of their staff who take care of our members.

(6) In what areas of service delivery does /did the reference subject excel?

They proactively learned the Kansas system, providers, members, advocates and other stakeholders. They put together a strong and capable team of leadership and management staff, including both local people experienced in the service areas and national support staff experienced in managed care operations. They are always solution-focused and responsive, extremely well organized with strong administrative staff and processes, and consistently good communicators and collaborators. They are achieving strong clinical and personal outcomes for our Medicaid members.

(7) In what areas of service delivery does /did the reference subject fall short?

Nothing systemic – but by exception, occasionally a staff person won’t be a good fit, either by skill set or interpersonal temperament, and when that has happened they have been prompt in identifying the concern and addressing it. Their CEO in Kansas has an expression – “run to the danger” – which summarizes their approach to getting to problem areas with solutions.

(8) What is the level of your satisfaction with the reference subject’s project management structures, processes, and personnel?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				x

What, if any, comments do you have regarding the score selected above?

As noted above, Amerigroup has formed – and over time maintained – a really strong core set of leadership and management staff for the Kansas program. That makes a huge difference in their capabilities and responsiveness, and leaves them well poised to identify and address areas of concern across the board. Their national project management structures and processes, coupled with the strong set of staff on this program, make them extremely effective in our market.

REFERENCE QUESTIONNAIRE — Page 3

- (9) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				x

What, if any, comments do you have regarding the score selected above?

This is the area of Amerigroup that we call their "secret weapon." They have – clearly not by accident – created an exceptionally competent, capable, communicative set of leadership and management staff for this program. Frequently I have looked to them as "setting the standard" on an issue that we then replicate across the other areas of the program. We have taken the approach of "a rising tide lifts all boats" in terms of having the three MCOs learn from and build on each other's processes and approaches, and often – especially over the first year of the program as we were setting things firmly in place – the Amerigroup staff would get teased by the other MCO staff for setting the bar so high.

- (10) Would you contract again with the reference subject for the same or similar services?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Disagree	2	3	4	5 Agree
				x

What, if any, comments do you have regarding the score selected above?

Included above. Amerigroup is a very effective partner in providing Medicaid services in Kansas.

Bobby Jindal
GOVERNOR



Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

April 23, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: Reference Letter for Amerigroup for Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009)

Dear Ms. Lindgren:

In my role as the Louisiana Medicaid Director, I am writing this letter of recommendation on behalf of **Amerigroup Iowa, Inc.** It is my understanding that they are submitting a proposal in response to the State of Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009).

Louisiana's DHH, Bureau of Health Services Financing (our single state Medicaid agency) recently undertook the monumental task of transitioning from a fee-for-service Medicaid delivery model to a risk bearing, managed and coordinated care delivery model for more than 900,000 of our Louisiana Medicaid enrollees. Since July, 2011 when the initial contracts were awarded, we have worked closely and in a highly collaborative manner with Amerigroup Iowa's affiliate company Amerigroup Louisiana, Inc., to administer our Bayou Health Medicaid benefit package which includes physical health, vision, pharmacy, and non-emergency medical transportation for eligible members. Under their Bayou Health Contract, Amerigroup Louisiana currently serves more than 143,000 TANF, CHIP, and ABD members statewide.

Amerigroup Louisiana was recently awarded a three year extension of their Contract during our 2014 competitive reprocurement. I have found Amerigroup Louisiana, Inc's leadership—at both the state and corporate levels—to be:

- experienced and professional,
- exceptionally well organized and committed to contract compliance, and
- highly responsive to the continually evolving needs of the State and our Medicaid enrollees.

We consider Amerigroup to be a valued partner in the already documented improvements in quality of care that have been achieved for our Medicaid enrollees since Bayou Health began.

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-9240 or #225/342-3032 • Fax #: 225/342-9508 • www.dhh.la.gov
"An Equal Opportunity Employer"

Lindgren, Carrie
April 23, 2015
Page 2

Enclosed please find a completed Reference Questionnaire that provides additional insight on our opinion of Amerigroup's performance in Louisiana.

Please feel free to contact me if you would like to discuss our letter of recommendation and/or Amerigroup further. My contact information is below:

J. Ruth Kennedy, Medicaid Director
State of Louisiana Department of Health & Hospitals
Bureau of Health Services Financing
628 North 4th St.
Baton Rouge, LA 70802
Phone: (225) 342-3032
Email: Ruth.Kennedy@la.gov

Sincerely,



J. Ruth Kennedy
Medicaid Director

Enclosure

REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: AMERIGROUP LOUISIANA, INC.*

Amerigroup Iowa, Inc. intends to submit a proposal to the Iowa Department of Human Services (DHS) in response to the Request for Proposals (RFP) for High Quality Healthcare Initiative (RFP #MED-16-009). This Questionnaire supplements the Reference Letter submitted on behalf of Amerigroup.

- (1) Please provide the following information about the individual completing this reference questionnaire on behalf of Amerigroup.

NAME:	Ruth Kennedy
TITLE:	Medicaid Director, Louisiana Department of Health & Hospitals, Bureau of Health Services Financing
TELEPHONE #	(225) 342-9240
E-MAIL ADDRESS:	Ruth.Kennedy@la.gov
SIGNATURE:	

- (2) What services does the reference subject provide to your organization?

Full risk Medicaid MCO for approximately 143,000 Louisiana residents. Health benefits and services; care coordination, case management, quality improvement, extra-contractual benefits to members.

- (3) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

- (4) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

*Referenced subject is an affiliate of Amerigroup Iowa, Inc. (Amerigroup) the bidding entity.

REFERENCE QUESTIONNAIRE — Page 2

How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

Highly satisfied

(5) In what areas of service delivery does /did the reference subject excel?

They were highly organized and proficient from the very beginning of their contract. A good implementation plan and also their carrying out of the plan. Strong clinical focus

(6) In what areas of service delivery does /did the reference subject fall short?

Amerigroup attracted fewer voluntary enrollments which I attribute to their enhanced (extra-contractual) benefits for members being less attractive than those offered by their competitors.

(7) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

Amerigroup operates in a consistently, highly proficient manner.

REFERENCE QUESTIONNAIRE — Page 3

- (8) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

Amerigroup, Louisiana recruited and hired highly qualified staff for key positions. Staff has corporate support but is given flexibility and autonomy to meet needs of state.

- (9) Would you contract again with the reference subject for the same or similar services?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Disagree	2	3	4	5 Agree
				X

What, if any, comments do you have regarding the score selected above?

Amerigroup was awarded a new Bayou Health contract in late 2014 following a competitive procurement.

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**Department
of Health**

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 24, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

**RE: Reference Letter for Amerigroup for Iowa's Request for Proposal for High Quality
Healthcare Initiative (RFP #MED-16-009)**

Dear Ms. Lindgren:

Please accept this letter of recommendation regarding Amerigroup Iowa, Inc., which is submitting a proposal in response to the State of Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009).

Since 2005, the State of New York Department of Health has worked with Amerigroup's affiliate company Amerigroup New York, LLC to administer publicly funded programs providing physical health services, behavioral health services, long-term care, dental, vision, and pharmacy for eligible members. Under the Medicaid and Family Health Plus Participating Managed Care Plan Agreement, Amerigroup New York currently serves approximately 388,000 members, and under the Child Health Plan Contract, they serve approximately 56,000 members.

Enclosed with this letter, I am including a Reference Questionnaire that provides additional insight on our opinion of Amerigroup's performance in New York. Please contact me if you would like to discuss our letter of recommendation and Amerigroup further. My contact information is below:

Patrick Roohan
New York State Department of Health
Director, Office of Quality and Patient Safety
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237
518-473-2941
patrick.roohan@health.ny.gov

Sincerely,

Patrick J. Roohan
Director
Office of Quality and Patient Safety

REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: AMERIGROUP NEW YORK, LLC*

Amerigroup Iowa, Inc. intends to submit a proposal to the Iowa Department of Human Services (DHS) in response to the Request for Proposals (RFP) for High Quality Healthcare Initiative (RFP #MED-16-009). This Questionnaire supplements the Reference Letter submitted on behalf of Amerigroup.

- (1) Please provide the following information about the individual completing this reference questionnaire on behalf of Amerigroup.

NAME:	Patrick Roohan
TITLE:	Director, Office of Quality and Patient Safety, New York State Department of Health
TELEPHONE #	(518) 473.2941
E-MAIL ADDRESS:	Patrick.roohan@health.ny.gov
SIGNATURE:	

- (2) What services does the reference subject provide to your organization?
 Medicaid managed care, Child Health Plus, Partial Cap Managed Long Term Care, Medicaid Advantage, Medicaid Advantage Plus.

- (3) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

- (4) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

yes. All services are in compliance w/ the terms of the contract.

*Referenced subject is an affiliate of Amerigroup Iowa, Inc. (Amerigroup) the bidding entity.

REFERENCE QUESTIONNAIRE — Page 3

(5) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

NYS DOT is very satisfied w/ Amengroup. They are a vital player to our program and have met or exceeded our expectations.

(6) In what areas of service delivery does /did the reference subject excel?

Amengroup is very responsive to changes in the program as it continues to evolve.

(7) In what areas of service delivery does /did the reference subject fall short?

—

(8) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

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STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

April 20, 2015

Carrie Lindgren
Iowa Department of Human Services
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: Reference Letter for Amerigroup for Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009)

Dear Ms. Lindgren:

Please accept this letter of recommendation regarding Amerigroup Iowa, Inc., which is submitting a proposal in response to the State of Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009).

Since 2006, the State of Tennessee Bureau of TennCare has worked with Amerigroup's affiliate company Amerigroup Tennessee, Inc. to administer publicly funded programs providing physical health, behavioral health, long-term services and supports, vision, and non-emergency medical transportation for eligible Middle Tennessee members. In a recent re-procurement of the TennCare Contractor Risk Agreement, Amerigroup was successful and won the right to a statewide contract which has moved Amerigroup's membership from 225,000 Middle Tennessee members to a statewide membership of 385,000.

Enclosed with this letter, I am including a Reference Questionnaire that provides additional insight on our opinion of Amerigroup's performance in Tennessee. Please contact me if you would like to discuss our letter of recommendation and Amerigroup further. My contact information is below:

Darin J. Gordon, Medicaid Director
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243
Phone: 615-507-6443
Email: darin.j.gordon@tn.gov

Sincerely,

Darin J. Gordon
Medicaid Director

REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: AMERIGROUP TENNESSEE, INC.*

Amerigroup Iowa, Inc. intends to submit a proposal to the Iowa Department of Human Services (DHS) in response to the Request for Proposals (RFP) for High Quality Healthcare Initiative (RFP #MED-16-009). This Questionnaire supplements the Reference Letter submitted on behalf of Amerigroup.

- (1) Please provide the following information about the individual completing this reference questionnaire on behalf of Amerigroup.

NAME:	Darin J. Gordon
TITLE:	Medicaid Director, Bureau of TennCare
TELEPHONE #	(615) 507-6443
E-MAIL ADDRESS:	darin.j.gordon@tn.gov
SIGNATURE:	

- (2) What services does the reference subject provide to your organization?

Amerigroup has been a full risk contractor since April 1, 2007 to present. The contract includes management of medical, behavioral, and transportation benefits for all types of members. TennCare started the Management of long term care services and supports beginning March 1, 2010. This includes a determination of the most appropriate setting to meet the enrollee's needs in a cost effective manner is in the community or a nursing home. They currently serve nearly 400,000 members on a statewide basis.

- (3) What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

- (4) If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

*Referenced subject is an affiliate of Amerigroup Iowa, Inc. (Amerigroup) the bidding entity.

REFERENCE QUESTIONNAIRE — Page 2

Services are being provided in compliance with the terms of the contract and on time. They are operating within their capitated rates.

REFERENCE QUESTIONNAIRE — Page 3

How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

We are very satisfied with their ability to perform. They have been good partners and continue to focus on improving their performance and the health outcomes of their members.

(5) In what areas of service delivery does /did the reference subject excel?

They excel in placing focus on connecting members to their primary care physician and assisting the PCP in efforts to manage their patient practice. They have been a leader in this. They have recently assisted in establishing integrated clinics in Memphis that focuses on Medicare and Medicaid members.

(6) In what areas of service delivery does /did the reference subject fall short?

Amerigroup has had issues with claims payment timeliness and accuracy; however, this has been infrequent and isolated over their 9 year history with Tennessee. These issues were corrected quickly. Our claims processing standards are fairly high with accuracy being 97% and timeliness of 90% of clean claims processed within 30 days and 99.5% percent within 60 days.

(7) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

Amerigroup works well with our staff on implementations, identifies issues quickly, and resolves them. We are in contact with their leadership on a daily basis and they are very engaged.

REFERENCE QUESTIONNAIRE — Page 4

- (8) Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

We interact with their staff on a daily basis and they are very responsive and knowledgeable. They have especially been an asset in developing new programs in the behavioral health area and advising on management reforms in behavioral health and patient centered medical homes.

- (9) Would you contract again with the reference subject for the same or similar services?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Disagree	2	3	4	5 Agree
				X

What, if any, comments do you have regarding the score selected above?

Within the last year we conducted a re-procurement that moved our program to statewide managed care organizations and Amerigroup was a successful incumbent bidder.

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COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

April 20, 2015

Carrie Lindgren
Hoover Building, 1st Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: Reference Letter for Amerigroup for Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009)

Dear Ms. Lindgren:

Please accept this letter of recommendation regarding Amerigroup, which is submitting a proposal in response to the State of Iowa's Request for Proposal for High Quality Healthcare Initiative (RFP #MED-16-009).

Since 1995, the State of Virginia Department of Medical Assistance Services (DMAS) has worked with Amerigroup Iowa's affiliate company HealthKeepers Plus, Inc. to administer publicly funded programs providing physical health, behavioral health, vision, pharmacy, and non-emergency medical transportation for eligible (TANF, ABD, Foster Care, SSI) members. Under the Medallion 3.0 (Medicaid) and FAMIS (CHIP) Programs, Health Keepers successfully serves more than 260,000 Medicaid and CHIP members and is the only health plan that covers the entire state. The plan also participates in our Commonwealth Coordinated Care program (CMS Medicare and Medicaid dual eligible demonstration) and serves an additional 10,000 lives.

After two decades of partnership with Virginia Medicaid, HealthKeepers Plus continues to work collaboratively with the Department on behalf of Virginia Medicaid. HealthKeepers Plus has always been a strong partner and has helped DMAS move forward with initiatives that reformed and enhanced managed care delivery system with the goal of providing access to quality health care for Medicaid beneficiaries across Virginia. HealthKeepers Plus delivers strong access for our members through its very large and robust statewide provider network, through its leadership in payment innovation and pay-for-performance programs, and NCQA accreditation and state of the art operations. Finally, Amerigroup's, ability to leverage multi-state operational efficiency on Virginia's behalf and its long-standing support,

both financial and intellectual, of many Governor and Agency initiatives have provided Virginia's managed care programs sustainability and stability . We are pleased to recommend Amerigroup/Health Keepers.

Enclosed with this letter, I am including a Reference Questionnaire that provides additional insight on our opinion of Amerigroup's performance in Virginia. Please contact me if you would like to discuss our letter of recommendation and Amerigroup further. My contact information is below:

Cheryl J. Roberts, J.D., Deputy Director – Programs
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
Phone: (804) 786-6147
Email: Cheryl.roberts@dmas.virginia.gov

Sincerely,

A handwritten signature in blue ink, appearing to read "Cheryl J. Roberts", is positioned above the typed name.

Cheryl J. Roberts, J.D.
Deputy Director – Programs

REFERENCE QUESTIONNAIRE**REFERENCE SUBJECT: HealthKeepers, Inc.***

Amerigroup Iowa, Inc. intends to submit a proposal to the Iowa Department of Human Services (DHS) in response to the Request for Proposals (RFP) for High Quality Healthcare Initiative (RFP #MED-16-009). This Questionnaire supplements the Reference Letter submitted on behalf of Amerigroup.

- (1) **Please provide the following information about the individual completing this reference questionnaire on behalf of Amerigroup.**

NAME:	Cheryl J. Roberts, J.D.
TITLE:	Deputy Director – Programs, Virginia Department Of Medical Assistance Services
TELEPHONE #	(804) 786-6147
E-MAIL ADDRESS:	Cheryl.roberts@dmas.virginia.gov
SIGNATURE:	

- (2) **What services does the reference subject provide to your organization?**

Anthem provides managed care services for eligible Virginia Medicaid members. These include traditional health care services, pharmacy, and traditional behavioral health care services.

- (3) **What is the level of your overall satisfaction with the reference subject as a vendor of the services described above?**

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

- (4) **If the reference subject is still providing services to your company or organization, are these services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.**

Yes

*Referenced subject is an affiliate of Amerigroup Iowa, Inc. (Amerigroup) the bidding entity.

REFERENCE QUESTIONNAIRE — Page 2

(5) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

Anthem consistently meets and exceeds the Department's service expectations and consistently performs in accordance with contract requirements.

(6) In what areas of service delivery does /did the reference subject excel?

Anthem consistently excels in its responsiveness to the Department. Anthem is supportive to the mission and goals of the agency and offers support and advice where needed to assist the Department in meeting its goals and objectives.

(7) In what areas of service delivery does /did the reference subject fall short?

N/A

(8) What is the level of your satisfaction with the reference subject's project management structures, processes, and personnel?

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

REFERENCE QUESTIONNAIRE — Page 3

- (9) **Considering the staff assigned by the reference subject to deliver the services described in response to question 3 above, how satisfied are you with the technical abilities, professionalism, and interpersonal skills of the individuals assigned?**

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Least Satisfied	2	3	4	5 Most Satisfied
				X

What, if any, comments do you have regarding the score selected above?

Anthem's team consists of highly professional staff focused on delivering care in the most efficient manner in the most appropriate setting. Anthem's Virginia Medicaid team has strong technical and business skills which serve the program and members well.

- (10) **Would you contract again with the reference subject for the same or similar services?**

Please respond by inserting an X or checkmark in the box under the appropriate number on the scale below.

1 Disagree	2	3	4	5 Agree
				X

What, if any, comments do you have regarding the score selected above?

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CHILD Short-Term Crisis Intervention Plan

Child/Family Information

Child's Name	D.O.B.	Diagnosis(s)	Date of Plan
Medications	Dosage	Physician Name / Number	Pharmacy Name / Number
Mother's Name	Phone(s)	Father's Name	Phone(s)

Description of child/family strengths:

Description of triggers (school, home, personal):

Description of immediate child/family needs:

Safety Concerns

Treatment Choices

Interventions preferred:

Interventions that have been used:

Interventions that should be avoided:

Professional Involvement

Psychiatrist Name / Phone	Therapist Name / Phone	School Contact / Phone	Case Mgr Name / Phone
Crisis Team Phone	Family Doctor Name / Phone	Hospital Name / Phone	Other

Supports to use in crisis resolution

Name / Phone	Name / Phone	Name / Phone	Name / Phone
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Resources

Advocacy Group	Support Group	MH Agency	Other
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Sample Transition Plan

Member Name:	Member ID:
Nursing Facility:	Service Coordinator:
Current Location City/County:	LTSS Manager:
Facility Contact:	Family Contact:
Phone:	Phone:

Age:	Funding Status:	Planned Discharge Date:
Responsible Party:	Transition To:	Back-Up Plan:
Future City/County:	Facility Transfer Name:	
<input type="checkbox"/> Self-Direct <input type="checkbox"/> Agency-Direct	Assistive Service:	
Diagnosis:	Current Medication List:	

Is there an open case with State Ombudsman or Adult Protective Services? Yes No

Pre-Transition Meeting

Meeting with member at nursing facility with applicable team members: Date:

Guardian/Representative DPOA Family Facility Representative

Targeted Case Manager Other:

Date:

Member identified as candidate for MFP Date:

Identified potential barriers to transition Date:

Complex Medical needs:

Independence with ADL's:

Housing/Accessibility:

Financial Management:

Availability of Informal Supports:

Behavioral Health/Cognitive challenges:

Health/Safety:

Waiver Transition Process

Member declined Waiver options Date:

Reason:

Member's Representative or Guardian declined Waiver options Date:

Reason:

Member is not a good candidate for transition Date:

Reason:

Member chooses to move forward with transition planning Date:

Community Transition Checklist emailed to: XXXXXX@amerigroup.com Date:

Member choice form completed Date:

Member coded correctly according to DCF Date:

Referral to ADRC/CDDO for Waiver eligibility Date:

Referral to MFP Program Manager Date:

Received notification of MFP eligibility Date:

UAT completed Date:

Planning Process

Reviewed UAT for continued accuracy Date:

Task Hour Guide Date:

Number of PCA hours determined:

Determine housing selection Date:

Completed referral to Behavioral Health Date:

Completed referral to Physical Health Date:

Completed referral for Transitional Coordination Services (TCS): Date:

Housing Assistance

Acquiring personal identification

Refer to Financial/Legal services

Link to community resource

Assist with Transition Funds

Completed pharmacy lock in referral Date:

Completed Environmental checklist Date:

Identified equipment needs Date:

Completed Home Modifications Referral Date:

PCP Visit Scheduled Date:

Completed Emergency Backup Plan Date:

- Completed Integrated Service Plan Date:
- Completed Physician/RN Statement (if member plans to Self-Direct) Date
- Obtained Discharge Documentation from Nursing Facility Date:
 - Discharge summary Face Sheet Progress Notes
 - Discharge Order Medication List
- Visit to Assisted Living Facility or member's home Date:

Discharge Planning Meeting

Discharge Planning Meeting Scheduled: Date: Time:

Attendees Present	Title/Relationship

Post Discharge

- Completed home visit within 48 hours of discharge Date:
- Provide update to nursing facility Transition Committee within 2 weeks of discharge Date:
- Reviewed Integrated Service Plan to ensure services are appropriate and needs are met Date:
- Completed home visits every 2 weeks for 2 months following discharge Date:
- Completed home visits every month for 1 year following discharge Date:
- Member requires more frequent contact based on assessment Date:
 - Define frequency: _____

Facility Transition Committee Meeting Notes

Discussion	Action
Coding: Choose an item. Coding Complete Date:	Rounds: Choose an item. Return Date:

Coding: Choose an item. Coding Complete Date:	Rounds: Choose an item. Return Date:



Person-Centered Service Plan

Member Name: _____

Waiver: _____

Service Plan: Initial [Click here to enter text.](#) Annual [Click here to enter text.](#) Revision [Click here to enter text.](#) Sections revised [Click here to enter text.](#)

Assessment Date: _____ Assessment Location of choice: _____ AGP Number: _____

Date of Birth: _____ Medicaid ID: _____

Address: _____ City: _____ Zip: _____ Phone Number: _____

Cultural Background and Preferences: _____ If Yes, what are the needs or accommodations:

How I communicate:

Preferred Language: _____

Interpreter Services identified: Yes _____ No _____

Interpreter service type: _____

Community Based Case Manager can access interpreter Services through Amerigroup by Calling 1-866-998-0337 then access code XXXX

Literacy Needs: _____ Vision Needs: _____

Contact list

Does Member have a Guardian? No ___ If Yes, Name, Address, Phone Number: _____

Does member have a Designated Representative? No ___ If Yes, Name, Address, Phone Number: _____

Representative Payee, No ___ If Yes, Name, Address, Phone Number: _____

Durable Power of Attorney (DPOA), No ___ If Yes, Name, Address, Phone Number: _____

Members under 18 years of age:

Who is the legal representative for the member? _____

Is the member in foster care? Yes ___ No ___ If Yes, list foster care provider and contact information: _____

Primary Care Provider Name and Phone Number:

Other Medical, Behavioral Health, and Ancillary Provider Names and Phone Numbers:

Meeting Participants invited by member and relationship to member:

Current Living Arrangement:

Individual apartment or house

Living with family

Group Home or other congregate living

ICF/DD

Nursing Facility

Supervision

Is supervision required for the member to reside safely in his or her chosen place of residence? _____

If yes, how many hours of on-site staff supervision is required? _____

The number of other waiver consumers who live with the member in the living unit: _____

Restriction of Rights:

List any restrictions on member rights, including maintenance of personal funds or self-administration of medications, and the justification for that restriction:

Member strengths and preferences

How I like to spend my day: [Click here to enter text.](#)

Places I like to go: [Click here to enter text.](#)

Activities and Hobbies I like to do: [Click here to enter text.](#)

Work, Volunteer, Help I like to do: [Click here to enter text.](#)

Who I want to spend my day with: [Click here to enter text.](#)

What are my hopes and dreams: [Click here to enter text.](#)

Employment:

Why I think working is important: [Click here to enter text.](#)

What I think is important for me to be successful at a job: [Click here to enter text.](#)

Places or types of work I am interested in: [Click here to enter text.](#)

Services and supports I need to be successful at my job: [Click here to enter text.](#)

What does home mean to me: [Click here to enter text.](#)

Who do I want to live with: [Click here to enter text.](#)

Where I want to live: [Click here to enter text.](#)

What I think is important for me at my home: [Click here to enter text.](#)

Chores and responsibilities I enjoy doing around my home: [Click here to enter text.](#)

People at my home that are important to me: [Click here to enter text.](#)

Things that I really dislike: [Click here to enter text.](#)

What a day in my life looks like: [Click here to enter text.](#)

Accomplishments and Goals:

New friends I have made this year: [Click here to enter text.](#)

Things I want to try or learn to do: [Click here to enter text.](#)

My accomplishments and significant events this past year: [Click here to enter text.](#)

My goals for this year: [Click here to enter text.](#)

Important information about how I communicate: [Click here to enter text.](#)

Special Devices/Assistive Technology: [Click here to enter text.](#)

Barriers that I face and ways to support me: [Click here to enter text.](#)

Transportation supports I need and use: (VAB and Access to Care) [Click here to enter text.](#)

Issues or concerns that need to be resolved in my life right now: [Click here to enter text.](#)

Health Needs (This would carry over from the UAT-goal but for now, they need to enter the information from the UAT)

Identified Health Needs	Provider	Appointment Needed	Date of Appointment	Who will assist with appointment	Transportation assistance needed, if yes, what type and who will provide	Amerigroup Referral
Blood Pressure (BP)						
Vision						
Mammo-(NA for men or children)						
Diabetic						
Obesity						
Dental						
Hearing						
Mental Health						
Substance Abuse						
Pain Management						
Other Medical Needs						

Goals

Overall Goal	How Progress will be Measured	Interim Short-Term Goal(s)	Target Date(s)	Long-Term Intended Outcome(s)	Target Date
Member-Selected Goals					
Additional Targeted Outcomes Identified through Functional and Risk Assessments					

Risks

Risk	Individual Risk Factors	Approaches to Mitigate Risk
Shelter		
Nutrition		
Fall Risk		
Medication Error		
Medical Emergency		
Social Isolation		
Interpersonal Violence, Abuse, or Neglect		
Financial Vulnerability		
Other		

Previous Interventions and supports for identified need (History of supports)

(To include risk factors that was minimized with the support provided)

Interventions/Supports	Source of Support/Provider	Frequency/Units	Outcomes

Individualized Emergency Backup Plan

Emergencies can happen at any time, but plans made in advance will make them easier to handle. As part of your Amerigroup Iowa health care service plan, your Community Based Case Manager will work with you and your support team to complete this emergency backup plan so you and your team know who to call and what to do during emergencies.

My Emergency Back Up Support Team who will help provide care in case of an emergency

Name	Name, Phone number and Address	Special needs/considerations/preferences
If my provider does not show up I can contact:		
When my emergency contact is not reachable contact:		
Who do I notify if I go into the hospital ?	Please contact Amerigroup Case Manager at 1-800-XXXX My Community Based Case Manager is XXX If IHH CC then enter information here:	
Who do I notify if I am unavailable for services (vacations, hospital)?		
If I feel, or if my family feels, that I am in crisis:		

Member Choice and Agreement for Waiver Services

Members Name

Amerigroup ID

Member Waiver Eligibility: _____

I understand I qualify for long term care services, and that services essential to my health and welfare can be provided to me in my home or community based setting. I have been informed that I am functionally eligible to receive services and may opt to remain in the community and receive the services as designated in my AGP service plan. My signature below indicates I have been informed of this choice.

My choice is to: (check one)

- Receive Home and Community Based Services.
- Refuse the Recommended Services
- Enter a Nursing Facility or ICF/DD

I understand that upon my choosing to receive Home and Community Based Services I have:

1. Free choice of which provider(s) will provide my needed services offered through Amerigroup's network.

Responsibilities of the Member: (Member/Legal Representative/Personal Representative initial each statement once reviewed)

I, _____, and my Community-Based Case Manager or Integrated Health Home Care Coordinator have discussed the following:

1. The services offered to me under the waiver program are subject to approval
2. My PCSP includes HCBS waiver services I receive under the waiver program and any Amerigroup services I am eligible to receive.
 - a. Physical and Behavioral Health Services
 - b. Durable medical equipment and supplies
 - c. AGP Value Added Benefits
3. I understand:
 - a. That it is my choice to participate in the waiver program services and I have the right to discontinue services at any time.
 - b. That I must meet functional, program, and financial eligibility in order to qualify for services.

- c. That any change in my functional, program, or financial eligible could result in termination of my waiver program services.
- d. That failure to report a change in my financial eligibility is considered fraud and could be punishable by law.
- e. That I must complete an annual assessment in order to maintain eligibility for the program.
- f. That I may be eligible to self-direct some services. If I self-direct, I am responsible for hiring providers and will assume all the risks and liabilities associated with self-direction.
- g. That I will create or update my Emergency Back Up Plan, that outlines my emergency response and safety needs.
- h. That my Primary Care Provider's (PCP) role is as my medical home.
- i. That services will suspended if I am hospitalized or institutionalized.
- j. That patient liability (if applicable) may be imposed for the cost of services as identified in my Service Plan (Plan of Care).
- k. What my Community Based Case Manager for Amerigroup does and have received my Community Based Case Manager's business card with the Outreach Case Specialist phone number and extension.
- l. If applicable, what my Integrated Health Home Care Coordinator does and have received my Integrated Health Home Care Coordinator's contact information, phone number and extension.
- m. How to report Abuse, Neglect and Exploitation including the Abuse Hotline number **1-800-362-2178**

Employment Interest (Check box for not interested) Yes No

- 4. I have discussed my interested in integrated community based employment such as HCBS waiver programs (Brain Injury and ID waivers), Vocational Rehabilitation Services and Iowa's Ticket to Work program.
- 5. I understand I am responsible for actively seeking rehabilitative progress and independence. The program is designed to assist and support with the completion of daily tasks but does not replace consumer responsibility. Failure to show progress in rehabilitative or independent goals can result in termination of program services.

My next visit with my **Community Based Case Manager/ Integrated Health Home Care Coordinator** will be _____

We will review: _____

If at any time I need a new assessment, review of services and supports, I can contact Amerigroup or my Community Based Case Manager:

Community Based Case Manager (or if applicable Integrated Health Home Care Coordinator)

Name: _____

Telephone number: _____

I have participated in the development of my essential lifestyle plan and to ensure implementation a copy will be given to my providers. My signature represents acknowledgement and discussion of the waiver program and my responsibilities while receiving services on the waiver.

Should I need assistance with a conflict with any of my waiver providers, physician, Community Based Case Manager or Amerigroup, I can contact member outreach advocate at **800-600-4441** or my Community Based Case Manager (or if applicable my Integrated Health Home Care Coordinator).

My providers will receive a copy of my service plan to ensure communication of my plan and to ensure the implementation of my services and supports. My plan will be sent to my providers by my Community Based Case Manager (or if applicable my Integrated Health Home Care Coordinator).

Member: _____

Date: _____

Designated Representative (if applicable): _____

Date: _____

Guardian (if applicable): _____

Date: _____

If the Member, Guardian, or Designated Representative does not wish to sign the plan, the Community Based Case Manager (or if applicable my Integrated Health Home Care Coordinator) will note the reason given and sign here:

Reason: _____

Actions taken to resolve any disagreement about the plan:

Signature: _____

I have participated in the development of this plan. I understand that this plan is developed to support _____ wants, needs and preferences to support and increase their independence in home, employment, and community activities.

I understand that it is my responsibility to support the member in making choices in a conflict free style that ensures no harm to the member.

If concerns or issues arise that could impact the members health and safety, I can contact member advocacy at [800-600-4441](tel:800-600-4441).

Meeting Participant: _____ **Relationship:** _____
Date: _____

Signatures of Providers included in the Plan, indicating their awareness and agreement to their responsibilities:

Provider Name: _____ **Signature:** _____ **Date:** _____

Consumer Direction Self-Assessment

To be in Consumer Direction, you must be able to do all of these things OR, you must have someone who can do all of these things for you:

- Find, interview and hire workers to provide care for you
- Define workers' job duties
- Develop a job description for your workers
- Train workers to deliver your care based on your needs and preferences
- Set the schedule at which your workers will give your care
- Make sure your workers use the call-in system to log in and out at each visit
- Make sure your workers provide only as much care as you are approved to receive
- Make sure that no worker gives you more than 40 hours of care in a week (they can't work overtime)
- Supervise your workers
- Evaluate your workers' job performance
- Address problems or concerns with your workers' performance
- Fire a worker when needed
- Decide how much your workers will be paid (within limits set by the State)
- Review the time your workers report to be sure it's right
- Ensure there are good notes kept in your home about the care your workers provide
- Develop a back-up plan to address times that a scheduled worker doesn't show up (you can't decide to just go without services)
- Activate the back-up plan when needed

BEFORE completing this assessment, do you think you understand what Consumer Direction is and how it works? If not, please stop and ask questions before you begin.

Do you have a family member or friend that you want to help you with consumer direction?
 Yes No

If yes, who is that person? _____

How often is that person in your home? (Drop Down Box)

Where does the person live? (Drop Down Box)

If in another town in IA, where? _____

Do you think they'll be willing to do all of the things you must do to be in Consumer Direction? (You can review the list above.)
 Yes No

The questions below will help decide if you can do all of these things by yourself, or if you will need help to be in Consumer Direction.

Do you know people you can hire to provide care for you?

Yes No

If not, do you know how to find people you can hire to provide care for you?

Yes No

Do you understand that you will be your workers' employer-they will actually work for you?

Yes No

Can you define the kinds of help you need and the specific tasks you want your workers to do for you?

Yes No

Can you put together a job description for your workers?

Yes No

Can you train your workers on how to give the care you need?

Yes No

Can you set a schedule for when you need your workers to provide your care?

Yes No

Can you make sure your workers stick to that schedule and provide only the hours of care you are approved to receive?

Yes No

Can you make sure your workers use the call-in system to log in and out at each visit?

Yes No

Can you make sure that no worker gives you more than 40 hours of care in a week (that they don't work overtime)?

Yes No

To direct your own care, you must be able to supervise your workers. This includes making sure your workers:

- show up on time
- stay for the amount of time they are scheduled to be there
- do the specific tasks they are supposed to do
- AND do a good job

Can you supervise your worker(s) and make sure they do all of those things?

Yes No

If you aren't happy with the care a worker gives you, will you be able to tell them why and what they must do to improve?

Yes No

Will you be able to fire a worker if you need to?

Yes No

Can you decide how much your worker(s) should be paid (within limits set by the State)?

Yes No

Can you review the time your workers report, make sure they actually worked the hours it says, and sign off so they can be paid?

Yes No

Can you make sure your workers write good notes about the care they give you, like the specific tasks they do for you each time they come, and keep it in your home?

Yes No

It is important to make sure you receive the care you need, so you must have a backup plan. Do you have family, friends, neighbors, or others that will come over to help you if a scheduled worker doesn't show up?

Yes No

Can you count on them to help you whenever you need them?

Yes No

If you qualify and choose Consumer Direction, you will receive training and support from Public Partnerships, LLC and a Supports Broker. Your Supports Broker can help you with some of the things you must do in Consumer Direction. Check the box below for each task that you will need help with:

- Finding workers
- Interviewing and hiring workers
- Defining what workers will do—the tasks they will perform
- Putting together a job description
- Training workers
- Scheduling workers
- Deciding what to pay workers
- Reviewing workers' reported time
- Making sure workers keep in the home good notes about care they give
- Putting together a back-up plan

Member Name: _____

Social Security Number: _____

Member Signature: _____

Date: _____

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Home- and Community-Based Services Consumer Choices Option Informed Consent and Risk Agreement

I, _____, choose to participate in the Consumer Choices Option.
Consumer

I understand that my participation in the Consumer Choices Option is completely voluntary. If I decide that the Consumer Choices Option is not right for me, I understand that I may withdraw from the Consumer Choices Option and receive the services for which I am eligible for under the traditional home- and community-based waiver services. I will not be penalized in any way. I will not lose any benefits to which I am entitled and I will not have to be placed on a waiting list.

(Initial to show you have read and understood the above information.)

I will receive a monthly budget in the amount \$_____ to buy services and make other purchases related to my long-term care needs. I understand that I will choose personal care services, community and employment supports and services, and other goods and services that will best meet my needs and are cost effective. I understand that there is an approved list of services and supports that I may purchase from and if I choose a service or support not on the approved list, I will have to seek approval from Amerigroup before purchasing. I understand that I will choose who provides my services, they do not need to be a Medicaid provider, and I will be the employer of record for employees I hire. I understand that by hiring my own employees I accept the risk associated with being an employer. I understand that I will be required to work with an independent support broker of my choosing. I will develop an individual budget with my independent support broker.

I understand that I will also be required to work with a Financial Management Services provider that will be responsible for issuing payment to my employees and for my purchases from my individual budget funds. I understand that if I overspend my budget and no longer have funds in my Individual budget, I am personally responsible to pay my employees and to pay for my purchases. I understand that I am legally required to pay employer-related taxes for the employees I hire. My individual budget must be used to pay for the employer-related taxes. My individual budget must be used to pay for the Financial Management Services fees and the independent support broker's fees. The Financial Management Services will pay for the employer-related taxes, the Financial Management Service fees and independent support broker fees from my individual budget on my behalf.

I will get help from my independent support broker in making sure the budget is being used correctly. I understand that if I misuse my individual budget, I may be transferred back to the traditional home- and community-based Medicaid services for which I am eligible. I understand that I cannot purchase room and board, childcare, and personal entertainment items with my budget.

(Initial to show you have read and understood the above information.)

I understand that I will be responsible for signing all my employees' time cards and by doing so I am verifying that my employees did work the hours claimed on the time card to provide services for me. I understand that signing an employee time card which contains false information about hours worked, may make me a party to Medicaid fraud and legal action could occur.

(Initial to show you have read and understood the above information.)

I have read and understood this consent form. I understand that I get to keep a copy of this consent form.

Consumer's Signature

Date Signed

If applicable, Guardian's Signature

Date Signed



P.O. Box 62509
Virginia Beach, VA 23466-2509



Join **Real Solutions**[®]
Healthy Rewards and
start earning!

¡Únase a **Real Solutions**[®]
Healthy Rewards y
comience a ganar!



Now you can earn \$10, \$15 or \$25 just for doing things that are good for your health.

It's simple.

All you have to do is to enroll. Then, you'll get dollars credited to your very own Healthy Rewards debit card every time you get certain health checkups or screenings, like:

- Well-child checkups
- Cancer screenings
- Diabetic exams
- Prenatal care

You can use your card to buy a variety of home and wellness items, such as:

- Baby and children's care
- Over-The-Counter (OTC) medicines
- Nutritional foods

You can use the card to buy items at **Family Dollar and Dollar General.**

You could be earning rewards right now.

Sign up today! Call 1-877-868-2004 (TTY 1-800-855-2880) or visit myamerigroup.com/HealthyRewards to enroll.



Ahora puede ganar \$10, \$15 o \$25 solo por hacer cosas que sean buenas para su salud.

Es simple.

Todo lo que debe hacer es inscribirse. Luego, recibirá dinero acreditado a su propia tarjeta de débito de Healthy Rewards cada vez que se hace ciertos chequeos o exámenes médicos, como:

- Chequeos de niño sano
- Exámenes de detección de cáncer
- Exámenes diabéticos
- Cuidado prenatal

Puede usar su tarjeta para comprar una variedad de artículos para el hogar y de bienestar, tales como:

- Cuidado de bebés y niños
- Medicamentos de venta libre (OTC)
- Alimentos nutricionales

Puede usar la tarjeta para comprar artículos en Family Dollar y Dollar General.

Usted podría estar ganando premios en este momento.

¡Inscríbese hoy mismo! Llame al 1-877-868-2004 (TTY 1-800-855-2884) o visite myamerigroup.com/HealthyRewards para inscribirse.



KS-MEM-0116-13 01.13

NFP_Client_Brochure_English_NYC.pdf 1 4/18/2012 11:30:02 AM

"My nurse helped me set goals and see that I could do so many other things. I could be there for my child and have my life as well."

- Vanessa, 19 year-old mom



Pregnant with your first baby?

Contact us in Louisiana:
Toll Free: 800.251.BABY (2229)
www.1800251baby.org



Let us help.

Nurse-Family Partnership
National Service Office
Toll Free: 866.864.5226
www.nursefamilypartnership.org



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What is Nurse-Family Partnership?

Nurse-Family Partnership is a program for women who are having their first baby. If you enroll, a registered nurse will visit you in your home throughout pregnancy and continue to visit until your baby is 2 years old.

How much does the program cost?

Nurse-Family Partnership is FREE to all eligible women.

How often will my nurse visit?

Your nurse will visit every week or two during your pregnancy and up until your baby is 2 years old. You and your nurse will decide the exact schedule.



“My nurse gave me the extra bit of confidence to acknowledge that continuing school would be beneficial to me.”

- Gabriela, 18 year-old mom



My nurse will help me:

- Have a healthy pregnancy and a healthy baby.
- Become a better parent.
- Build a strong network of support for me and my baby.
- Make my home a safe place for my baby to live and play.
- Get referrals for healthcare, childcare, job training and other support services available in my community.
- Find ways to continue my education and develop job skills.
- Set goals for my family’s future and find ways to help me reach them.

Can my baby’s father participate, too?

- Nurse-Family Partnership encourages fathers, family members and even friends to be involved in the visits and learn how they can best support you.
- You and your nurse decide who gets involved.
- Because you are the one who carries the baby and you are the first person to take care of your baby, you are the one who is actually enrolled in the program and you are the main focus of the nurse.

Who can enroll in the program?

Any woman who:

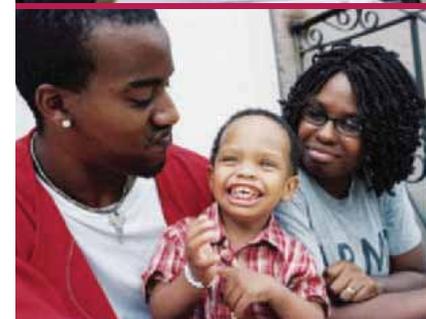
- Is pregnant with her first child.
- Meets income requirements.
- Lives in the service area.

You are encouraged to enroll as early as possible in your pregnancy.



“What really made the difference for me, was that my nurse didn’t tell me to do something—she showed me how to do it the right way.”

- Rebecca, 17 year-old mom



Attachment 8.7.1-2 Maternal and Child Health Materials includes the following components:

- Attachment 8.7.1-2a Prenatal Incentive Mailer
- Attachment 8.7.1-2d Taking Care of Baby and Me Information Flyer

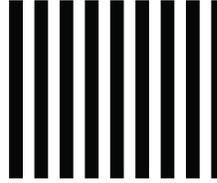
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moisten here, close and mail ■ humedezca aquí, cierre y envíe por correo



NO POSTAGE
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UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 14 LOUISVILLE KY

POSTAGE WILL BE PAID BY ADDRESSEE

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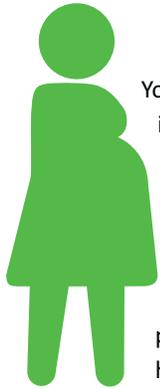


\$30 gift for a prenatal checkup
Un regalo de \$30 por hacerse el chequeo prenatal

*Taking Care of Baby and Me®
(Cuidando a mi bebé y cuidándome)*

www.myamerigroup.com/GA

HP-C-1129-13 01.14



Your baby grows fast. That's why it's important to go for a prenatal visit within the first 30 days of joining Amerigroup Community Care. Prenatal care is the health care you receive during pregnancy. Seeing your doctor as soon as possible for your prenatal checkups can help you have a healthy baby.

Go within 30 days, get a \$30 gift card

We will send you a \$30 gift card for your efforts to begin prenatal care. Go to your doctor for your first prenatal visit as an Amerigroup member within 30 days of enrollment. Just take this card with you, fill out the member section and have your doctor's office sign it. Seal the postcard and mail it to us. We even pay the postage!

Need help with transportation or making an appointment?

Call Member Services at **1-800-600-4441**.

If you are deaf or hard of hearing, call the toll-free AT&T Relay Service at **1-800-855-2880**.

Su bebé crece muy rápido. Por eso que es importante que usted acuda a una consulta prenatal en los primeros 30 días de hacerse miembro de Amerigroup Community Care. La atención prenatal es la atención médica que usted recibe durante el embarazo. Acudir a consulta con su doctor tan pronto como sea posible para sus chequeos prenatales puede ayudarle a que su bebé nazca sano.

Acuda a su doctor en los próximos 30 días y recibirá una tarjeta de regalo de \$30

Le enviaremos una tarjeta de regalo de \$30 por su iniciativa de comenzar la atención prenatal. Vaya a su doctor para su primera consulta prenatal como miembro de Amerigroup en los primeros 30 días de su inscripción. Simplemente lleve esta tarjeta a su doctor, complete la sección del miembro y pida en el consultorio que firmen la tarjeta. Selle la postal y envíenosla por correo. ¡Nosotros pagamos el franqueo!

¿Necesita ayuda con el transporte o para hacer una cita?

Llame a Servicios al Miembro al **1-800-600-4441**.

Si es sordo o tiene problemas de audición, llame gratis al servicio de retransmisión de AT&T al **1-800-855-2884**.

HPGA/NMMPR/1213



Amerigroup
RealSolutions
in healthcare

Name/Nombre

Address/Dirección

City, State ZIP code/Ciudad, Estado código Postal

Amerigroup ID #/Número de identificación de Amerigroup

Doctor's name/Nombre del doctor

Authorized signature/Firma autorizada

Prenatal visit date of service/Fecha de servicio de la consulta prenatal

Gestational age/Edad gestacional

Congratulations!

Taking Care of Baby and Me® ■ *Cuidando a Mi Bebé y Cuidándome*®

Best wishes on the birth of your baby! Amerigroup Community Care can help you get the care you need. We also want to help you get the care your baby needs for a healthy start.

Checkup Time for the Two of You

Your body goes through many changes after giving birth. This is the best time to see your doctor for a postpartum checkup. When you go for your postpartum checkup, you will get a special gift. See the attached postcard for details.

Your baby also needs to see his or her doctor. Regular checkups and immunizations, or shots, will help keep your baby healthy.

Easy to Find, Quick Answers

New mothers sometimes wonder:

- Is my baby getting enough to eat?
- When should I call my baby's doctor?
- How can I comfort my crying baby?

You can find answers to these questions and other questions in your copy of *Caring for Your Newborn*.

Talk to a Nurse, Day or Night!

Having a new baby can be stressful. It is normal to feel tired or unsure. Or you may have questions or concerns after the baby is born. If so, you can call our 24-hour Nurse HelpLine at **1-800-600-4441**. Day or night, our nurses can assist you.

Call Your Doctor Today

Call your doctor for a postpartum checkup today. Your baby also needs a checkup. Call your baby's doctor to schedule a visit, too.



Real



Solutions



**Member Services and
24-hour Nurse HelpLine:
1-800-600-4441
TTY: 1-800-855-2880**



Amerigroup
RealSolutions[®]
in healthcare

www.myamerigroup.com

¡Felicitaciones!

Taking Care of Baby and Me® ■ *Cuidando a Mi Bebé y Cuidándome*®

Los mejores deseos por el nacimiento de su bebé. Amerigroup Community Care puede ayudarla a obtener la atención que usted necesita. También queremos ayudarla a obtener la atención que su bebé necesita para comenzar su vida en forma saludable.

Es hora de chequeos para los dos.

El cuerpo pasa por muchos cambios después del parto. Este es el mejor momento para consultar a su médico y realizarse un chequeo postparto. Cuando asista a su chequeo postparto, recibirá un obsequio especial. Para obtener más detalles, consulte la tarjeta adjunta.

También debe llevar a su bebé al médico. Los chequeos y las inmunizaciones o vacunas regulares ayudarán a que su bebé se mantenga sano.

Respuestas rápidas y fáciles de encontrar

Las madres recientes a veces se preguntan:

- ¿Está mi bebé comiendo lo suficiente?
- ¿Cuándo debo llamar al médico de mi bebé?
- ¿Cómo puedo consolar a mi bebé cuando está llorando?

Puede encontrar las respuestas a estas y otras preguntas en su copia de *Cuidar de su recién nacido (Caring for Your Newborn)*.

Hable con un integrante del personal de enfermería, de día o de noche.

Tener un nuevo bebé puede ser estresante. Es normal sentir cansancio o inseguridad. O bien, es posible que tenga preguntas o inquietudes después de que nazca el bebé. Si es así, puede llamar a nuestra Línea de Ayuda de Enfermería de 24 horas al **1-800-600-4441**. De día o de noche, nuestro personal de enfermería puede ayudarla.

Llame hoy a su médico

Llame hoy a su médico para realizarse un chequeo postparto. Su bebé también necesita un chequeo. También comuníquese con el médico de su bebé para hacer una cita.

Si desea una copia de *Cuidar de su recién nacido (Caring for Your Newborn)* en español, llame a Servicios al Miembro.

**Servicios al Miembro y
Línea de Ayuda de
Enfermería de 24 horas:
1-800-600-4441
TTY: 1-800-855-2884**



Attachment 8.7.1-3 Health Ed - Initiatives Ameritip Flyers includes the following components:

- Attachment 8.7.1-3a Health Ed - Initiatives Ameritip Flyer – Diabetes
- Attachment 8.7.1-3c Health Ed- Initiatives Ameritip Flyer - Immunization 2-18

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AmeriTips

Health Tips That Make Health Happen

WHAT IS DIABETES?

LIVING WITH DIABETES IS A LEARNING PROCESS. EVEN IF SOME CHANGES ARE NEEDED, MOST PEOPLE WITH DIABETES STILL LEAD A NORMAL, ACTIVE LIFE.

What Is Diabetes?

Diabetes occurs when your body cannot make enough of a hormone called insulin or cannot use insulin properly.

Our bodies turn most of what we eat and drink into a type of sugar called glucose. Glucose travels through the bloodstream.

Insulin helps turn glucose into energy. If you have diabetes, that process does not work right. Glucose builds up in the blood and passes out of the body in the urine. Your body does not get the fuel it needs.

Words to Know

Glucose: A simple sugar used by the body as its main source of energy

Hyperglycemia: High blood sugar level

Hypoglycemia: Low blood sugar level

Insulin: A hormone that helps the body turn glucose into energy

What Are the Main Types of Diabetes?

Check the type you have:

- Type 1 diabetes** – This is a less common form of diabetes. With this type, the body does not produce insulin.
- Type 2 diabetes** – Around 95 percent of people with diabetes have type 2. The body develops insulin resistance and can't properly use insulin.

What Can I Do?

Be sure to see your doctor often. He or she will help you make a plan for controlling your diabetes. The more you

know about diabetes, the better you will be at living with it.

Here are a few questions you may want to ask your doctor:

- What is my blood sugar level, and how do I keep it under control?
- What should I do if my blood sugar level is too high or low?
- What tests do I need?
 - Eye exam each year
 - Hemoglobin test each year
 - LDL screening each year
 - Kidney function each year

Write down other questions here:

1. _____

2. _____

Tips for Living with Diabetes:

- Take medication
- Check blood sugar levels regularly
- Eat 3 meals a day, 4 or 5 hours apart
- Plan meals and snacks
- Avoid high-sugar foods and drinks
- Become more active

Learn more about living well with diabetes at www.diabetes.org.

Amerigroup is a culturally diverse company. We welcome all eligible individuals into our healthcare programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit www.myamergroup.com.

Helpful Phone Numbers for Amerigroup Members Only

Member Services or 24-hour Nurse HelpLine:
1-800-600-4441 • TTY: 1-800-855-2880



www.myamergroup.com



AmeriTips

Consejos Para Mantener La Buena Salud

¿QUÉ ES LA DIABETES?

VIVIR CON DIABETES ES UN PROCESO DE APRENDIZAJE. AUNQUE SON NECESARIOS ALGUNOS CAMBIOS, LA MAYORÍA DE LAS PERSONAS CON DIABETES LLEVA UNA VIDA ACTIVA Y NORMAL.

¿Qué es la diabetes?

La diabetes se produce cuando el cuerpo no puede producir cantidad suficiente de una hormona llamada insulina, o bien no puede utilizarla en forma adecuada.

Nuestros cuerpos transforman la mayoría de lo que comemos y bebemos en un tipo de azúcar llamado glucosa. La glucosa viaja a través del torrente sanguíneo.

La insulina ayuda a transformar la glucosa en energía. Si tiene diabetes, ese proceso no funciona correctamente. La glucosa se acumula en la sangre y se elimina del cuerpo a través de la orina. Su cuerpo no obtiene la energía que necesita.

Palabras para tener en cuenta

Glucosa: Un monosacárido utilizado por el cuerpo como su principal fuente de energía.

Hiper glucemia: Nivel de glucemia elevado

Hipoglucemia: Nivel de glucemia bajo.

Insulina: Una hormona que permite que el cuerpo convierta la glucosa en energía.

¿Cuáles son los principales tipos de diabetes?

Marque el tipo de diabetes que usted tiene:

- Diabetes tipo 1:** Este es un tipo de diabetes menos frecuente. Con este tipo de diabetes, el cuerpo no produce insulina.
- Diabetes tipo 2:** Alrededor del 95 % de las personas con diabetes tienen el tipo 2. El cuerpo desarrolla resistencia a la insulina y no puede utilizar la insulina adecuadamente.

¿Qué puedo hacer?

Asegúrese de consultar a su médico con frecuencia. Él o ella le ayudarán a elaborar un plan para controlar su diabetes.

Cuanto más sepa acerca de la diabetes, mejor se sentirá al vivir con ella.

Estas son algunas preguntas que puede hacerle a su médico:

- ¿Qué es el nivel de glucemia y cómo puedo mantenerlo bajo control?
- ¿Qué debo hacer si mi nivel de glucemia es demasiado elevado o bajo?
- ¿Qué pruebas necesito?
 - Examen de la vista cada año
 - Análisis de hemoglobina cada año
 - Análisis de LDL cada año
 - Prueba de la función renal cada año

Escriba otras preguntas aquí:

1. _____

2. _____

Consejos para vivir con diabetes:

- Tome los medicamentos
- Revítese los niveles de glucemia con regularidad
- Coma 3 comidas por día, cada 4 o 5 horas
- Planifique comidas y refrigerios
- Evite las comidas y bebidas con alto contenido de azúcar
- Sea más activo

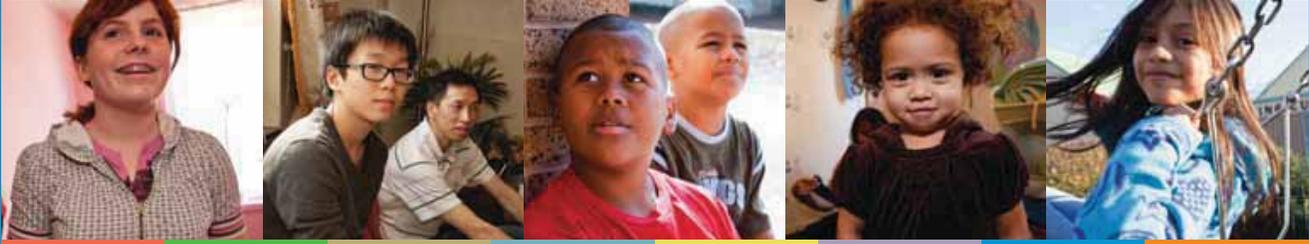
Obtenga más información sobre Vivir bien con diabetes en www.diabetes.org.

Amerigroup es una compañía con diversidad cultural. Todas las personas elegibles son bienvenidas a nuestros programas de atención médica, independientemente de su estado de salud. Si tiene preguntas o inquietudes, llame al 1-800-600-4441 (TTY 1-800-855-2884) y pida hablar con la extensión 34925. O visítenos en www.myamerigroup.com.

Números telefónicos útiles solo para miembros de Amerigroup
Servicios al Miembro o Línea de Ayuda de Enfermería de 24 horas:
1-800-600-4441 • TTY: 1-800-855-2884



www.myamerigroup.com



Help your child grow up healthy!

Immunizations, or shots, help protect your child from getting sick. Make sure your child gets the right shots at the right ages. Immunizations that are missed should be given as soon as possible. Use the chart on the back to know when your child needs immunizations.

Well-child checkups may include hearing, dental, vision and lead screenings.

Is it time to schedule your child's next well-child checkup?

Call your child's primary care provider (PCP) today. Enter your child's PCP information in the space below for easy access.

Name of PCP: _____

PCP's phone number: _____

For help with making an appointment, call Amerigroup Member Services toll free at **1-800-600-4441 (TTY 1-800-855-2880)**.



Amerigroup is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit www.myamerigroup.com.

ST-IMMF 2 to 18-0212

www.myamerigroup.com

Immunization Chart: 2 to 18 Years

Immunization Due	2-3 Years	4-6 Years	7-10 Years	11-12 Years	13-18 Years
DTaP/Tdap (Diphtheria, tetanus, pertussis)		<input type="checkbox"/> 1 Dose		<input type="checkbox"/> 1 Dose	
IPV (Polio)		<input type="checkbox"/> 1 Dose			
Influenza	Given each fall or winter 2-18 years				
MMR (Measles, mumps, rubella)		<input type="checkbox"/> 1 Dose			
Varicella (Chickenpox)		<input type="checkbox"/> 1 Dose			
MCV4 (Meningococcal)				<input type="checkbox"/> 1 Dose	<input type="checkbox"/> Booster at 16 years
HPV (Human Papillomavirus) For both males and females				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 3 Doses 11-12 years	

ST-IMMF 2 to 18-0212

HP-C-0677-12 06.12

www.myamerigroup.com

My Asthma Action Plan

 Green Means Go  Yellow Means Caution  Red Means Danger

Use the colors of a traffic light to help you control your asthma.

NAME: _____ DATE: _____

GO Use these daily medicines to help prevent asthma attacks.

How You Feel:

- Can breathe easy
- Do not cough or wheeze
- Sleep through the night

MEDICINE	AMOUNT	WHEN

ACTION: You can work and play.

CAUTION Take your daily medicines and add these rescue medicines.

How You Feel:

- Chest is tight
- Coughing or wheezing
- May have the start of a cold

MEDICINE	AMOUNT	WHEN

ACTION: Call your doctor.

DANGER Use these emergency medicines. Call your doctor **NOW**.

How You Feel:

- Hard to breathe
- Hard to talk
- Medicine not helping

MEDICINE	AMOUNT	WHEN

ACTION: Call your doctor.
Your doctor will want to see you right away. If you cannot contact your doctor, go to the emergency room. Call 911 if needed.

Doctor: _____ Pharmacy: _____

Daytime Phone: _____ Phone: _____

After Hours: _____

You can talk to a nurse anytime day or night. Just call our 24-hour Nurse HelpLine at 1-800-600-4441.

Amerigroup is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit www.myamergroup.com.



ST-AAP-0111

BR-HP-0021-10.12.10

Mi plan de acción contra el asma



El Verde Significa Adelante



El Amarillo Significa Precaución



El Rojo Significa Peligro

Use los colores del semáforo para ayudarlo a controlar el asma.

NOMBRE:

FECHA:

SEGUIR ADELANTE

Use estos medicamentos diariamente para ayudar a prevenir los ataques de asma.

Cómo se siente:

- Puede respirar con facilidad
- No tose ni presenta respiración sibilante
- Duerme toda la noche

MEDICAMENTOS	CANTIDAD	CUÁNDO

ACCIÓN: Puede trabajar y jugar.

PRECAUCIÓN

Tome sus medicamentos diariamente y añada estos medicamentos de rescate.

Cómo se siente:

- Tiene opresión en el pecho
- Tose o presenta respiración sibilante
- Le puede estar empezando de un resfrío

MEDICAMENTOS	CANTIDAD	CUÁNDO

ACCIÓN: Llame a su médico.

PELIGRO

Use estos medicamentos de emergencia. Llame a su médico AHORA.

Cómo se siente:

- Le es difícil respirar
- Le es difícil hablar
- Los medicamentos no ayudan

MEDICAMENTOS	CANTIDAD	CUÁNDO

ACCIÓN: Llame a su médico.

Su médico querrá verlo inmediatamente. Si no se puede comunicar con su médico, acuda a la sala de emergencias. Llame al 911 si es necesario.

Médico:

Farmacia:

Teléfono durante el día:

Teléfono:

Después de las horas normales de oficina:

Puede hablar con un enfermero en cualquier momento durante el día o la noche. Simplemente llame a nuestra Línea de ayuda atendida por enfermeros las 24 horas del día al 1-800-600-4441.

Amerigroup es una compañía con diversidad cultural. Todas las personas elegibles son bienvenidas a nuestros programas de atención médica, independientemente de su estado de salud. Si tiene preguntas o inquietudes, llame al 1-800-600-4441 (TTY 1-800-855-2884) y pida hablar con la extensión 34925. O visítenos en www.myamerigroup.com.



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in healthcare

ST-AAP-0111

I want to stop my substance use

Take this quiz to see what you know about stopping substance use.
Put a check in the box for true or false.
Then, check your answers on the back.

True or False Quiz – Stopping Substance Use	True	False
1. Addiction is a chronic or long-term disease.	<input type="checkbox"/>	<input type="checkbox"/>
2. Untreated mental illness puts me at risk for substance abuse.	<input type="checkbox"/>	<input type="checkbox"/>
3. Stopping my substance use suddenly or cold turkey is the best way to stop.	<input type="checkbox"/>	<input type="checkbox"/>
4. I want treatment for my substance use, but I have been told it will take six months.	<input type="checkbox"/>	<input type="checkbox"/>
5. I am addicted when I keep using despite negative effects on my health.	<input type="checkbox"/>	<input type="checkbox"/>
6. Families affected by substance use experience high levels of stress.	<input type="checkbox"/>	<input type="checkbox"/>

Thinking About Stopping Your Substance Use?

Learn more about it. Talk to your Primary Care Provider (PCP). Your PCP can help you find support or a treatment program in your area. If you need help finding a PCP, call Member Services at 1-800-600-4441 (TTY: 1-800-855-2880).

Other Resources

You can also contact the Alcohol and Drug Addiction Resource Center by calling 1-800-390-4056 or going online to www.addict-help.com.

Other resources include:

- Substance Abuse and Mental Health Services Administration (SAMSHA) — www.samhsa.gov
- The National Alliance on Mental Illness (NAMI) — www.nami.org



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Amerigroup is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit www.myamerigroup.com.

Answer Key – Stopping Substance Use

	True	False
1. Addiction is a chronic or long-term disease. True. According to the National Institute of Drug Abuse and Addiction (NIDA), drug addiction is a lot like other long-term illnesses such as diabetes. Therefore, long-term behavioral and lifestyle changes may be needed to avoid relapse.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Untreated mental illness puts me at risk for substance abuse. True. People with mental illnesses are twice as likely to also suffer from substance use. It is very important to treat substance use and mental illness together.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Stopping my substance use suddenly or cold turkey is the best way to stop. False. Stopping substance use suddenly may lead to withdrawal symptoms. Withdrawal from certain substances may be harmful. The safest way to stop is under a doctor's care.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. I want treatment for my substance use, but I have been told it will take six months. False. The goal of substance abuse treatment is to stop drug use and allow people to live productive and active lives. The amount of time needed for treatment varies per person. Treatment options may include counseling, support groups, and inpatient and outpatient treatment programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. I am addicted when I keep using despite negative effects on my health. True. There are many health problems that may be related to substance use such as heart disease, stroke, HIV, hepatitis and lung disease. Brain changes that occur with substance use can affect coordination and decision making.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Families affected by substance use experience high levels of stress. True. High levels of stress, domestic violence and intense family conflicts are more common in families with a substance user. Family therapy can often help the substance user and his or her family.	<input checked="" type="checkbox"/>	<input type="checkbox"/>



Amerigroup Iowa, Inc.
Member Explanation of Benefits

October 1, 2015

Mary Jane Smith
123 Anywhere St.
Des Moines, IA 50301

Dear Member:

Thank you for choosing Amerigroup Iowa, Inc. as your health plan. We want you to be informed about your health care. This is an explanation of benefits (EOB). It lists services that your provider said he or she gave you for your health care. This is being set to you for one of the following reasons:

1. You need to pay for a part of the bill for the Skilled Nursing Facility and/or Home- and Community-Based services you received.
OR
2. We will not pay for one or more of the services that you received because it is not a covered benefit. In the chart on the next page, the service is listed under "Procedure Description." The reason we will not pay for it is listed under "Explanation Code."
OR
3. We would like to verify that you received these services.

What do you need to do next?

Look at the "What You Need to Pay" column	Then do this:
<p>Is it more than zero? If so, you will need to pay that amount for the Skilled Nursing Facility or Home- and Community-Based services you received.</p>	<p>Please mail your payment for the amount(s) in the "What You Need to Pay" column to:</p> <p>Amerigroup Iowa, Inc. P.O. Box 12345 Des Moines, IA</p>
<p>Is it zero or blank? Look at the amount in the "Provider Paid" column. Is that zero or blank too? If so, we will not pay for that service that you received because it is not a covered benefit.</p>	<p>Nothing. If your provider tells you that you have to pay for the service, please call us at 1-800-600-4441 (TTY: 711). Do not pay anything. If you do not agree with this decision, read the "Appeals" section below.</p>

<p>If neither of the above situations applies, we're sending you this to verify that you received the services that your provider billed.</p>	<p>Review the list of services and confirm that you did receive them on the date listed. If you did not, please call us immediately at 1-800-600-4441 (TTY: 711).</p>
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Appeals

If you do not like the decisions we have made about what we will pay for, you can ask for an appeal. An appeal means you can ask to have this decision looked at again by another qualified medical professional. You must ask for an appeal within <30 calendar days> from when you get this letter. If you need help filing an appeal, call us toll free at 1-800-600-4441 (TTY 711). You may choose someone, including an attorney or provider, to represent you and act on your behalf. You must sign a consent form allowing this person to represent you. Amerigroup does not pay for any fees or payments to your representatives. That is your responsibility.

If you have any questions about this EOB or need it translated at no cost to you, please call Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, call TTY 711.

Sincerely,
Amerigroup Iowa, Inc.



Amerigroup Iowa, Inc.
Member Explanation of Benefits

PATIENT NAME: Mary Jane Smith

PATIENT#: 0123456789

PROVIDER NAME: Dr. James Bean

Claim Number	Service Number	Dates of Service	Paid to Provider	What You Need to Pay	Procedure Description	Explanation Code(s)
012345678901	1	07-02-2015 to 07-02-2015	\$00.00	\$0.00	Ambulance Service Basic Life Support Emergency Transport	ST
012345678902	2	07-02-2015 to 07-02-2015	\$00.00	\$0.00	Ground Mileage Per Statute Mile	ST
Totals			\$00.00	\$0.00		

Explanation Code Description:

ST – Termination

ST – El afiliado no es elegible para los beneficios

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

IMPORTANT

Please review the chart above to check for any errors. Confirm the services listed match the services you received. If they do not match, this could be fraud, so please call us right away at 1-800-600-4441 (TTY: 711).

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Amerigroup

SPECIAL INVESTIGATIONS UNIT

FRAUD, WASTE, AND ABUSE PLAN

STATE of Iowa

As of April 30, 2015

This version of our Draft Program Integrity Plan is truncated and only includes the Table of Contents and Implementation Overview. Per Statement of Work § 12.2, Amerigroup Iowa will submit an official draft of the Program Integrity Plan to the Agency within 30 days of Contract execution.

Amerigroup
FRAUD, WASTE, AND ABUSE PLAN

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FRAUD, WASTE, AND ABUSE PLAN

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Amerigroup
FRAUD, WASTE, AND ABUSE PLAN

FRAUD, WASTE AND ABUSE PLAN IMPLEMENTATION

The initial Special Investigations Unit (SIU) Fraud, Waste and Abuse Plan was implemented in 2004. The Fraud, Waste and Abuse Plan is considered a “living” document and the SIU will continue to evaluate, on an ongoing basis, the organizational, operational, training and staffing requirements to keep up with the current changes in the industry and ever changing fraud schemes. This re-evaluation will also allow the SIU to ensure that the operation conforms to the strictest statutory and contractual obligations.

When the Fraud, Waste and Abuse Plan is amended, the changes will be reflected in the written plan and notification will be issued to appropriate regulatory authorities when requested or on the appropriate submission schedule. If contractual requirements dictate notification more frequently than an annual basis, such will be noted in the state’s addendum to this plan.

SIU shall maintain up-to-date and accurate records on their fraud, waste and abuse plan, which shall at minimum, include those necessary to prepare the reports as required in each contract as detailed in the addendum.

Amerigroup
Information Technology
Information System Plan
DRAFT

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Executive Summary

Amerigroup has been compliant with HIPAA Privacy and Security since the CMS required dates in 2003 and 2005 respectively. Additionally, we have been Transactions and Code Sets compliance since the CMS required date in 2002. We take compliance seriously and have it baked into what we do and how we do it; it's a company-wide focus. We have policies and procedures guiding the compliance of our operations, systems and our day-to-day practices, including our engagements with business associates and trading partners. We maintain compliance as additional rules and directives come out, including becoming 5010 compliant as mandated on January 1, 2012 and having a company-wide program in place for ICD-10 compliance effective October 1, 2015. Because we have a fully functioning internal Information Systems (IS) department, we have the knowledge and flexibility necessary to maintain compliance with the regulations as well as flexing with our state partners when they drive variations in the rule, such as the period of non-enforcement for 5010.

Updates to Systems

This section guides the planning, developing, testing and implementing new operating rules, new or updated versions of electronic transaction standards, and new or updated national standard code sets.

System updates, including those related to compliance activities, follow our change management and compliance policies and procedures, including:

[Change Management Standard](#)

[Electronic Data Management](#)

[System Development Life Cycle Standard](#)

[Electronic Transaction Standards](#)

[Code Sets](#)

Transactions and Code Sets Versions

This section covers concurrent use of multiple versions of electronic transaction standards and codes sets.

As governed by our policies and procedures, we maintain our systems to utilize compliant transactions and code sets. We have the ability to meet compliance rules requiring hard cut over or dual use. We enforce transaction compliance through our compliance checker and have the ability to configure this to

transaction standards universally or by market. This flexibility allows us to manage periods of dual use such as the one that resulted from CMS's period of non-enforcement for 5010 and to do so in keeping with our state partner decisions around strict enforcement or allowing the grace period.

Our code set tables include effective begin and end dates on each code. This allows us to maintain a historical perspective of our code sets and allows us to reference what was active when. It also allows us to enforce code set changes with a hard cut over date or with overlapping dates. Additionally, within the compliance editing of our transactions, we are able to apply market specific controls for which code sets to accept.

Trading Partners

This section covers the registration and certification of new and existing trading partners.

Our trading partners are primarily in two groups: providers submitting claims and subcontractors performing contracted functions.

Amerigroup has contract relationships with four national clearinghouses. Providers submitting through these clearinghouses by way of their own clearinghouse or direct relationship would follow their registration processes. Amerigroup also supports direct submission of claims by providers through Availity. Providers using the direct submission through Availity to submit to Amerigroup will follow Availity's trading partner registration and certification processes.

Subcontractors are managed through their contracted relationship and specific interfaces, including only the unique data related to their contract, will be developed and tested between Amerigroup and the trading partners. We utilize the HIPAA standard x12 transactions (834, 837, 835, etc.) where relevant with subcontractors. Where we are exchanging data not covered by a transaction standard, such as provider data, we exchange a mutually agreed upon proprietary format.

Companion Guides

This section guides the creation, maintenance and distribution of transaction companion guides for trading partners.

Where possible we do not publish unique companion guides or details beyond the TR3s; however, where there are state specific nuances to be conveyed to our trading partners, our EDI Support Team creates and maintains the Amerigroup companion guides. Distribution of our guides is managed at the point of service through our multi-payer Availity portal and our EFT service provider for providers

seeking our claims and remittance advice guides respectively. For vendors, or other non-provider trading partners, our EDI Support Team provides the guides directly

EDI Support Team

This section details the staffing plan for electronic data interchange (EDI) help desk to monitor data exchange activities, coordinate corrective actions for failed records or transactions, and support trading partners and business associates.

Our EDI Support Team staffs an EDI help desk, or EDI hotline. The EDI help desk is available through the 800 number published in our Provider Manual and on our Provider Portal and is available 8a to 8p ET Monday through Friday. The team is available to assist providers with questions around claims rejections and is staffed to meet a response turnaround time service level agreement (SLA) of 2 days. In addition to responding to incoming issues, the team proactively monitors reject rates and reasons and reaches out to providers to identify and assist with recurring issues.

HIPAA Privacy and Security Compliance

This section guides compliance with all aspects of HIPAA Privacy and Security rules.

Compliance with HIPAA Privacy and Security is baked into what we do and how we do it and we have been compliant since the initial compliance dates for each. We hold annual compliance training for all associates. Our systems and processes are built and maintained to help us stay compliant. We have extensive policies and procedures guiding our operations and compliance and make these available to all associates through the following links:

[Corporate Privacy](#)

[Medicaid Business Unit \(MBU\) Compliance Policy and Procedure](#)

[Information Security](#)

HIPAA Related Mandates

This section identifies the strategies for maintaining up-to-date knowledge of HIPAA related mandates with defined or expected future compliance deadlines.

Our Public Policy department is the team responsible analyzing proposed legislation and regulations, developing the company's positions on public policy and managing issues. This team ensures company

alignment with the policies by facilitating the timely flow of key information between the Government Affairs, business units and shared service areas. For major issues impacting multiple areas of the company, the team utilizes its Public Policy Steering Committee and for less significant issues impacting primarily one area of the company, the team partners with subject-matter experts.

In addition to the efforts of our Public Policy department, individuals throughout the organization take steps to maintain up-to-date knowledge of HIPAA related mandates. These efforts include participating in workgroups, organizations, and conferences in addition to reviewing materials, legislation, etc.

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For issues rising to the level of a disaster, we have detailed Business Continuity and Disaster Recovery Plans. These system problem resolution and escalation procedures provide guidance on how to handle those issues not rising to the level of a disaster.

System Problem Resolution Plan

Overall we maintain a stable, reliable systems environment with proactive monitoring for performance. Occasionally we experience an issue to our core systems which could impact members and/or providers. When such events occur our Information Systems (IS) Client Account Manager (CAM) leadership is notified, along with the impacted business area(s) and technical team(s). The CAMs are aligned with the states in which we do business along with their counterparts in our Regulatory Compliance Department. The CAM team monitors the issue and coordinates required state updates, along with Regulatory, according to state direction and timing. Notification of our state partners includes informing of the issue, identifying impact to operations, plans for resolution, and time for resolution along with interim workarounds.

Escalation Procedures

- Technical helpdesk (combination of monitoring teams throughout IS) identifies network hardware or software failure or sub-standard performance
- Technical helpdesk notifies IS management team
- IS management team notifies IS CAM leadership and business leadership
- IS CAM informs Regulatory
- IS CAM and Regulatory prepare state notification
- IS CAM monitors impact, resolution, workaround, etc. and keeps Regulatory informed
- IS CAM and Regulatory keep state informed and maintain responsibility for related state deliverables

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Project Status Report

Program Manager:	Enter Sponsor		Project:	Project 1
Reported By:	Select Name		Period Ending:	5/1/2015

Executive Summary

ES

Key Milestones

Green Highlight = Deadline Sound

Amber Highlight = Deadline at Risk

Red Highlight = Deadline will be Missed

Gray Highlight = Completed

Past Due	5/8/2015	5/15/2015	5/22/2015	5/29/2015	6/5/2015	6/12/2015	6/19/2015	6/26/2015
Task 1								
Task 2								

Current status of overall project

Time	Cost	Resources
Green	Green	Green
Overall Percentage Complete		1.00%

Project Milestones	Start Date	Baseline Due Date	Current Due Date	Actual Comp Date / Commitment	% Complete	Status
Task 1	5/1/2015	5/1/2015	5/1/2015	Tentative	1.00%	Green
Task 2	5/1/2015	5/1/2015	5/1/2015	Committed	1.00%	Green

Accomplishments Last Week

Accomplishments

Planned Accomplishments for This Week

Planned

Obstacles

Obstacles

*** RISK LOG ***

Risk Details	Identified	Next Status	Current Due Date	Actual Comp Date / Commitment	% Complete	Status
Description: Risk 1 Risk Rating: Low Risk Area: Schedule Risk Comments: Risk description Mitigation: Risk Mitigation Plan Contingency: Risk Contingency Plan	5/1/2015	5/1/2015	5/1/2015	Committed	1.00%	Green

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AMERIGROUP CORPORATION		DEPARTMENT PROCEDURE
Subject: Encounters Management – Inbound File Process Flow		
Primary Department: Premium Integrity & Encounters Management	Secondary Department(s): IT, Health Plan Executives	Prior Procedure Reference(s): N/A
Effective Date of Procedure: 01/01/2008	Date Procedure Last Reviewed: 05/03/2010	Date Procedure Last Revised: 05/03/2010
Plan CEO Approval/Signature:	Corporate Dept Sr Mgmt Approval/Signature:	Check Only One: Procedure is Corporate Owned <input type="checkbox"/> Procedure is Health Plan Owned <input type="checkbox"/>
Check All That Apply: Procedure is applicable to: Corporate <input type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): _____ (Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)		

Purpose

The inbound file process flow addresses the procedural steps necessary to accept an inbound encounters file. Inbound encounters files will be sent to AMERIGROUP to provide verification of accepted encounters records, or to identify those encounters records rejected by the state/federal partner, or their respective agent(s). The purpose of this procedure is to ensure consistency across the organization regarding acceptance of inbound encounters files.

Definitions

Encounter – Any level of health care data required by our state/federal partners or their agents.

Inbound File – Encounter files transmitted to AMERIGROUP from our state/federal partners or their agents; typically reflect a receipt of accepted encounters and an accounting of those encounters which have been rejected.

Federal Entity – Typically CMS, or the Centers for Medicare and Medicaid Services.

State Entity – The state government agency with whom we contract.

Agent – the party with whom either the state or federal agency contracts to undertake encounters management tasks on their behalf.

Procedures

- 1) See chart on next page to determine who initiates receipt of inbound file and who notifies the Application Analyst that they need to post the file to the Encounters Management System (differs by Market).
- 2) Encounters Business Analyst (ENBA) reviews rejected encounters, determines cause
- 3) ENBA works with functional area within organization to resolve issue (e.g. – Provider Data Management, Claims, Enrollment)
- 4) Once encounters issue resolved, encounters are channeled through encounters management system as resubmissions
- 5) Follow Outbound Encounters process flow

<u>Plan</u>	<u>Files Retrieval Initiated By:</u>	<u>Notifies AA to Post File to MDE:</u>
NY	ISOPS	ENBA
NJ	ISOPS	ENBA
MD	ITBA	ENBA
VA	ENBA	ENBA
GA	ITBA	ENBA
TX	ENBA	ENBA
NM	ENBA	ENBA
NV*	N/A	N/A
FL(837)	ISOPS	ENBA
OH	ENBA	ENBA
TN	ISOPS	ENBA

ENBA – Encounters Business Analyst
 ITBA – Information Technology Business Analyst
 ISOPS – Information Services Operations

* Nevada does not submit remittance files

Exceptions	None
References	N/A
Related Policies and Procedures	Encounters Management – Outbound File(s)
Related Materials	N/A

AMERIGROUP CORPORATION		DEPARTMENT PROCEDURE
Subject: Encounters Management – Outbound File Process Flow		
Primary Department: Premium Integrity & Encounters Management	Secondary Department(s): IT, Health Plan Executives	Prior Procedure Reference(s): N/A
Effective Date of Procedure: 01/01/2008	Date Procedure Last Reviewed: 05/03/2010	Date Procedure Last Revised: 05/03/2010
Plan CEO Approval/Signature:	Corporate Dept Sr Mgmt Approval/Signature:	Check Only One: Procedure is Corporate Owned <input checked="" type="checkbox"/> Procedure is Health Plan Owned <input type="checkbox"/>
Check All That Apply: Procedure is applicable to: Corporate <input checked="" type="checkbox"/> All Health Plans <input type="checkbox"/> Only the following Health Plans (please list): _____ (Note: If there are multiple Health Plans within a state, please list each specific Health Plan directly above, as appropriate)		

Purpose

The outbound file process flow addresses the procedural steps necessary to create, validate and transmit an outbound encounters file. The purpose of this procedure is to ensure consistency across the organization regarding execution of outbound encounters files.

Definitions

Encounter – Any level of health care data required by our state/federal partners or their agents.

Outbound File – Encounter files transmitted to our state/federal partners or their agents. Attestation Reports are attestations which are approved by the Health Plan Executive, attesting to the accuracy and completeness of the encounters data to which they refer. The Attestation Report will vary by the entity requesting the information; however, the report will typically contain control totals of both record counts and dollar amounts, along with the timeframe represented by the file.

Batch Certification Report – Certifies that the data in MDE are accounted for, for any given batch. Provides an accounting of the data in the MDE database for a given batch (starting point), which reconciles to the sum of pended claims, claims excluded from submission and the final submitted batch.

Batch Reconciliation Report – reports that confirm that all source data for the batch (i.e.: FACETS, vendor tables, etc.) was successfully transmitted to the MDE database.

Federal Entity – Typically CMS, or the Centers for Medicare and Medicaid Services.

State Entity – The state government agency with whom we contract.

Agent – the party with whom either the state or federal agency contracts to undertake encounters management tasks on their behalf.

Procedures

- 1) Encounters Management Staff initiates outbound file - Encounters Business Analyst (ENBA) works with IT tech staff to initiate
- 2) ENBA runs file through editing software
 - a) If edits are within acceptable levels, move to step 3)
 - b) If edits exceed acceptable levels, ENBA engages IT tech staff for troubleshooting, re-execution. Escalate to developers, as needed.
- 3) Batch Certification and Batch Reconciliation reports created through encounters management tool
- 4) ENBA validates encounters against source system totals.
 - a) If totals match source system numbers, move to step 4)
 - b) If totals do not match source system numbers, ENBA engages tech staff for troubleshooting, re-execution. Escalate to developers, as needed.

- 5) Attestation report filled out by ENBA
- 6) ENBA forwards Batch Certification and Attestation reports to Health Plan Executive for approval, where required
 - a) If HP Exec approves, move to step 7)
 - b) If HP Exec does not approve, undertake additional discussion and research, up to re-initiating process from step 1)
- 7) Final file preparation prior to transmission, notification of file posting and actual file posting varies by market. The table below outlines responsibilities, by title/area, for each market.

<u>Plan</u>	<u>Final File Prep</u>	<u>Notification Sent By:*</u>	<u>Files Posted to State By:</u>
NY	ENBA	ENBA	ISOPS
NJ	ENBA	ITBA	ISOPS
MD	ENBA	N/A	ITBA
VA	ENBA	N/A	ITBA
GA	ENBA	N/A	ITBA
TX	ENBA	ENBA	ISOPS
NM	ENBA	ENBA	ISOPS
NV	ENBA	ENBA	ISOPS
FL/837	ENBA/ENBA	ITBA	ISOPS/ENBA
OH	ENBA	ITBA	ISOPS
TN	ENBA	ENBA	ISOPS

ENBA – Encounters Business Analyst
 ITBA – Information Technology Business Analyst
 ISOPS – Information Services Operations

* Where ENBA or ITBA posts file, no notification necessary. FL has different submissions by product.

** FL/837 signifies two types of submissions; the first (FL) for proprietary files, and the second (837) for HIPAA files.

Exceptions	None
References	N/A
Related Policies and Procedures	Encounters Management – Inbound File(s)
Related Materials	N/A

The purpose of the annual QM work plan is to outline measurable activities for the year. The scope of the QM work plan is based upon the goals and objectives outlined in the Quality Improvement Program Evaluation from the prior year.

The QI Work Plan is viewed as a dynamic document and is updated throughout the year to reflect progress on QI activities. Specific objectives for 2015 include:

Amerigroup Iowa 2015 Medicaid Quality Management Work Plan

Reason for Selection	NCOA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation Contract		Accreditation Updates	Ensure health plan readiness for exchanges and health care reform	Monitor and evaluate the progress towards state and regional accreditation and annual updates with new standards			Ongoing monthly, as needed, and annual	
Contract		External Quality Review Organization (EQRO) Audit	Ensure all activities related to the EQRO for QI are complete	Provide all requested reports, policies and documents requested by the EQRO			Annual	
Annual training		QI Operations	Ongoing training is essential for QI accountability	Annual staff training on: QI initiatives, Accreditation standards, Regional process/policies and procedures, guidelines and requirements			Ongoing	
Contract		Medical Record Standards	To evaluate practitioner documentation of member medical records	Annually review charts using the approved Medical Record Review tool, Ensure that Provider medical records are well maintained and adequate documentation. Implement corrective action when areas of non-compliance are identified, Publish Medical Record Standards annually via newsletter, as well as by implementing other educational tools as needed				
Accreditation	Website	Member and provider communication	Making information available to members and providers	Quality and content review of member and provider website content/updates, QI staff maintains grid of all required member/ provider communication that must be posted to websites, At least annual review of websites to ensure accuracy, Work with communications and other departments as needed to maintain compliance			Annual and Ongoing	
RFP		QI Operations	Medicaid expansion and RFP Support	QI will have responsibilities for expansion of Medicaid - Provide RFP and implementation support		As needed	As requested and needed	
Accreditation Contract	QI	Regional Policy Review	Complete full review with revisions as needed for policies	Annual review of all QI policies			Annual	
Accreditation Contract	QI 1	Program Description	Define the quality structure and processes	Annual review and approval of QI and UM program descriptions			Annual	
Accreditation Contract	QI 1 A	Program Description	Define the quality structure and processes	Annual review by plan and Corporate Quality Improvement Committee -describe the strategy, scope and frame work for all quality initiatives			Annual	
Accreditation Contract	QI 1 A	Annual Work Plan	Quarterly review of accomplished versus planned activities on Work Plan.	The work plan is a dynamic document that reflects ongoing progress on QI activities throughout the year and addresses: • Yearly planned QI activities and objectives for improving: - Quality of clinical care. - Safety of clinical care. - Quality of service. - Members' experience. • Time frame for each activity's completion. • Staff members responsible for each activity. • Monitoring of previously identified issues. • Evaluation of the QI program. All bulleted requirements must be met for factor 7 to be scored "yes." Annual review by plan and Corporate Quality Improvement Committee • Yearly planned QI activities and objectives for improving:			Quarterly	
Accreditation, Contract	QI 1 A	QI Operations Board of Director/Manager Reports	QI Accountability to the Governing Body	Quarterly summary review by QMC			Annual	
Accreditation Contract	QI 1 B and UM 1 D	Annual QI/UM Program Evaluation	Complete evaluation of all QI activities.	Annual review by plan and Corporate Quality Improvement Committee	Achieve measurable improvements in QI		Annual	
Medical Advisory Committee (MAC)		Oversight of Clinical Quality Activities	Assess levels and quality of care provided to members - evaluate and monitor minimum standards of care - oversight of clinical practice guidelines; - conduct peer review process;	Quarterly summary review by QMC			Quarterly	
Medical Operations Committee (MOC)		Oversight of UM/DM/CM Activities	Review and approve policy related to UM - Review and approve UM NCOA documents	Quarterly summary review by QMC			Quarterly	
Medical Policy Technology Advisory Committee (MPTAC)		Oversight of Clinical Practice Guidelines (CPG)s	Serves as the official medical/clinical policy approving body for the development of clinical standards.	Quarterly summary review by QMC			Quarterly	
Consumer Advisory Committee (CAC)		Member Advisory Activities	To provide a forum for members by guidance and recommendations to the plan regarding enrollment activities, plan documents, benefits, and quality activities.	Quarterly summary review by QMC			Quarterly	
Accreditation, Contract	QI 2 A	Plan Medical Advisory Committee	QI Committee and practitioners develop, implement and oversee the QI program	- Safety of clinical care.			Annual	
Accreditation	QI 2 B	QI Program	Inform members & practitioners of QI process	- Quality of service.			Annual	
Accreditation	QI 3 A-C	Contracts with practitioners	Provider and Specialist Contracts	- Members' experience.			Annual	
Accreditation Contract	QI 4 A	Availability of Practitioners	To ensure the network has sufficient numbers and types of practitioners who provide primary care, and specialty care that meets the cultural, linguistic, racial and ethnic needs of the membership.	- Time frame for each activity's completion.			Annual and Ongoing	
Accreditation Contract	QI 4 B	Geographical Availability of Health Plan Providers	Monitoring Geographical Availability of Health Plan Providers for Members 1. Distance in miles to PCP, Specialist, and OB/Gyn 2. Distance in miles to hospital 3. Ancillary provider access	- Staff members responsible for each activity.			Annual and Ongoing	
Accreditation Contract	QI 4 C	Practitioners providing Specialty Care	To ensure the availability of specialty care practitioners in its delivery system	- Monitoring of previously identified issues.	Networking contracting team		Annual and Ongoing	
Accreditation Contract	QI 4 D	Geo & access for BH practitioners	Ensure BH provider availability meets geographical and cultural linguistic requirements and identify opportunities of improvement, if needed.	- Evaluation of the QI program.	According to contract		Annual and Ongoing	
Accreditation Contract	QI 5 A	Customer Service Access:	Monitor statistics to ensure meeting established goal: Rate of telephone abandonment Rate of speed to answer phone Rate of response to member email inquiries	Collect and perform an annual analysis of data to measure performance against standards for access to: Regular and routine care appointments; Urgent care appointments; After-hours care; Member Services, by telephone	According to contract		Annual and Ongoing	
Accreditation Contract	QI 5 A	Provider Access	Monitor statistics to ensure meeting established goals Appointment Wait Times for: Preventive Care Apt Routine Apt Symptomatic Routine Apt Non-symptomatic Urgent apt - same day Emergency care After hours care	Monitor member access to set standards to ensure meeting established goals and identify opportunities of improvement, if needed. -Secret shopper calls, member satisfaction survey -Review annual CAHPS results -Monitor member complaint r/t access	According to contract		Annual	

Amerigroup Iowa 2015 Medicaid Quality Management Work Plan

Reason for Selection	NCQA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation Contract	QI 5 B-C	BH ACCESS	To ensure members have access to BH in accordance with standards.	Annual oversight of BH for compliance with appointment availability and telephone Access			Annual	
Accreditation Contract	QI 6 A RR 2 A	Grievance/ Complaint Analysis	Complaint trending and analysis to include a full complaints analysis for the 5 applicable categories (QOC, Billing and Financial, Access, Attitude and Service, Quality of Practitioner Site).	Complaints per 1000 members: Track by call reason and complaint category, Monitor trends and implement interventions for areas as identified, Complaint trending and analysis of top appeal reason and turn around time, provider complaints trending	100% meet timelines		Annual	
Accreditation Contract	QI 6 A RR 2 B	Appeals analysis	Appeal trending and analysis to include a full appeal analysis for the 5 applicable categories (QOC, Billing and Financial, Access, Attitude and Service, Quality of Practitioner Site). Appeals overturns tracking and trending	Appeals per 1000 members -Monitor trends and implement interventions for areas as identified. -Appeal trending and analysis of top appeal reason and turn around time. -Analysis of appeals Upheld, Overturn rate -provider appeals trending and tracking	100% meet Turn around times		Annual	
Accreditation Contract	QI 6 A	Member satisfaction - surveys, such as CAHPS Survey, Member understanding of Health Plan policies and complaints	Implement mechanisms to assess and improve member satisfaction	Monitor member satisfaction through DSS Research, report and analysis, implement interventions for areas not meeting goal.			Annual	
Accreditation Contract	QI 6 A Patient Safety	Patient Safety-Adverse Events and Quality of Care monitoring and trending	To identify potential trends of adverse events and act upon those identified	Investigate, track and analyze adverse events by adverse event type, provider and facility			Quarterly and Ongoing	
Accreditation Contract	QI 6 B	Opportunities for improvement for Member Satisfaction	To identify opportunities for improvement	Analyze CAHPS Survey and complaint and appeal data, identify areas of improvement, set priorities and decide which opportunities to pursue			Annual	
Accreditation	QI 6 C-D	Annual Assessment of Behavioral Healthcare and Services	To identify opportunities for improvement and act upon those identified.	Evaluate member complaints and appeals; member experience survey. Implement interventions for areas not meeting goal.			Annual	
Accreditation Contract	QI 7A	Population Analysis	Complex Case Management-The health plan's demographic profile is an important tool for selecting case management programs that are meaningful and applicable to health plan membership.	Identify demographic characteristics and high volume diagnoses to ensure appropriate CM programs are in place to serve the membership			Annual	
Accreditation	QI 7 B-E	Case Management Process	To ensure coordinated services for members with complex conditions and access needed resources	Participate in annual review of all CCM documents, participate in work groups when changes are needed to ensure NCQA compliance is met for: 1. CCM member identification; 2. Access to CM; 3. Support CM Systems & member integration; 4. Assessments			Annual and Ongoing	
Accreditation	QI 7 F-H	CCM FILE AUDIT	Appropriate assessment, ongoing case management, follow up and documentation of members enrolled into CCM.	Audit, at a minimum 10 files, for documentation and compliance.			Quarterly	
Accreditation Contract	QI 7 I	Member Experience with Case Management	Evaluate satisfaction with the CCM program	Evaluation and analysis of CCM satisfaction survey and analysis go through QMC to identify and act upon opportunities for improvement; Analysis of member complaints			Annual	
Accreditation	QI 7 J-K	Measuring the Effectiveness of CM Programs	Measure the effectiveness of CCM programs using three measures.	For each measure: Identify a relevant process or outcome, Use valid methods that provide quantitative results, Set performance goal, Identify measure specifications, Analyze results, Identify opportunities for improvement, Develop plan for intervention and remeasurement.			Annual	
Accreditation	QI 8 A	(2) Disease Management programs	Evaluate program to improve health status of members with chronic conditions	Identifies (2) DM programs that are relevant to the member population			Annual	
Accreditation Contract	QI 8A	Program Description	Define the quality structure and processes	Annual review and approval of DM program descriptions			Annual	
Accreditation	QI 8 B- C	Member Identification for DM programs	Identify sources to identify members who qualify for DM programs.	Claim or encounter data, Pharmacy data, Health appraisal results, Laboratory results, Data collected through the UM process, case management process, Data from health management, wellness or health coaching programs, information from EHRs, Member and practitioner referrals			Monthly	
Accreditation	QI 8 D	Member information on DM program	Provides member with written information about the DM program	Inform Members re: DM instructions on how to use DM services how the organization works with a practitioner's patients in the program			Annual	
Accreditation	QI 8 E	Interventions Based on Assessments	Provides members with interventions based on assessments	Provide interventions based on disease stratification and assessments			Ongoing	
Accreditation	QI 8 F	DM Active Participation Rate	Annually measure member active participation in the DM program	Measure the active member participation rate that have had at least one interactive contact in an intervention			Annual	
Accreditation	QI 8 G	Provider/Practitioner information on DM program	Provides Providers with written information about the DM program	Inform Providers re: DM instructions on how to use DM services how the organization works with a practitioner's patients in the program			Annual and Ongoing	
Accreditation	QI 8 H	Integrating Member Information	Integrate member information from various resources into the DM program	Ensure the following systems are capturing member information to for continuity of care for members in DM: Health Information Line, DM Program, CM Program, UM Program, Wellness Program			Annual	
Accreditation Contract	QI 8 I	DM Experience	Annually evaluates experience with it's DM services.	Evaluation and analysis of DM experience survey and analysis of member complaints go through QMC			Annual	
Accreditation	QI 8 J	Measuring the Effectiveness of DM Programs	Employ and track one performance measure for each DM program. (2 Programs)	Identify and act upon opportunities for improvement Pressure annual DM program summary which will: Address relevant outcomes, Produce quantitative results, Population based, Measure effectiveness of outcome data, Measure against benchmark or goal, Satisfaction, Active Participation, Opt Out Percentage, Identification, Compliance Monitoring			Annual	
Accreditation Contract	QI 9 A	Clinical guidelines	Adoption and Distribution of Clinical Practice Guidelines	Annual Review and approval of Clinical Practices Guidelines.			Annual	
Accreditation Contract	QI 9A	BH Clinical guidelines	Measure 2 important BH aspects of guideline annually. Annual distribution of guidelines to practitioners via newsletter, fax blast, website.	Annual distribution of guidelines to practitioners via newsletter, fax blast, website. Health Plan oversight			Annual	
Accreditation Contract	QI 9 B	Preventive Health Guidelines	Maintain up-to-date preventive health guidelines and promote those guidelines.	Establish the scientific basis for guidelines: Update guidelines at least every 2 years, Annual committee review and approval of guidelines, Annual distribution of guidelines, to members and providers			Annual	
Accreditation Contract	QI 9 C	CPG's Relation to DM Programs	Two of the organization's adopted clinical practice guidelines are the clinical basis for DM programs	DM Annual evaluation will define the annual review of evidence of how clinical guidelines are used to develop the organization's DM program.			Annual	
Accreditation Contract	QI 9 D	Clinical Guidelines Performance Measurement	Measures performance against at least two important aspects of clinical practice, behavioral health and preventive guidelines.	Address two specific aspects of care covered in the Clinical and Preventive Health guidelines Measure effectiveness of care against the aspects of care covered in the guidelines.			Annual	
Accreditation	QI 10 A-B	Continuity and Coordination of Medical Care.	Seamless, continuous and appropriate care for members among practitioners is key for quality care.	Identify and evaluate aspect of continuity of care across inpatient and outpatient settings. Identify and select 4 opportunities for improvement based on issues or sources of problems that were found in the analysis. Act on opportunities.			Annual	
Accreditation	QI 10 C	Continuity and Coordination of Medical Care.	Measuring effectiveness	Annually measure the effectiveness of improvement actions taken for identified opportunities.			Annual	
Accreditation	QI 10 D	Notification of Termination	Ensure continuity and coordination of care occurs when a provider terms and if a member is undergoing active treatment.	Ensure members affected by the termination are notified at least 30 calendar days prior to the effective termination date. Ensure a mechanism is in place for identifying members and assess if continuity of care occurred.		Ongoing	Ongoing	

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Reason for Selection	NCQA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation	QI 10 E	Continued Access to Practitioners	Ensure continuity and coordination of care occurs when a provider terms and if a member is undergoing active treatment.	If a practitioner's contract is discontinued, the organization allows affected members continued access to practitioner: -Continuation of treatment through the current period of active tx, or for us to 90 calendar days, whichever is less, for members undergoing tx for a chronic or acute med condition; -Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.			Ongoing	
Accreditation Contract	QI 10 F	Transition to Other Care	To assist with a members transition to other care if necessary	Ensure that members are assisted with obtaining other services when their benefits end with alternative resources and education			Ongoing	Ongoing
Accreditation Contract	QI 11 A - B	Continuity and Coordination of Care between Medical and Behavioral Healthcare	Seamless, continuous and appropriate care for members among practitioners and BH providers is key for quality care.	Develop opportunities to improve the collaboration between Medical and behavioral aspects of care			Ongoing	Annual
Accreditation	QI 11 C	Continuity and Coordination of Care between Medical and Behavioral Healthcare	Measuring effectiveness	The organization annually measures the effectiveness of improvement actions taken for 2 identified opportunities				Annual
	QI 12	Marketplace Network Transparency and Experience		N/A for Medicaid Plans				
Accreditation	QI 13 A-F	Delegation of QI	Oversight of delegated QI activities	Ensure vendor is meeting appropriate standards: Annual policy evaluation, Approval of QI program, if applicable, Annual file review, if applicable, Semiannual reporting, Identify and act on opportunities for improvement			Ongoing	Quarterly
Accreditation Contract	UM	Regional Policy Review	Complete full review with revisions as needed for policies	Annual review of all UM policies			Ongoing	Annual
Accreditation Contract	UM	Utilization Statistics	Monitor UM statistics	Auth Request Turn-around Time. Monitor trends in: ER Utilization, Admits/1000, Inpatient days/1000, Average LOS, Denied Inpatient Days, Observation Days, Readmissions, Preauthorization phone statistics, Preauthorization utilization			Ongoing	Quarterly
Accreditation Contract	UM 1 A-D	Program Description	Define the quality structure and processes	Annual review and approval of UM program descriptions; Senior-level physician active involvement in implementing the organizations UM program; BH practitioner active involvement in implementing the BH aspects of the UM program			Ongoing	Annual
Accreditation	UM 2 A-C	Ensuring UM Decision Consistency & Procedural Accuracy Through Inter-Rater Reliability	Consistency and accuracy are key components of the quality of all UM processes. Interpreter Reliability Review – Review for Medical Directors and Nurses to insure the consistent application of clinical criteria	Annual review of clinical criteria and corp policies. Identify opportunities to improve the consistency in applying criteria based off of IRR staffing assessment	Contract Goals			Annual
Accreditation	UM 2 A-C	Ensuring UM Decision Consistency & Procedural Accuracy Through Inter-Rater Reliability	Consistency and accuracy are key components of the quality of all UM processes. Interpreter Reliability Review – Review for Medical Directors and Nurses to insure the consistent application of clinical criteria	Annual testing of the UM staff. Implement Corrective action as needed.			Ongoing	Annual IRR
Accreditation	UM 3 A	Utilization Management Access	Customer/Provider access to the plan is a key component to overall customer satisfaction	Make criteria available to practitioners upon request Ensure corporate policies are in place and that communication of services is available to all Members and Providers.			Ongoing	Annual
Accreditation	UM 3 A	Utilization Management Access	Customer/Provider access to the plan is a key component to overall customer satisfaction	Ensure UM access is communicated to Members and Providers			Ongoing	Annual
Accreditation	UM 4 A-B	Appropriate Professionals	To ensure Health Plan has qualified licensed health professionals assess the clinical information used to support UM decisions.	Ensure polices and procedures and job descriptions are in place and are reviewed and approved in accordance with standards			Ongoing	Annual
Accreditation	UM 4 C	UM files Appropriate Professionals	Ensure utilization decisions are made in a timely manner and reviewed by the appropriate reviewer.	Audit, at a minimum 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 4 D	Practitioner Review of Behavioral Healthcare Denials	Ensure BH that a physician, appropriate BH practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity.	Audit, at a minimum 10 files, for documentation and compliance				Quarterly
Accreditation	UM 4 E	Board Certified Consultants	Ensure all medical necessity decisions are made by board-certified consultants	Note - this element is N/A if the org and its delegates do not make UM decisions and all services are auto approved; or if BH services are carved out.			Ongoing	Ongoing
Accreditation	UM 4 F	Affirmative Statement About Incentives	Encourage appropriate utilization and discourage underutilization	Utilize only board-certified consultants by contracting appropriately with vendors who have board- certified physicians Distribute affirmative statement to all practitioners, members and staff that UM Decision making is only based on appropriateness of care and service and that members, practitioners or staff are not rewarded or incentivized in issues denials or making decisions resulting in under utilization			Ongoing	Annual
Accreditation	UM 5 A-B	UM files	Ensure non-behavioral health utilization decisions are made in a timely manner and reviewed by the appropriate reviewer.	Audit, at a minimum 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 5 C-D	UM Files	Ensure Behavioral health utilization decisions are made in a timely manner and reviewed by the appropriate reviewer	Audit, at a minimum, 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 5 E	UM P&P Timeliness	Ensure the organization has P&P in place for UM timeliness	Annual review of documented process for UM decisions with appropriate timeframes. ** This element applies to Interim Surveys only				Annual
Accreditation	UM 6 A	File Review Clinical Information	Obtain relevant clinical information and consult with treating practitioners when making UM decisions	Audit, at a minimum 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 6 B	File Review Clinical Information	Obtain relevant clinical information and consult with treating practitioners when making Behavioral Health UM decisions	Audit, at a minimum, 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 7 A-C	File Review Denial Notices	To ensure the reasons for the denial are clearly documented and communicated to members and providers	Audit, at a minimum 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 7 D-F	File Review Denial Notices	To ensure the reasons for the BH denial are clearly documented and communicated to members and providers	Audit, at a minimum, 10 files, for documentation and compliance. This element is N/A if BH services are carved out.				Quarterly
Accreditation Contract	UM 8 A-C	Policy for Appeals	To establish process for resolving member disputes and responding to requests for reconsideration of decisions	Ensure polices and procedures address thorough, appropriate and timely resolution of member appeals				Annual
Accreditation Contract	UM 9 A-F	Appeal files	Appropriate Handling of Appeals	Audit, at a minimum 10 files, for documentation and compliance.				Quarterly
Accreditation	UM 10 A-B	Evaluation of New Technology	Evaluation of new developments in technology for inclusion into plan benefits	1. Evaluate new technology for Medical Procedures, BH procedures, RX and devices 2. Review of case examples for evaluation of implementation				Annual
Accreditation Contract	UM 11 A	Member and Provider Experience	To continuously improve Member and Provider experience with UM process.	Annual analysis of Member and Provider Experience Survey including: - Experience with UM Process - Experience with change of information, treatment and referral with BH providers and BH vendor -Identify opportunities for improvement.				Annual

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Reason for Selection	NCOA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation Contract	UM 12 A	Emergency Services	Provide, arrange or facilitate needed emergency services including appropriate coverage and costs	Ensure Health Services policies address: 1. to screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed 2) If an authorized representative, acting for the organization, authorized the provision of emergency services.			Ongoing	
Accreditation	UM 13A-8, D-E	Procedures for Pharmaceutical Management	To ensures procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals	Evaluation of: Drug Formulary and restrictions process. Ensure measures are in place to evaluate pharmaceutical Pt. Safety, drug recalls drug interaction report high risk medication			Ongoing	Annual
Accreditation	UM 13 C	Pharmaceutical Patient Safety	Ensure measures are in place to evaluate pharmaceutical Pt. Safety	Evaluation of: drug recalls drug interaction report high risk medication			Ongoing	Quarterly
Accreditation	UM 14 A-B	Triage and Referral for BH	To ensure that its centralized triage and referral functions for behavioral healthcare services are appropriately implemented, monitored and managed.	The organization's protocols for behavioral healthcare triage and referral: -Address all relevant mental health and substance abuse situations; -Define level of urgency; -Define appropriate setting of care; -Have been reviewed or revised in the past two years; -Use licensed practitioners to make decisions that require clinical judgment. Staff who make clinical decisions are supervised by appropriately trained and licensed practitioner.				Ongoing
Accreditation	UM 15 A-F	Delegation of UM	Oversight of delegated UM activities	Ensure vendor is meeting appropriate standards. Annual policy evaluation Approval of UM Program, if applicable Annual file review, if applicable Semiannual reporting Opportunities for improvement identified and followed up on for each delegate that has been in effect for more than 12 months.				Ongoing
Accreditation Contract	CR	Regional Policy Review	Complete full review with revisions as needed for policies	Annual review of all CR policies				Annual
Accreditation	CR	Credentialing	Provider Network Quality is a component of care provided to our members	Compliance with State, Federal and Accreditation regulations and standards. -new providers are credentialed within 45 days of obtaining a complete application. -Ensure practitioners are recertified within 3 years	NCOA Goals			Quarterly
Accreditation	CR 1 A	Credentialing Policies meet NCOA Standard	Ensure credentialing policies meet all NCOA criteria	Policies specify: Types of practitioners to credential and recredential Verification sources Criteria Process for decisions, managing, delegating, non discriminatory review, practitioner notification of information received and decision making Medical Director responsibility and participation in credentialing committee Confidentiality process Provider Directory rules Tracking and identifying discrimination of credentialing and recredentialing process by, provider age, sex, ethnicity -Assess provider complaints alleging discrimination	NCOA Goals			Annual
Accreditation	CR 1 B	Credentialing Rights	Notify Practitioners of rights to review information regarding their credentialing application, their right to correct erroneous information and rights to be informed of credentialing status upon request	Notify Practitioners of the rights via fax blast, website or credentialing application	NCOA Goals			Annual
Accreditation Contract	CR 2 A	Credentialing Committee	The Credentialing Committee uses a peer-review process to make recommendations regarding credentialing decisions.	Ensure Adequate Provider Participation and representation in Cred Committee. Annual review and approval of committee charter and responsibilities committees Review credentials for practitioners who do not meet established thresholds and ensure files the committee does not see are reviewed and approved by the medical director.	NCOA Goals			Monthly
Accreditation	CR 3 A-C Audits	Credentialing Verification	Compliance with State, Federal, and Accreditation regulations and standards during the credentialing process	Review files for correct credentialing verification and recredentialing cycle length. Audit 10 files per quarter	NCOA Goals			Quarterly
Accreditation	CR 4 A File Audits	Recredentialing Cycle Length	Compliance with State, Federal, and Accreditation regulations and standards during the credentialing process	Review files for correct credentialing verification and recredentialing cycle length. Audit 10 files per quarter	NCOA Goals			Quarterly
Accreditation	CR 5 A-B	Practitioner Office Site Quality	Set site performance standards and thresholds to ensure that the offices of all practitioners meet office-site standards.	Tracking and Identifying complaints for practitioner office site standards and perform site visits when thresholds have been met and implement corrective action if needed.	NCOA Goals			Annual and ongoing
Accreditation	CR 6 A	Ongoing Monitoring	Ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles	Investigate, track and analyze: - Adverse Events -Sanctions or Limitations on Licensure - Member complaints - to include quality of cares -Medicare and Medicaid sanctions Implement appropriate interventions when instances related to poor quality have been identified.	NCOA Goals			Ongoing
Accreditation	CR 7 A-C	Notification to authorities and Practitioner Appeal Rights	To use objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards.	Determine if any actions have been taken against a practitioner for quality reasons. Ensure provider appeal rights have been addressed and State fair hearing provided Report to the appropriate authorities and offers the practitioner a formal appeal process.	NCOA Goals			Annual
Accreditation	CR 8 A-E	Assessment of Organizational Providers	To evaluate the quality of organizational providers with which Health Plan contracts.	Ensure that organizational providers licensing, accreditation and site visits, as applicable are up to date for: Hospitals. Home health agencies. Behavioral Health Providers Skilled nursing facilities. Free-standing surgical centers.	NCOA Goals			Annual

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Reason for Selection	NCQA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation	CR 9 A-F	Delegation of Credentialing	Remain accountable for credentialing and recredentialing its practitioners even if it delegates all or part of the activities	Have a delegation agreement that describes the delegates activities and responsibilities, requires semi annual reporting, describes the process to evaluate the delegates performance and the remedies if the delegate does not fulfill its obligations. Annual review of Member Rights and Responsibilities statement in accordance with standards and regulatory requirements. Review policy	NCQA Goals		Semi-Annual and Ongoing Annual	
Accreditation Contract	RR 1 A	Member Rights and Responsibilities	To treat members in a manner that respects their rights, and its expectations of members' responsibilities.					
Accreditation	RR 1 B	Member Rights and Responsibilities	To treat members in a manner that respects their rights, and its expectations of members' responsibilities.	Ensure the Distribution of rights and responsibilities to members and practitioners upon enrollment and annually thereafter. New members - Member Handbook Existing members - Member Newsletter New practitioner - Provider Manual Existing Practitioners - Practitioner Newsletter			Annual & upon enrollment	
Accreditation	RR 2A-B	Policies for Complaints and Appeals	To ensure written policies and procedures are in place for thorough, appropriate and timely resolution of member complaints and appeals.	Annual review of Member complaints policy in accordance with standards and regulatory requirements			Annual	
Accreditation	RR 3 A	Subscriber Information	To provide each subscriber with the information necessary to understand benefit coverage and obtain care	Distribution of written information to subscribers re: benefits, etc. upon enrollment and annually thereafter			Annual & upon enrollment	
Accreditation Contract	RR 3 B	Access to Language Line	Provide access to interpreter services based on linguistic needs of members	Assessment of linguistic needs of members, language line usage and ensure member calls are completed in a timely manner.			Annual	
Accreditation Contract	RR4 A, C-E, G-J	Provider & Hospital Directories	To provide information to help members and prospective members choose physicians and hospitals.	Ensure functionality of Provider/Hospital directories meet the requirement as well as appropriate validation			Annual	
Accreditation Contract	RR 4 B, F	Provider & Hospital Directory updates	Provide information to help members and prospective members choose physicians and hospitals	Based on HEDIS measure. Members who were ages 3-6 and received one or more well-child visit in the measurement year. The Contractor shall be eligible for payment of a portion of the performance withhold based on meeting or exceeding the established benchmark.			Annual and ongoing	
Accreditation Contract	RR 5 A, C-D, G-H	PHI & security processes	To protect the confidentiality of member information and records	Ensure corporate wide privacy and security policies are reviewed and approved in accordance with Standards and Regulatory Guidelines.			Annual	
Accreditation Contract	RR 5 B, E	PHI & security processes	To protect the confidentiality of member information and records Inform members of HIPAA policies and procedures	1. Train staff on accountability and responsibility 2. Distribution of PHI use and disclosure to members 3. Ensure all HP Websites have a privacy statement 4. ensure protections are in place for physical and electronic access		Upon hire and ongoing	Annual	
Accreditation	RR 5 F	Accountability and Responsibility	Identification, reporting and improvement of impermissible uses or disclosures of sensitive information	Track and trend impermissible uses of HIPAA and educate staff on HIPAA policies and procedures		Upon hire and ongoing	Annual	
Accreditation	RR 6 A-B	Accountability and Responsibility	Prospective members receive an accurate description of the organization's benefits and operating procedures.	Review organizational marketing materials and presentations, communications with prospective members.				
Accreditation	RR 6 C	Assessing Member Understanding	The organization systematically takes steps to assess how well new members understand policies and procedures.	Implement procedures to maintain accuracy of marketing communication; Act on opportunities for improvement, if applicable.				
Accreditation	RR 7 A-F	Accountability and Responsibility	If the organization delegates any RR activities, there is evidence of oversight of the delegated activities.	Delegation Oversight				Annual and ongoing
Accreditation	MED 1 A	Direct Access	Allow direct access to women's health specialist	Member communication via website, newsletters, and member handbook			Annual	
Accreditation	MED 1 B	Second Opinions	Provides second opinions for members	Second opinion policy and notification to members via newsletters, website and member handbook			Annual	
Accreditation	MED 1 C	Out of Network Services	Provide timely out of network services if the organization cannot provide the service in network	Out of Network policy and notification to members via newsletters, website and member handbook			Annual	
Accreditation	MED 1 D	Out of Network Cost to Members	Out of network approved services will be of no extra cost to the member than in network services	Out of Network policy and notification to members via newsletters, website and member handbook			Annual	
Accreditation	MED 1 E	Hours of Operation	Hours of operations by practitioner are no less than what is offered to commercial members	Determine contract requirements for hours of operation are documented, and in provider manual			Annual	
Accreditation	MEM 1 A-G	Health Appraisals	The organization helps adult members manage their health by providing a Health Appraisal, disclosing how the information will be used and protecting it in accordance with privacy policies.	Documented process and materials for appropriate HA with PHI protection per NCQA standards.			Annual	
Accreditation	MEM 2 A, C	Self-Management Tools	The organization provides self-management tools to help members stay healthy and reduce risk.	Documented process for development and routine updating of evidence based self-management tools, that provide members with information on at least the following wellness and health promotion areas: -Healthy weight (BMI) maintenance; -Smoking and tobacco use cessation; -Encouraging physical activity; -Healthy eating; -Managing stress; -Avoiding at-risk drinking; -Identifying depressive symptoms.			Annual	
Accreditation	MEM 2 B, D	Self-Management Tools	For each of the required seven health areas in the scope of review, the organization evaluates its self-management tools for usability.	Evaluate self-management tools at least every 36 months with consideration that: -Language is easy to understand; -Member special needs, including vision and hearing are considered. -Are offered by digital services and in print or by telephone.			Annual	
Accreditation	MEM 3 A-B	Functionality of Claims Processing	The organization provides members with timely and accurate information about their claims.	Documented process, reports, materials demonstrating that members can track the status of their claims in the claims process and obtain claims information, as needed and required, via web site or by telephone request.			Annual	
Accreditation	MEM 4 A-B, D	Pharmacy Benefit Information	The organization provides members with the information they need to understand and use their pharmacy benefit.	Documented process, reports, materials demonstrating that members can complete the following actions on the organizations web site or by telephone in one attempt or contact: -Determine their financial responsibility for a drug, based on the pharmacy benefit; -Initiate the exceptions process; -Order a refill for an existing, unexpired, mail-order prescription; -Find the location of an in-network pharmacy; -Conduct a proximity search based on zip code; -Determine potential drug-drug interactions; -Determine a drug's common side effects; -Determine the availability of generic substitutes.			Annual	
Accreditation	MEM 4 C	Pharmacy Benefit Information	QI Process on accuracy of information	The organization updates member pharmacy benefit information on its web site and materials used by telephone staff, as the effective date of the formulary change and as new drugs are made available or recalled. Documented process and reports demonstrating that the organization's QI process for pharmacy benefit information collects data on the quality and accuracy of pharmacy benefit information, analyzes data results, acts to improve identified deficiencies.			Annual	
Accreditation	MEM 5 A-B	Personalized Information on Health Plan Services	Providing members with the information they need to easily understand and use health plan benefits.	Documented process, reports, materials demonstrating functionality of member web site to obtain personalized health plan services. Documented process, reports and materials demonstrating members can complete activities over the telephone.			Annual	
Accreditation	MEM 5 C	Personalized Information on Health Plan Services	Quality and accuracy of information	At least annually, the organization must evaluate the quality and accuracy of the information it provides to its members via the Web and telephone.			Annual	

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Reason for Selection	NCQA req.	Topic	Objective	Activity	Goal / Benchmark	Start Date	Date Due	Q1
Accreditation	MEM 5 D	Personalized Information on Health Plan Services	Timely, accurate response to member email.	The organization has a process for responding to member email inquiries within one business day; has a process for annually evaluating the quality of email responses; annually collects data on email TAT, quality; acts to improve identified deficiencies.			Annual	
Accreditation	MEM 6 A	Member Support	Use of technology to improve member services	The organization uses, supports or facilitates a minimum of 4 of 9 technology-supported processes as stated by NCQA.			Annual	
Accreditation	MEM 7 A-B	Health Information Line	Informing members about wellness and prevention, using the organizations health information line.	Policies specify a health information line that is staffed by licensed nurses or clinicians that: -Is available 24hr/day; -Provides secure transmission of electronic communication, and a 24hr TAT; -Provides interpreter services			Annual	
Accreditation	MEM 7 C	Health Information Line	Informing members about wellness and prevention, using the organizations health information line.	Policies specify that the organization: -Tracks telephone and Web statistics at least monthly; -Tracks member use of the health information line at least quarterly; -Monitors calls periodically;			Monthly	
Accreditation	MEM 7 C	Health Information Line	Evaluate member satisfaction with Health Information Line	Evaluate member satisfaction with health information line at least ; -Analyze data at least annually and, if applicable, identify opportunities and establishes priorities for improvement.			Annual	
Accreditation	MEM 8 A, B	Support for Healthy Living	The organization actively works to keep members healthy.	Policies and reports describe use of data to identify and target members eligible for wellness activities.			Annual	
Accreditation	MEM 8 C	Support for Healthy Living	The organization actively works to keep members healthy.	Policies and reports describe the use of member incentives to promote wellness. ** This element is NA if the organizations elects not to be surveyed for this element.			Annual	
Accreditation	MEM 9	Delegation of MEM	Accountability and Responsibility	Documented processes and reports describing oversight of any delegated MEM functions, including an annual evaluation of delegate(s) using appropriate NCQA standards.			Annual	
Accreditation	Contract	HEDIS	Prepare annual HEDIS	Prepare Roadmap Schedule audit Complete IDSS tool Prepare MRR			Annual	
Accreditation	Contract	HEDIS	HEDIS analysis	Comparative analysis to identify opportunities for improvement.	Prepare annual report with results/benchmarks/barriers		Annual	
Accreditation	Contract	HEDIS	HEDIS Improvement Initiatives	Ongoing QI initiatives to improve HEDIS rates on strategic measures	Present report at QMC. Targeted member follow up.		Monthly	
Accreditation	Contract	HEDIS	Immunization Schedule	Maintain up-to-date preventive guidelines and promote those guidelines.	Annual committee review and approval to ensure most current guidelines are adopted -Annual distribution of guidelines, to members and provider		Annual	
Accreditation		HEDIS	Flu Shots	Increase number of high risk members receiving flu shot	Reminders by DM call center and CCM (telephonic) Phone – on-going Mail – Fall		Annual	
Contract		EPSDT	Monitor EPSDT activities for opportunities for improvement	Overview of Activities Related to EPSDT			Annual	
Contract		Performance Improvement Project (PIP)					Annual	
Contract		Performance Improvement Project (PIP)					Annual	
Delegate		Fill in Vendor information	Monitor and oversee UM delegated performance and activities	Ensure vendor is meeting appropriate standards. Annual policy evaluation Approval of UM program Semiannual reporting	NCQA Requirements		Semi-Annual	
Delegate		Fill in Vendor information	Monitor and oversee credentialing and UM delegated performance and activities	Ensure vendor is meeting appropriate standards. Annual policy evaluation Approval of UM program Annual file review Semiannual reporting	NCQA Requirements		Semi-Annual	
Delegate		Fill in Vendor information	Monitor and oversee credentialing and UM delegated performance and activities	Ensure vendor is meeting appropriate standards. Annual policy evaluation Approval of UM program, if applicable Annual file review Semiannual reporting	NCQA Requirements		Semi-Annual	
Delegate		Fill in Vendor information	Monitor and oversee UM delegated performance and activities	Ensure vendor is meeting appropriate standards. Annual policy evaluation Approval of UM program, if applicable Annual file review, if applicable Semiannual reporting	NCQA Requirements		Semi-Annual	
Accreditation	DVOC	CR, UM, QI, DVOC	Delegated Vendor Oversight Committee	Perform all annual reviews; Implement corrective actions; Semi-annual reporting; Ensure annual reviews are shared with the regional DVOC			Semi-Annual	

Litigation

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

We are defending a certified class action filed as a result of the 2001 demutualization of Anthem Insurance Companies, Inc., or Anthem Insurance. The lawsuit names Anthem Insurance as well as Anthem, Inc. and is captioned *Ronald Gold, et al. v. Anthem, Inc. et al.* Anthem Insurance's 2001 Plan of Conversion, or the Plan, provided for the conversion of Anthem Insurance from a mutual insurance company into a stock insurance company pursuant to Indiana law. Under the Plan, Anthem Insurance distributed the fair value of the company at the time of conversion to its Eligible Statutory Members, or ESMs, in the form of cash or Anthem common stock in exchange for their membership interests in the mutual company. Plaintiffs in *Gold* allege that Anthem Insurance distributed value to the wrong ESMs. Cross motions for summary judgment were granted in part and denied in part on July 26, 2006 with regard to the issue of sovereign immunity asserted by co-defendant, the state of Connecticut, or the State. The trial court also denied our motion for summary judgment as to plaintiffs' claims on January 10, 2005. The State appealed the denial of its motion to the Connecticut Supreme Court. We filed a cross-appeal on the sovereign immunity issue. On May 11, 2010, the Supreme Court reversed the judgment of the trial court denying the State's motion to dismiss the plaintiff's claims under sovereign immunity and dismissed our cross-appeal. The case was remanded to the trial court for further proceedings. Plaintiffs' motion for class certification was granted on December 15, 2011. We and the plaintiffs filed renewed cross-motions for summary judgment on January 24, 2013. On August 19, 2013, the trial court denied plaintiffs' motion for summary judgment. The trial court deferred a final ruling on our motion for summary judgment. On March 6, 2014, the trial court denied our motion for summary judgment finding that an issue of material fact existed. A trial on liability commenced on October 14, 2014 and concluded on October 16, 2014. The matter was taken under advisement by the trial court, which has requested post-trial briefing. We expect the trial court to issue its decision on liability sometime in 2015. We intend to vigorously defend the *Gold* lawsuit; however, its ultimate outcome cannot be presently determined.

We are currently a defendant in eleven putative class actions relating to out-of-network, or OON, reimbursement that were consolidated into a single multi-district lawsuit called *In re WellPoint, Inc. (n/k/a Anthem, Inc.) Out-of-Network "UCR" Rates Litigation* that is pending in the United States District Court for the Central District of California. The lawsuits were filed in 2009. The plaintiffs include current and former members on behalf of a putative class of members who received OON services for which the defendants paid less than billed charges, the American Medical Association, four state medical associations, OON physicians, OON non-physician providers, the American Podiatric Medical Association, California Chiropractic Association and the California Psychological Association on behalf of putative classes of OON physicians and all OON non-physician health care providers. The plaintiffs have filed several amended complaints alleging that the defendants violated the Racketeer Influenced and Corrupt Organizations Act, or RICO, the Sherman Antitrust Act, ERISA, federal regulations, and state law by using an OON reimbursement database called Ingenix and by using non-Ingenix OON reimbursement methodologies. We have filed motions to dismiss in response to each of those amended complaints. Our motions to dismiss have been granted in part and denied in part by the court. The most recent pleading filed by the plaintiffs is a Fourth Amended Complaint to which we filed a motion to dismiss most, but not all, of the claims. In July 2013 the court issued an order granting in part and denying in part our motion. The court held that the state and federal anti-trust claims along with the RICO claims should be dismissed in their entirety with prejudice. The court further found that the ERISA claims, to the extent they involved non-Ingenix methodologies, along with those that involved our alleged non-disclosures should be dismissed with prejudice. The court also dismissed most of the plaintiffs' state law claims with prejudice. The only claims that remain after the court's decision are an ERISA benefits claim relating to claims priced based on Ingenix, a breach of contract claim on behalf of one subscriber plaintiff, a breach of implied covenant claim on behalf of one subscriber plaintiff, and one subscriber plaintiff's claim under the California Unfair Competition Law. The plaintiffs filed a motion for reconsideration of the motion to dismiss order, which the court granted in part and denied in part. The court ruled that the plaintiffs adequately allege that one Georgia provider plaintiff is deemed to have exhausted administrative remedies regarding non-Ingenix methodologies based on the facts alleged regarding that plaintiff so those claims are back in the case. Fact discovery is complete. The plaintiffs filed a motion for class certification in November 2013 seeking the following classes: (1) a subscriber ERISA class as to OON claims processed using the Ingenix database as the pricing methodology; (2) a physician provider class as to OON claims processed using Ingenix; (3) a non-physician provider class as to OON claims processed using Ingenix; (4) a provider ERISA class as to OON claims processed using non-Ingenix pricing methodologies; (5) a California subscriber breach of contract/unfair competition class; and (6) a subscriber breach of implied covenant class for all Anthem states except California. Following expert discovery and briefing, oral argument was held on the motion. In late 2014, the court denied the plaintiffs' motion for class certification in its entirety. The California subscriber plaintiffs filed a motion for leave to file a renewed motion for class certification with more narrowly defined proposed classes, which the court denied. Earlier in the case, in 2009, we filed a motion in the United States District Court for the Southern District of Florida, or the Florida Court, to enjoin the claims brought by the physician plaintiffs and certain medical association plaintiffs based on prior litigation releases, which was granted in 2011. The Florida Court ordered those plaintiffs to dismiss their claims that are barred by the release. The plaintiffs then filed a petition for declaratory judgment asking the court to find that these claims are not barred by the releases from the prior litigation. We filed a motion to dismiss the declaratory judgment action, which was granted. The plaintiffs appealed the dismissal of the declaratory judgment to the United States Court of Appeals for the Eleventh Circuit, but the dismissal

was upheld. The enjoined physicians and some the medical associations did not dismiss their barred claims. The Florida Court found those enjoined plaintiffs in contempt and sanctioned them in July 2012. Those plaintiffs appealed the Florida Court's sanctions order to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit upheld the Florida court's enforcement of the injunction as it relates to the plaintiffs' RICO and antitrust claims, but vacated it as it relates to certain ERISA claims. The plaintiffs filed a petition for rehearing en banc as to the antitrust claims only, which was denied. The plaintiffs then filed a petition for writ of certiorari with the U.S. Supreme Court. The American Medical Association filed an amicus brief in support of the petition. The U.S. Supreme Court denied the petition on February 23, 2015. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA as well as Blue Cross and/or Blue Shield licensees across the country. The cases were consolidated into a single multi-district lawsuit called *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama. Generally, the suits allege that the BCBSA and the Blue plans have engaged in a conspiracy to horizontally allocate geographic markets through license agreements, best efforts rules (which limit the percentage of non-Blue revenue of each plan), restrictions on acquisitions and other arrangements in violation of the Sherman Antitrust Act and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. Subscriber and provider plaintiffs each filed consolidated amended complaints on July 1, 2013. The consolidated amended subscriber complaint was also brought on behalf of putative state classes of health plan subscribers in Alabama, Arkansas, California, Florida, Hawaii, Illinois, Louisiana, Michigan, Mississippi, Missouri, New Hampshire, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Texas. Defendants filed motions to dismiss in September 2013, which were argued in April 2014. In June 2014, the court denied the majority of the motions, ruling that plaintiffs had alleged sufficient facts at this stage of the litigation to avoid dismissal of their claims. Following the subsequent filing of amended complaints by each of the subscriber and provider plaintiffs, we filed our answer and asserted our affirmative defenses in December 2014. Discovery has commenced. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves, for all of those proceedings is from \$0.0 to approximately \$250.0 at March 31, 2015. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Cyber Attack Incident

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

Currently, we are in the process of addressing the cyber attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We will provide credit monitoring and identity protection services to those who have been affected by this cyber attack. While the cyber attack did not have an impact on our business, cash flows, financial condition and results of operations for the year ended December 31, 2014, we have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although we are unable to quantify the ultimate magnitude of such expenses and any other impact to our business from this incident at this time, they may be significant. We will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. State and federal agencies, including state insurance regulators, state attorneys general,

the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigations, are investigating events related to the cyber attack, including how it occurred, its consequences and our responses. Although we are cooperating in these investigations, we may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation on February 10, 2015 and will be heard by the Panel on May 28, 2015.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, we cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain health care and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner's petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation. An initial plan was filed on April 30, 2013. The Insurance Commissioner filed an amended plan on August 8, 2014 and a second amended plan on October 8, 2014. The state court ordered a hearing to consider motions in response to and in connection with the second amended plan on May 11, 2015, which has been set for July 15, 2015. The Insurance Commissioner has filed a Notice of Appeal asking the Pennsylvania Supreme Court to reverse the order denying the liquidation petition. The Supreme Court held oral argument on the appeal in September 2014. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments, and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

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RFP Forms (3.2.7.1)

Per RFP Section 3.2.7.1 RFP Forms, we have included the following documents:

- Attachment 3.2.7.1-1 Release of Information Form
- Attachment 3.2.7.1-2 Primary Bidder Detail & Certification Form
- Attachment 3.2.7.1-3 Subcontractor Disclosure Forms

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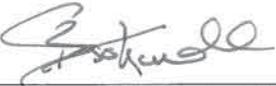
Exhibit A: Release of Information

(Return this completed form behind Tab 6 of the Bid Proposal.)

Amerigroup Iowa, Inc. (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Amerigroup Iowa, Inc.
Printed Name of Bidder Organization


Signature of Authorized Representative

May 18, 2015
Date

Tunde Sotunde, M.D.
Printed Name

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Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Tunde Sotunde, M.D.
Address:	303 Perimeter Center North, Suite 400, GA 30356
Tel:	678-587-4844
Fax:	888-240-4821
E-mail:	Tunde.Sotunde@amerigroup.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Amerigroup Iowa, Inc.
"Doing Business As" names, assumed names, or other operating names:	TBD
NAIC Number:	0671-TBD
Parent Corporation, if any:	Anthem, Inc. is the ultimate parent company of Amerigroup Iowa, Inc.
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation
State of Incorporation/organization:	Iowa
Primary Address:	5550 Wild Rose Ln, West Des Moines, IA 50266
Tel:	
Fax:	
Local Address (if any):	5550 Wild Rose Ln, West Des Moines, IA 50266
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Amerigroup Iowa, Inc.'s local operations will be supported by Anthem's National Services from the following offices: 4425 Corporation Ln, Virginia Beach, VA 23462 5800 Northhampton Blvd, Norfolk, VA 23502 1330 Amerigroup Way, Virginia Beach, VA 23464
Number of Employees:	380 Iowa-based employees projected by start of contract operations on January 1, 2016
Number of Years in Business:	Less than 1 year
Primary Focus of Business:	Managed Health Care
Federal Tax ID:	47-3863197
Bidder's Accounting Firm:	Ernst & Young, LLP
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	April 28, 2015
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	Yes. See attached Subcontractor Disclosure Forms

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	Statutory Basis for Confidentiality	Description/Explanation
See pages 995-996	See pages 995-996	See pages 995-996

Request for Confidential Treatment

Location in Bid (Tab/Page)	Statutory Basis for Confidentiality	Description/Explanation
Tab 3, §3, Page 115	Iowa Code §22.7(3)	Amerigroup considers this language as proprietary and a trade secret as defined in Iowa Code §550.2, as it “derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by a person able to obtain economic value from its disclosure or use.”
Tab 3, §3, Page 130	Iowa Code §22.7(3)	
Tab 3, §3, Page 220-221	Iowa Code §22.7(3)	
Tab 3, §3, Page 239	Iowa Code §22.7(3)	
Tab 3, §3, Pages 242-252	Iowa Code §22.7(3)	
Tab 3, §4, Page 274	Iowa Code §22.7(3)	
Tab 3, §4, Page 277	Iowa Code §22.7(3)	
Tab 3, §4, Pages 301-303	Iowa Code §22.7(3)	
Tab 3, §4, Page 338	Iowa Code §22.7(3)	
Tab 3, §4, Page 350	Iowa Code §22.7(3)	
Tab 3, §6, Page 390	Iowa Code §22.7(3)	
Tab 3, §6, Page 400	Iowa Code §22.7(3)	
Tab 3, §9, Page 524	Iowa Code §22.7(3)	
Tab 3, §9, Page 570-578	Iowa Code §22.7(3)	
Tab 3, §9, Page 586-592	Iowa Code §22.7(3)	
Tab 3, §9, Page 601-604	Iowa Code §22.7(3)	
Tab 3, §10, Page 641	Iowa Code §22.7(3)	
Tab 3, §10, Pages 647-652	Iowa Code §22.7(3)	
Tab 3, §10, Pages 657-659	Iowa Code §22.7(3)	
Tab 3, §10, Page 661	Iowa Code §22.7(3)	
Tab 3, §11, Page 674	Iowa Code §22.7(3)	
Tab 3, §13, Page 750	Iowa Code §22.7(3)	
Tab 6, §3.2.7.4, Page 1076-1189 <i>*Part d of Tables Only</i>	Iowa Code §22.7(3)	

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BID PROPOSAL CERTIFICATION

By signing below, Bidder certifies that:

1. Reserved;
2. Bidder accepts all capitation rates established by the Agency via the Agency's actuary.
3. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein.
4. Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;
5. Reserved;
6. Bidder has received any amendments to this RFP issued by the Agency;
7. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP;
8. The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive agreements outlined above;
9. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change.
10. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
11. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract.
12. Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier; and,
13. Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: <http://www.state.ia.us/tax/business/business.html>.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	
Printed Name/Title:	Tunde Sotunde, M.D., President, North Region, Medicaid Business Unit
Date:	May 18, 2015

Attachment 3.2.7.1-3 Subcontractor Disclosure Form includes the following components:

- Attachment 3.2.7.1-3a Anthem
- Attachment 3.2.7.1-3b PPL
- Attachment 3.2.7.1-3c ESI
- Attachment 3.2.7.1-3d AIM
- Attachment 3.2.7.1-3e Logisticare
- Attachment 3.2.7.1-3f Superior Vision
- Attachment 3.2.7.1-3g HearUSA
- Attachment 3.2.7.1-3h McKesson
- Attachment 3.2.7.1-3i Breakthrough
- Attachment 3.2.7.1-3j Careticker
- Attachment 3.2.7.1-3k Remind Tech
- Attachment 3.2.7.1-3l MySupport
- Attachment 3.2.7.1-3m National Disability
- Attachment 3.2.7.1-3n Telligen

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Anthem, Inc. (and its subsidiaries)
Address:	120 Monument Circle, Indianapolis, IN 46204
Tel:	317-488-6000
Fax:	317-488-6863 – Corporate Secretary Dept.
E-mail:	jack.young@anthem.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Anthem, Inc.
"Doing Business As" names, assumed names, or other operating names:	There are no "DBAs" for Anthem, Inc.; however, in the State of California, it is qualified as "Anthem, Inc., which will do business in California as Anthem Health, Inc."
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Indiana For-Profit Domestic Corporation
State of Incorporation/organization:	Indiana
Primary Address:	120 Monument Circle, Indianapolis, IN 46204
Tel:	317-488-6000
Fax:	317-488-6863 – Corporate Secretary Dept.
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	4425 Corporation Lane, Virginia Beach, VA 23462 5800 Northhampton Blvd, Norfolk, VA 23502 1330 Amerigroup Way, Virginia Beach, VA 23464 c/o Amerigroup Corporation
Number of Employees:	51,500
Number of Years in Business:	14
Primary Focus of Business:	Health benefit company
Federal Tax ID:	35-2145715
Subcontractor's Accounting Firm:	Ernst & Young
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	More than 5%
General Scope of Work to be performed by this Subcontractor	
Administrative and support services including finance, claims administration, call center activities, information technology, legal, regulatory, treasury and compliance	
Detail the Subcontractor's qualifications for performing this scope of work	
Anthem, Inc. is one of the largest health benefits companies in terms of medical membership in the United States, serving 37.5 medical members through its affiliated health plans as of December 31, 2014.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

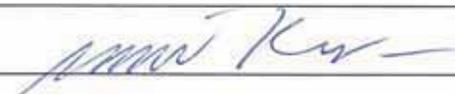
Signature for Subcontractor:	
Printed Name/Title:	R. David Kretschmer, Treasurer
Date:	May 1, 2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	PCG Public Partnerships, LLC (PPL)
Address:	40 Broad Street, 4 th Floor, Boston, MA. 02109
Tel:	617-717-1700
Fax:	888-752-8250
E-mail:	ppl@pegus.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Public Partnerships, LLC (PPL)
"Doing Business As" names, assumed names, or other operating names:	PCG Public Partnerships, LLC
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Limited Liability Company
State of Incorporation/organization:	Delaware
Primary Address:	40 Broad Street, 4 th Floor, Boston, MA. 02109
Tel:	617-717-1700
Fax:	888-752-8250
Local Address (if any):	Not Applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	One Cabot Road, Suite 102, Medford, MA. 02155 7776 S. Pointe Parkway West, Suite 150, Phoenix, AZ. 85044
Number of Employees:	Over 400
Number of Years in Business:	16
Primary Focus of Business:	Financial Management Services
Federal Tax ID:	04-3468852
Subcontractor's Accounting Firm:	DiCicco, Gulman & Company LLP
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	Not Applicable
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Participant-directed financial service model enabling members to choose which services they receive, how they are delivered, and by whom, within their budgets.	

Detail the Subcontractor's qualifications for performing this scope of work
<ul style="list-style-type: none"> • Financial Management For Each Individual Employer serving as the agent of the employer (participant or representative) in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. • Materials Development to establish individual Employer of Records and applicable employer accounts, establish employment relationships and educational information. • Information Systems Implementation and Management: Public Partnerships tailors and implements a fully integrated PPL Web Portal and Payroll Processing system to support our clients. This web portal supports: <ul style="list-style-type: none"> ○ Role-based secured access for defined groups ○ Integrated timesheet entry and processing ○ Prior authorization tracking and utilization ○ Authorization management via business rules engine ○ Document management • Reporting and Data Analysis • Customer Service • Quality Management and Compliance

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Marc H. Fenton
Date:	4/29/2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Express Scripts, Inc.
Address:	One Express Way, St. Louis, MO 63121
Tel:	314- 996-0900
Fax:	800-417-8163
E-mail:	www.express-scripts.com/contact us

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Express Scripts, Inc.
"Doing Business As" names, assumed names, or other operating names:	Express Scripts
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	Delaware
Primary Address:	One Express Way, St. Louis, MO 63121
Tel:	314-996-0900
Fax:	800-417-8163
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	See Attachment I
Number of Employees:	~28,695
Number of Years in Business:	29 years (est. 1986)
Primary Focus of Business:	Pharmacy Benefit Management
Federal Tax ID:	43-1420563
Subcontractor's Accounting Firm:	PricewaterhouseCoopers LLP
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	Originally registered in 1992; re-activation of registration in 2015
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	More than 5%
General Scope of Work to be performed by this Subcontractor	
Pharmacy Benefits Management	
Detail the Subcontractor's qualifications for performing this scope of work	
Express Scripts, Inc. is one of the nation's leading full-service pharmacy benefit management ("PBM") companies. The Company coordinates the distribution of outpatient pharmaceuticals through a combination of benefit management services, including retail drug card programs, Home Delivery services, formulary management programs and other clinical management programs. We also distribute a full range of injectable biopharmaceutical products directly to	

patients or their physicians, and provide extensive cost-management and patient-care services. We provide these types of services for clients that include health maintenance organizations, health insurers, employers, union-sponsored benefit plans, third-party administrators, workers' compensation and governmental health programs.

Founded in 1986, Express Scripts aligns its interests with those of clients and patients. Alignment of interests means that we make money when our clients and patients save money — when patients use more generics, choose lower-cost brand drugs and take advantage of our cost-effective Home Delivery services. Our legacy of independence means that our programs and original research benefit our clients.

Every day, we handle more than a million prescriptions through our networks of retail pharmacies and our Home Delivery facilities. On the receiving end are tens of millions of individuals who count on us and their plan sponsors to provide a sound pharmacy benefit today and into the future.

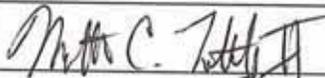
You may view our Corporate Overview PDF document here: <http://express-scripts.com/pressroom/informationresources/corporateoverview/corporateOverview.pdf>

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Matthew Totterdale, Vice President
Date:	4/30/15

ATTACHMENT I

Corporate HQ

Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

Contact Center Locations

Bloomington

6301 Cecilia Circle, Suite 200
Bloomington, MN 55439
800.344.3405

Dublin

5151 Blazer Parkway, Suite B
Dublin, OH 43017
800.282.2881

Orlando

6252 Lee Vista Boulevard
Orlando, FL 32822
888.773.7376

Port St. Lucie*

10045 S U.S. Highway 1
Port Saint Lucie FL 34952
866.907.0835

Pueblo

1045 West 6th Street
Pueblo, CO 81003
800.305.7880

St. Marys

2603 Osborne Road Unit CC
St. Marys, GA 31558
800.795.7643

Tampa

5701 East Hillsborough Avenue, Suite 1300
Tampa, FL 33610
866 308.7548

Tempe

3001 Priest Drive
Tempe, AZ 85282
800.955.4879

Home Delivery Locations (yellow highlights are dispensing pharmacies)**Phoenix**

7909 South Hardy Drive, #106
 Tempe, AZ 85284
 800.955.1171

St. Louis

4600 North Hanley Drive
 St. Louis, MO 63134
 866.440.2845

Florence

2040 Route 130 North
 Burlington, NJ 08016
 609.360.0001

Columbus (West)

255 Phillippi Road
 Columbus, OH 43228
 800.282.2833

Fairfield

4865 Dixie Highway
 Fairfield, OH 45014-1932
 800.959.3146

North Huntingdon (new location)

501 Ronda Court, North Huntingdon, PA 15642

North Versailles

1810 Lincoln Highway, Route 30
 North Versailles, PA 15137
 800.654.4390

Indiana

4750 East 450 South
 Whitestown, IN 46075
 877.633.2694

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	AIM Specialty Health
Address:	8600 W. Bryn Mawr Avenue, Suite 800S, Chicago, Illinois 60631
Tel:	773-864-4600
Fax:	773-864-4601
E-mail:	armatas@aimspecialtyhealth.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	American Imaging Management, Inc.
"Doing Business As" names, assumed names, or other operating names:	AIM Specialty Health
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	Illinois
Primary Address:	8600 W. Bryn Mawr Avenue, Suite 800S, Chicago, IL 60631
Tel:	773-864-4600
Fax:	773-864-4601
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	1200
Number of Years in Business:	25
Primary Focus of Business:	Specialty benefit management
Federal Tax ID:	36-3692630
Subcontractor's Accounting Firm:	
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Utilization management support activities specific to cardiology, radiology, and sleep-testing services.	
Detail the Subcontractor's qualifications for performing this scope of work	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	<i>Nancy A Armatas</i>
Printed Name/Title:	<i>Nancy A Armatas / Counsel</i>
Date:	<i>April 29, 2015</i>

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Sandy Reifel
Address:	1275 Peachtree Street NE, 6 th Floor; Atlanta, GA 30309
Tel:	(800) 486-7647
Fax:	(404) 888-5999
E-mail:	SandyR@logisticare.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Logisticare Solutions, LLC
"Doing Business As" names, assumed names, or other operating names:	LogistiCare
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Delaware
Primary Address:	1275 Peachtree Street NE, 6 th Floor; Atlanta Ga 30309
Tel:	(800) 486-7647
Fax:	(404) 888-5999
Local Address (if any):	n/a
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Wisconsin Call Center 2335 City View Drive, Suite 200 Madison, WI 53717
Number of Employees:	Approximately 3,000
Number of Years in Business:	25 (including as predecessor entity)
Primary Focus of Business:	Non-emergency medical transportation brokerage
Federal Tax ID:	58-2491253
Subcontractor's Accounting Firm:	KPMG, LLC
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	March 12, 2010
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Non-emergent transportation services	
Detail the Subcontractor's qualifications for performing this scope of work	
Please refer to Attachment A for Logisticare's qualifications and work performance.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Albert Cortina/Chief Administrative Officer
Date:	April 28, 2015



Attachment A: LogistiCare's Qualifications and Work Performance

LogistiCare strongly believes that transportation to authorized medical services is an essential function within the healthcare delivery continuum. Quality healthcare delivery for Iowa Members begins with effective and efficient transportation services. With the understanding that the coordination service we provide is critical to the health and well-being of eligible Iowa Members, LogistiCare will work to meet the highest level of performance expectations in a sensitive and compassionate manner. LogistiCare will transition the existing NEMT network to one that is compliant, cost effective, and committed to NEMT stakeholder satisfaction.

LogistiCare is the Largest and Most Experienced NEMT Broker

We are the largest and most experienced broker in the country. This distinction is earned through the management of 250+ NEMT accounts in 40 states, representing a variety of transportation solutions for both state agencies and managed care organizations. To serve these programs, we operate 20 dedicated NEMT call centers with approximately 1,400+ Customer Service Representatives (CSRs) specifically trained to deliver NEMT services. In the true spirit of NEMT brokerage, LogistiCare does not own vehicles. Instead, we have built an extensive network of contracted transportation alternatives including commercial Transporters, community and faith based Transporters, transit organizations, gas reimbursement and volunteer drivers. Our network of over 23,000 vehicles provides over 56 million trips annually.

Our People, Processes and Technology Lead the NEMT Industry

Our NEMT programs combine proven NEMT leadership and innovative technology including:

- ▶ Tested Gate Keeping Ability
- ▶ Proven Network Development and Management
- ▶ Extensive Outreach
- ▶ State of the Art Technology
- ▶ Ability to Manage and Track Stringent Program Requirements
- ▶ Long Proven Gatekeeping Capabilities

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it “not applicable.” If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Adrienne Bennett, Vice President, Quality and Account Management
Address:	939 Elkridge Landing Road, Suite 200, Linthicum, MD 21090
Tel:	800.243.1401 x1026
Fax:	443.625.1596
E-mail:	abennett@superiorvision.com

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	Superior Vision Benefit Management, Inc.
“Doing Business As” names, assumed names, or other operating names:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	New Jersey
Primary Address:	939 Elkridge Landing Road, Suite 200, Linthicum, MD 21090
Tel:	800.243.1491 x1026
Fax:	443.625.1596
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	3033 North 44 th Street, Suite 270, Phoenix, AZ 85108
Number of Employees:	140
Number of Years in Business:	25 years
Primary Focus of Business:	Vision benefits manager
Federal Tax ID:	22-2512930
Subcontractor’s Accounting Firm:	Grant Thornton LLP
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	12/5/2011
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Vision benefits management	
Detail the Subcontractor’s qualifications for performing this scope of work	
Superior Vision has been managing vision care programs for more than 20 years, including for Medicaid, CHIP, and Medicare programs. Superior vision has an extensive network of credentialed participating vision care providers across the nation, including in the State of Iowa. Call center representatives, with extended hours, are available to answer member and provider inquiries in multiple languages, with special assistance for the hearing impaired. Superior Vision has experience in providing services in a culturally-competent manner with assistance to members who have special needs.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

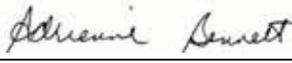
Signature for Subcontractor:	
Printed Name/Title:	Adrienne Bennett / Vice President, Quality and Account Management
Date:	April 29, 2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Cindy Beyer
Address:	10455 Riverside Drive, Palm Beach Gardens FL
Tel:	561.478.8770 x 113
Fax:	561-598-7257
E-mail:	cbeyer@hearusa.com

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	Audiology Distribution LLC
“Doing Business As” names, assumed names, or other operating names:	HearUSA
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Delaware
Primary Address:	10455 Riverside Drive, Palm Beach Gardens FL 33410
Tel:	561.478.8770
Fax:	561-598-7257
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	600
Number of Years in Business:	28
Primary Focus of Business:	Audiology and Hearing Aids
Federal Tax ID:	45-2723671
Subcontractor’s Accounting Firm:	
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Hearing care programs and access to professionals, latest technology	
Detail the Subcontractor’s qualifications for performing this scope of work	
HearUSA is an accredited health network (URAC) and has over 25 years of experience in managed hearing care. HearUSA administers Medicaid programs in 15 states and has over 8 million lives under capitation, including 5 million in managed Medicaid. HearUSA has subject matter expertise, experience in Medicare and Medicaid markets and the internal resources to manage the Medicaid population in Iowa.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

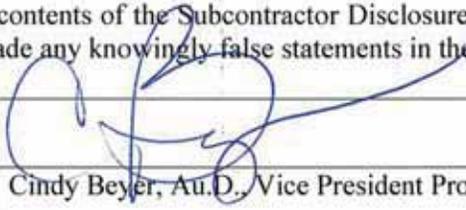
Signature for Subcontractor:	
Printed Name/Title:	Cindy Beyer, Au.D., Vice President Professional Services
Date:	4.28.15

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	McKesson Technologies, Inc. d.b.a. McKesson Care Management
Address:	11000 Westmoor Circle, Suite 125 Westminster, CO 80021
Tel:	617-273-2894
Fax:	303.466.5949
E-mail:	Jude.Okolie@McKesson.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	McKesson Technologies, Inc.
"Doing Business As" names, assumed names, or other operating names:	McKesson Care Management
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	Delaware
Primary Address:	11000 Westmoor Circle Suite 125, Westminster, CO 80021
Tel:	617-273-2894
Fax:	303.466.5949
Local Address (if any):	11000 Westmoor Circle Suite 125, Westminster, CO 80021
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	11000 Westmoor Circle Suite 125, Westminster, CO 80021
Number of Employees:	Approximately 740 employees
Number of Years in Business:	McKesson Corporation has been in continuous operations since 1833 (182 years).
Primary Focus of Business:	McKesson Care Management focuses on care coordination through various products and services.
Federal Tax ID:	58-1651222
Subcontractor's Accounting Firm:	Not applicable
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	Not applicable
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
McKesson Care Management provides VITAL Nurse Advice Line services to over 30 million eligible people fielding nearly 1 million calls each year. The staff, consisting of hundreds of registered nurses backed by physicians, is available to field healthcare-related telephone calls 24 hours a day, seven days a week. McKesson employs a nationwide virtual call center environment with 100 percent of our clinical and non-clinical staff across all product lines working from home. A centralized resourcing process is in place so that all clinical resource procedures, including the handling of a crisis call, are managed the	

same way as a physical call center. In addition, the work at home staff is held accountable to the same performance expectations, quality processes, polices, and training requirements.

Detail the Subcontractor's qualifications for performing this scope of work

McKesson is the most experienced and largest provider of the 24/7 Nurse Advice Line Services in the United States. We service approximately 30 million lives and handle over one million calls each year. We have been providing telephonic Nurse Advice Line services since 1986, beginning with the nationally recognized Ask-Our-Nurse program. Our NCQA-certified and URAC-accredited program is delivered using McKesson's proprietary algorithmic based platform and is supported by two fully redundant technical data centers to ensure 100 percent up time.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

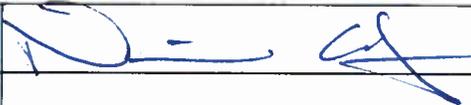
Signature for Subcontractor:	
Printed Name/Title:	Naoise Colgan - VP/General Manager, McKesson Care Management
Date:	4/28/15

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it “not applicable.” If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Breakthrough Behavioral, Inc.
Address:	702 Marshall Street, Suite 340, Redwood City, CA 94063
Tel:	650-461-4116
Fax:	650-257-3454
E-mail:	office@breakthrough.com

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	Breakthrough Behavioral, Inc.
“Doing Business As” names, assumed names, or other operating names:	<i>not applicable</i>
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	C - corp
State of Incorporation/organization:	DE
Primary Address:	702 Marshall Street, Suite 340, Redwood City, CA 94063
Tel:	650-461-4116
Fax:	650-257-3454
Local Address (if any):	<i>not applicable</i>
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	<i>not applicable</i>
Number of Employees:	12
Number of Years in Business:	6
Primary Focus of Business:	Tele mentalhealth via HIPAA compliant video platform
Federal Tax ID:	27-0474230
Subcontractor’s Accounting Firm:	In house
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	In process of securing
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%
General Scope of Work to be performed by this Subcontractor	
Provide a HIPAA compliant video based platform for behavioral health Providers to use to see patients/clients. Provide network development services.	
Detail the Subcontractor’s qualifications for performing this scope of work	
Breakthrough is the leading company in the nation providing these services.	

By signing below, Subcontractor agrees to the following:

- 1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
- 2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
- 3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
- 4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor’s organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Julian L. Cohen
Date:	4/14/2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder ("Primary Bidder"):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Chiara Bell
Address:	1010 Singer Drive, Singer Island, FL 33404
Tel:	1-561-371-5735
Fax:	N/A
E-mail:	cbell@careticker.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Careticker, Inc.
"Doing Business As" names, assumed names, or other operating names:	Careticker
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	Delaware
Primary Address:	1010 Singer Drive, Singer Island, FL 33404
Tel:	1-561-371-5735
Fax:	N/A
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	N/A
Number of Employees:	3 + 5 Board Members/Directors (Contract Staff = 8)
Number of Years in Business:	3
Primary Focus of Business:	Careticker Technology & Incentive Platform
Federal Tax ID:	272434926
Subcontractor's Accounting Firm:	Dorra & Dugan, P.A

If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	less than 1%
General Scope of Work to be performed by this Subcontractor	
Caregiver Engagement and Incentive Platform. Caregiver support & analytics	
Detail the Subcontractor's qualifications for performing this scope of work	
Company is a leader in development of caregiving technology platforms that support Managed Medicaid and Medicare Advantage plans.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

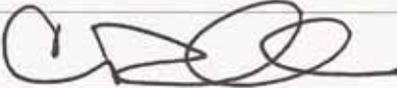
Signature for Subcontractor:	
Printed Name/Title:	CITRA M. BELL
Date:	April 15, 2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it “not applicable.” If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	REMIND TECHNOLOGIES INC.
Address:	17731 Booners Cove Ct, Humble, TX 77346
Tel:	(713) 338 - 9431
Fax:	not applicable
E-mail:	nicole@remind-technologies.com

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	REMIND TECHNOLOGIES INC.
“Doing Business As” names, assumed names, or other operating names:	Remind Tech
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corp
State of Incorporation/organization:	Texas
Primary Address:	17731 Booners Cove Ct, Humble TX 77346
Tel:	(713) 338 - 9431
Fax:	not applicable
Local Address (if any):	not applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	not applicable
Number of Employees:	3
Number of Years in Business:	2
Primary Focus of Business:	Health IT, mhealth, software
Federal Tax ID:	46-3491906
Subcontractor’s Accounting Firm:	Lake Houston CPAs
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	not applicable
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	less than 1%

General Scope of Work to be performed by this Subcontractor

Remind Technologies will be customizing, deploying and implementing for Amerigroup an Integrated Care Management Platform focused on connecting patients and healthcare providers in an ***on demand - real time manner***. The platform will help to track key aspects of care management, medication adherence, initial and follow up clinical screening and assessments, while utilizing data points and interactive tools such as adherence score per medication, side effect reporting, and a provider-patient-caregiver messaging board.

Detail the Subcontractor’s qualifications for performing this scope of work

Remind Technologies Inc. is a Texas based Health Technology Company committed to delivering advanced mobile health-tech solutions to help patients, their caregivers, and medical providers achieve radically improved Medication Adherence and Quality of Care. Our team has over 20 years of collective experience in the Medical Device/Biotech space. Our team includes clinicians and engineers with strong background in management of chronic conditions by using innovative solutions including mobile health technologies.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Nicole Pardo, MD., MBA / Chief Executive Officer
Date:	04/16/2015

Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it “not applicable.” If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Ari Ne’eman
Address:	1401 Blair Mill Rd. #901 Silver Spring, MD 20910
Tel:	(510) 545-6257
Fax:	
E-mail:	<u>ari@mysupport.com</u>

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	MySupport Inc.
“Doing Business As” names, assumed names, or other operating names:	MySupport
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	C Corp
State of Incorporation/organization:	Delaware
Primary Address:	1401 Blair Mill Rd. #901 Silver Spring, MD 20910
Tel:	(510) 545-6257
Fax:	
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	129 N 3rd St. Suite 203 Brooklyn, NY 11249
Number of Employees:	5
Number of Years in Business:	1
Primary Focus of Business:	Information Technology
Federal Tax ID:	46-5746402

Subcontractor's Accounting Firm:	Wilkin & Guttonplan
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	less than 1%
General Scope of Work to be performed by this Subcontractor	
<p>MySupport is an online platform designed to help older adults, people with chronic health conditions and disabilities connect with direct support workers with skills that match their individual needs, preferences and values. Members participating in one of the six HCBS waiver programs who use personal care attendants (PCAs) and other support workers providing individualized in-home and community-based services will have access to the MySupport system. Members looking for support and support job seekers answer questions to identify skills and attributes that support a successful relationship; the platform is able to recommend potential matches based on information provided.</p> <p>In addition, MySupport makes it easy for members and/or their family to coordinate and schedule with their PCAs and file their time sheets through a seamless online process. A text messaging notification feature is also available alerting workers about messages received, upcoming shifts, and reminders to submit their timesheets. Through the MySupport platform, we will also be able to cascade important health and wellness messages to a personal inbox dedicated to the member.</p>	
Detail the Subcontractor's qualifications for performing this scope of work	
<p>MySupport's team has decades of experience in Medicaid-financed home and community based services, with several former state directors of developmental disability services among our board and team. Our development team has significant experience in building HIPAA compliant information technology platforms and our management team has experience in federal disability policy, including the new CMS HCBS Settings rule and the pending FLSA home care changes.</p>	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor’s organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Ari Ne’eman, CEO, MySupport
Date:	4/16/2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Elizabeth Jennings
Address:	1667 K Street NW, Suite 640
Tel:	202-296-2040
Fax:	202-296-2047
E-mail:	ejennings@ndi-inc.org

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	National Disability Institute
“Doing Business As” names, assumed names, or other operating names:	
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	501(c)3
State of Incorporation/organization:	Maryland
Primary Address:	1667 K Street NW, Suite 640, Washington, DC 20006
Tel:	202-296-2040
Fax:	202-296-2047
Local Address (if any):	
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Iowa Office 615 Taylor Street, Waukon, IA 52172
Number of Employees:	27
Number of Years in Business:	10
Primary Focus of Business:	Economic advancement of individuals with disabilities
Federal Tax ID:	20-4205838
Subcontractor’s Accounting Firm:	CohnReznick LLP
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	less than 1%
General Scope of Work to be performed by this Subcontractor	
As a value-added benefit for Medicaid recipients, provide multi-modal training on financial capability strategies to build the capacity of individuals, their families, and both formal and informal supports.	
Detail the Subcontractor’s qualifications for performing this scope of work	
Over the past ten years, NDI has provided national training and technical assistance to Federal agencies (SSA, DOL, HHS, IRS), state offices, local providers and individuals with disabilities and their supports on financial capability, return to work strategies, and SSA Disability benefits and work incentives to improve the employment and economic advancement of individuals across the spectrum of disability.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

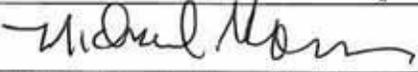
Signature for Subcontractor:	
Printed Name/Title:	Michael Morris, Executive Director
Date:	April 17, 2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 6 of the Bid Proposal. Fully complete a form for each proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)

Primary Bidder (“Primary Bidder”):	Amerigroup Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Peg Mason
Address:	1776 West Lakes Parkway
Tel:	West Des Moines, IA 50266
Fax:	515-223-2932
E-mail:	pmason@telligen.com

Subcontractor Detail	
Subcontractor Legal Name (“Subcontractor”):	Telligen, Inc.
“Doing Business As” names, assumed names, or other operating names:	Telligen
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation/organization:	IA
Primary Address:	1776 West Lakes Parkway, West Des Moines, IA 50266
Tel:	515-223-2900
Fax:	515-223-2932
Local Address (if any):	n/a
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	
Number of Employees:	650
Number of Years in Business:	44
Primary Focus of Business:	Population Health Management
Federal Tax ID:	42-0992483
Subcontractor’s Accounting Firm:	Denman & Company
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	12/13/13
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Less than 1%

General Scope of Work to be performed by this Subcontractor

Specific services to be further defined in discussion over next sixty days. The following is a list of services that are currently in discussions between the parties.

- Minimum Data Set transmission support, onsite MDS validation, automation and education
- Level of care determinations for nursing facility, waiver programs, ICF/IDs and PMICs
- Onsite quality review of ICF/IDs, NFMIs, MHIs and PMICS in compliance with 42 CFR, Part 456

- Private duty nursing and home health aide quality review
- HCBS quality oversight:
 - Review of new provider applications
 - Provider certification, quality reviews and corrective action plans
 - Member surveys – IPES and MFP
- Core standardized assessments – Supports Intensity Scale® and interRAI™ suite of tools

Detail the Subcontractor's qualifications for performing this scope of work

Telligen has performed the above listed services for the Iowa Medicaid program for the past 10 years and some of the services for the past 35 years. Telligen's standards of quality are validated by its URAC certification for utilization management and care management; its designation as a QIO for Iowa, Illinois and Colorado; and its recent selection by CMS to serve as the national Coordinating Center for the QIO-QIN Program. Telligen also has extensive analytic skills providing data analysis, predictive modeling and other analytic support to CMS and state Medicaid programs.

Telligen brings experience and expertise in these key areas that will benefit from continuity. Telligen will assist in facilitating a successful transition to managed care and provide a continuation of quality in these designated services for Iowa Medicaid's members and providers.

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement.
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications.
3. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.
4. Subcontractor does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap;

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and he/she has not participated, and will not participate, in any action contrary to the anti-competitive obligations agreements outlined above.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

Signature for Subcontractor:	
Printed Name/Title:	Jeff Chungath, CEO
Date:	April 20, 2015

Financial Statements (3.2.7.2)

As Attachment 3.2.7.2-1, we are submitting the following financial statements:

- 2012 WellPoint, Inc. 10K
- 2014 WellPoint, Inc. 10K
- 2014 Anthem, Inc. 10K

Amerigroup Iowa (Amerigroup) is a new entrant to the Iowa market and is currently in the process of obtaining an HMO license from the Iowa Insurance Division. Amerigroup submitted our application on April 6, 2015, and fully expects to be licensed as an HMO prior to the Contract effective date.

Amerigroup is a wholly owned subsidiary of Anthem, Inc. (Anthem). Consequently, Amerigroup is submitting audited financial statements of Anthem from independent auditors for the last three years to demonstrate the financial strength of our organization as Attachments 3.2.7.2-1. Please note that Anthem underwent a legal name change on December 3, 2014. As such, attachments for those requested documents may reference the prior legal name of this entity, WellPoint, Inc. (WellPoint).

Capital contributions from Anthem will fund required Amerigroup accounts upon incorporation and licensure. As of December 31, 2014, Anthem held approximately \$2.7 billion in cash and investments.

Our ultimate parent company, Anthem, is ranked 38th on the 2014 Fortune 500 list, and its insurance and HMO subsidiaries are well funded at levels above the minimum threshold of 200 percent of Authorized Control Level Risk-Based Capital (ABL RBC) set by the Code of Federal Regulations. In 2014, Anthem's combined ACL RBC across its insurance and HMO operating subsidiaries was 563 percent, almost three times the federal and State requirements.

We submit our NAIC number in Exhibit B of this RFP.

TUNDE SOTUNDE, M.D., M.B.A.

Amerigroup Iowa - Contract Administrator

As a member of the Transition Team, Dr. Sotunde will serve as Amerigroup Iowa's Contract Administrator

Experience

Anthem, Inc.

President North Region, Medicaid Business Unit

2013 – Present

- Responsible for the business and financial operations of the Medicaid business unit in the North region, comprised of 5 states with a membership of approx. 1.2 million and annual revenues in excess of \$4.5 billion.

Amerigroup Georgia

President

2008 – 2013

- Direct responsibility for the Georgia subsidiary of Amerigroup Corporation, one of the largest public sector focused managed care companies in the United States prior to its acquisition by WellPoint in December of 2012.
- Doubled pre-tax earnings from \$45 million to over \$120 million between 2008 and 2012. Revenue base increased 50% during same period despite a global recessionary economic environment and public sector budget pressures.
- Drove 40% membership growth in a 4 year period to 280,000 by year end 2012.
- Expanded statewide and rolled out a Medicare Advantage and Special Needs plan.
- Realized double digit million dollar medical expense savings year over year, consistently exceeding budgeted goals.
- Mitigated all adverse legislation proposed in 5 consecutive legislative sessions including ancillary carve-outs, premium rate cuts and premium tax levies on Medicaid managed care companies in the State of Georgia.
- Awarded excellent accreditation status by the National Commission for Quality Assurance (NCQA) in 2012. The only Medicaid plan to achieve such recognition.
- Developed a strategic alliance with Kaiser Permanente creating first Pediatric Accountable Care Organization serving the Medicaid population in GA.
- Improved employee satisfaction and achieved single digit voluntary turnover rates three consecutive years in a row.

Solera Capital

Chief Medical Officer of The Little Clinic

2007 - 2008

- Established clinical guidelines and practice parameters for mid-level practitioners.
- Built supervising physician network and developed practice protocols.

- Developed a quality and patient safety program within the clinics eventually resulting in accreditation of the clinics by the Joint Commission in 2009.
- Deployed a fully fledged Practice Management and Electronic Medical Record system interconnecting all clinic sites.
- Instituted a pricing structure that resulted in double digit revenue growth in 1 year
- Diversified the portfolio of clinic services by introducing specialized services Travel Health, aesthetic procedures, health & wellness programs and weight management programs.
- Drove rapid site expansion. Tripled clinic locations in less than a year.
- Successfully planned and executed on the exit strategy for Solera Capital ultimately resulting in the sale of a controlling stake to The Kroger Company in 2008.
- Maintained a part-time Pediatric practice at the Mercy Children's Clinic, Franklin.

UnitedHealthcare***Southeast Regional Vice President and Chief Medical Officer******2001 – 2007***

- Responsible for clinical operations in the Southeast region, comprising Florida, Georgia, Louisiana, Alabama, Mississippi, Tennessee and Arkansas with combined membership of 2.5 million and revenues exceeding \$6 billion in 2006.
- Key member of a management team that has driven sequential double-digit revenue growth over the past five years. Improved employee and customer satisfaction results year over year since 2001.
- Successfully took the health plan through accreditation by the Joint Commission in 2001 and in 2004 the health plan was awarded an excellent accreditation status by the National Committee for Quality Assurance.
- Developed and implemented a medical expense strategy addressing unit cost and utilization generating savings in excess of \$10 million over a 3-year period.
- Co-implemented with Network Management a Hospital, Physician and Ancillary recontracting strategy that beat unit cost targets and improved network stability.
- Led team responsible for measuring physician performance based on quality and efficiency and implementation of a physician designation and P4P program.
- Consolidated care coordination activities to centralized care management centers. This led to improvements in customer service statistics and efficiencies due to streamlined workflows, staffing and processes.
- Led the turnaround of the Provider-Credentialing unit. Reduced turnaround times for physician credentialing from 180 days to less than 90 days within six months.
- Participated in several committees including Executive Oversight, Network Oversight, Quality Improvement and the Physician Advisory Committee.
- Maintained a part-time Pediatric practice at the Mercy Children's Clinic, Franklin.

Education

University of Ibadan, Nigeria
Medical degree

University of Memphis
Master's Degree in Business Administration

JOHN K. CROWLEY

Amerigroup Iowa - Chief Operating Officer

As a member of the Transition Team, Mr. Crowley will serve as Amerigroup Iowa's Chief Operating Officer

Experience

Anthem, Inc.

Staff Vice President, Medicaid Provider Networks

2014—Present

- Responsible for a team of 119 that own the strategy and governance of Medicaid provider networks, national provider/vendor relationships, provider communications, Medicaid/Medicare provider collaboration and risk contracting support, and support new Medicaid network development.

Consumers' Choice Health Plan of South Carolina

Vice President-Strategic Initiatives

2013 – 2104

- Part of the leadership team that formed a new not for profit health plan entering the health insurance market in South Carolina. Consumers' Choice is the only federally certified "CO-OP" (as defined by the ACA) for South Carolina.
- Operating in a matrix leadership role working for the CEO (over two "CO-OP" plans -- Tennessee and South Carolina). Responsible for ensuring cross department communication and strategic leadership in his physical absence (located in Tennessee). Examples of this leadership are: chairing regular leadership meetings, leading development of 2015 product/pricing/network strategy and acting as local leader (not day to day contact) with Department of Health and Human Services and Department of Insurance.
- Led efforts to develop a new provider network in South Carolina. There was only one hospital and less than 100 physician contracts executed in June 2013. Developed strategy and used historic relationships to build a 6000+ physician and 42 hospital statewide provider network (in four months) that meets adequacy standards and beats pricing goals.

Wellcare Health Plans

VP-Corporate Network Management

2010 - 2013

- Responsible for a team of 52 that owned the governance of provider contracting, all national contract relationships, integrity / compliance of all provider networks and supported new Greenfield network development.
- Inherited national contracting unit that managed 28 contracts and transformed it into a unit that managed in excess 70 contracts. Projected savings driven to enterprise is in excess of \$60 million since 2010.
- Enterprise had over 800 different provider templates in use in February 2010. Created and filed one (except for state required differences) new modular contract template in all markets. Selected and implemented a contract management system in all markets in less than one year.

- Supported network development for Medicare Advantage, Integrated Dual Eligible, Managed Long Term Care, and traditional Medicaid Programs. Team assisted development in Arizona, Texas, Indiana, South Carolina, Texas, Tennessee, Ohio, Missouri, Hawaii, Kentucky, New York, New Jersey, and Florida.

CIGNA Healthcare***VP—Medical Cost Lead—Carolinas Region******2007 – 2010***

- Responsible for a team of 24 that owns our overall unit cost trend, access growth and provider satisfaction results in SC and NC.
- Each year achieved the budgeted pricing unit cost results, met all targets for access growth and provider satisfaction.
- Focused on a 3-year unit cost competitiveness turnaround plan in the Carolinas markets. Identified 41 agreements throughout the Carolinas where CIGNA was disadvantaged to the best in class unit cost competitor by more than 5%. Outcome was that CIGNA Carolinas was within 5% of the best in class unit cost competitor in 7 out of its 10 primary rating areas and within 3% in 4 of these rating areas.

CIGNA Healthcare***VP—Contracting and Provider Services—Mid-Atlantic and Carolinas Region******2005 – 2007***

- Responsible for a team of 35 that owns our overall unit cost trend, access growth and provider satisfaction results in the District of Columbia, Maryland, Virginia, South Carolina, and North Carolina.
- Achieved the budgeted unit cost results, met all targets for access and provider satisfaction.
- Part of the leadership team in Mid-Atlantic that led a turnaround and produced over 95,000 new members in sales results in 2005 and 2006 (while meeting aggressive persistency goals). This result represents the top sales result for CIGNA in the entire country during 2005 and in the top three in 2006.

Education***University of South Carolina 1993******MA Economics******Clemson University 1992******BA Financial Management***

JOHN CHANG, MD

Amerigroup Iowa - Medical Director

As a member of the Transition Team, Dr. Chang will serve as Amerigroup Iowa's Medical Director

Experience

Anthem, Inc.

Staff Vice President/Chief Medical Officer, Medicaid Business Unit

2014 - Present

- Lead strategic planning and execution of Medical Cost Management for integrated Medicaid Business across 19 states for \$4.5M members
- Lead medical management strategy for \$3B Medicaid business
- Manage team of National Medical Directors to support Medical Operations, Cost of Care, Medical Policy, Quality Management, and local health plan operations

WellPoint, Inc.

National Medical Director—Government Business Division

2011 – 2014

- Expanded responsibility to lead strategy development and execution of Medical Cost Management for combined Medicaid and Medicare Advantage Businesses.
- Lead strategy development and execution for Medical Cost Management strategies for combine Medicaid organization.
- Lead oversight of investment portfolio to ensure execution of over 40 medical cost management initiatives with annualized savings in 2013 of \$55M. Led collaboration in combined executive team to administer \$23M SG&A investment portfolio to enhance cost of care initiatives across L-WLP business.
- Led strategy and execution of care management programs for 163K High Risk, and Aged, Blind, and Disabled Medicaid members across all WellPoint membership of 1.9M.
- Executed local plan initiatives to optimize field-based case management outreach models for high-risk membership.
- Executed and managed cost of care initiatives and key vendored relationships involving pharmacy and medical management totaling over \$31M, and \$3.2M in admin savings
- Recognized as one of 28 company-wide leaders as “high potential” by senior leadership and enrolled in 15-month “Executive Preparation” leadership curriculum for senior leadership training.

SUMMIT PHYSICIAN SERVICES (SPS)

Lead Surgeon (Divisional Head)

2005 - 2010

- Managed clinical and non-clinical staff of surgical division (15 FTEs) in Otolaryngology in Hospital staff model.
- Served senior leadership roles to facilitate physician alignment within Hospital multidisciplinary staff model:
 - Utilization Management Committee
 - Physician Performance Improvement Committee
 - Executive Physician Advisory Council for SPS

Education

University of Michigan

Master's in Business Administration

Hahnemann University

Doctorate in Medicine

AIMEE K. DAILEY, CPA

Amerigroup Iowa - Chief Financial Officer

As a member of the Transition Team, Ms. Dailey will serve as Amerigroup Iowa's Chief Financial Officer

Experience

Amerigroup Corporation

Vice President Finance, Medicaid Business Unit

2013 - Present

- Responsible for providing financial leadership, decision support and strategic consultation to senior management within the GBD and their leadership teams.
- Lead major financial functions for the Medicaid Programs Business Unit including financial analysis, financial reporting, cost allocation analysis, forecasting, planning and budgeting - includes management reporting, analysis, planning and forecasting.

Amerigroup Corporation

VP-Financial Reporting (2008 – 2013), Associate VP Financial Reporting (2005 – 2008)

- Established policies, procedures and framework for monthly, quarterly and annually financial reporting to internal and external users for a multiple entity organization with greater than \$8B in annualized revenue.
- Responsible for the supervision of the corporate accounting function including oversight of complex accounting analyses. Oversight of consolidation and financial reporting of 15+ legal entities.
- Oversight of accounting functions for cash and investments, fixed assets, stock compensation, payroll accounting, debt, leases and routine administrative expense accounting.
- Lead analysis and application of accounting treatment for the entire finance department including analysis for revenue recognition, contingency recognition, complex convertible debt instrument and related hedge and warrant transactions.
- Lead preparation and submission of prospectus supplement for initial and follow-on debt offering totaling \$475M including leading the interface with external legal and accounting professionals, lead contributor in analysis and evaluation of most desirable covenants and derivative instrument design resulting in recommendations to senior management.
- Oversight of acquisition and disposal accounting and goodwill impairment analyses for \$100M+ assets.
- Liaison to investor relations for preparation and oversight of financial analysis of quarterly and annual operating results.
- Key contributor to preparation of financial information and analysis included in press releases and investor presentations on a quarterly and ad hoc basis.
- Lead contact with senior management and audit committee regarding SEC reports, SEC comment letters and reviews and quarterly presentation of financial results and required disclosure in public filings.
- Oversight of implementation of XBRL reporting with the SEC and in-sourcing of public filings through web-based service provider, WebFilings.

- Financial partner with legal department in the oversight and preparation of non-financial filings with the SEC.
- Oversight of monitoring and compliance with internal controls in accordance with the Sarbanes-Oxley Act for the finance function.
- Responsible for oversight of external audit through direct interface and coordination of quarterly and annual reviews with external auditors including presentation of complex accounting issues and discussion and resolution of audit findings.
- Lead cross-functional teams for integration of new business in the finance department including most recent integration into WellPoint.

Education

University of Virginia 1994

BS Commerce

Professional Associations, Licenses and Awards

- Certified Public Accountant, Virginia Licensee #19825 Issued May 1995
- Virginia Society of Certified Public Accountants Member
- Nominated and accepted into and successfully completed Amerigroup Senior Level Leadership Program 2011
- Hampton Roads Top 40 Under 40 Honoree 2011

GEORGIA DODDS FOLEY

Amerigroup Iowa - Compliance Officer

As a member of the Transition Team, Ms. Dodds Foley will serve as Amerigroup Iowa's Compliance Officer

Experience

Anthem, Inc.

Vice President and Medicaid Compliance Officer, Medicaid Business Unit

2011 – Present

- Chief Compliance Officer for national Medicaid managed care organization responsible for administration of health care benefits and related services on behalf of approximately 5 million beneficiaries under state-sponsored programs across 19 states.
- Leads, directs, and oversees all material aspects of the company's Medicaid Business Unit compliance and ethics program, including identifying critical issues and risks, defining gaps in compliance, implementing remediation measures, formulating appropriate policies and procedures, and promoting a culture of integrity and compliance.
- Administers a strategic and consistent model for legal and regulatory compliance risk assessment, remediation, and reporting.
- Provides regular consultation and interpretation advice to senior management team on regulatory oversight requirements within multi-state operations,
- Maintains relevant compliance benchmarks for the company, addressing issues such as training completion, Ethics Helpline inquiries and reports, and regulatory examination/audit activity.
- Administers program integrity/special investigations function designed to detect fraud, abuse, and other unlawful/inappropriate practices.
- Operates business unit privacy officer to ensure adherence to federal and state privacy/confidentiality regulations and other government mandates related to information protection.
- Communicates compliance program initiatives at all levels across the company, from staff-level employees to executive leadership teams and the Audit Committee of the Anthem Board of Directors.

Cigna Corporation

Deputy Chief Compliance and Ethics Officer, Strategy and Domestic Compliance

2008 – 2011

- Responsible for strategic direction, focus and implementation of the enterprise-wide corporate compliance program.

MMM Healthcare/Preferred Medicare Choice

Vice-President, Chief Compliance Officer and Corporate Counsel

2006 - 2008

- Oversaw compliance activities for the largest Medicare organization in the Commonwealth of Puerto Rico.

Education

University of Pittsburgh School of Law
Juris Doctor

Pennsylvania State University
BA Pre-Law

PAMELA M. PERRY

Amerigroup Iowa - Government Relations Officer

As a member of the Transition Team, Ms. Perry will serve as Amerigroup Iowa's Government Relations Officer

Experience

Anthem, Inc.

Regional Vice President, Government Affairs

2003 - 2015

- Develop, lead, and execute government relations market entry strategy for states where AMERIGROUP does not currently operate.
- Provide interim government relations support for newly established markets.

Health Resources and Services Administration

Deputy Director of Policy

1998 – 2003

- Manage policy related to Federally-qualified health centers.
- Track and report on developments related to health center reimbursement from Medicaid, Medicare, and other payors.
- Establish and maintain liaison with other Federal and non-Federal organizations.

Substance Abuse and Mental Health Services Administration

Program Analyst

1995 – 1998

- Develop policy initiatives and respond to legislative inquiries and directives for Federal substance abuse and mental health programs.
- Manage Advisory Committee for Women's Services.

Education

University of Georgia

Master of Public Administration, Public Finance, University of Georgia

University of Chapel Hill

Bachelor of Arts, Public Policy Analysis and Sociology, University of Chapel Hill

PATRICK CONVEY, PHARM. D.

Amerigroup Iowa - Pharmacy Director

As a member of the Transition Team, Mr. Convey will serve as Amerigroup Iowa's Pharmacy Director

Experience

Anthem, Inc.

Staff Vice President, Pharmacy Sales and Account Management - Medicaid

2013 – Present

- Lead a team of regional account directors and pharmacist program managers in seventeen (17) states representing approximately 4.5 million full risk pharmacy lives.
- Act as the primary pharmacy interface with Medicaid business owners, PBM's, and state regulators.
- Manage and deliver pharmacy information, cost/trend detail to help business owners make informed decisions impacting pharmacy operations and cost of care management.
- Collaborate with the pharmacy analytics team to better understand drivers of trend; analyze data and identify opportunities to improve operational efficiencies and to drive cost of care savings strategies to meet pharmacy and company goals.
- Provide pharmacy expertise and leadership for new business launches, ACA expansions, and RFP detail for new and existing business opportunities that drive profitable Anthem Medicaid growth.
- Implement quality initiatives that focus on maximizing quality based revenues from state governments.
- Lead the development of innovative, cost effective pharmacy networks for Medicaid (narrow, specialty, mail); formulary enhancements; carve-in strategies, and other strategic initiatives that differentiate Anthem.
- Partner in the development of provider collaboration initiatives focused on improving pharmacy metrics.
- Lead PBM migration of nearly 3 million Medicaid members between June 2014 and June 2015.
- Represent Anthem Medicaid pharmacy in inter-department, health plan and state pharmacy interactions.
- With regulatory and compliance teams, ensure pharmacy programs meet contractual compliance, regulatory and clinical expectations, and are operating according to state and CMS requirements.
- Support and lead end-to-end Medicaid specific PBM issue resolution (reliability).

WellPoint

Staff Vice President Business Planning and Strategic Initiatives

2011 – 2013

- Supported both Commercial and Government Business EVP's on all aspects of business operation activities targeted to meet goals and drive results, including:
 - Manage and effectively communicate weekly, monthly and quarterly updates on key strategic activities, successes, performance metrics, and progress toward goals.
 - Effectively collect, synthesize, and present information to ensure that decisions are made, documented, and communicated.
 - Facilitate the flow of people and information to the executive leaders to focus attention at the right time and place.

- Develop presentations, talking points, briefings for the EVP's around key strategies and innovation.
- Identify opportunities to continuously improve the day-to-day mechanics of the organization.
- Support the multi-year and annual strategic planning process.
- Facilitate annual goal and performance planning.
- Act as advisor and key point of contact.
- In partnership with corporate communications, develop an annual communication plan that accesses both internal and external communication channels to share Consumer successes, progress toward goals, priority initiatives.
- Facilitate and promote processes that strengthen business partnerships and clarity around expectations.
- Ensure that cross-business collaborative goals and initiatives are aligned and appropriately prioritized.
- Oversee management of the Plan of Record project funding.
- Actively participate in the development and execution of key business initiatives that drive membership growth, operating gain, and administrative efficiencies.
- Lead and manage special projects as they arise; supervise cross-organizational teams and resources; keep the team on task; negotiate with senior level management to build consensus; consistently execute on time.

WellPoint

Regional Vice President, Commercial Cost of Care (West Region)

2008 - 2011

- In partnership with PE&C analytics group and the cost of care (COC) actuarial team, coordinate data mining efforts that evaluate and assess cost trend changes/increases including unit cost, utilization, product mix, shifts in population dynamics, and other contributing factors.
- Analyze medical cost trend data and identify potential COC savings opportunities.
- Develop trend optimization strategies and industry best practices for physician, hospital, and ancillary network and product development, utilization management, and contract negotiation strategies.
- Define and scope the strategic initiatives that best mitigate rising cost trends, drive operating gain, and employ best practices focused on delivering safer and more affordable health care.
- Lead cross-organizational teams to implement the initiatives to deliver predictable, competitive COC trends
- Monitor progress of ongoing COC initiatives/trends versus budgeted forecast levels.
- Provide deep dive COC findings, trend optimization strategies and successes to our business partners.
- Coordinate all COC meetings, annual planning sessions, tracking and reporting of all COC projects.
- Serve on, and lead, enterprise and regional COC committees.
- Identify successful and scalable COC strategies employed in specific markets/regions and roll out to multiple markets and business segments to maximize COC trend mitigation activity.

Education

University of Southern California 1994
Doctor of Pharmacy

University of California at Davis 1990
BS Biological Sciences

BRADLEY D. SOTO

Amerigroup Iowa - Human Resources Manager

As a member of the Transition Team, Mr. Soto will serve as Amerigroup Iowa's Human Resources Manager

Experience

Anthem, Inc.

Director, Human Resources – North Region & Strategic Business Functions

2014 – Present

- Lead Human Resources strategy and execution for Anthem's Medicaid business across the North Region (New York New Jersey, Maryland, Indiana, and Wisconsin markets), as well as for executive business leaders with the New Business Development, Product Development, Provider Networks, Medicaid Blue Alliance, and Strategic Partnerships organizations within the Government Business Division.
- Lead a seasoned HR Business Partner team of seven direct reports to align HR strategy with business goals to effectively drive strategic human capital initiatives in diversity and leadership development, talent acquisition, performance management, organizational development, employee relations, and succession planning.

Amerigroup

Director, Human Resources

2011 – 2014

- Strategic business partner to the New York Medicaid market's leadership in defining and aligning HR strategy with market goals – including acquisition integrations – and effectively supported, proposed and drove strategic initiatives in achieving \$1.35B in revenue in 2012 with overall responsibility for a \$64.4M SG&A personnel budget.

1199SEIU Funds

Manager, Human Resources Employee and Labor Relations

2008 - 2011

- Led a cross-functional team in all aspects of day-to-day employee and labor relations activities for a workforce of 1,800 employees throughout the New York tri-state area.
- Created and integrated innovative and cost-effective human capital management strategies and policies that maximized operational flexibility, increased employee engagement and productivity, provided for employee and leadership development, minimized associated costs and mitigated legal risk.
- Provided management with reports measuring employee engagement and defining short-term and long-range business plans.

Coca-Cola Refreshments USA

Labor Relations Representative

2005 – 2007

- Actively liaised between a broad range of HR departments, outside agencies, union representatives and operations teams to enhance labor relations processes for the company's northeast business (13 states; 10,000+ employees represented by 13 Teamster Unions).

American Arbitration Association***International Case Manager*****2003 - 2005**

- Teamed with attorneys and arbitrators from boutique and large global firms.
- Managed complex commercial arbitration disputes totaling more than \$3 billion.

Education***New York University 2002******MA University Personnel Management******New York University 2000******BA Sociology***

TAMARA C. LATHAN

Amerigroup Iowa - Grievance & Appeals Manager

As a member of the Transition Team, Ms. Lathan will serve as Amerigroup Iowa's Grievance & Appeals Manager

Experience

Anthem, Inc.

Director, Grievances and Appeals

2012 – Present

- Leading contributor for transformation of the Medicaid appeals management system; conducted market research to streamline and ensure enterprise compliance; collaborated with business users across several functions in the Medicaid business and IT departments on the successful implementation of NextGEN Appeals (Pega), a single platform for appeals management. The NextGEN Appeals application earned the Health Care Business Transformation Award from Pegasystems, a prestigious industry award.
- Business Owner responsible for development and implementation of Grievance and Appeal activity for new and migrated markets; directly responsible for creation of member and provider grievance and appeal collaterals for compliance with State contract requirements and NCQA standards; provide requirements for IT Enterprise report development; develop plan processes for compliance with State and NCQA guidelines; train staff on grievance and appeal processes and applications.
- Direct activities and set priorities for NextGen Appeals application development and enhancements; develop application business process engine rules; approve design of user interfaces.
- Report project status and progress to senior management; ensure accuracy and timeliness of output and deliverables for assigned functional areas; implements and ensures compliance with corporate management policies, practices, and procedures through bi-annual Health Plan audits of member appeals.
- Deliver analyses and project updates to business areas for management reporting, analysis and executive decision-making.
- Direct forecasting activities focusing on setting and achieving short and long-term strategic goals.
- Research and compare market contracts for strategic alignment of market and enterprise business needs.
- Direct team of Business Analysts responsible for requirements gathering, development of NextGEN Appeal enhancements, application testing, and application troubleshooting.
- Direct Corporate Complaint team responsible for tracking and acknowledgment of member complaints.

Carolinas Medical Center

Performance Improvement Analyst

2008 - 2012

- Recipient of the Key Employee Incentive Award for demonstrated excellence in the implementation and execution of The Joint Commission survey readiness program, which

successfully prepared 27 physician practice offices for the Joint Commission accreditation survey; and for successful execution of additional functions within the business unit which contributed to a successful survey.

- Responsible for identifying, implementing, and monitoring The Joint Commission survey readiness program requirements and plans to ensure program goals, methodologies and processes are realized; coordinate, integrate, and participate in project activities; identify and resolve issues related to implementation and sustain project goals.
- Lead physician office teams in the implementation of the CMC Health Literacy initiative and Patient Centered Medical Home projects to enhance patient safety, quality, and improve practice performance.
- Direct and assist health care professionals in the development and administration of specific policies and procedures to ensure accreditation standards compliance; monitor and report the status of CMC physician offices' operational adherence to regulatory compliance and accreditation standards.
- Facilitate performance improvement teams; apply analytical and evaluative techniques to assist office teams in the creation of modified or corrective work methods and approaches, identify best practice process/models and provide appropriate training for and replication of those models/processes.
- Monitor and provide interpretation of accreditation standards, Centers for Medicare and Medicaid Services regulation, corporate policy, and department directives.
- Advise senior management of departmental performance and improvements through collection, analysis, and preparation of summary reports; present findings at CMC Performance Improvement Committee meetings.
- Responsible for data warehouse reporting; liaison with Information Services to enhance database report elements and functionality.
- Assist practice management in alignment of strategies to meet CHS quality metrics and goals.
- Facilitate development of corrective action plans and provide oversight of completion.
- Perform physician office tours to conduct patient medical record audits, administer employee competency interviews, and perform environment of care tours to ensure all areas of the office meet regulatory compliance with CMS regulations and the Joint Commission accreditation standards.

UnitedHealthcare

Manager of Operations

2001 - 2006

- Monitored and managed operations and activities for triage, review, and completion of the company's administrative complaints, appeals, and grievances from health plan members and providers with regulatory and contractual obligations in multiple state regulatory affiliations.
- Served as department preceptor of Maryland Insurance Administration, Office of Personnel Management, and UHC grievances, complaint, and appeal regulations and processes.
- Represented company as Subject Matter Expert in administrative provider disputes at the Maryland Insurance Administration through sworn, in-person testimony at dispute hearings.
- Improved complaint and appeal response timeliness through creation, development, and implementation of an electronic system which improved customer response time by four business days.

- Developed risk mitigation tools and processes which successfully decreased denial and multi-level appeal overturn rate by 35%.
- Primary manager responsible for process, coordination, and resolution of company-wide expedited appeals.
- Supported the ongoing re-credentialing of existing provider agreements.
- Created written resource guidelines, standard operating procedures as well as developed and implemented department policies that improved complaint and appeal investigation processes.
- Developed risk assessments to identify required audit areas and audit frequency
- Identified, evaluated and recommended appropriate interventions to resolve complex, interrelated problems, issues and disputes.
- Facilitated development of corrective action plans and monitored implementation.
- Conducted internal complaint and appeal chart audits to ensure regulatory compliance with federal and state regulations.
- Facilitated project teams for analysis of document flow throughout the company and recommended changes.
- Developed audit reports to identify areas of noncompliance, proposed and implemented recommendations for improvement.
- Managed and conducted semi-annual audits related to file storage ensuring HIPAA and company compliance.
- Managed eight individuals, responsible for screening, interviewing and hiring candidates; writing employee performance appraisals as well as employee coaching and counseling; and training.

Education

University of Phoenix 2008

Master of Business Administration

James Madison University 1997

BS Communication Sciences and Disorders

BARBARA KUPFERMAN, RN

Amerigroup Iowa - Quality Management Manager

As a member of the Transition Team, Ms. Kupferman will serve as Amerigroup Iowa's Quality Management Manager

Experience

Anthem, Inc.

Vice President, Quality Management - Medicaid

2015 – Present

- Responsible for providing leadership, administrative and management support, strategic planning and overall direction of the Anthem Medicaid Quality Improvement Program for all Anthem Medicaid plans.
- Responsible for the overall regional success and in meeting and exceeding all QI program goals and metrics including HEDIS, CAHPS, accreditation EQRO audits and PIPs.
- Responsible for the development of a collaborative relationship with local health plans to develop strategic initiatives for ongoing improvement.
- Responsible for the development of a collaborative relationship with local health plans to develop strategic initiatives for ongoing improvement.

New York Plan

Vice President, Quality Management

2013 – 2015

- Responsible for providing leadership and guidance for the Quality Management Department, including HEDIS/QARR program, Health Promotion and Grievance and Appeals.
- Responsible for the overall success and in meeting and exceeding all QI program goals and metrics including HEDIS/QARR, NCQA accreditation.
- Responsible for working with local departments in identifying process issues and creating workflows and/or process changes for improved collaborative practices.
- Responsible for assisting various departments with challenging projects, creating solutions in order to bring the project to conclusion.
- Enhanced the process of medical record collection for the multiple audits including HEDIS. Significant improvement in HEDIS medical record collection for HEDIS and CRG programs.

United Healthcare Community Plan

Northeast Regional Quality Director

2008 - 2013

- Responsible for providing leadership, administrative and management support, strategic planning and overall direction of the regional Quality Improvement Program to the Quality Management Departments of the Northeast.
- Responsible for the overall regional success and in meeting and exceeding all QI program goals and metrics including HEDIS, CAHPS, accreditation EQRO audits and PIPs.
- Brought the United Healthcare Community Plans in the Northeast to be an example of best practices in member incentive programs and HEDIS project management.
- Responsible for management of 10M budget.

- Responsible for the development of a collaborative relationship with local health plans to develop strategic initiatives for ongoing improvement.
- Responsible for working with local and National departments in identifying process issues and creating workflows and/or process changes for an improved practice.

Education

St. Joseph's College of Maine
Master's of Health Care Administration

State University of New York/Empire College
BS Health Care Administration

LISA F. MCCORMICK, RN

Amerigroup Iowa-Utilization Management Manager

As a member of the Transition Team, Ms. McCormick will serve as Amerigroup Iowa's Utilization Management Manager

Experience

Anthem, Inc.

Director of Health Care Programs, Clinical Operations

2013 – Current

- Leadership and direction for Health Care Management UM activities related to new market development/implementations.
- Responsible for the leadership, goal definition and budget for the Clinical Operations Department.
- Business owner for medical management UM infrastructure and governance – including policies and procedures, workflows, training content, systems content, UM delegation oversight, UM governance committee structure, precert rule management and governance.
- Oversight and direction for the annual Utilization Management Program description.
- Oversight and direction for ensuring compliance to NCQA Utilization Management standards.

Anthem, Inc.

Associate Vice President Development, Managed Care Services

2004 - 2013

- Lead the Managed Care Services area in the implementation, ensuring execution of the implementation project plan.
- Strategic thinking and business planning from a medical management perspective.
- Due diligence related to new markets, new products, mergers, and acquisitions.
- Provide leadership in the development of business model design.

ValueOptions

Vice President Corporate Clinical Services

1993 - 2003

- Lead the Managed Care Services area in the implementation, ensuring execution of the implementation project plan.
- Strategic thinking and business planning from a medical management perspective.
- Due diligence related to new markets, new products, mergers, and acquisitions.
- Provide leadership in the development of business model design.

Education

Thomas Nelson Community College

AASN

CHARLES B. GROSS

Amerigroup Iowa -Behavioral Health Manager

As a member of the Transition Team, Mr. Gross will serve as Amerigroup Iowa's Behavioral Health Manager

Experience

Anthem, Inc.

Vice President, Behavioral Health

2014 – Present

- Key member of Anthem Government Business Division Medicaid/Medicare Behavioral Health C-Suite.
- Responsible for behavioral health clinical and operational functions for North Region.
- Provides Behavioral Health expertise to integrated health initiatives throughout organization.
- Support/liaison to Government Relations, Sales and Account Management throughout enterprise.
- Lead Investigator- Corporate Pilot “Patient Health Activation Level & the Triple Aim for Behavioral Health Patients”.

WellPoint

Director II

2014

- Clinical program development, implementation, P & L for medically complex, co-morbid patients.
- Health homes- patients with medical and behavioral disorders.
- Advanced Practice Nurse home visit care coordination outreach program.
- “Concierge” medical practice for difficult to engage Medicaid members- contracting, operations, and P & L responsibility.
- John Hopkins Hospital post discharge provider follow-up program.
- Visiting home physician program.

Amerigroup

Vice President, Clinical Programs Behavioral Health

2013

- Opiate Lock-in program- initiation, implementation, and operation of provider and pharmacy lock-in with 27% improvement in quality metrics and annualized \$2 million cost of care reduction.
- Vendor initiatives for HEDIS Asthma and Hypertension interventions.
- P & L responsibility-Mid-Atlantic Clinical Programs health operations.

Amerigroup

Vice President, Healthcare Management Services

2007 - 2012

- P & L responsibility-Mid-Atlantic Medicaid and Medicare behavioral health operations.
- Initiated Behavioral Health Medical Home exploration and presented initial findings at enterprise level 2011.

- Identified and initiated patient assessment/ intervention tool “Patient Activation Measure” pilot 2012.
- Demonstrated significant utilization and service level mix impact for “Patient Activation Measure” for medically complex patients.
- Behavioral Health subject matter expert on corporate Inpatient Utilization Management Group (Maryland, Virginia, Florida, Ohio, New York, Tennessee, Nevada).

United Behavioral Health***Vice President******2005 – 2007***

- Clinical identification, evaluation and development of new product initiatives; E-Therapy Condition product suite for depression, stress, anxiety, and problem drinking using online consumer self assessment to steer type and intensity of intervention.
- Manage installation of new products into Service Center operations including 3rd party vendor interfaces.

Education***Yeshiva University 1984******PhD Clinical Psychology******Yeshiva University 1983******MA Psychology******University of Michigan 1977******BA Psychology***

FRED NELSON

Amerigroup Iowa - Membership Services Manager

As a member of the Transition Team, Mr. Nelson will serve as Amerigroup Iowa's Membership Services Manager

Experience

Anthem, Inc.

Director II, National Customer Care

2011 – Present

- Currently lead nine Anthem Government Business Division call center sites serving eighteen markets.
- Lead over 1100 employees at these nine sites, performing both inbound and outbound call center functions.
- Responsible for timely delivery of quality service to Medicaid members and providers.
- Responsible for meeting multiple contractual and non-contractual servicing requirements across multiple markets (states).
- Have lead responsibility for operations team for current internal quality program, behavioral coaching model and member survey process.
- Served on multiple task forces and work teams created to identify efficiency and quality opportunities in the call center.
- Selected for prestigious internal leadership program “Winning Leaders”.

HSBC

Director of Quality Measurement and Analysis

1977 - 2009

- Responsible for ensuring appropriate relationships were built with customers to enhance the customer experience through direct call monitoring, training and customer feedback.
- Oversaw more than 200 audit processes for multiple credit card functions to ensure compliance to Federal and State regulations as well as to internal business requirements.
- Prepared professional presentations for senior management team to outline current results and identified areas of improvement.
- Designed and delivered a leading edge quality program to over 2000 employees that drove significantly improved customer satisfaction.
- Conducted on-going full-scale reviews of internal polices to create consistency.
- Aggressively implemented key system controls that ultimately drove increased accuracy.
- Substantially expanded scope of responsibility to include employees in the U.S., Canada, India and the Philippines.

Education

Suffolk County Community College

Associates Degree in Business

JULIE SKAGGS

Amerigroup Iowa - Provider Services Manager

As a member of the Transition Team, Ms. Skaggs will serve as Amerigroup Iowa's Provider Services Manager

Experience

Anthem, Inc.

Director, Health Plan Support/National Provider Relations, Medicaid Business Unit

2002 - Current

- 12 years in key roles within Provider Relations, most recently as the Vice President of Provider Relations in Nevada and currently with National Provider Relations supporting several markets.
- Extensive contract negotiation experience for all provider types and products. Experience includes risk, shared savings, pay for performance and capitation. I have overseen, led or participated in many complex negotiations while maintaining an aggressive medical loss ratio.
- Consistently earned some of the highest provider satisfaction results (compared to other markets); achieved through JOC meetings, timely resolution of operational issues and a strategic team of associates dedicated to educating providers.
- Instrumental in the development of the Nevada market for Amerigroup. I joined the Nevada team just prior to go-live and over the course of 4 years built a successful team and network while establishing AGP as the preferred MCO.
- Responsibility for medical savings opportunities (CoC) for the state of Nevada.
- Developed and implemented key initiatives resulting in millions of dollars in savings in Nevada and Texas over the course of many years.
- Developed and administered network strategies based on historical utilization, membership growth, and market conditions that support corporate goals and client expectations.
- Rolled out a Patient Centered Medical Home model in Las Vegas, which covered over 25k lives. First of its kind in Managed Medicaid in the state.
- Created the company's first OB Pay for Performance program as a pilot in Nevada, with plans to implement in Texas.

Aetna Health Plans

Network Manager

1997 - 2001

- Led the Provider Relations staff responsible for the HMO filing, expansion and development of 13 new counties in Texas, meeting an aggressive 6-month deadline.
- Negotiated and managed IPA risk relationships involving 100+ physicians and 50,000 risk members, as well as large multi-hospital systems in Dallas/Ft. Worth.
- Extensive provider contract negotiation, especially with hospitals and key physician groups. Success in completing complex provider agreements filling key network gaps.
- Recruited and trained key staff responsible for servicing of physicians, hospitals and ancillary providers in North Texas.
- Acted as key liaison with Medical Management and Operations staff to identify cost saving opportunities.

Education

University of Texas 1990

ROBIN FAVRET

Amerigroup Iowa – Information Systems Manager

As a member of the Transition Team, Ms. Favret will serve as Amerigroup Iowa's Information System's Manager

Experience

Anthem, Inc.

Director, Business Relationship Management

2012 – Present

- Provides a dedicated focus to understand the unique operational needs related to process and system optimization; provides short-term and long-term business technology planning.
- Serves as the lead technical contact for the State and associated State partners, participating in technical and operational meetings, audits, and readiness reviews; leverages industry, national, and health plan knowledge to partner with the State in developing solutions to operational or system issues.
- Collaborates with ITS development areas to offer technology solutions by leveraging existing capabilities whenever possible.
- Supports the development of new business requirements and technical solutions in collaboration with the business and ITS development areas.

Amerigroup Corporation

Associate Vice President, Customer Service Account Management

2011 - 2012

- Lead technical contact with the State and associated State partners, participating in technical and operational meetings, audits, readiness reviews, and implementations; leveraged industry, national and health plan knowledge to partner with the State in developing solutions to operational or system issues.
- Collaborated with senior management team to make sure that goals/plans align with broader strategic plans and objectives throughout the organization and Regional Health Plan and Service Center initiatives.
- Made sure that key service and performance measures were communicated to the health plans and customers in a timely, well-executed manner.
- Facilitated multi-functional review sessions with mid- and senior-level staff as appropriate when at-risk issues developed pertaining to State contract compliance; organized communication between the Health Plan and the Customer Service departments when there were escalated issues and was accountable for resolution and execution of plans.

Amerigroup Corporation

Director, Service Operations/Account Management

2009 - 2011

- Functioned as primary contact for State technical business partners and coordinated multi-functional participation in requirement changes and issue resolution for assigned markets.

- Responsible for compliance with all State-requested system changes, ad hoc ITS requests, and ITS contractual deliverables; provided feedback and alternate solutions on State-proposed changes; served as ITS Lead for State audits and assessments, and coordinated on-site reviews.
- Responsible for understanding the requirements of the State programs in terms of business rules, nuances between programs, system requirements, and interdependencies.
- Worked with Customer Service Organization departments, the Health Plan, and Regulatory to resolve operational/ITS issues and business/technical requirement changes, including enrollment, benefit configuration, call metrics, authorizations, pended claims, Provider data, appeals, encounters, Provider contracting, customer service, regulatory reporting, technical interfaces, vendors, and Facets-related issues.
- Coordinated and facilitated multi-functional issue resolution work sessions, emphasizing issue identification, assignment, global correction, and root-cause eradication to facilitate compliance with State contract.

Amerigroup Corporation

Business Analyst Principal II

2000 - 2009

- Responsible for understanding the functional areas of the organization, including claims processing, enrollment and capitation, Provider data management, and encounters reporting, and how these areas interrelate.
- Responsible for gathering requirements; performing analysis; supporting the development testing processes; and understanding the applications, data, and associated technologies for the organization.
- Served as Lead Analyst on new business, new product assessments, and implementations for assigned health plans.
- Served as technical liaison with multiple state agencies and state trading partners, with responsibility for all systems requirements, changes, and ITS compliance per State contracts.
- Responsible for assessing all contracts and regulatory changes for ITS impact
- Served as ITS Lead and managed project deliverables to make sure that all required changes were completed within contractual timeframes.
- Responsible for State ITS audits, assessments, and corrective action remediation activities; provided responses to all ITS questions; coordinated on-site reviews.
- Provided analytical and technical expertise to health plans to support internal initiatives, day-to-day operations, and strategic goals.

Education

Old Dominion University

BS Business Administration

LESLIE LANGSLOW

Amerigroup Iowa - Claims Administrator

As a member of the Transition Team, Ms. Langslow will serve as Amerigroup Iowa's Claims Administrator

Experience

Amerigroup Corporation

Director II, Claims

2007 - Present

- Managed a staff up to 11 direct reports, 250 indirect reports.
- Manage various markets; interpret and implement regulatory requirements per state requirements; manage to ensure requirements are met.
- Serve as key contact for the Health Plan, State and Regulatory departments; actively participate with reporting specifications, data review and submission of various state mandated reports.
- Oversight of inventory management to ensure compliance is met among multiple markets; including involvement with capacity planning; engaging in process and production initiatives.
- Represent claims on projects, initiatives and implementations.

Amerigroup Corporation

Claims Manager

2006 - 2007

- Manage a staff up to 30; with oversight of work delegated to 15 staff members off-site.
- Interpret and implement regulatory requirements; manage to ensure requirements are met.
- Active participant of market implementation initiatives; including system testing, process and policy development and training of staff.
- Manage inventory, balance daily workload and resources; develop reduction and maintenance plans.
- Coordinate with various functional areas to identify and resolve issues; as well as, provide communication to impacted areas of process updates and changes.
- Serve as key contact for the Health Plan, State and Regulatory departments; actively participate with reporting specifications, data review and submission of various state mandated reports.

Amerigroup Corporation***Appeals Manager******2003 – 2006***

- Manage a staff of 36-40 including clinical and non-clinical staff in the daily Intake of general correspondence and appeals as well as the processing and all functions of the medical and payment appeals processing.
- Work closely with Associate Services and Management on the following activities: staff alignment of positions and structuring to absorb company growth without adding resources and to have positions graded and outlined accurately and in alignment within the department, posting and filling of positions. Team has maintained a high retention rate.
- Manage daily inventory, team priorities and assign resources. Perform appeals processing and researching of high-level complaints.

Education***Tidewater Beach Community College 1993******VA, Education***

LINDA C. HOPKINS, MBA, BSN, RN

Amerigroup Iowa - Care Coordination Manager

As a member of the Transition Team, Ms. Hopkins will serve as Amerigroup Iowa's Care Coordination Manager

Experience

Anthem, Inc.

Staff Vice President, Health Care Management Services

2014 - Present

- Responsible for Case Management governance and infrastructure, Disease Management service delivery, member-facing health promotion materials development, and ER strategy for the Government Business Division.
- Oversight of multiple teams, 120+ employees, and budget of more than \$12M.

Anthem, Inc.

Director II, Medicaid Management

2011 - 2014

- Responsible for Georgia Total Population Health Management, including UM/CM Integrated DM operations for Local Commercial Business.
- Led multiple teams charged with utilization management, acute/chronic disease management, cost containments project implementation.
- Management of offshore team resources and virtual teams.
- Oversaw clinical staffing/training of new large (550K+) group; supported RFP development and implementation.

Anthem, Inc.

Director, Medical Management

2009 - 2011

- Responsible for overseeing case management operations for WellPoint's Eastern Region (New York, Connecticut, Maine, New Hampshire, Virginia, and Georgia).
- Led multiple teams of clinicians (100+) charged with promoting quality member outcomes, optimizing member benefits, and promoting effective use of health care resources.

Anthem, Inc.

HMC Operations Clinical Oversight Director, Anthem, Inc.

2008 - 2009

- Developed, implemented, and facilitated Health Management Corporation's (HMC's) seven Regional Operations Quality Councils, which focused on identifying opportunities for process and outcome improvement.
- Initiated process improvements in the areas of communications, clinical support tools, and client administrative information access.
- Co-presented study, NurseLine QIP: Retrospective Analysis and Confirmation of NurseLine Post Intent ER Dispositions, at URAC's Ninth Annual Quality Summit.

Health Quality Center (VHQC)

Senior Director, Consumer Outreach and Clinical Evaluation, Virginia

2001 - 2008

- Member of the VHQC (Virginia-designated CMS Quality Improvement Organization) senior leadership team, responsible for the Medical Case Review strategic business unit.
- Directed and managed all operational aspects of consumer outreach and clinical evaluation as related to public and private sector contracts, including staff and budget management.
- Implemented process re-design, improving Medicare case review timeliness from 15 percent to approximately 100 percent, exceeding CMS's expectations of the medical case review contract standard.
- Primary medical case review contact with government officials, such as CMS and the Virginia Board of Insurance.

Education

College of William and Mary

Master's in Business Administration

Old Dominion University

BS, Biochemistry

Old Dominion University

BS, Nursing Science

MARY BEACH

Amerigroup Iowa - Program Integrity Manager

As a member of the Transition Team, Ms. Beach will serve as Amerigroup Iowa's Program Integrity Manager

Experience

Anthem, Inc.

Director, Special Investigations Unit

2007 - Present

- Manages investigation assignments from planning stages through preparation of the final investigative report, to presentation to the appropriate audience.
- Manages investigative resources to develop and implement consistent methodologies and reporting.
- Assures adequate resource coverage on investigation activities to comply with applicable contracts, laws, regulations and policies/procedures.
- Conducts comprehensive interviews/interrogations with providers, members and witnesses to obtain information which would be considered admissible under generally accepted criminal and civil rules of evidence.
- Manages contractually required reporting activities including reports that are sent to state agencies related to fraud, abuse and/or waste.
- Conducts special studies for management that usually entail change implementation in the organization or areas of key concern to management such as pre-implementation activities or activities required to determine compliance with new contract provisions, laws or regulations
- Supports development of the annual plan for investigation activities.

Disetronic Medical Systems, Inc.

Manager, Customer Reimbursement

2005 – 2007

- Responsible for the management of the Customer Reimbursement Department which includes Billing, Cash Postings and Collections, Insurance Reimbursement and Medicare.

TriCenturion

Manager, Investigations

2003 – 2007

- Responsible for supervising fraud and abuse control activities of benefit integrity operations, to deter, prevent, identify, develop and refer for prosecution instances of Medicare fraud and abuse of Home Health and Hospice providers.
- Supervise two (2) regions, total of eight (8) states with associates located in five (5) states.
- Participated in Response for Proposal (RFP) to Center for Medicare and Medicaid Services (CMS), including the writing and verbal presentation.
- Regular communication with CMS, Department of Justice, and Office of the Inspector General.

Education

Indiana University 1984

BS Business/Accounting

Accreditations/Certifications

Accredited Healthcare Fraud Investigator (AHFI) - National Healthcare Fraud Association

Certified Fraud Examiner (CFE) – Association of Certified Fraud Examiners

Health Care Anti-Fraud Associate (HCAFA) – Association of Health Insurance Plans

Health Insurance Associate (HIA) – Association of Health Insurance Plans

Managed Healthcare Professional (MHP) - Association of Health Insurance Plans

LAURA JOHNS

Amerigroup Iowa - Long-Term Care Manager

As a member of the Transition Team, Ms. Johns will serve as Amerigroup Iowa's Long-Term Care Manager

Experience

Anthem, Inc.

Director, Health Services, Corp. Long Term Services & Supports (LTSS)

2014 – Present

- Corp. LTSS team representative involved in Business Development activities, contributing content/language to RFP proposal responses; assisting markets with LTSS related research/data needs.
- Expand and manage activities of the Corp. LTSS team enterprise-wide across multiple initiatives/projects.
- Supervise management of quarterly LTSS data dashboard including financials and utilization by market, specific service, etc. to trend data.
- Work in conjunction with CareCompass (case management documentation system) team to address system gaps needed for LTSS and Medicare/Medicaid Duals Demonstration Program (MMP) documentation to provide data needed for regulatory reports requirements. Collaborate with CareCompass configuration leadership to review LTSS market-specific requests to determine justification and priority of request/need, as well as applicability each enterprise-wide.
- Instituted LTSS Steering Committee, successfully bringing multiple health plans and corporate stakeholders together to for a forum on LTSS initiatives, best practices, process changes, needs, etc.
- Collaborated with Health Care Analytics on development of an annual LTSS Program Evaluation.
- Extensive engagement with corporate training department to review/revise/develop training agendas and training content relevant to LTSS, Case Management, and UM. Instituted workgroup to conduct comprehensive review of all LTSS training material.
- Extensive work to develop new and revise existing workflows relevant to MMP implementation, impacting LTSS members.
- Engaged with consultants to revise Model of Care and UM reference documents for CA and TX to prepare for regulatory submissions.
- Collaborate with multiple corporate and health plan departments to develop business requirements for CMS and state-madated reports.
- Provide extensive direct support to all MMP/LTSS stakeholders prior to and after hiring of market-specific MMP team staff. Provide periodic support - review of contractually required documents, P&Ps, assisting w/ staffing model development.
- Extensive involvement/collaboration on recruiting/hiring/onboarding/training clinical & non-clinical MMP/LTSS staff in preparation for on-time go-live in multiple markets.
- Provide regular “ deep dive” orientation and support to new MMP management teams (California, Virginia)

Molina Healthcare, Inc.

Manager, Care Management/Healthcare Services***2013 – 2014***

- Member of team managing & overseeing corporate policy and program implementation of Molina standardized integrated care management processes focused on assisting members with overall healthcare needs to achieve optimal clinical, financial, and quality of life outcomes.
- Specific assignments for policy and program development and implementation for key initiatives within the integrated care management model.
- Perform and promote enterprise-wide and interdepartmental integration/collaboration to enhance case management services including Long Term Care and Behavioral Health services.

Molina Healthcare of New Mexico***Director, Healthcare Services******2010 – 2013***

- Molina New Mexico's state plan Healthcare Services senior leader for program and policy.
- Development, planning and readiness for New Mexico's restructured Medicaid managed care system, Centennial Care.
- Daily oversight and management of Healthcare Services budget and all lines of business including Third Party Assessor long term care services and supports reviews; Salud, State Coverage Insurance, and Medicare utilization management functions - prior authorization, concurrent review, and care management.
- Implementation of Healthcare Services Redesign into statewide regional team structure.
- Oversight & development of Healthcare Services new employee orientation & training.
- Facilitating development of Behavioral Health (BH) Program with new BH leadership.
- Significantly expand Healthcare Services Department to three times current size per Centennial Care contract requirements.
- Expansion of Molina Healthcare Transitions Program.
- Restructure of Community Connector Program serving 300+ members statewide. Annual cost savings over \$2.0 million.
- Collaborate with plan and corporate staff to address Medicare processes.
- Update long term care provider training materials.
- Coordinate audit preparation for NCQA and External Quality Review compliance audits, resulting in excellent scores.
- Maintain strong working relationship with key New Mexico Human Services Department/Medical Assistance Division staff.

New Mexico Human Services Department***Program Manager, Coordination of Long Term Services (CoLTS)******2006 - 2008***

- Contract management and oversight of External Quality Review Organization (EQRO) contract.
- NM Medical Review Association, providing technical assistance to all stakeholders.
- Responsible for program implementation, quality improvement and fiscal management for the EQRO contract with the State of New Mexico.
- Performance assessment of managed care contractors in relation to federal/state requirements.

Education

Stephen F. Austin State University
MA Psychology

University of Texas at Austin
BA

KEVIN G. HUGHES

Amerigroup Iowa - Community Relations Manager

As a member of the Transition Team, Mr. Hughes will serve as Amerigroup Iowa's Community Relations Manager

Experience

Anthem, Inc.

Staff Vice President, Marketing Operations and Retention

2007 – Present

- Senior corporate marketing operations leader.
- Work with local Marketing Officers in building strategies and marketing plans to ensure growth and maintenance of our membership through effective community outreach, engagement, and retention.
- Responsible for analytic support, CRM systems, retention, budgeting, and new market development in 19 states and 24 markets, representing over 5 million members.
- Work with departments like Provider relations and Quality to support outreach to our network and improve access by best practice sharing, community activities, by building strong community relationships both locally and nationally.

Anthem, Inc.

Senior Vice President Operations

2001 – 2006

- Oversaw multiple customer service center sites for member services, provider services, and clinical service operations in a 24/7 health care environment.
- Established synergies in our operations that included both clinical and non-clinical functions.
- Managed an operating budget of \$24 million, ~600 employees, and three physical locations.
- Operations took over 30,000 calls daily from our members and providers while being able to resolve the issue on the first call over 94% of the time.
- Our clinical team consisted of prior authorization services as well as nurse help line.

Education

Old Dominion University

B.S.B.A Marketing

RHYS JONES

Amerigroup Iowa - Member Advocate/Non-Discrimination Manager (Ombudsman)

As a member of the Transition Team, Mr. Jones will serve as Amerigroup Iowa's Member Advocate/Non-Discrimination Manager (Ombudsman)

Experience

Anthem, Inc.

Senior Director, Medicaid Business Development

2014 – Present

- Advise policymakers and state Medicaid agency staff on policy and program design pertaining to managed Medicaid programs, including long-term services and supports, and programs for Medicare-Medicaid dual eligible beneficiaries
- Advocate for programs that improve the quality of care and services for beneficiaries while saving taxpayer dollars.
- Evaluate proposed federal and state legislation and regulations to assess potential business impacts and develop advocacy positions.
- Support Product and Business Development staff in responding to state Medicaid procurements.
- Maintain relations and participation with related industry organizations such as America's Health Insurance Plans, SNP Alliance, National Association of Medicaid Directors, Medicaid Health Plans of America and National Association of State Budget Officers.

Amerigroup Corporation

Vice President, Medicare Policy and Market Development

2005 – 2014

- Responsible for Medicare market development and ongoing management and enhancement of Amerigroup's *Amerivantage* Medicare product line. By 2013, the *Amerivantage* Medicare plans enrolled over 50,000 members in nine states, generating revenues of over \$500 million.
- **Market development.** Direct annual process to identify new markets, support network development staff in assessing provider network adequacy. Develop Medicare Advantage and Part D contract applications, service area expansion applications and SNP proposals; principal liaison with CMS in application review process. Coordinate with Government Relations staff to negotiate SNP/Medicaid agreements with state Medicaid agencies.
- **Dual eligible integration financial alignment demonstrations.** Lead company's assessment of dual eligible demonstration opportunities; develop preferences for program design; lead work groups; developed integrated operational processes to support demonstrations. Consult and advocate with CMS and state Medicaid agencies; analyze proposals and prepare comments. Speak on dual eligible program issues, Medicare/ Medicaid integration at conferences.
- **Medicare bids and benefits.** Lead annual Medicare benefits definition and development process. Identify competitors, analyze competitor plan benefits, determine medical and drug benefit modifications and new offerings in consultation with Medicare sales directors. Coordinate benefit pricing with consulting actuaries, direct development of approximately 20 MA-PD Plan Benefit

Packages for submission to CMS. Advocate for company in benefit negotiations with CMS; finalize benefits in rebate reallocation process.

- **Medicare program policy.** Assess impacts of new laws and regulations, prepare briefings on Medicare issues for executive leadership, members of Congress; participate with federal GR staff in advocating with congressional and agency staff. Speak on Medicare and Part D program issues at industry conferences. Represent Amerigroup in SNP Alliance and AHIP Medicare workgroups.
- **Training and documentation.** Key business owner for annual Medicare implementation projects relating to benefits configuration, development of key member disclosure and sales materials (e.g. Summary of Benefits, Evidence of Coverage), training and documentation of benefits and coverage policies for functions such as health care management claims processing and network development.

Education

University of California, Berkeley

Master of Public Health, Health Policy & Administration

San Francisco State University

BA Biology

Contract Lists (3.2.7.4)

As a new DHS partner, Amerigroup Iowa (Amerigroup) will leverage the broad organizational expertise administering state-sponsored programs of our affiliate health plans and ultimate parent company, Anthem, Inc. (Anthem). As part of the Anthem family of companies, we are the nation’s leading provider of healthcare solutions for state-sponsored programs. Blending local and national resources allows us to stay close to stakeholders in the communities we serve and employ strategies that drive administrative efficiencies and streamline plan administration. Collectively, we have 24 years of experience administering Medicaid, CHIP, and other health programs for our state customers and currently serve more than 5.2 million members through programs across 19 states, including nearly one million in specialized populations (see Figure 3.2.7-1 below). The strength of our experience and organizational structure allows Amerigroup to bring best practices from lessons learned in innovative programs across the country, and focus on opportunities and strategies to improve appropriate utilization, quality gains, and health outcomes for Iowa members, while achieving cost efficiencies for the State.

Figure 3.2.7-1. Amerigroup Affiliates Serve Nearly 5.2 Million Medicaid Members across All Populations in 19 States

Amerigroup Health Plans and Programs they Serve, by State											
	Medicaid	CHIP	Foster	Dual Demos	ABD	SMI	ID/DD	AIDS/HIV	TBI	ACA Expansion	LTSS
CA	✓	✓		✓	✓		✓	✓		✓	✓
FL	✓	✓	✓		✓		✓	✓	✓		✓
GA	✓	✓	✓								
IN	✓	✓	✓		✓						
KS	✓	✓	✓		✓	✓	✓		✓		✓
KY	✓	✓	✓		✓					✓	
LA	✓	✓	✓		✓						
MA		✓									
MD	✓	✓	✓		✓					✓	
NV	✓	✓				✓				✓	
NJ	✓	✓	✓		✓		✓	✓	✓	✓	✓
NY	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
SC	✓				✓			✓			
TN	✓				✓		✓	✓			✓
TX	✓	✓		✓	✓		✓				✓
VA	✓	✓	✓	✓	✓	✓	✓				
WA	✓	✓	✓		✓					✓	
WV	✓				✓		✓				
WI	✓				✓						
Total	4.1 million	334,000	41,000	15,000	470,000	250	2,300	10,000	2,100	461,000	202,000

¹ Membership numbers presented above are inclusive of membership as of December 31, 2014 for our parent company Anthem, Inc. and its state sponsored health plans. Members may be counted in more than one category and numbers may not be exact. In addition, in February 2015, our parent company completed the acquisition of two Florida managed care organizations, Simply Healthcare Plans, Inc. (Simply) and Better Health, Inc. (Better).

Key to our success in Iowa is our shared core competency in successfully designing and implementing complex new programs, including those involving large-scale changes across a care delivery system, in a manner that smoothly transitions members, providers, and stakeholders, while avoiding disruptions in services.

Over the past 24 years, our organization has successfully completed more than 100 public-sector healthcare program implementations, service area expansions, and program enhancements, including three new health plans between February 2012 and January 2013. During that 15-month period, we managed the start-up of Medicaid health plans in Kansas, Louisiana, and Washington, comprising more than 256,000 new members. We completed these implementations without any disruption in service. In fact, our call center abandonment rate during those 11 months was just 1.04 percent.

In our collective history of Medicaid program implementations, neither Anthem nor our affiliate health plans have ever missed an operational start date.

Amerigroup's affiliate health plans and Anthem also have proven track records of managing those administratively complex programs, such as the Iowa Initiative, to serve members of all ages with diverse needs via innovative solutions across the spectrum of physical/behavioral healthcare services. Many have special needs, such as members who are Aged, Blind, or Disabled (ABD); those with intellectual or developmental conditions; children in foster care; or individuals who need Long Term Services and Supports (LTSS).

3.2.7.4.1 Reserved

The State marked this requirement as "Reserved" in the RFP.

3.2.7.4.2 Table

1. Identify in table format all of your publicly-funded managed care contracts for Medicaid, CHIP and other low-income populations within the last five (5) years. If a Bidder does not have direct experience, it may include the experience of its parent company if it includes a parent guarantee with its proposal. For each prior experience identified, provide a brief description of the following:
 - a. Scope of work and covered benefits (state whether physical health, behavioral health, and long-term services and supports (LTSS) were in or out of scope)
 - b. Duration of the contract
 - c. Start and end dates of contract as originally entered into between the parties, including any alteration(s) to the timeframe. If the timeframe was altered, provide the reason(s) for the alteration(s)
 - d. Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s)
 - e. Contact name and phone number
 - f. Number of members served by population type
 - g. Annual contract payments and description if payment was capitated
 - h. Any improvements made in utilization trends and quality indicators
 - i. How the contract emphasizes member choice, access, safety, independence, and responsibility
 - j. The role of subcontractors, if any

Tables 3.2.7-1 through 3.2.7-77 provide an overview of the publicly-funded managed care contracts of Amerigroup's affiliate health plans for state-sponsored health programs within the last five years.

This document contains certain forward-looking information about us that is intended to be covered by the safe harbor for "forward-looking statements" provided by the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not generally historical facts. Words such as "expect(s)," "feel(s)," "believe(s)," "will," "may," "anticipate(s)," "intend," "estimate," "project" and similar expressions are intended to identify forward-looking statements, which generally are not historical in nature. These statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements.

A parent guarantee is included at the end of this Section, after page 1193.

Arizona

Table 3.2.7-1. CareMore, Medicare Advantage Special Needs Plan (SNP) Contract

CareMore Health Plan of Arizona, Inc. – Medicare Advantage SNP Contract H2593					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Medicare Advantage, Prescription Drug Plan HMO, and HMO SNP in Phoenix (Maricopa County-partial) and Tucson (Pima County).				
b. Duration of Contract	5 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/15 – 12/31/15 Original Contract Start: 1/1/10 N/A – Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services (312) 353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicare SNP	Population: Medicare SNP	Population: Medicare SNP	Population: Medicare SNP	Population: Medicare SNP
	No. of Members: 1,044	No. of Members: 3,602	No. of Members: 6,629	No. of Members: 8,325	No. of Members: 15,712*
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$12.64 million	\$56.95 million	\$108.13 million	\$141.23 million	\$187.78 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Under the CareMore model of care, dedicated physicians and case management teams coordinate care and transitions for members in the hospital and skilled nursing facility settings.</p> <p>CareMore hospital utilization results are significantly lower than the Medicare Fee-For-Service (FFS) average: 29 percent fewer admissions, 28 percent shorter length of stay, 48 percent fewer bed days, and 34 percent fewer readmissions. With the average CareMore Risk Adjustment Factor, results are even lower than Medicare FFS: 43 percent fewer admissions, 44 percent shorter length of stay, 59 percent fewer bed days, and 48 percent fewer readmissions.</p> <p>With our intense focus on the post-discharge care transition, which includes a follow-up visit with the physician, 30-day medication reconciliation rates in 2013 were 33 percent to 46 percent, compared to the Medicare mean of 17 percent (HEDIS® 2014 Medication Reconciliation Post-Discharge).</p> <p>We offer a comprehensive Diabetes Management Program in the CareMore Care Centers. Based on HEDIS results, more than 80 percent of diabetics have HbA1c blood sugar under control. As of 2013, diabetic amputation rates were 66 percent lower than the Medicare average.</p> <p>Patients in our Chronic Kidney Disease Program are aggressively managed to delay the onset of end-stage renal disease (ESRD). According to our modeling, the average CareMore member with chronic kidney disease Stage 3 would progress to dialysis in slightly over 24</p>				

CareMore Health Plan of Arizona, Inc. – Medicare Advantage SNP Contract H2593

Reference Information (Current/Prior Services Performed For:)

	<p>years, as opposed to less than six years noted in the landmark Modification of Diet in Renal Disease study.</p> <p>For our patients with ESRD, we offer dedicated Case Management and Nurse Practitioners who closely collaborate with nephrologists and dialysis centers. CareMore ESRD program participants are less likely to be hospitalized, with acute admission rates 50 percent below Medicare.</p> <p>Patients in our Chronic Obstructive Pulmonary Disease (COPD) Management Program receive self-care education and management of routine and rescue medications. COPD program members on oxygen have 52 percent fewer acute hospitalizations than the Medicare average.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

California

Table 3.2.7-2. Anthem Blue Cross –County Medical Services Program (CMSP) Contract

Anthem Blue Cross Life and Health Insurance Company – County Medical Services Program (CMSP) Program

Reference Information (Current/Prior Services Performed For:)

a. Scope of work and covered benefits	<p>Program Administrator for County Medical Services Program; provides care coordination and covered services for low-income, indigent adults in 35 primarily rural California counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba</p> <p>Responsible for the provision of physical health, dental, and pharmacy services. Not responsible for the provision of behavioral health services; however, as part of the Medicaid Section 1115 Waiver, CMSP and Path2Health included an expanded benefit packaged for mental health and substance use counseling services effective January 1, 2012 through December 31, 2014.</p>
b. Duration of Contract	10 years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 10/1/05 – 04/01/2015 (plus a six-month run-out period) Original contract start: 10/01/05</p> <p>Path2Health was CMSP’s Low Income Health Program (LIHP) authorized under California’s Section 1115 Medicaid Demonstration Waiver to leverage county-based coverage as a bridge to federal health reform. CMSP’s program, Path2Health, was effective January1, 2012 through December 31, 2013. All 35 CMSP counties participated in Path2Health.</p> <p>Federal LIHP requirements state that all Plans include 19 and 20 year olds. California included</p>

Anthem Blue Cross Life and Health Insurance Company – County Medical Services Program (CMSP) Program					
Reference Information (Current/Prior Services Performed For:)					
	19 and 20 year olds as potentially eligible for Path2Health.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Kari Brownstein CMSP Governing Board 916-649-2631, ext. 14 kbrownstein@cmspcounties.org				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals
	No. of Members: 53,218	No. of Members: 53,906	No. of Members: 61,855	No. of Members: 76,739	No. of Members: 1,134
g. Annual Contract Payment:	Year: 2010 \$12.09 million	Year: 2011 \$15.17 million	Year: 2012 \$16.27 million	Year: 2013 \$16.39million	Year: 2014 \$1.74 million
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: Administrative Services Organization (ASO)				
h. Improvements in utilization trends and quality indicators	<p>Our California Statewide initiatives include:</p> <ul style="list-style-type: none"> • Improved collection of lab data from vendors and improved encounter data submissions from providers, which have led to improvements in the administrative data for MY 2014 in all counties • Implemented Maternal Postpartum Outreach program statewide in August 2014 • Implemented Provider Incentive Program for top eight high-volume Physician Medical Groups in North and Central Regions (June 2014) with improved outcomes through 3rd Quarter for key HEDIS measures: CIS, PPC, CDC, and Well-Child • Implemented provider education and outreach to key OB provider groups in each region • Implemented and modified member outreach and member incentive programs 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-3. Blue Cross of California – Medi-Cal Two-plan Contract: Central Valley/Bay Area

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Two-plan Contract: Central Valley/Bay Area (Alameda, Contra Costa, San Francisco, Santa Clara)					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating as a “commercial plan” in California’s Medi-Cal (Medicaid) managed care program in the counties of Alameda, Contra Costa, San Francisco, and Santa Clara</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation</p>				
b. Duration of Contract	16 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 12/1/03 – 3/31/19</p> <p>Original Contract Start: 9/1/96</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 86,365</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 94,241</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 99,393</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 105,751</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 139,413*</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$149.18 million	\$163.05 million	\$236.60 million	\$307.03 million	\$468.59 million*
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Blue Cross of California implemented an initiative in the Central Valley/Bay area with a vision vendor for member outreach, sending 5,161 mailers in San Francisco, Alameda, Santa Clara, and Contra Costa counties November 7, 2014. Clinic days for these counties were scheduled with the vision vendor for June 2015. Improvements included:</p> <ul style="list-style-type: none"> Alameda county has gone from worst performing county MY 2013 to high performing in MY 2014 <ul style="list-style-type: none"> HbA1c testing administration rate increased from 72.12 percent in MY 2013 to 78.73 percent in MY 2014. With the hybrid data collection, the rate is at 81.97 percent – above the minimum performance level Prenatal administration rate increased from 68.64 percent MY 2013 to 68.64 percent MY 2014 Contra Costa county had many improvements, including: 				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Two-plan Contract: Central Valley/Bay Area (Alameda, Contra Costa, San Francisco, Santa Clara)

Reference Information (Current/Prior Services Performed For:)

	<ul style="list-style-type: none"> ➢ HbA1c poor control admin rate (lower is better) went from 96.38 percent in MY 2013 to 66.31 percent in MY 2014 ➢ Diabetic Eye Exam administration rate increased from 26.81 percent MY 2013 to 38.65 percent MY 2014. ➢ HbA1c good control admin rate increased from 2.54 percent MY 20013 to 21.99 percent MY 2014 • San Francisco continues to perform at a high level with 11 out of 22 measures already at the minimum performance level, including hybrid chases • Santa Clara continues to perform at a high level with 14 out of 22 measures already at the minimum performance level, including hybrid chases • All Central Valley/Bay Area counties have hit the minimum performance level already for nephropathy
<p>i. Contract emphasis on Member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

**Data provided are combined totals for several contracts in California: Medi-Cal Central Valley/Bay Area Counties (Alameda, Contra Costa, San Francisco, Santa Clara); Medi-Cal San Joaquin County Local Initiative contract run out; and Medi-Cal Stanislaus County Local Initiative contract run out.*

Table 3.2.7-4. Blue Cross of California – Medi-Cal Two-plan Contract: Tri-County

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Two-plan Contract: Tri-County (Fresno, Kings, Madera)					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating as a “commercial plan” in California’s Medi-Cal (Medicaid) managed care program in the counties of Fresno, Kings, and Madera</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation</p>				
b. Duration of Contract	25 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 12/1/11 – 2/2/21</p> <p>Original Contract Start: 9/1/96</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 85,233</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 98,117</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 93,949</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 98,779</p>	<p>Population: TANF, ABD, Medicaid Expansion</p> <p>No. of Members: 117,540</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$137.24 million	\$155.31 million	\$169.41 million	\$211.08 million	\$297.28 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Medi-Cal in the Tri-County implemented Clinic Days for Childhood Immunizations in Fresno with moderate success:</p> <ul style="list-style-type: none"> • Madera county had large improvements <ul style="list-style-type: none"> ➢ HbA1c administration rate increased from 35.12 percent MY 2013 to 81.07 percent MY 2014 hitting the minimum performance level ➢ Prenatal admin rate increased from 59.39 percent MY 2013 to 75.0 percent MY 2014 • Well-Child admin rates increased in all three counties <ul style="list-style-type: none"> ➢ Fresno 59.13 percent MY 2013 to 69.82 percent MY 2014 ➢ Kings 55.17 percent MY 2013 to 62.04 percent MY 2014 ➢ Madera 70.34 percent MY 2013 to 80.62 percent MY 2014 				
i. Contract emphasis on Member choice, access,	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Two-plan Contract: Tri-County (Fresno, Kings, Madera)

Reference Information (Current/Prior Services Performed For:)

safety, independence, and responsibility	that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-5. Blue Cross of California – Medi-Cal Sacramento County Geographic Managed Care

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Sacramento County Geographic Managed Care Contract

Reference Information (Current/Prior Services Performed For:)

a. Scope of work and covered benefits	Participating as a “commercial plan” in the state’s Medi-Cal (Medicaid) managed care program in Sacramento County Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	25 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/08 – 12/31/19 Original Contract Start: 04/01/94 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Sacramento County Geographic Managed Care Contract

Reference Information (Current/Prior Services Performed For:)

	Population: TANF, ABD, Medicaid Expansion No. of Members: 91,929	Population: TANF, ABD, Medicaid Expansion No. of Members: 95,753	Population: TANF, ABD, Medicaid Expansion No. of Members: 98,771	Population: TANF, ABD, Medicaid Expansion No. of Members: 100,578	Population: TANF, ABD, Medicaid Expansion No. of Members: 124,050
g. Annual Contract Payment:	Year: 2010 \$179.57 million	Year: 2011 \$168.75 million	Year: 2012 \$201.99 million	Year: 2013 \$238.69 million	Year: 2014 \$376.75 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Medi-Cal Utilization and Quality initiatives in Sacramento County have resulted in the following improvements:</p> <ul style="list-style-type: none"> • Cervical Cancer Screening administration rate increased from 43.90 percent MY 2013 to 50.55 percent MY 2014 • Diabetes HbA1c good control administration rate increased from 21.79 percent MY 2013 to 29.85 percent MY 2014 • Diabetic Eye Exam administration rate increased from 25.93 percent MY 2013 to 32.17 percent MY 2014 • Nephropathy administration rate increased from 71.56 percent MY 2013 to 77.74 percent MY 2014 • Prenatal administration rate increased from 59.52 percent MY 2013 to 69.85 percent MY 2014 • Postpartum administration rate increased from 39.63 percent MY 2013 to 45.24 percent MY 2014 • Medication management for members on Ace Inhibitors increased from 70.44 percent MY 2013 to 84.12 percent MY 2014 • Medication management for members on Diuretics increased from 70.62 percent MY 2013 to 82.61 percent MY 2014 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>Amerigroup is the nation’s leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-6. Blue Cross of California – Medi-Cal Two-plan Contract: Tulare County

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Tulare County Local Initiative Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating as a “local initiative plan” in the state’s Medi-Cal (Medicaid) managed care program in Tulare County Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	20 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 4/1/05 – 12/31/19 Original Contract Start: 02/01/99 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: TANF, ABD, Medicaid Expansion	Population: TANF, ABD, Medicaid Expansion	Population: TANF, ABD, Medicaid Expansion	Population: TANF, ABD, Medicaid Expansion	Population: TANF, ABD, Medicaid Expansion
	No. of Members: 75,005	No. of Members: 71,211	No. of Members: 68,363	No. of Members: 74,939	No. of Members: 81,401
g. Annual Contract Payment:	Year: 2010 \$115.11 million	Year: 2011 \$108.89 million	Year: 2012 \$123.91 million	Year: 2013 \$139.44 million	Year: 2014 \$169.13 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	California Statewide Initiatives included: <ul style="list-style-type: none"> Improved collection of lab data from vendors and improved encounter data submissions from providers, which have led to improvements in the administrative data for MY 2014 in all counties Implemented Maternal Postpartum Outreach program statewide in August 2014 Implemented Provider Incentive Program for top eight high-volume Physician Medical Groups in North and Central Regions (June 2014) with improved outcomes through 3rd Quarter, for key HEDIS measures: CIS, PPC, CDC and Well-Child Implemented provider education and outreach to key OB provider groups in each region Implemented and modified member outreach and member incentive programs Improvements included: <ul style="list-style-type: none"> Prenatal administration rate increased from 71.87 percent MY 2013 to 77.11 percent MY 2014 Diabetic Eye Exam administration rate increased from 23.84 percent MY 2013 29.21 percent MY 2014 Well-Child 3-6 years administration rate increased from 62.69 percent MY 2013 to 68.46 percent MY 2014 				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Tulare County Local Initiative Contract

Reference Information (Current/Prior Services Performed For:)

i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-7. Blue Cross of California – Medi-Cal Rural Expansion Contract

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Rural Expansion Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating as a “commercial plan” in California’s Medi-Cal (Medicaid) managed care program in the counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 11/1/13 – 10/31/23 Original Contract Start: 11/01/13 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	Population: N/A	Population: N/A	Population: N/A	Population: TANF, ABD, Medicaid Expansion	Population: TANF, ABD, Medicaid Expansion
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: 70,054	No. of Members: 105,200

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Rural Expansion Contract					
Reference Information (Current/Prior Services Performed For:)					
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 \$20.18 million	Year: 2014 \$286.10 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	California Statewide Initiatives: <ul style="list-style-type: none"> Improved collection of lab data from vendors and improved encounter data submissions from providers have led to improvements in the administrative data for MY 2014 in all counties Implemented Maternal Postpartum Outreach program statewide in August 2014 Implemented Provider Incentive Program for top eight high-volume Physician Medical Groups in North and Central Regions June 2014 with improved outcomes through 3rd Quarter, for key HEDIS measures: CIS, PPC, CDC and Well-Child Implemented provider education and outreach to key OB provider groups in each region Implemented and modified member outreach and member incentive programs For the rural regions, HEDIS 2015 (MY 2014) is the baseline year, so we do not yet have comparison rates. We are implementing the following in the rural regions to improve HEDIS rates: <ul style="list-style-type: none"> Improved data collection Lab data collection Opportunities for electronic medical record access Access to immunization registries Monthly tracking of clinical indicators Gap In Care Reports 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract started in 2013.

Table 3.2.7-8. Blue Cross of California – Medi-Cal San Benito County Contract

Blue Cross of California Partnership Plan, Inc. – Medi-Cal San Benito County Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating as a “commercial plan” in California’s Medi-Cal (Medicaid) managed care program in San Benito County Responsible for the provision of physical health services, behavioral health services, LTSS, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 11/1/13 – 10/31/23 Original Contract Start: 11/01/13 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: TANF, ABD, Medicaid Expansion No. of Members: 6,148	Population: TANF, ABD, Medicaid Expansion No. of Members: 6,513
g. Annual Contract Payment:	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	N/A	N/A	N/A	\$1.84 million	\$14.98 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	California Statewide Initiatives: <ul style="list-style-type: none"> Improved collection of lab data from vendors and improved encounter data submissions from providers have led to improvements in the administrative data for MY 2014 in all counties Implemented Maternal Postpartum Outreach program statewide in August 2014 Implemented Provider Incentive Program for top 8 high volume Physician Medical Groups in North and Central Regions June 2014 with improved outcomes through 3rd Quarter, for key HEDIS measures: CIS, PPC, CDC and Well-Child Implemented provider education and outreach to key OB provider groups in each region Implemented and modified member outreach and member incentive programs <p>For the rural regions, HEDIS 2015 (MY 2014) is the baseline year, so we do not yet have comparison rates. We are implementing the following in the rural regions to improve HEDIS rates:</p>				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal San Benito County Contract	
Reference Information (Current/Prior Services Performed For:)	
	<ul style="list-style-type: none"> • Improved data collection • Lab data collection • Opportunities for electronic medical record access • Access to immunization registries • Monthly tracking of clinical indicators • Gap In Care Reports
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Not applicable – contract started in 2013.

Table 3.2.7-9. Blue Cross of California – AIM HMO and EPO Contract

Blue Cross of California dba Anthem Blue Cross – Access for Infants and Mothers (AIM) HMO and EPO Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating plan to provide low-cost health care coverage to uninsured, middle-income pregnant women who do not qualify for Medi-Cal (Medicaid) in the counties of Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, and Yuba</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, and pharmacy</p>
b. Duration of Contract	23 years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/04 – 9/30/15</p> <p>Original Contract Start: 02/01/92</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION

Blue Cross of California dba Anthem Blue Cross – Access for Infants and Mothers (AIM) HMO and EPO Contract					
Reference Information (Current/Prior Services Performed For:)					
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals	Population: low-income individuals
	No. of Members: 4,195	No. of Members: 4,693	No. of Members: 5,170	No. of Members: 4,074	No. of Members: 3,317
g. Annual Contract Payment:	Year: 2010 \$70.94 million	Year: 2011 \$82.68 million	Year: 2012 \$96.53 million	Year: 2013 \$91.1 million	Year: 2014 \$48.54 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>California Statewide Initiatives:</p> <ul style="list-style-type: none"> Improved collection of lab data from vendors and improved encounter data submissions from providers have led to improvements in the administrative data for MY 2014 in all counties Implemented Maternal Postpartum Outreach program statewide in August 2014 Implemented Provider Incentive Program for top eight high-volume Physician Medical Groups in North and Central Regions (June 2014) with improved outcomes through 3rd Quarter, for key HEDIS measures: CIS, PPC, CDC and Well-Child Implemented provider education and outreach to key OB provider groups in each region Implemented and modified member outreach and member incentive programs 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-10. Blue Cross of California – Healthy Families HMO and EPO Contract

Blue Cross of California (dba Anthem Blue Cross) – Healthy Families HMO and EPO Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating plan in California’s Healthy Families (CHIP) program that serves uninsured children ages 0 to 19 who are not eligible for Medi-Cal (Medicaid) for the counties of Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, and Yuba</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, and pharmacy</p>				
b. Duration of Contract	16 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>The Healthy Families Program ended after members transitioned to Medi-Cal in January 2013. Contract Start and End Dates: 7/1/05 – 6/30/14 Original Contract Start: 05/01/98 Contract has ended.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2009	Year: 2010	Year: 2011	Year: 2012	Year: 2014
	Population: CHIP No. of Members: 215,575	Population: CHIP No. of Members: 205,837	Population: CHIP No. of Members: 194,625	Population: CHIP No. of Members: 207,870	Population: CHIP No. of Members: N/A
g. Annual Contract Payment:	Year: 2009	Year: 2010	Year: 2011	Year: 2012	Year: 2014
	\$264.22 million	\$245.16 million	\$234.05 million	\$264.54 million	\$4.08 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	The Healthy Families Program ended after members transitioned to Medi-Cal in January 2013.				

Blue Cross of California (dba Anthem Blue Cross) – Healthy Families HMO and EPO Contract	
Reference Information (Current/Prior Services Performed For:)	
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-11. Blue Cross of California – Major Risk Medical Insurance PPO Contract

Blue Cross of California (dba Anthem Blue Cross) – Major Risk Medical Insurance Program (MRMIP) PPO Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating plan and administrator in state’s high-risk program to provide health insurance for Californians unable to obtain coverage in the individual health insurance market because of pre-existing conditions				
	Responsible for the provision of physical health services, behavioral health services, and pharmacy				
b. Duration of Contract	23 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 7/1/03 – 12/31/14* Original Contract Start: 02/01/91				
	Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010 Population: Low-income individuals No. of Members: 2,656	Year: 2011 Population: Low-income individuals No. of Members: 2,216	Year: 2012 Population: Low-income individuals No. of Members: 1,848	Year: 2013 Population: Low-income individuals No. of Members: 2,026	Year: 2014 Population: Low-income individuals No. of Members: 1,482
g. Annual Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014

Blue Cross of California (dba Anthem Blue Cross) – Major Risk Medical Insurance Program (MRMIP) PPO Contract

Reference Information (Current/Prior Services Performed For:)

Payment:	\$33.38 million	\$33.80 million	\$31.34 million	\$31.45 million	\$22.67 million
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: MRMIP subscribers participate in the payment for the cost of their coverage through their monthly premiums, an annual deductible, and co-payments. MRMIP receives supplemental funding annually from tobacco tax funds.				
h. Improvements in utilization trends and quality indicators	California Statewide Initiatives: <ul style="list-style-type: none"> Improved collection of lab data from vendors and improved encounter data submissions from providers have led to improvements in the administrative data for MY 2014 in all counties Implemented Maternal Postpartum Outreach program statewide in August 2014 Implemented Provider Incentive Program for top eight high-volume Physician Medical Groups in North and Central Regions (June 2014) with improved outcomes through 3rd Quarter, for key HEDIS measures: CIS, PPC, CDC and Well-Child Implemented provider education and outreach to key OB provider groups in each region Implemented and modified member outreach and member incentive programs 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

** Contract negotiation for a one year extension (10/1/14 – 9/30/15) is in process. We continue to do business as usual while in negotiations.*

Table 3.2.7-12. Blue Cross of California – CaliforniaKids Contract

Blue Cross of California (dba Anthem Blue Cross) – CaliforniaKids Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Program Administrator for CaliforniaKids Health Care Foundation, an independent, non-profit organization that provides comprehensive outpatient preventive and primary medical and dental insurance for children; CalKids mostly enrolls undocumented children as they are not eligible for Medi-Cal or Healthy Families (Medicaid and CHIP).</p> <p>Responsible for the provision of physical health services, behavioral health services, and pharmacy</p>				
b. Duration of Contract	22 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/12 – 6/30/14 Original Contract Start: 07/30/92 Contract has ended.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Mike Koch, Executive Administrator* CaliforniaKids Health Care Foundation 818-480-1032 cakidsmk@aol.com</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2009</p> <p>Population: Low-income individuals</p> <p>No. of Members: 5,733</p>	<p>Year: 2010</p> <p>Population: Low-income individuals</p> <p>No. of Members: 4,068</p>	<p>Year: 2011</p> <p>Population: Low-income individuals</p> <p>No. of Members: 1,883</p>	<p>Year: 2012</p> <p>Population: Low-income individuals</p> <p>No. of Members: 2,035</p>	<p>Year: 2014</p> <p>Population: Low-income individuals</p> <p>No. of Members: 1,243</p>
g. Annual Contract Payment:	<p>Year: 2009 \$3.37 million</p>	<p>Year: 2010 \$2.90 million</p>	<p>Year: 2011 \$2.02 million</p>	<p>Year: 2012 \$1.37 million</p>	<p>Year: 2014 \$0.8 million</p>
Capitated Payment:	<p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: Funded solely through private donations.</p>				
h. Improvements in utilization trends and quality indicators	N/A – Anthem provided limited administrative services only.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Anthem provided limited administrative services only.				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

*Most recent contact information

Table 3.2.7-13. Blue Cross of California – Medi-Cal Stanislaus County Local Initiative Contract

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Stanislaus County Local Initiative Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating as the “local initiative plan” in California’s Medi-Cal (Medicaid) managed care program Responsible for the provision of physical health services, LTSS, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	15 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 10/01/97 – 12/31/12 Original Contract Start: 10/01/97 Contract has ended.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013*	Year: 2014*
	Population: TANF, CHIP, ABD No. of Members: 50,300	Population: TANF, CHIP, ABD No. of Members: 55,059	Population: TANF, CHIP, ABD No. of Members: 49,125	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013*	Year: 2014*
Capitated Payment:	\$89.32 million	\$97.60 million	\$125.10 million	N/A	N/A
h. Improvements in utilization trends and quality indicators	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A Our quality initiatives focused on avoidable Emergency Room (ER) utilization and increasing the postpartum care utilization rate. Avoidable ER Utilization Efforts began in 2007 with baseline data from CY 2006 used to identify barriers. Final measurement: CY 2010. Initially the rates increased; however, a significant decline was noted once initiatives were fully in use. Results: CY 2010 / RY 2011 ER Rate Summary Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare all had a statistically significant decrease in the rate from CY 2009 to CY 2010 Sacramento showed no statistically significant change CY 2010 / RY 2011 Avoidable ER Rate Summary Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, and Stanislaus had a statistically significant decrease from CY 2009 to CY 2010 Postpartum QIP We initiated the following Interventions to improve postpartum care utilization, including: <ul style="list-style-type: none"> • Prenatal education, post-delivery calls • Prenatal education on postpartum care 				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal Stanislaus County Local Initiative Contract	
Reference Information (Current/Prior Services Performed For:)	
	<ul style="list-style-type: none"> • Maternal Post Delivery Calls – Interactive Voice Response (IVR) calls to women who have just delivered • A new hospital requirement to give us “Notification of Delivery” enabling us to improve our post-delivery member outreach • Reinforcement of member education message on importance of postpartum care through collaboration with clinics and local agencies • Increased HEDIS staff for collection in 2011 • Case management work with individual high risk members • Reminder mailing and calls • Member Incentive gift cards • Distribution of Provider Toolkits • Distribution of transportation information <p>Results: From baseline 2009 to 2011, Alameda, Contra Costa and Tulare Counties showed statistically significant improvement From 2010 (re-measurement) to 2011 (re-measurement 2) San Francisco and Tulare Counties showed statistically significant improvement</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	Amerigroup is the nation’s leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

**Not applicable – contract has ended.*

Table 3.2.7-14. Blue Cross of California – Medi-Cal San Joaquin County Local Initiative Contract

Blue Cross of California Partnership Plan, Inc. – Medi-Cal San Joaquin County Local Initiative Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating as the “local initiative plan” in California’s Medi-Cal (Medicaid) managed care program</p> <p>Responsible for the provision of physical health services, LTSS, vision, pharmacy, and non-emergency medical transportation</p>
b. Duration of Contract	Nine years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 02/01/03 – 12/31/12</p> <p>Original Contract Start: 02/01/03</p> <p>Contract has ended.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s)	CONTAINS CONFIDENTIAL INFORMATION

Blue Cross of California Partnership Plan, Inc. – Medi-Cal San Joaquin County Local Initiative Contract					
Reference Information (Current/Prior Services Performed For:)					
for alteration(s)					
e. Contact name and phone number	Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013*	Year: 2014*
	Population: TANF, CHIP, ABD No. of Members: 27,190	Population: TANF, CHIP, ABD No. of Members: 29,003	Population: TANF, CHIP, ABD No. of Members: 22,354	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010 \$39.33	Year: 2011 \$42.46	Year: 2012 \$51.62	Year: 2013* N/A	Year: 2014* N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Our quality initiatives focused on avoidable ER utilization and increasing the postpartum care utilization rate.</p> <p><u>Avoidable ER Utilization</u></p> <ul style="list-style-type: none"> • Efforts began in 2007 with baseline data from CY 2006 used to identify barriers • Final measurement: CY 2010 • Initially the rates increased • Significant decline noted once initiatives were fully in use <p>Results: CY 2010 / RY 2011 ER Rate Summary Alameda, Contra Costa, Fresno, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare all had a statistically significant decrease in the rate from CY 2009 to CY 2010; Sacramento showed no statistically significant change CY 2010 / RY 2011 Avoidable ER Rate Summary Alameda, Contra Costa, Sacramento, San Francisco, San Joaquin, and Stanislaus had a statistically significant decrease from CY 2009 to CY 2010</p> <p><u>Postpartum QIP</u></p> <p>We initiated the following Interventions to improve postpartum care utilization, including:</p> <ul style="list-style-type: none"> • Prenatal education, post-delivery calls • Prenatal education on postpartum care • Maternal Post Delivery Calls – IVR calls to women who have just delivered • A new hospital requirement to give us “Notification of Delivery” enabling us to improve our post-delivery member outreach • Reinforcement of member education message on importance of postpartum care through collaboration with clinics and local agencies • Increased HEDIS staff for collection in 2011 • Case management work with individual high risk members • Reminder mailing and calls • Member Incentive gift cards • Distribution of Provider Toolkits • Distribution of transportation information <p>Results:</p>				

Blue Cross of California Partnership Plan, Inc. – Medi-Cal San Joaquin County Local Initiative Contract	
Reference Information (Current/Prior Services Performed For:)	
	<p>From baseline 2009 to 2011, Alameda, Contra Costa and Tulare Counties showed statistically significant improvement</p> <p>From 2010 (re-measurement) to 2011 (re-measurement 2) San Francisco and Tulare Counties showed statistically significant improvement</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>Amerigroup is the nation’s leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

**Not applicable – contract has ended.*

Table 3.2.7-15. CareMore – Medicare Advantage SNP Contract

CareMore Health Plan Medicare Advantage – SNP Contract H0544	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Medicare Advantage, Prescription Drug Plan HMO, and HMO SNP in the counties of Los Angeles, Orange County, San Bernardino, Santa Clara, and Stanislaus</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage). Responsible for the provision of physical health services and behavioral health services.</p>
b. Duration of Contract	<p>12 years</p>
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/2015 – 12/31/2015</p> <p>Original Contract Start: 2/1/2003</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	<p>CONTAINS CONFIDENTIAL INFORMATION</p>

e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population:	Population:	Population:	Population:	Population:
	Medicare, including Dual Eligibles	Medicare, including Dual Eligibles	Medicare, including Dual Eligibles	Medicare, including Dual Eligibles	Medicare, including Dual Eligibles
	No. of Members:	No. of Members:	No. of Members:	No. of Members:	No. of Members:
	13,247	15,728	17,999	20,784	22,859
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$284.54 million	\$375.30 million	\$449,27 million	\$504.24 million	\$518.65 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Under the CareMore model of care, dedicated physicians and case management teams coordinate care and transitions for members in the hospital and skilled nursing facility settings.</p> <p>CareMore hospital utilization results are significantly lower than the Medicare FFS average: 29 percent fewer admissions, 28 percent shorter length of stay, 48 percent fewer bed days, and 34 percent fewer readmissions. Taking the average CareMore RAF adjustment, results are even lower than Medicare FFS: 43 percent fewer admissions, 44 percent shorter length of stay, 59 percent fewer bed days, and 48 percent fewer readmissions.</p> <p>With our intense focus on the post-discharge care transition, which includes a follow-up visit with the physician, 30-day medication reconciliation rates in 2013 were 33 percent to 46 percent, compared to the Medicare mean of 17 percent (HEDIS 2014 Medication Reconciliation Post-Discharge).</p> <p>We offer a comprehensive Diabetes Management Program in the CareMore Care Centers. Based on HEDIS results, more than 80 percent of diabetics have HbA1c blood sugar under control. As of 2013, diabetic amputation rates were 66 percent lower than the Medicare average.</p> <p>Patients in our Chronic Kidney Disease Program are aggressively managed to delay the onset of end-stage renal disease. According to our modeling, the average CareMore member with chronic kidney disease Stage 3 would progress to dialysis in slightly over 24 years, as opposed to less than six years noted in the landmark Modification of Diet in Renal Disease study.</p> <p>For our patients with ESRD, we offer dedicated Case Management and Nurse Practitioners who closely collaborate with nephrologists and dialysis centers. CareMore ESRD program participants are less likely to be hospitalized, with acute admission rates 50 percent below Medicare.</p> <p>Patients in our COPD Management Program receive self-care education and management of routine and rescue medications. COPD program members on oxygen have 52 percent fewer acute hospitalizations than the Medicare average.</p>				

<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-16. Blue Cross of California – Cal MediConnect Contract

<p>Blue Cross of California Partnership Plan, Inc. – Dual Eligibles Coordinated Care Demonstration - Cal MediConnect, H6229</p>					
<p>Reference Information (Current/Prior Services Performed For:)</p>					
<p>a. Scope of work and covered benefits</p>	<p>Participating at-risk managed care organization in the state and CMS Medicaid and Medicare managed care program in Los Angeles and Santa Clara counties.</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, and pharmacy.</p>				
<p>b. Duration of Contract</p>	<p>Two years</p>				
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 12/31/13 – 12/31/17 Original Contract Start: 12/31//13</p> <p>Program expanded and extended in 2014 and 2015.</p> <ul style="list-style-type: none"> • Los Angeles: 7/1/17 • Santa Clara: 1/1/17 				
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>				
<p>e. Contact name and phone number</p>	<p>Jennifer Kent Director, California DHCS 916-440-7400 jennifer.kent@dhcs.ca.gov</p>				
<p>f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract</p>	<p>Year: 2010*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2011*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2012</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2013*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2014</p> <p>Population: Dual Eligibles</p> <p>No. of Members: 1,744</p>
<p>g. Annual Contract</p>	<p>Year: 2010*</p>	<p>Year: 2011*</p>	<p>Year: 2021*</p>	<p>Year: 2013*</p>	<p>Year: 2014</p>



Payment:	N/A	N/A	N/A	N/A	N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>West Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our Average Length of Stay (ALOS) in the Skilled Nursing Facility (SNF) setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions per 1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This assures that the member receives the care they need at the level of care most appropriate. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers, as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

**Not applicable – enrollment started in 2014.*

Florida

Table 3.2.7-17. Amerigroup Florida – Medicaid Non-Reform HMO Contract

Amerigroup Florida, Inc. – Agency for Health Care Administration Standard Contract Medicaid Non-Reform HMO Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Florida’s Medicaid managed care program in the counties of Hernando, Lake, Volusia, Pasco, Pinellas, Hillsborough, Manatee, Polk, Brevard, Orange, Osceola, Seminole, Sarasota, Palm Beach, and Miami-Dade</p> <p>Responsible for the provision of physical health, behavioral health, vision, and pharmacy services</p>				
b. Duration of Contract	12 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates:: 09/01/12 – 8/31/15</p> <p>Original Contract Start: 01/01/03</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>David Rogers or Abby Riddle Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com, david.rogers@ahca.myflorida.com</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid No. of Members: 149,044	Population: Medicaid No. of Members: 153,510	Population: Medicaid No. of Members: 166,432	Population: Medicaid No. of Members: 176,000	Population: Medicaid No. of Members: N/A*
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	\$228.60 million	\$241.81 million	\$267.79 million	\$437 million	N/A
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Amerigroup successfully transitioned to an MMA (Managed Medical Assistance) Agreement mid 2014 – Regions 5 & 6 (went live June 2104); Region 11 (went live July 2014), & Region 7 (went live August 2014)</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development</p>				

	and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Members transitioned to the MMA contract

Table 3.2.7-18. Amerigroup Florida – Long-term Care Community Diversion Pilot Contract

Amerigroup Florida, Inc. – Florida Department of Elder Affairs Standard Contract Long-term Care Community Diversion Pilot Project					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in Florida’s Long-term Care (LTC) Community Diversion Pilot Project, excluding the counties of Dixie and Lafayette Responsible for the provision of physical health, behavioral health, LTSS, and pharmacy services				
b. Duration of Contract	11 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 9/1/13 – 2/28/14 Original Contract Start: 1/1/03 Contract has ended. The LTC Community Diversion Pilot Project was sunsetted when Florida launched its Managed LTC program. Amerigroup Florida was selected as one of the State’s LTC MCOs and currently operates under that agreement. Information about FP004: State of Florida Agency for Health Care Administration Standard Contract (SMMC-LTC) is provided in Table 3.2.7.2-20.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Chuck Corley, Secretary, Department of Elder Affairs Florida Department of Elder Affairs 850-414-2000 corleyct@elderaffairs.org				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: 28,166	No. of Members: 26,196	No. of Members: 27,713	No. of Members: 1,000	No. of Members: N/A*
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$212.98 million	\$212.75 million	\$220.70 million	\$38 million	N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				

h. Improvements in utilization trends and quality indicators	Amerigroup successfully transitioned to an SMMC-LTC (Statewide Managed Medical Care / Long Term Care) Agreement late 2013 – Region 10 (went live Nov 2013); Region 11 (went live Dec 2013)
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Members transitioned to the SMMC-LTC Agreement

Table 3.2.7-19. Amerigroup Florida – Florida Healthy Kids Contract

Amerigroup Florida, Inc. – Florida Healthy Kids Corporation Contract for Medical Services					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in the Florida Healthy Kids (CHIP) program for the counties of Lake, Volusia, Pasco, Pinellas, Hillsborough, Polk, Orange, Palm Beach, Broward, and Miami-Dade				
	Responsible for the provision of physical health, behavioral health, vision, and pharmacy services				
b. Duration of Contract	12 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 10/01/12 – 9/30/15 Original Contract Start: 01/01/03				
	Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Fred Knapp, Interim Executive Director, Florida Healthy Kids Corporation Florida Healthy Kids Corporation 850-701-6111 knappf@healthykids.org				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP
	No. of Members: 83,713	No. of Members: 74,637	No. of Members: 59,849	No. of Members: 55,000	No. of Members: 42,395



the Contract					
g. Annual Contract Payment:	Year: 2010 \$85.16 million	Year: 2011 \$92.67 million	Year: 2012 \$87.89 million	Year: 2013 \$80 million	Year: 2014 \$73.41 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Keeping our FHK members healthy is our primary goal, and we are committed to promoting strong immunization rates among FHK Enrollees. Among other efforts to promote immunizations, we have instituted innovative solutions to bring immunizations to Members, such as: Health Connect, Healthy Schools, and Mobile Clinics programs/initiatives.. During 2013, we experienced significant improvements in our NCQA certified FHK HEDIS rates for immunizations in our adolescent FHK population.</p> <p>In addition, for measurement year 2013, Amerigroup Florida exceeded the 75th percentile for each of the age bands, 5-11 and 12-18 years of age, and the total rate for Use of Appropriate Medications for People with Asthma. Our ICHP rates were as follows: Ages 5-11: 95.2%, Ages 12-18: 91.1%, for a total rate of 93%.</p> <p>We were the Top Scoring Health Plan:</p> <ul style="list-style-type: none"> - Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance - Immunization for Adolescents – Combination 1 - Immunization for Adolescents – Tdap/Td - Use of Appropriate Medications for People with Asthma – Ages 5-11 - Potentially Preventable Admissions - Chlamydia Screening in Women, Ages 16-20 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-20. Amerigroup Florida – SMMC-LTC Contract

Amerigroup Florida, Inc. – State of Florida Agency for Health Care Administration Standard Contract (SMMC-LTC) FP004					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in Florida’s Medicaid Managed LTC program for Region 10 (Broward County) and Region 11 (Miami-Dade and Monroe counties) Responsible for the provision of LTSS and non-emergency medical transportation				
b. Duration of Contract	Four months				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 8/1/13 – 12/31/13 Original Contract Start: 08/01/13 Contract has ended. The LTC program moved from the Department of Elder Affairs to the Agency for Health Care Administration, effective 12/31/13. As part of that process, it was decided to have one centralized contract for Statewide Medicaid Managed Care. The LTC bids were awarded first, as it was the first time the Agency for Healthcare Administration would be administering these types of contracts. After the LTC regions were implemented, the managed care plans were awarded Managed Medical Assistance bids and had their contracts combined into one comprehensive contract that covers both LTC and MMA. This was done upon execution of the comprehensive contract, which in Florida’s case was FP021.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	David Rogers or Abby Riddle Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com, david.rogers@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010* Population: Medicaid LTC No. of Members: N/A	Year: 2011* Population: Medicaid LTC No. of Members: N/A	Year: 2012* Population: Medicaid LTC No. of Members: N/A	Year: 2013 Population: Medicaid LTC No. of Members: 5,000	Year: 2014 Population: Medicaid LTC No. of Members: N/A
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 \$16 million	Year: 2014 N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Amerigroup transitioned to SMMC-LTC (Statewide Managed Medical Care / Long Term Care) Agreement late 2013 – Region 10 (went live Nov 2013); Region 11 (went live Dec 2013) LTSS Benefit comprised of two beneficiary classes: Home and Community Based (HCBS) & Nursing Facility (NF): Underwritten MLRs: <ul style="list-style-type: none"> • HCBS 90.8% • Nursing Facility 96.7% • TOTAL LTC 94.1% Utilization ran high in Contract Year 1, with Nursing Home well above 100% MLR & HCBS performing as expected				
i. Contract emphasis on	As the nation’s leader in state-sponsored and other publicly funded health programs,				



<p>member choice, access, safety, independence, and responsibility</p>	<p>Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable – contract started in 2013.

** Total value reflects Florida Department of Elder Affairs Standard Contract Long-term Care Community Diversion Pilot Project. Program now part of Managed Medical Assistance AHCA Contract FP021

Table 3.2.7-21. Amerigroup Florida –Managed Medical Assistance AHCA Contract

<p>Amerigroup Florida, Inc. – Managed Medical Assistance and Long Term Care AHCA Contract FP021</p>	
<p>Reference Information (Current/Prior Services Performed For:)</p>	
<p>a. Scope of work and covered benefits</p>	<p>Participating at-risk MCO in Florida’s Medicaid managed care program for the counties of Miami-Dade, Monroe, Brevard, Orange, Osceola, Seminole, Hardee, Highlands, Hillsborough, Manatee, Polk, Pasco, and Pinellas</p> <p>Responsible for the provision of physical health, behavioral health, dental, vision, pharmacy, long term care services, and non-emergency medical transportation.</p>
<p>b. Duration of Contract</p>	<p>Four years</p>
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 1/1/14 – 12/31/18 Original Contract Start: 01/01/14</p> <p>The LTC program moved from the Department of Elder Affairs to the Agency for Health Care Administration, effective 12/31/13. As part of that process, it was decided to have one centralized contract for Statewide Medicaid Managed Care. The LTC bids were awarded first, as it was the first time the Agency for Healthcare Administration would be administering these types of contracts. After the LTC regions were implemented, the managed care plans were awarded Managed Medical Assistance bids and had their contracts combined into one comprehensive contract that covers both LTC and MMA. This was done upon execution of the comprehensive contract, which in Florida’s case was FP021.</p>
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>
<p>e. Contact name and phone number</p>	<p>David Rogers or Abby Riddle, Assistant Deputy Secretary for Medicaid Health Systems Florida Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com, david.rogers@ahca.myflorida.com</p>

	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: TANF, ABD, Dual Eligibles No. of Members: 318,882
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013* N/A	Year: 2014 \$833.2 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Amerigroup Florida instituted Quality Improvement initiatives on advance care planning, medication review, and functional status assessment procedures in 2014. The health plan is currently collecting data to analyze the results of these initiatives. With respect to the SMMC-LTC Contract Care for Older Adults, we instituted the following measures: required record documentation, face-to-face encounters, Case Manager training, and timeliness of service monitoring. The baseline measurement period was January 1, 2014 – December 31, 2014, and we are presently collecting data for review.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract started in 2014.

Table 3.2.7-22. Amerigroup Florida – Medicare Advantage D-SNP Contract

Amerigroup Florida, Inc. – Medicare Advantage D-SNP Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Medicare Advantage Special Needs Plan (Dual Eligible) coordination agreement with state Medicaid agency for the counties of Broward, Hillsborough, Miami-Dade, Orange, Palm Beach, Pasco, Pinellas, and Polk Florida D-SNP coordination contract is an at-risk agreement for coverage of Medicaid benefits beyond Medicare coverage limits with some exceptions. Additional information on Medicare covered services is provided in the corresponding CMS contract listing (H8991).
b. Duration of Contract	Six years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 2/9/11 – 12/31/17 Original Contract Start: 2/9/11 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.

d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Frank Dichio Agency for Health Care Administration 850-412-4137 frank.dichio@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010* Population: N/A No. of Members: N/A	Year: 2011* Population: N/A No. of Members: N/A	Year: 2012* Population: N/A No. of Members: N/A	Year: 2013* Population: N/A No. of Members: N/A	Year: 2014* Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013* N/A	Year: 2014* N/A
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: N/A – Contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Contract is a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

**Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H8991.*

Table 3.2.7-23. Amerigroup Florida – Medicare Advantage SNP Contract

Amerigroup Florida, Inc. – Medicare Advantage SNP Contract H8991	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating Medicare Advantage MCO offering a SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage). Responsible for the provision of physical health and behavioral health services
b. Duration of Contract	Nine years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/15 – 12/31/17 Original Contract Start: 1/1/08 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.

d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010 Population: Medicare No. of Members: 2,204	Year: 2011 Population: Medicare No. of Members: 2,237	Year: 2012 Population: Medicare No. of Members: 2,008	Year: 2013 Population: Medicare No. of Members: 2,000	Year: 2014 Population: Medicare No. of Members: 2,831
g. Annual Contract Payment:	Year: 2010 \$24.58 million	Year: 2011 \$28.57 million	Year: 2012 \$25.03 million	Year: 2013 \$29 million	Year: 2014 \$31.60 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>East Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions per 1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This assures that the member receives the care they need at the level of care most appropriate. Through our stabilization case management, we reduced our 30 day all cause readmission rate from 15% in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-24. *Simply Healthcare Plans, Inc. – Florida SMMC & MMA Program*

Simply Healthcare Plans, Inc. – Florida Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Contract FP018					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk managed care organization in the State's Medicaid managed care program for TANF, ABD, and Dual Eligible populations in Region 11: Miami-Dade and Monroe Counties. (FP018) Covered services include physical health, behavioral health, dental, vision, pharmacy, non-emergency medical transportation				
b. Duration of Contract	Four years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 02/03/14 - 12/31/18 This is the original contract. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	David Rogers, Assistant Deputy Secretary Abby Riddle, Bureau Chief, Health Systems Tamara Zanders, Contract Manager Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com david.rogers@ahca.myflorida.com tamara.zanders@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010 Population: N/A No. of Members: N/A	Year: 2011 Population: N/A No. of Members: N/A	Year: 2012 Population: N/A No. of Members: N/A	Year: 2013 Population: N/A No. of Members: NA	Year: 2014 Population: TANF, ABD, Dual Eligibles No. of Members: 41,125
g. Annual Contract Payment:	Year: 2010 N/A	Year: 2011 N/A	Year: 2012 N/A	Year: 2013 N/A	Year: 2014 \$165.6 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Simply Healthcare Plans' Case and Disease Management (CM/DM) Unit works closely with other departments to promote early identification of members with complex medical conditions and special needs. In 2014, completion of health risk assessments presented challenges. Interventions, such as the recruitment of staff with specific experience to address the needs of those members, and enhancements in reporting capabilities have contributed to the improvement of this quality indicator. Health risk assessment completion for newly				

	<p>enrolled or invited in CM/DM increased to 97.6 percent.</p> <p>Our third quarter 2013 Medical Records Review identified deficiencies in Pediatric Preventive Care documentation. Interventions included increased education of providers and their office staffs, and a follow-up review within six months. By the end of the year, the score for pediatrics documentation increased from 79 to 90 percent</p> <p>Children’s Health Check-Up Program/Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual measures have improved as evidenced by an analysis of year-over-year 2012-2013 and 2013-1014 results. There was a nine percent Improvement on 90-Day Screening Ratio, five percent on Participation Ratio (now compliant with goal) and nine percent on the Eight-Month Screening Ratio. We achieved this through interventions in various departments, including Provider Relations, Member Services, as well as Quality Management. Maternity Case Managers also assisted by encouraging women who had recently delivered to schedule well-care visits for their babies. An increase in personal interactions between members and Plan staff also contributed to the improved results in 2013-2014.</p> <p>HEDIS Performance Measures rates also improved year-over-year for Better Health, Simply Healthcare Plans. An example is Adult BMI Assessment (ABA). For Simply Healthcare, the rate increased to 84.90 percent in 2014 from 63.70 percent in 2013. Better Health’s rate increased from 42.0 percent in 2013 to 60.3 percent in 2014. Improvement strategies included a fax blast to providers about the importance of assessing BMI in their adult patients, recruitment of case managers to focus specifically on helping members identified as obese by their primary care provider with weight loss efforts, and a weight loss incentive program for members with a BMI ≥ 30.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-25. *Simply Healthcare Plans, Inc. – Florida Medicare Advantage SNP Contract*

<p>Simply Healthcare Plans, Inc. – Florida Medicare Advantage SNP FP047</p>	
<p>Reference Information (Current/Prior Services Performed For:)</p>	
<p>a. Scope of work and covered benefits</p>	<p>Participating Medicare Advantage MCO offering a SNP for Dual Eligible enrollees; responsible for coordination of benefits activities for Miami-Dade, Orange, Osceola, Polk and Seminole Counties. (FP047)</p>
<p>b. Duration of Contract</p>	<p>Two years</p>
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 01/01/2015 - 12/31/2017 This is the original contract. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>

e. Contact name and phone number	Frank Dichio Agency for Health Care Administration 850-412-4137 frank.dichio@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010 N/A	Year: 2011 N/A	Year: 2012 N/A	Year: 2013 N/A	Year: 2014 N/A
Capitated Payment:	<input type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A – Contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Contract is a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Contract took effect January 1, 2015.

Table 3.2.7-26. *Simply Healthcare Plans, Inc. – Florida SMMC & MMA Contract*

Simply Healthcare Plans, Inc. (dba Clear Health Alliance) – Florida Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Contract FP030	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating at-risk managed care organization in Florida’s Statewide Medicaid Managed Care MMA Program Contract for TANF, ABD, and Dual Eligible individuals in all regions, except Region 4 Covered services include physical health, behavioral health, dental, vision, pharmacy, non-emergency medical transportation
b. Duration of Contract	Four years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 02/03/14 - 12/31/18 This is the original contract. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.

d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	David Rogers, Assistant Deputy Secretary Abby Riddle, Bureau Chief, Health Systems Tamara Zanders, Contract Manager Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com david.rogers@ahca.myflorida.com tamara.zanders@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: TANF, ABD, and Dual Eligible
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: 2,574*
g. Annual Contract Payment:	Year: 2010 N/A	Year: 2011 N/A	Year: 2012 N/A	Year: 2013 N/A	Year: 2014 \$114.9 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Simply Healthcare Plans' CM/DM Unit works closely with other departments to promote early identification of members with complex medical conditions and special needs. In 2014, completion of health risk assessments presented challenges. Interventions such as the recruitment of staff with specific experience to address the needs of those members and enhancements in reporting capabilities have contributed to the improvement of this quality indicator. Health risk assessment completion for newly enrolled or invited in CM/DM increased to 97.6 percent.</p> <p>Our third quarter 2013 Medical Records Review identified deficiencies in Pediatric Preventive Care documentation. Interventions included increased education of providers and their office staffs, and a follow-up review within six months. By the end of the year, the score for pediatrics documentarian increased from 79 to 90 percent</p> <p>Children's Health Check-Up Program/EPSTDT annual measures have improved as evidenced by an analysis of year-over-year 2012-2013 and 2013-1014 results. There was a nine percent improvement on 90-Day Screening Ratio, five percent on Participation Ratio (now compliant with goal) and nine percent on the Eight-Month Screening Ratio. We achieved this through interventions in various departments, including Provider Relations, Member Services, as well as Quality Management. Maternity Case Managers also assisted by encouraging women who had recently delivered to schedule well-care visits for their babies. An increase in personal interactions between members and Plan staff also contributed to the improved results in 2013-2014.</p> <p>HEDIS Performance Measures rates also improved year-over-year for Better Health, Simply Healthcare Plans. An example is Adult BMI Assessment. For Simply Healthcare, the rate increased to 84.90 percent in 2014 from 63.70 percent in 2013. Better Health's rate increased from 42.0 percent in 2013 to 60.3 percent in 2014. Improvement strategies included a fax blast to providers about the importance of assessing BMI in their adult patients, recruitment of case managers to focus specifically on helping members identified as obese by their primary care provider with weight loss efforts, and a weight loss incentive program for members with a BMI ≥ 30.</p>				
i. Contract emphasis on	As the nation's leader in state-sponsored and other publicly funded health programs,				

<p>member choice, access, safety, independence, and responsibility</p>	<p>Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-27. Better Health, Inc. – Florida SMMC & MMA Contract FP013

<p>Better Health, Inc. – Florida Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Contract FP013</p>					
<p>Reference Information (Current/Prior Services Performed For:)</p>					
<p>a. Scope of work and covered benefits</p>	<p>Participating at-risk MCO in Florida’s Statewide Medicaid Managed Care Managed Medical Assistance program (FP013) for TANF, ABD and Dual Eligible individuals in Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk Counties, and Region 10 Broward County.</p> <p>Covered services include physical health, behavioral health, dental, vision, pharmacy, non-emergency medical transportation.</p>				
<p>b. Duration of Contract</p>	<p>Four years</p>				
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 02/03/14 - 12/31/18 This is the original contract.</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>				
<p>e. Contact name and phone number</p>	<p>David Rogers, Assistant Deputy Secretary Abby Riddle, Bureau Chief, Health Systems Tamara Zanders, Contract Manager Agency for Health Care Administration 850-412-4000 abby.riddle@ahca.myflorida.com david.rogers@ahca.myflorida.com tamara.zanders@ahca.myflorida.com</p>				
<p>f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly</p>	<p>Year: 2010</p>	<p>Year: 2011</p>	<p>Year: 2012</p>	<p>Year: 2013</p>	<p>Year: 2014</p>
	<p>Population: N/A</p>	<p>Population: N/A</p>	<p>Population: N/A</p>	<p>Population: Medicare</p>	<p>Population: Medicare</p>
	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members:</p>



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

funded) for each Year of the Contract					48,809
g. Annual Contract Payment:	Year: 2010 N/A	Year: 2011 N/A	Year: 2012 N/A	Year: 2013 N/A	Year: 2014 \$134.4 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Simply Healthcare Plans' CM/DM Unit works closely with other departments to promote early identification of members with complex medical conditions and special needs. In 2014, completion of health risk assessments presented challenges. Interventions such as the recruitment of staff with specific experience to address the needs of those members and enhancements in reporting capabilities have contributed to the improvement of this quality indicator. Health risk assessment completion for newly enrolled or invited in CM/DM increased to 97.6 percent.</p> <p>Our third quarter 2013 Medical Records Review identified deficiencies in Pediatric Preventive Care documentation. Interventions included increased education of providers and their office staffs, and a follow-up review within six months. By the end of the year, the score for pediatrics documentarian increased from 79 to 90 percent</p> <p>Children's Health Check-Up Program/Early Periodic Screening, Diagnosis, and Treatment annual measures have improved as evidenced by an analysis of year-over-year 2012-2013 and 2013-2014 results. There was a nine percent improvement on 90-Day Screening Ratio, five percent on Participation Ratio (now compliant with goal) and nine percent on the Eight-Month Screening Ratio. We achieved this through interventions in various departments, including Provider Relations, Member Services, as well as Quality Management. Maternity Case Managers also assisted by encouraging women who had recently delivered to schedule well-care visits for their babies. An increase in personal interactions between members and Plan staff also contributed to the improved results in 2013-2014.</p> <p>HEDIS Performance Measures rates also improved year-over-year for Better Health, Simply Healthcare Plans. An example is Adult BMI Assessment. For Simply Healthcare, the rate increased to 84.90 percent in 2014 from 63.70 percent in 2013. Better Health's rate increased from 42.0 percent in 2013 to 60.3 percent in 2014. Improvement strategies included a fax blast to providers about the importance of assessing BMI in their adult patients, recruitment of case managers to focus specifically on helping members identified as obese by their primary care provider with weight loss efforts, and a weight loss incentive program for members with a BMI \geq 30.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-28. Better Health – MediPass Provider Service Network Program (FP964)

Better Health, Inc. – MediPass Provider Service Network (PSN) Program Contract FP964					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Managing entity for MediPass Provider Service Network (PSN) serving Medicaid recipients in 31 counties statewide, including Alachua, Bradford, Bay, Calhoun, Collier, Columbia, Charlotte, Desoto, Dixie, Escambia, Franklin, Gilchrist, Glades, Gulf, Hamilton, Hardee, Holmes, Indian River, Jackson, Lafayette, Levy, Monroe, Okaloosa, Okeechobee, St. Johns, Santa Rosa, Suwannee, Taylor, Union, Walton, and Washington Counties (FP964)</p> <p>Responsible for providing case management program services, implementing utilization management and preauthorization initiatives that result in improved care coordination, improved health status of recipients, and reduction of costs to the Florida Agency for Health Care Administration</p>				
b. Duration of Contract	Two years				
c. Contract start/end dates, alterations to timeframe	Contract Start and End Dates: 05/14/12 - 07/31/14. Contract has ended.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	David Rogers, Assistant Deputy Secretary Tracy Hurd-Alvarez, Health Systems Dev. Tracy Jeter-Cummings, Contract Manager Agency for Health Care Administration 850-412-4000 david.rogers@ahca.myflorida.com tracy.hurd-alvarez@ahca.myflorida.com tracy.jeter-cummings@ahca.myflorida.com				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: Medicaid No. of Members: 75,941	Population: Medicaid No. of Members: 147,960	Population: Medicaid No. of Members: 55,862
g. Annual Contract Payment:	Year: 2010 N/A	Year: 2011 N/A	Year: 2012 \$3.8 million	Year: 2013 \$13.58 million	Year: 2014 \$5.12 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Simply Healthcare Plans' CM/DM Unit works closely with other departments to promote early identification of members with complex medical conditions and special needs. In 2014, completion of health risk assessments presented challenges. Interventions such as the recruitment of staff with specific experience to address the needs of those members and enhancements in reporting capabilities have contributed to the improvement of this quality indicator. Health risk assessment completion for newly enrolled or invited in CM/DM increased to 97.6 percent.</p> <p>Our third quarter 2013 Medical Records Review identified deficiencies in Pediatric Preventive Care documentation. Interventions included increased education of providers and their office</p>				

	<p>staffs, and a follow-up review within six months. By the end of the year, the score for pediatrics documentarian increased from 79 to 90 percent</p> <p>Children’s Health Check-Up Program/Early Periodic Screening, Diagnosis, and Treatment annual measures have improved as evidenced by an analysis of year-over-year 2012-2013 and 2013-1014 results. There was a nine percent improvement on 90-Day Screening Ratio, five percent on Participation Ratio (now compliant with goal) and nine percent on the Eight-Month Screening Ratio. We achieved this through interventions in various departments, including Provider Relations, Member Services, as well as Quality Management. Maternity Case Managers also assisted by encouraging women who had recently delivered to schedule well-care visits for their babies. An increase in personal interactions between members and Plan staff also contributed to the improved results in 2013-2014.</p> <p>HEDIS Performance Measures rates also improved year-over-year for Better Health, Simply Healthcare Plans. An example is Adult BMI Assessment. For Simply Healthcare, the rate increased to 84.90 percent in 2014 from 63.70 percent in 2013. Better Health’s rate increased from 42.0 percent in 2013 to 60.3 percent in 2014. Improvement strategies included a fax blast to providers about the importance of assessing BMI in their adult patients, recruitment of case managers to focus specifically on helping members identified as obese by their primary care provider with weight loss efforts, and a weight loss incentive program for members with a BMI \geq 30.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Georgia

Table 3.2.7-29. Amerigroup Georgia – Georgia Families Contract

Amerigroup Georgia Managed Care Company, Inc. – Georgia Families					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Georgia’s Medicaid and CHIP (PeachCare for Kids) managed care program (Georgia Families); Foster Care added in 2014 (Georgia Families 360°)</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, and pharmacy</p>				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/15 – 6/30/16 Original Start Date: 6/1/06</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Linda Wiant Chief Medicaid Division 404-651-8681 lwiant@dch.ga.gov or Lynnette R. Rhodes Deputy Director, Medicaid Operations 404-656-7513 lrhodes@dch.ga.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 265,636</p>	<p>Year: 2011</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 255,826</p>	<p>Year: 2012</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 287,555</p>	<p>Year: 2013</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 294,000</p>	<p>Year: 2014</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 352,860</p>
g. Annual Contract Payment:	Year: 2010 \$691.33 million	Year: 2011 \$729.28 million	Year: 2012 \$734.00 million	Year: 2013 \$794 million	Year: 2014 \$1.05 billion
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Amerigroup Community Care Georgia has extensive experience in reducing preventable ER visits. Through targeted network expansion, information sharing, and incentive payments, namely with our medical homes, we have been able to drive an overall 11.3 percent decrease in ER from 2012-2014 and an increase in PCP and Urgent Care Center visits. For a comparison, six months before and six after ER case management in 2013, there was a 22 percent decrease in total ER visits, 30 percent decrease in total inpatient visits, and five percent decrease in total outpatient. Our team notifies key hospitals of members who frequently access the ER through our Case Management Program. We share weekly ER utilization reports</p>				

	<p>and scorecards with high volume practices to assist them with tracking and population management. In addition to our quality gain share program, we incentivize appointments after hours and outside of normal business hours so that members have access to appropriate care.</p> <p>We enhanced our pharmacy program in 2012 with PCP lock-in. Before this enhancement in 2011 and 2012, for a comparison three months prior and after lock-in, there was an average 25 percent decrease in average number of prescriptions. After implementing the enhancement, that average jumped to 43.5 percent in 2013 and 2014. We also offer Right Care, Place, and Time education such as “Ask my PCP first” to members, Being Healthy Brings Rewards, and interventions such as clinic days and health promotions calls and mailings. Amerigroup Community Care Georgia is NCQA ranked #32 nationally, #1 in Georgia, #1 in region, and #2 in the company nationally. We were awarded auto-assignment for seven out of 12 six-month cycles based on state quality indicators. Our success stems from a high-touch collaboration approach with high-volume practices to improve quality, produce significant cost savings, and increase our membership in high quality/low cost groups.</p> <p>In 2011, we began with five provider groups, 12 sites, 61 providers, and 20,537 members in Patient-Centered Medical Homes. In 2014, we grew to include 19 provider groups, 75 sites, 293 providers, and 52,984 members.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-30. Amerigroup Georgia – Medicare Advantage D-SNP Contract

Amerigroup Georgia Managed Care Company, Inc. – Medicare Advantage D-SNP Contract	
Reference Information (Current/Prior Services Performed For:)	
<p>a. Scope of work and covered benefits</p>	<p>Medicare Advantage D-SNP coordination agreement with the state Medicaid agency for Chatham and Fulton counties</p> <p>Georgia D-SNP coordination contract is required to coordinate benefits, not specific covered services. Additional information on Medicare covered services is provided in the corresponding CMS contract listing.</p>
<p>b. Duration of Contract</p>	<p>Three years</p>
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 1/1/2014 – 12/31/2015 Original Contract Start: 1/1/2012</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
<p>d. Total value of the Contract at execution and any alteration(s) to that</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>

amount. Provide reason(s) for alteration(s)					
e. Contact name and phone number	Marcey D. Alter, Program Director Division of Medicaid/Aging and Special Populations 404-657-5467 malter@dch.ga.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	N/A	N/A	N/A	N/A	N/A
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: N/A – contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Contract is a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H2411.

Table 3.2.7-31. Amerigroup Georgia – Medicare Advantage D-SNP Contract

Amerigroup Georgia Managed Care Company, Inc. – Medicare Advantage D-SNP Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating Medicare Advantage MCO offering a SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state. SNP plan is for Chatham and Fulton counties. Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage). Responsible for the provision of physical health and behavioral health services
b. Duration of Contract	Three years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/12 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s)	CONTAINS CONFIDENTIAL INFORMATION

for alteration(s)					
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012	Year: 2013	Year: 2014
	Population: N/A	Population: N/A	Population: Medicare, including Dual Eligibles	Population: Medicare, including Dual Eligibles	Population: Medicare, including Dual Eligibles
	No. of Members: N/A	No. of Members: N/A	No. of Members: 95	No. of Members: 100	No. of Members: 92
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012 \$842,468	Year: 2013 \$800,000	Year: 2014 \$909,857
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Central Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions per 1000 members also decreased year-over-year 2013 to 2014 by 24%. This reduction was achieved through an increased utilization of outpatient observation status. This assures that the member receives the care they need at the level and intensity that is most appropriate. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including: enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract started in 2012.

Indiana

Table 3.2.7-32 .Anthem Insurance – Hoosier Healthwise and Healthy Indiana Plan Contract

Anthem Insurance Companies, Inc. – Hoosier Healthwise and Healthy Indiana Plan Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the state’s Medicaid, CHIP, and uninsured adults managed care programs</p> <p>Responsible for the provision of physical health services, behavioral health, dental, vision, and non-emergency medical transportation</p>				
b. Duration of Contract	Seven years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Current Contract Start and End Dates: 1/1/2011 – TBD*</p> <p>Original Contract Start: Hoosier Healthwise – 01/01/07; Healthy Indiana Plan –01/01/08</p> <p>*Termination date of contract not yet finalized</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Douglass L. Montgomery, Director of Indiana Health Coverage Programs, Indiana Family and Social Service Administration (FSSA) Operations 317-233-2834 Doug.Montgomery@FSSA.in.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: Medicaid, CHIP, low-income individuals</p> <p>No. of Members: 201,711</p>	<p>Population: Medicaid, CHIP, low-income individuals</p> <p>No. of Members: 241,565</p>	<p>Population: Medicaid, CHIP, low-income individuals</p> <p>No. of Members: 240,954</p>	<p>Population: Medicaid, CHIP, low-income individuals</p> <p>No. of Members: 237,651</p>	<p>Population: Medicaid, CHIP, low-income individuals</p> <p>No. of Members: 242,702</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, describe: N/A</p>				
g. Annual Contract Payment:	\$365.12 million	\$426.07 million	\$427.57 million	\$426.33 million	\$479.7 million
h. Improvements in utilization trends and quality indicators	<p>Anthem has been serving Hoosier Healthwise (HHW) members, including those who qualify under TANF and CHIP, since 2007. We have decreased utilization by addressing unnecessary utilization and through programs to improve quality and our members’ overall health. From 2012 to 2013, high tech radiology utilization decreased 12.6 percent, outpatient surgeries 2.8 percent, inpatient admissions per thousand members 4.4 percent, and specialist physician visits 2.8 percent.</p> <p>We have been serving the Healthy Indiana Plan (HIP) population since 2008 and have had success decreasing utilization among those members. From 2012 to 2013, high tech radiology decreased 4.2 percent, with a corresponding 13.3 percent cost savings; outpatient surgery</p>				

	<p>utilization was down 3 percent; and inpatient admissions per thousand and inpatient days per thousand dropped 16.5 and 19.4 percent respectively. Emergency room visits for members were also down 11.1 percent.</p> <p>We have also improved quality in both Hoosier Healthwise and Healthy Indiana Plans. From reporting year 2013 to reporting year 2014, Indiana Medicaid improved our scores in 33 HHW HEDIS measures. In the same period, for Healthy Indiana Plan, we improved in 20 measures. In 2014, we achieved the 50th percentile in 16 of 28 HHW measures and 13 of 15 HIP measures. Indiana Medicaid experienced incremental increases in each of the last two HEDIS seasons in 16 HHW and eight HIP measures. Our best-in-class Behavioral Health Transition Appointment Program has driven our Follow up after Hospitalization rates for Hoosier Healthwise, achieving the 75th or 90th percentile year after year.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Kansas

Table 3.2.7-33. Amerigroup Kansas – KanCare Contract

Amerigroup Kansas, Inc. – Kansas Department of Health and Environment KanCare Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the Kansas Medicaid managed care program (KanCare) with no carved-out Medicaid populations</p> <p>Responsible for the provision of physical health services, behavioral health services, long-term care, dental, vision, pharmacy, and non-emergency medical transportation, LTSS Waiver Services, nursing facility, and Intermediate Care Facility for the Mentally Retarded (ICF/MR)</p>				
b. Duration of Contract	Two years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/13 – 12/31/15</p> <p>Original Start Date: 1/1/13</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Michael Randol Director, Division of Health Care Finance 785-296-3512 mrandol@kdheks.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	<p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 125,000</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 130,158</p>
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 \$721 million	Year: 2014 \$900.9 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Health Homes</p> <p>Amerigroup Kansas, worked with the state over an 18-month period to implement health homes for those with Serious Mental Illness (SMI) in August 2014. The model includes the MCO as the Lead Entity with Community Mental Health Centers and other agencies and providers acting as Health Home Providers.</p> <p>Amerigroup has experienced a very high level of interest from members identified as meeting criteria for the health home, and we currently have more than 7,000 of them participating, with higher than an 85 percent retention rate.</p> <p>Through our coordination processes, we are able to work with our community partners to better support those members with SMI in their home communities by developing Health Action Plans that address their health goals.</p> <p>Intellectual Disabilities/Developmental Disabilities (ID/DD)</p> <p>Amerigroup Kansas worked with the state, as well as community partners and providers, to implement a carve-in of ID/DD Long-term Services and Supports (LTSS) for our 3,500 participating members from FFS into KanCare, the Medicaid Managed Care program on</p>				

	February 1, 2014. This year-long process included stakeholder, member, and family engagement; piloting service delivery, claims, and administrative processes, as well as intensive community education. Although the ID/DD waiver participants had been enrolled into KanCare for other Medicaid services, the LTSS transition represented a very large paradigm shift for them. Through collaboration with our state and community partners, we effected a seamless implementation where members benefitted from the continuity and support of their service plans and service providers.
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

* Not applicable – contract started in 2013.

Table 3.2.7-34. UNICARE – Kansas HealthWave XIX and XXI Contract

UNICARE Health Plan of Kansas, Inc. – Kansas HealthWave XIX and XXI Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in the Kansas Medicaid and CHIP managed care program Responsible for the provision of physical health services, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	Five years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/07 – 12/31/12 Original Contract Start: 01/01/07 Contract has ended. HealthWave XIX and XXI were subsumed by the comprehensive Kansas Medicaid managed care program, KanCare.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Paul Endacott Kansas Department of Health and Environment (KDHE) 785-296-3981 Pendacott@kdheks.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly	Year: 2010	Year: 2011	Year: 2012	Year: 2013*	Year: 2014*
	Population: Medicaid, CHIP	Population: Medicaid, CHIP	Population: Medicaid, CHIP	Population: N/A	Population: N/A
	No. of Members:	No. of Members:	No. of Members:	No. of	No. of



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

funded) for each Year of the Contract	56,486	76,843	87,951	Members: N/A	Members: N/A
g. Annual Contract Payment:	Year: 2010 \$141.85 million	Year: 2011 \$153.88 million	Year: 2012 \$176.49 million	Year: 2013* N/A	Year: 2014* N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	HealthWave XIX and XXI were subsumed by the comprehensive Kansas Medicaid managed care program, KanCare. Details on improvement trends and quality indicators of UniCare's affiliate Amerigroup Kansas in the KanCare program are presented in Table 3.2.7-33.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract ended in 2012.

Kentucky

Table 3.2.7-35. Anthem Health Plans of Kentucky – Medicaid Managed Care Program Contract

Anthem Health Plans of Kentucky, Inc. – Department for Medicaid Services Medicaid Managed Care Program Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in Kentucky’s Medicaid managed care program Responsible for the provision of physical health services, behavioral health services, dental, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	18 months				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/14 – 6/30/15 Original Contract Start: 01/01/14 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Corey Kennedy Department of Medicaid Services (502) 564-9444 ext 3776 Corey.Kennedy@ky.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014
	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: Medicaid No. of Members: 60,148
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 N/A	Year: 2014 \$267.4 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	The Kentucky Anthem BlueCross and BlueShield Medicaid health plan went live January 1, 2014. Since that time, we have implemented initiatives to impact member health outcomes related to utilization management and quality indicators, including: <ul style="list-style-type: none"> • Warm Health, a pregnancy-related initiative • Pay for Performance initiatives with high volume providers targeted to improving HEDIS outcomes • Teledoc, which offers telephonic MD access to members to help reduce ER super utilization • A Medication Therapy Management Program with Physicians Pharmacy Alliance, providing pharmacy-specific case management in home visits and medication inventory, medication synchronization, mailing of medication, and ongoing adherence and compliance 				
i. Contract emphasis on member choice,	Amerigroup is the nation’s leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes				

access, safety, independence, and responsibility	member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

**Not applicable – contract started in 2014. Q2 CY 2014 members*

Louisiana

Table 3.2.7-36. Amerigroup Louisiana – Bayou Health Contract

Amerigroup Louisiana, Inc. – Department of Health and Hospitals Bayou Health Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in Louisiana’s Medicaid managed care program (Bayou Health) Responsible for the provision of physical health services, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	Six years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 2/1/15 – 1/31/18 Original Start Date: 2/1/12 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Ruth Kennedy, Medicaid Director Louisiana Department of Health and Hospitals 225-342-3032 Ruth.Kennedy@la.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010* Population: N/A No. of Members: N/A	Year: 2011* Population: N/A No. of Members: N/A	Year: 2012 Population: Medicaid, CHIP No. of Members: 105,390	Year: 2013 Population: Medicaid, CHIP No. of Members: 129,000	Year: 2014 Population: Medicaid, CHIP No. of Members: 133,131
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012 \$269.8 million	Year: 2013 \$412 million	Year: 2014 \$396.56 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and	Amerigroup Louisiana has launched two new initiatives as part of its new contract February 1, 2015. We developed and launched system logic for a pediatric health risk screener. We				

quality indicators	<p>include the pediatric screener in all new member welcome packets and our HCMS Manager is work tirelessly with the CareCompass team to score members and enter them into specific categories based on returned assessments. This allows us to more proactively manage our new members.</p> <p>Additionally, we have deployed our Case Management Nurses with IPADs[®] that have both the Adult & Pediatric Assessments loaded. We have field-based case management staff available to meet with members and, with the new contract, we have provided Clinical Case Managers the opportunity to manage their documentation in the field directly with the member and provider.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>Amerigroup is the nation’s leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable – contract started in 2012.

Maryland

Table 3.2.7-37. Amerigroup Maryland – MCO HealthChoice Provider Agreement Contract

Amerigroup Maryland, Inc. – Managed Care Organization HealthChoice Provider Agreement Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Maryland’s Medicaid managed care program (HealthChoice)</p> <p>Responsible for the provision of physical health services, LTC, vision, and pharmacy</p>				
b. Duration of Contract	15 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/00 (Contract renews annually) Original Start Date: 6/1/99</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Rosemary E. Murphey, MBA, RN HealthChoice and Acute Care Administration 410-767-6758 rosemary.murphey@maryland.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD,	<p>Year: 2010</p> <p>Population: Medicaid</p>	<p>Year: 2011</p> <p>Population: Medicaid</p>	<p>Year: 2012</p> <p>Population: Medicaid</p>	<p>Year: 2013</p> <p>Population: Medicaid</p>	<p>Year: 2014</p> <p>Population: Medicaid</p>



BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	No. of Members: 201,882	No. of Members: 208,995	No. of Members: 217,681	No. of Members: 256,000	No. of Members: 261,152
g. Annual Contract Payment:	Year: 2010 \$705.88 million	Year: 2011 \$713.37 million	Year: 2012 \$702.73 million	Year: 2013 \$757 million	Year: 2014 \$1.069 billion
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Amerigroup Maryland implemented its Corrective Managed Care Program (CMCP), which identifies members who need additional clinical supports to better manage their pharmaceutical utilization. Our Information Technology team addresses the programmatic problem of pharmaceutical misuse, abuse, and diversion by using data to provide members with care management services in collaboration with pharmacies, physicians, and our state partner. The goal is improving members' health outcomes, promoting medication according to medical guidelines, and eliminating inappropriate prescription drug expenditures. CMCP has had a significant impact on overall pharmaceutical spending – decreasing spending on opiates by 30 percent and non-opiate prescription drugs by 25 percent. It also lowered the number of pharmaceutical scripts written – 36 percent fewer for opiates and 27 percent fewer for non-opiate prescription drugs – while also reducing the number of ER visits by 26 percent.</p> <p>Amerigroup Maryland's CMCP reduced overall health spending by approximately 20 percent for members identified for the intervention. It was driven by a decline in unnecessary pharmaceutical scripts and avoidable medical incidents, such as non-emergent ER visits. Overall, the program promotes ongoing quality of care for all members, as well as more efficient delivery of services by limiting waste, fraud, and abuse, while preserving valuable resources for those who need them. It supports our ability to deliver the right care, at the right time, and at the right location.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>Amerigroup is the nation's leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-38. Amerigroup Maryland – Medicare Advantage D-SNP Contract

Amerigroup Maryland, Inc. – Medicare Advantage D-SNP Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Medicare Advantage Special Needs Plan (Dual Eligible) coordination agreement with state Medicaid agency for counties of Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George’s</p> <p>Maryland D-SNP coordination contract is required to coordinate benefits, not specific covered services. Additional information on Medicare covered services is provided in the corresponding CMS contract listing H5896.</p>				
b. Duration of Contract	One year.				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/2010 – 12/31/2010 Original Contract Start: 1/1/2010</p> <p>Contract ended. Unable to negotiate reimbursement terms</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Rosemary E. Murphey, MBA, RN HealthChoice and Acute Care Administration 410-767-6758 rosemary.murphey@maryland.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010**	Year: 2011***	Year: 2012***	Year: 2013***	Year: 2014***
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010** N/A	Year: 2011** N/A	Year: 2012*** N/A	Year: 2013*** N/A	Year: 2014*** N/A
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: N/A – contract was a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract was a coordination agreement that ended in 2010.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Contract was a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

* Last available contact information

**Not applicable – contract was a coordination agreement. Membership and contract payments were included under CMS contract listing H5896.

***Not applicable – contract ended in 2010.

Table 3.2.7-39. Amerigroup Maryland – Medicare Advantage SNP Contract

Amerigroup Maryland, Inc. – Medicare Advantage SNP Contract H5896					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating Medicare Advantage MCO offering an SNP for dual eligible enrollees; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health and behavioral health services</p>				
b. Duration of Contract	One year				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/2010-12-31/2010</p> <p>Original Contract Start: 1/1/2010</p> <p>Contract has ended. Unable to negotiate reimbursement terms.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011**	Year: 2012**	Year: 2013**	Year: 2014**
	Population:	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: 272	No. of Members: N/A			
g. Annual Contract Payment:	Year: 2010 Unavailable	Year: 2011** N/A	Year: 2012** N/A	Year: 2013** N/A	Year: 2014** N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A –Contract was a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract was a coordination agreement that began and ended in 2010.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A – Contract was a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract began in 2010.

**Not applicable – contract ended in 2010.

Massachusetts

Table 3.2.7-40. UNICARE – Children’s Medical Security Plan Contract

UNICARE Life & Health Insurance Company – Children’s Medical Security Plan Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Administrator for the Children’s Medical Security Plan Responsible for the provision of physical health services, behavioral health services, dental, and pharmacy				
b. Duration of Contract	20 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 7/1/02 – 6/30/15 Original Contract Start: 06/16/95 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Mara H. Yerow, FACHE Massachusetts Executive Office of Health & Human Services 617-847-6521 Mara.Yerow@state.ma.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010* Population: Low-income individuals No. of Members: 21,647	Year: 2011* Population: Low-income individuals No. of Members: 18,894	Year: 2012* Population: Low-income individuals No. of Members: 19,247	Year: 2013* Population: Low-income individuals No. of Members: 20,966	Year: 2014* Population: Low-income individuals No. of Members: 17,048
g. Annual Contract Payment:	Year: 2010* \$3.46 million	Year: 2011* \$3.51 million	Year: 2012* \$3.55 million	Year: 2013* \$3.72 million	Year: 2014* \$3.24 million
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: Administrative Services Organization (ASO)				
h. Improvements in utilization trends and quality indicators	N/A: Contract is an administration agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				

j. Role of any Subcontractors:

Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Nevada

Table 3.2.7-41. Amerigroup Nevada – Medicaid and Nevada Check Up Managed Care Program

Amerigroup Nevada, Inc. – RFP/Contract #1988 Medicaid and Nevada Check Up Managed Care Program					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Nevada’s Medicaid and Nevada Check Up (CHIP) managed care program in the counties of Urban Clark and Washoe</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, and pharmacy</p>				
b. Duration of Contract	18 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/13 – 6/30/17</p> <p>Original Contract Start: 02/01/09</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>John Whaley Chief of Business Lines 775-684-3691 jwhaley@dncfp.nv.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 79,211</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 81,033</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 85,612</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 98,000</p>	<p>Population: Medicaid, CHIP</p> <p>No. of Members: 176,412</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	\$161.51 million	\$176.26 million	\$185.41 million	\$188 million	\$401 million
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Amerigroup Nevada’s Quality Management and Improvement Program is essential to making sure our members’ medical and service needs are being met, and that we are continuously improving the quality of care and services we provide.</p> <p>Inpatient Utilization Goals have been met and admissions were below target. Neonatal Intensive Care Unit (NICU) admission and bed days, OB/Nursery admission and bed days, and Med/Surg admission and bed days were all below target. Nevada implemented a Hospitalists Program to assist with inpatient management. Pre-term delivery rate decreased from 12.5/1000 to 8.6/1000 over a two-year period.</p> <p>Amerigroup Nevada assesses our members’ case management experience via Morpace</p>				

	<p>satisfaction survey and monitoring member complaint data. The quantitative analysis of the case management member satisfaction survey data and the case management complaint data shows consistently high performance year over year. During 2014, Amerigroup’s performance goal of 90% “Very Satisfied”/“Satisfied” was met for member satisfaction with Amerigroup Health Plan’s Complex Care Management Program.</p> <p>The 2014 quality interventions were possible because we added additional quality resources (clinical staff), which allowed us to dedicate more focused improvement on both the member and provider side to close HEDIS gaps. On the provider side, we established a collaborative, quality network strategy through more focused and higher quality public relations and outreach.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-42. CareMore – Medicare Advantage SNP Contract

CareMore Health Plan of Nevada – Medicare Advantage SNP Contract H4346	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Medicare Advantage, Prescription Drug Plan HMO, and HMO SNP in Las Vegas (Clark County-partial)</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage). Responsible for the provision of physical health and behavioral health services. Coverage of behavioral health benefits includes psychiatric partial hospitalization, inpatient and outpatient substance abuse services.</p>
b. Duration of Contract	5 years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/10</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION
e. Contact name and phone number	<p>CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov</p>

<p>f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract</p>	<p>Year: 2010</p>	<p>Year: 2011</p>	<p>Year: 2012</p>	<p>Year: 2013</p>	<p>Year: 2014</p>
	<p>Population: Medicare SNP</p>	<p>Population: Medicare SNP</p>	<p>Population: Medicare SNP</p>	<p>Population: Medicare SNP</p>	<p>Population: Medicare SNP</p>
	<p>No. of Members: 603</p>	<p>No. of Members: 1,281</p>	<p>No. of Members: 2,083</p>	<p>No. of Members: 2,773</p>	<p>No. of Members: 5,935</p>
<p>g. Annual Contract Payment:</p>	<p>Year: 2010 \$8.15 million</p>	<p>Year: 2011 \$22.61 million</p>	<p>Year: 2012 \$36.39 million</p>	<p>Year: 2013 \$41.18 million</p>	<p>Year: 2014 \$71.99 million</p>
<p>Capitated Payment:</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>				
<p>h. Improvements in utilization trends and quality indicators</p>	<p>Under the CareMore model of care, dedicated physicians and case management teams coordinate care and transitions for members in the hospital and skilled nursing facility settings.</p> <p>CareMore hospital utilization results are significantly lower than the Medicare FFS average: 29 percent fewer admissions, 28 percent shorter length of stay, 48 percent fewer bed days, and 34 percent fewer readmissions. Taking the average CareMore RAF adjustment, results are even lower than Medicare FFS: 43 percent fewer admissions, 44 percent shorter length of stay, 59 percent fewer bed days, and 48 percent fewer readmissions.</p> <p>With our intense focus on the post-discharge care transition, which includes a follow-up visit with the physician, 30-day medication reconciliation rates in 2013 were 33 percent to 46 percent, compared to the Medicare mean of 17 percent (HEDIS 2014 Medication Reconciliation Post-Discharge).</p> <p>We offer a comprehensive Diabetes Management Program in the CareMore Care Centers. Based on HEDIS results, more than 80 percent of diabetics have HbA1c blood sugar under control. As of 2013, diabetic amputation rates were 66 percent lower than the Medicare average.</p> <p>Patients in our Chronic Kidney Disease Program are aggressively managed to delay the onset of end-stage renal disease. According to our modeling, the average CareMore member with chronic kidney disease Stage 3 would progress to dialysis in slightly over 24 years, as opposed to less than 6 years noted in the landmark Modification of Diet in Renal Disease study.</p> <p>For our patients with ESRD, we offer dedicated case management and nurse practitioners who closely collaborate with nephrologists and dialysis centers. CareMore ESRD program participants are less likely to be hospitalized, with acute admission rates 50 percent below Medicare.</p> <p>Patients in our COPD Management Program receive self-care education and management of routine and rescue medications. COPD program members on oxygen have 52 percent fewer acute hospitalizations than the Medicare average.</p>				
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				

j. Role of any Subcontractors:

Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

New Jersey

Table 3.2.7-43. Amerigroup New Jersey – Medicaid Managed Care Contract NJ FamilyCare Program

Amerigroup New Jersey, Inc. – Medicaid Managed Care Contract NJ FamilyCare Program					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in New Jersey’s Medicaid managed care program except for Salem County				
	Responsible for the provision of physical health services, LTSS, dental, vision, and pharmacy				
b. Duration of Contract	19 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 10/1/00 – 6/30/15 Original Start Date: 2/1/96				
	Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Valerie J. Harr, Medicaid Director New Jersey Department of Human Services 609-588-2601 Valerie.J.Harr@dhs.state.nj.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid, CHIP, low-income individuals	Population: Medicaid, CHIP, low-income individuals	Population: Medicaid, CHIP, low-income individuals	Population: Medicaid, CHIP, low-income individuals	Population: Medicaid, CHIP, low-income individuals
	No. of Members: 131,496	No. of Members: 152,675	No. of Members: 147,477	No. of Members: 147,000	No. of Members: 214,992
g. Annual Contract Payment:	Year: 2010 \$378.00 million	Year: 2011 \$468.86 million	Year: 2012 \$588.90 million	Year: 2013 \$590 million	Year: 2014 \$909 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Amerigroup New Jersey’s Quality Management and Improvement Program is essential to assure members’ medical and service needs are met, and the quality of care and services are continuously improved. <ul style="list-style-type: none">Inpatient Utilization Goals have been met and admissions were below target. NICU admission and bed days, OB/Nursery admission and bed days, and Nursing Facility admission and bed days were all below target.				

	<ul style="list-style-type: none"> • About two-thirds of HEDIS measures improved from prior year reporting (22/33 = 66.6 percent). Fifteen measures met goal at the 50th National benchmark. Four measures met goal at the 75th National benchmark. Commendable NCQA status was maintained with a final HEDIS Effectiveness of Care score of 17.6752 for MY 2013. • New Jersey State contract EPSDT sanction measures – 5/6 (83.3%) EPSDT sanction measures met or exceeded established contract goals. <p>Amerigroup New Jersey assesses the member case management experience via a telephone satisfaction survey and monitoring member complaint data.</p> <ul style="list-style-type: none"> • The quantitative analysis of the case management member satisfaction survey data and the case management complaint data shows consistently high performance year over year. • During 2014, Amerigroup’s performance goal of 90 percent “Very Satisfied/Satisfied” was met by Amerigroup Health Plan’s Complex Care Management Program. The satisfaction survey results showed a 98 percent member satisfaction rate for overall satisfaction with the Complex Care Management Program. Member satisfaction scores on the remaining measures ranged from 96 to 97 percent. Fifty-three percent of members gained more confidence in their ability to take their medication after participating in the program. Forty-three percent indicated that their ability to talk with their PCP about their health has improved. <p>The 2014 quality interventions were possible because we added additional resources (clinical staff) that allowed us to focus on closing HEDIS gaps on both the member and provider side. Also on the provider side, we established a collaborative, quality network strategy through higher quality public relations and outreach, clinical detailing, and a quality bonus payment program.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Table 3.2.7-44. Amerigroup New Jersey – Medicare Advantage D-SNP Contract

Amerigroup New Jersey, Inc. – Medicare Advantage D-SNP Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Medicare Advantage Special Needs Plan (Dual Eligible) coordination agreement with state Medicaid agency in the counties of Bergen, Burlington, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic, Somerset, and Union</p> <p>New Jersey D-SNP coordination contract is an at-risk agreement for coverage of Medicaid benefits beyond Medicare coverage limits with some exceptions.</p> <p>Additional information on Medicare covered services is provided in the corresponding CMS contract listing H3240.</p>				
b. Duration of Contract	Three years.				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/12</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p> <p>There was an earlier contract, which covered 2008, but the state intentionally skipped 2009-2011.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Valerie J. Harr, Medicaid Director New Jersey Department of Human Services 609-588-2601 Valerie.J.Harr@dhs.state.nj.us</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012**	Year: 2013**	Year: 2014**
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010*	Year: 2011*	Year: 2012**	Year: 2013**	Year: 2014**
	N/A	N/A	N/A	N/A	N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe:				

<p>h. Improvements in utilization trends and quality indicators</p>	<p>East Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions per 1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This assures that the member receives the care they need at the level of care most appropriate. Through our stabilization case management program, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers, and focused care management for our members with ESRD.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>Amerigroup is the nation's leader in state-sponsored and other publicly funded health programs because we are passionate about promoting a health care delivery system that emphasizes member choice, independence and engagement. All Amerigroup health plans across the nation maintain a member-centered care model that is the core of all we do. It emphasizes member responsibility in every aspect of our programs – from our most basic member communications and outreach through our selection of value-added services and member incentive programs. We deliver exceptional member access to care by developing and maintaining robust provider networks that reflect the diversity, geographic location, and preferences of our members. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

**Not applicable – contract started in 2012.*

***Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H3240.*

Table 3.2.7-45. Amerigroup New Jersey – Medicare Advantage SNP Contract

Amerigroup New Jersey, Inc. – Medicare Advantage SNP Contract H3240	
Reference Information (Current/Prior Services Performed For:)	
<p>a. Scope of work and covered benefits</p>	<p>Participating Medicare Advantage MCO offering an SNP for dual eligible enrollees. Responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health and behavioral health services</p>
<p>b. Duration of Contract</p>	<p>Six years</p>
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/08 Contract has ended.</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>



d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicare SNP No. of Members: 2,455	Population: Medicare SNP No. of Members: 3,397	Population: Medicare SNP No. of Members: 4,848	Population: Medicare SNP No. of Members: 6,000	Population: Medicare SNP No. of Members: 5,568
g. Annual Contract Payment:	Year: 2010 \$25.13 million	Year: 2011 \$33.30 million	Year: 2012 \$56.96 million	Year: 2013 \$69 million	Year: 2014 \$71.53 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Quality initiatives focused on inpatient utilization admissions/1,000 members and realized a decrease of 8.7 percent for 2014 compared to 2013. The program's Star Rating improved from 2.5 to 3.0.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

New Mexico

Table 3.2.7-46. Amerigroup Community Care of New Mexico – CoLTS Program Contract

Amerigroup Community Care of New Mexico, Inc. – Coordination of Long-term Services (CoLTS) Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in New Mexico’s Coordination of Long-term Services (CoLTS) Program Responsible for the provision of physical health services, dental, vision, pharmacy, LTSS, and transportation				
b. Duration of Contract	Five years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 07/01/12 – 12/31/13 Original Contract Start: 08/01/08 Contract has ended.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Julie B Weinberg, Director, Human Services Department New Mexico Human Services Department 505-827-6253 julie.weinberg@state.nm.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014*
	Population: Medicaid No. of Members: 19,778	Population: Medicaid No. of Members: 20,364	Population: Medicaid No. of Members: 20,829	Population: Medicaid No. of Members: 20,000	Population: Medicaid No. of Members: N/A
g. Annual Contract Payment:	Year: 2010 \$183.02 million	Year: 2011 \$206.12 million	Year: 2012 \$459.20 million	Year: 2013 \$69 million	Year: 2014* N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				

h. Improvements in utilization trends and quality indicators

Date of Study Period: 1/1/2009 to 12/31/2012

In February 2010 following an analysis of the HEDIS rates for 2009, Amerigroup chose to focus improvement on selected Comprehensive Diabetes Care (CDC) of HbA1c and LDL-C testing screening measures for a performance improvement project (PIP). The decision was made based on far-reaching implications in the long term care and progression of diabetes, QMC

Study question(s):

Study question 1: Does outreach to non-dual CoLTS members with diabetes that meet HEDIS specifications improve the percentage of members that receive one or more HbA1c test during the measurement period?

Study question 2: Does outreach to non-dual CoLTS members with diabetes that meet HEDIS specifications improve the percentage of members that receive one or more LDL-C screening during the measurement period?

Summary of interventions from 2010 -2012

- In April of 2010, AGP pilot Lab-In-An Envelope through Home Healthcare Laboratory of America (HHLA). HHLA is a Lab Corp company that offers an innovative system designed to accommodate specimen collection by members in the convenience of their own homes. The program allows for HgbA1c and LDL-C testing of members through a finger stick and the sample is collected on a card. The specimen is then packaged in a pre-paid envelope for easy mailing to the laboratory.
- In November of 2010, AGP obtained approval for a Medicaid Outreach Associate to address member's potential knowledge deficit related to importance of diabetes and annual exams, potential for missed opportunities to screen during a sick or well visit, transportation barriers to healthcare and support services, particularly if the lab is not located at the doctor's office (includes lack of understanding about transportation services provided by AGP), and missed appointments for screening.
- Provider Interventions included coordinating and scheduling with the practitioner for member appointments; and requests that the practitioner consider addressing the wellness services or screening tests that our claims data indicate that the member is lacking.
- Member Interventions included a letter to AGP members who have been identified as having diabetes from our claims and pharmacy data, and informing them of important tests or screenings which should be done annually to monitor their diabetes.
- And a second member intervention mailed to AGP member after Member Outreach Call to member. This letter reminded the member of their appointment date with their practitioner (determined during Member Outreach call) and of the important health screenings or lab tests that our claims data indicates they have not yet had this year.
- January 1-September, 15, 2012: the Medicaid Member Outreach Associate continued to make calls to those members identified as having diabetes to encourage them to obtain the necessary testing to monitor their diabetes throughout the measurement period. The Outreach Associate also makes appointments and arranges transportation for the member when the member agrees to the offer of assistance in appointments and transportation. The Outreach Associates aides the member by 3-way call with the providers. Member Outreach Associate has made 1,921 calls. Of note, the Member Outreach Associate is bilingual.

Results Measurement and measurement for the periods 2011-2012 demonstrated significant improvement

Baseline: HEDIS 2010 was 68.50% - 76.52% for HbA1c testing

Re-measurement 1: HEDIS 2011 rate of 82.46% demonstrated statistically significant improvement, and exceeded NCQA's 50th percentile mark of 81.1% for the HEDIS Comprehensive Diabetes Care measure for HbA1c testing.

Re-measurement 2 HEDIS year 2012 (1/1/11 through 12/31/11) was 86.21%. The HEDIS 2011 rate of 86.21% is above the upper limit of 76.52%. Therefore, there was statistically significant improvement .

Baseline: HEDIS 2010 was (LDL-C screening in 2010 was 60.53%

Re-measurement 1: HEDIS 2011 rate of 71.33% is above the upper limit of 64.93% and demonstrated statistically significant improvement . This also exceeded the State of New Mexico benchmark of 71%, but was below NCQA's 50th percentile mark of 75.4% for the HEDIS Comprehensive Diabetes Care measure for LDL-C screening.

<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable. Contract ended in 2013.

Table 3.2.7-47. Amerigroup Community Care of New Mexico – Medicare Advantage D-SNP Contract

Amerigroup Community Care of New Mexico, Inc. – Medicare Advantage D-SNP Contract					
Reference Information (Current/Prior Services Performed For:)					
<p>a. Scope of work and covered benefits</p>	<p>Medicare Advantage Special Needs Plan (Dual Eligible) coordination agreement with state Medicaid agency in the counties of Bergen, Burlington, Essex, Hudson, Middlesex, Monmouth, Ocean, Passaic, Somerset, and Union</p> <p>New Jersey D-SNP coordination contract is an at-risk agreement for coverage of Medicaid benefits beyond Medicare coverage limits with some exceptions.</p> <p>Additional information on Medicare covered services is provided in the corresponding CMS contract listing H3240.</p>				
<p>b. Duration of Contract</p>	<p>6 years</p>				
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 10/1/09</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>				
<p>e. Contact name and phone number</p>	<p>Julie B Weinberg, Director, Human Services Department New Mexico Human Services Department 505-827-6253 julie.weinberg@state.nm.us</p>				
<p>f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract</p>	<p>Year: 2010*</p>	<p>Year: 2011*</p>	<p>Year: 2012*</p>	<p>Year: 2013*</p>	<p>Year: 2014*</p>
	<p>Population: N/A</p>	<p>Population: N/A</p>	<p>Population: N/A</p>	<p>Population: N/A</p>	<p>Population: N/A</p>
	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>	<p>No. of Members: N/A</p>
<p>g. Annual Contract</p>	<p>Year: 2010*</p>	<p>Year: 2011*</p>	<p>Year: 2012*</p>	<p>Year: 2013*</p>	<p>Year: 2014*</p>

Payment:	N/A	N/A	N/A	N/A	N/A
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: N/A – contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

**Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H3240.*

Table 3.2.7-48. Amerigroup Community Care of New Mexico – Medicare Advantage D-SNP Contract

Amerigroup Community Care of New Mexico Inc. – Medicare Advantage SNP Contract H5746					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating Medicare Advantage MCO offering an SNP for dual eligible enrollees; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health and behavioral health services				
b. Duration of Contract	Six years.				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/15 – 12/31/15 Original Contract Start: 1/1/09 (Contract renews annually) Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Population: Medicare SNP No. of Members: 1,604	Population: Medicare SNP No. of Members: 2,138	Population: Medicare SNP No. of Members: 3,392	Population: Medicare SNP No. of Members: 4,000	Population: Medicare SNP No. of Members: 3,408
g. Annual Contract Payment:	Year: 2010 \$16.49 million	Year: 2011 \$22.85 million	Year: 2012 \$34.86 million	Year: 2013 \$44 million	Year: 2014 \$37.83 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>West Region Medical Management initiatives include inpatient admission reviews to facilitate the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting, as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with better outcomes for this population. ALOS in 2013 was 16.1, and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year by 24 percent from 2013 to 2014. We achieved that reduction through increased utilization of outpatient observation status, thereby verifying that members receive the care they need at the most appropriate level. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers, and focused care management for our members with ESRD.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

New York

Table 3.2.7-49. Amerigroup New York – Medicaid and Family Health Plus Participating Managed Care Plan Contract

Amerigroup New York, LLC – Medicaid and Family Health Plus Participating Managed Care Plan Agreement					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in New York’s Medicaid managed care program for the counties of Kings, Bronx, New York, Queens, Nassau, Putnam, and Richmond</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, and pharmacy</p>				
b. Duration of Contract	14 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start Date and End Dates: 3/1/2014 – 2/28/2019</p> <p>Original Contract Start: 01/01/05</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Francis Roberts, Project Manager New York State Department of Health 518-474-5515 francis.roberts@health.ny.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010</p> <p>Population: Medicaid, low-income individuals</p> <p>No. of Members: 93,099</p>	<p>Year: 2011</p> <p>Population: Medicaid, low-income individuals</p> <p>No. of Members: 94,602</p>	<p>Year: 2012</p> <p>Population: Medicaid, low-income individuals</p> <p>No. of Members: 369,437</p>	<p>Year: 2013</p> <p>Population: Medicaid, low-income individuals</p> <p>No. of Members: 388,000</p>	<p>Year: 2014</p> <p>Population: Medicaid, low-income individuals</p> <p>No. of Members: 408,550</p>
g. Annual Contract Payment:	Year: 2010 \$225.88 million	Year: 2011 \$253.34 million	Year: 2012 \$987.93 million	Year: 2013 \$1.6 billion	Year: 2014 \$1.76 billion
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>The New York Health Plan has made significant strides in improving member and provider engagement. For example, the state has 17 health plans. In 2013, it was rated #10 in the state quality program. In 2014, the Plan improved to #5 in the state and included:</p> <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Coding education conducted with large and small practice groups • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services 				

	<ul style="list-style-type: none"> • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for rescue medications, but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services. • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-50. Amerigroup New York – Child Health Plus Contract

Amerigroup New York, LLC – Child Health Plus Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the Child Health Plus (CHIP) program for the counties of Kings, Bronx, New York, Queens, Richmond, Nassau, Westchester, and Suffolk</p> <p>Responsible for the provision of physical health services, behavioral health services, dental, vision, and pharmacy</p>				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 01/01/08 – 12/31/15</p> <p>Original Contract Start: 01/01/05</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Gabrielle Armenia, Director New York State Department of Health 518-474-4124 Gabrielle.armenia@health.ny.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP
	No. of Members:	No. of Members:	No. of Members:	No. of Members:	No. of Members:



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

	8,774	7,863	29,061	56,000	45,548
g. Annual Contract Payment:	Year: 2010 \$13.87 million	Year: 2011 \$13.78 million	Year: 2012 \$49.82 million	Year: 2013 \$121 million	Year: 2014 \$136 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>The New York Health Plan has made significant strides in improving member and provider engagement. For example, the state has 17 health plans. In 2013, it was rated #10 in the state quality program. In 2014, the Plan improved to #5 in the state and included:</p> <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Coding education conducted with large and small practice groups • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for rescue medications, but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services. • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-51. Amerigroup New York – Medicaid Advantage Contract

Amerigroup New York, LLC – Medicaid Advantage Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in New York’s Medicaid Advantage managed care program for counties of Kings, Bronx, New York, Queens, and Richmond Responsible for the provision of physical health services, behavioral health services, dental, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/11 – 12/31/15 Original Contract Start: 07/01/10 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Donna Lochner, Contract Manager New York State Department of Health 518-474-7540 Donna.lochner@health.ny.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Dual Eligibles No. of Members: 843	Population: Dual Eligibles No. of Members: 1,050	Population: Dual Eligibles No. of Members: 8,098	Population: Dual Eligibles No. of Members: 10,000	Population: Dual Eligibles No. of Members: 10,529
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	\$9.83 million \$11.70 million \$65.52 million \$108 million \$118.57				
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	The New York Health Plan has made significant strides in improving member and provider engagement. For example, the state has 17 health plans. In 2013, it was rated #10 in the state quality program. In 2014, the Plan improved to #5 in the state and included: <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Coding education conducted with large and small practice groups • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for rescue medications, but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services. 				

	<ul style="list-style-type: none"> • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care, through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Not applicable – contract started in 2010.

Table 3.2.7-52. Empire HealthChoice HMO – Child Health Plus Contract

Empire HealthChoice HMO, Inc. (dba Empire Blue Cross Blue Shield) – Child Health Plus Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the Child Health Plus (CHIP) program for the counties of Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Montgomery, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington</p> <p>Responsible for the provision of physical health services, behavioral health services, dental, vision, and pharmacy</p>				
b. Duration of Contract	24 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/07 – 12/31/15</p> <p>Original Contract Start: 6/13/91</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Gabrielle Armenia, Director New York State Department of Health 518-474-4124 Gabrielle.armenia@health.ny.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010</p> <p>Population: CHIP</p> <p>No. of Members: 64,168</p>	<p>Year: 2011</p> <p>Population: CHIP</p> <p>No. of Members: 61,195</p>	<p>Year: 2012</p> <p>Population: CHIP</p> <p>No. of Members: 55,337</p>	<p>Year: 2013</p> <p>Population: CHIP</p> <p>No. of Members: 8,888</p>	<p>Year: 2014</p> <p>Population: CHIP</p> <p>No. of Members: 8,565</p>

g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	The New York Health Plan has made significant strides in improving member and provider engagement. For example, the state has 17 health plans. In 2013, it was rated #10 in the state quality program. In 2014, the Plan improved to #5 in the state and included: <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Coding education conducted with large and small practice groups • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for rescue medications, but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services. • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

Table 3.2.7-53. Amerigroup New York – Managed Long-term Care Partial Capitation Contract

Amerigroup New York, LLC – Managed Long-term Care Partial Capitation Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in New York’s Managed Long-Term Care program for the counties of Kings, Bronx, New York, Queens, and Richmond</p> <p>Responsible for the provision of physical health services, behavioral health services, dental, vision, pharmacy, and non-emergency medical transportation</p>				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/12 – 12/31/15 Original Contract Start: 12/01/05</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Donna Lochner, Contract Manager New York State Department of Health 518-474-7540 Donna.lochner@health.ny.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: Medicaid</p> <p>No. of Members: 943</p>	<p>Population: Medicaid</p> <p>No. of Members: 1,445</p>	<p>Population: Medicaid</p> <p>No. of Members: 2,117</p>	<p>Population: Medicaid</p> <p>No. of Members: 3,000</p>	<p>Population: Medicaid</p> <p>No. of Members: 2,966</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>				
h. Improvements in utilization trends and quality indicators	<p>The New York Health Plan has made significant strides in improving member and provider engagement. For example, the state has 17 health plans. In 2013, it was rated #10 in the state quality program. In 2014, the Plan improved to #5 in the state and included:</p> <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Coding education conducted with large and small practice groups • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for rescue medications, but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services. 				

	<ul style="list-style-type: none"> • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-54. Amerigroup New York – Medicare Advantage D-SNP Contract

Amerigroup New York, LLC – Medicare Advantage D-SNP Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Medicare Advantage Special Needs Plan (Dual Eligible) coordination agreement with state Medicaid agency in the counties of Bronx, Kings, Nassau, New York, Queens, and Richmond</p> <p>New York D-SNP contract is required to coordinate benefits, but not to provide specific covered services. Additional information on Medicare covered services is provided in the corresponding CMS contract listing.</p>				
b. Duration of Contract	Three years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and Duration: 1/1/14 – 12/31/15</p> <p>Original Contract Start: 1/1/12</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Donna Lochner, Contract Manager New York State Department of Health 518-474-7540 Donna.lochner@health.ny.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012**	Year: 2013**	Year: 2014**
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010*	Year: 2011*	Year: 2012**	Year: 2013**	Year: 2014**
	N/A	N/A	N/A	N/A	N/A

Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A – Contract is a coordination agreement.
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Not applicable – contract started in 2012.

**Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H6181.

Table 3.2.7-55. Amerigroup New York – Medicare Advantage SNP Contract H6181

Amerigroup New York, LLC – Medicare Advantage SNP Contract H6181					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating Medicare Advantage MCO offering a SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health services and behavioral health services				
b. Duration of Contract	Seven years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/08 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicare,	Population: Medicare,	Population: Medicare,	Population: Medicare,	Population: Medicare,

Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	including Dual Eligibles No. of Members: 374	including Dual Eligibles No. of Members: 427	including Dual Eligibles No. of Members: 531	including Dual Eligibles No. of Members: 5,044	including Dual Eligibles No. of Members: 10,899
g. Annual Contract Payment:	Year: 2010 \$6.41 million	Year: 2011 \$6.83 million	Year: 2012 \$8.47 million	Year: 2013 \$83.36 million	Year: 2014 \$118.58 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>East Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This verifies that members receive the care they need at the level of care most appropriate. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

Table 3.2.7-56. Amerigroup New York – Medicare Advantage SNP Contract H6264

Amerigroup New York, LLC – Medicare Advantage SNP Contract H6264	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating Medicare Advantage MCO offering a SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health services and behavioral health services</p>

b. Duration of Contract	One year				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 5/1/12 – 12/31/12 Original Contract Start: 5/1/12 Consolidated with H6181 as of 1/1/13.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012	Year: 2013**	Year: 2014**
	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: Medicare, including Dual Eligibles No. of Members: 3,616	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012 \$57.05 million	Year: 2013** N/A	Year: 2014** N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>East Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This verifies that members receive the care they need at the level of care most appropriate. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized				

services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Not applicable – contract started in 2012.

**Not applicable – consolidated with H6181 as of 1/1/13.

Table 3.2.7-57. Amerigroup New York – Fully Integrated Duals Advantage (FIDA) Contract H8417

Amerigroup New York, LLC – Fully Integrated Duals Advantage (FIDA) Contract H8417					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk managed care organization in the state and CMS Medicaid and Medicare managed care program in New York</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, and pharmacy</p>				
b. Duration of Contract	Three years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates:7/8/14 – 12/31/17</p> <p>Original Contract Start:7/8/14</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Charmaine Wilson, Plan Manager, State of New York, New York State Department of Health 518-402-5110 Charmaine.wilson@health.ny.gov</p> <p>or</p> <p>Melanie Bella, Director, Medicare-Medicaid Coordination Office Centers for Medicare and Medicaid Services 202-260-1291 Melanie.Bella@cms.hhs.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2011*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2012*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2013*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2014*</p> <p>Population: Dual Eligibles</p> <p>No. of Members: N/A</p>
g. Annual Contract Payment:	<p>Year: 2010*</p> <p>N/A</p>	<p>Year: 2011*</p> <p>N/A</p>	<p>Year: 2012*</p> <p>N/A</p>	<p>Year: 2013*</p> <p>N/A</p>	<p>Year: 2014*</p> <p>N/A</p>
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, describe: N/A</p>				
h. Improvements in utilization trends and quality indicators	N/A – Contract started in 2014, with enrollment beginning 1/1/15.				
i. Contract emphasis on member choice, access,	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system				

safety, independence, and responsibility	that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

**Not applicable – contract started in 2014, with enrollment beginning 1/1/15.*

Ohio

Table 3.2.7-58. Amerigroup Ohio – Medicaid Managed Care Program Contract

Amerigroup Ohio, Inc. – Medicaid Managed Care Program Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in Ohio’s Medicaid managed care program for the counties of Butler, Hamilton, Warren, Clermont, Clinton, Brown, Highland, Adams, Darke, Preble, Montgomery, Miami, Shelby, Greene, Clark, and Champaign				
	Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, pharmacy, and non-emergency medical transportation				
b. Duration of Contract	Eight years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 7/1/12 – 6/30/13 Original Contract Start: 9/1/05				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Dale Lehmann, Chief, Managed Care Contracting Ohio Department of Job and Family Services 614-752-4778* Dale.Lehmann@medicaid.ohio.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014**
	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: 55,460	No. of Members: 55,379	No. of Members: 53,672	No. of Members: 50,000	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010 \$151.57 million	Year: 2011 \$151.56 million	Year: 2012 \$173.85 million	Year: 2013 \$80 million	Year: 2014 N/A

Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A
h. Improvements in utilization trends and quality indicators	Through back-to-basics Utilization Management (UM) and Care Management (CM) approaches, Amerigroup Ohio reduced its overall inpatient admissions significantly from 115.9 admissions/1000 in 2008 to 86.3 in 2012 – a 25 percent reduction. To do that, we implemented the CI3 risk stratification model to verify that we were focusing on the members with the highest risk for manageable conditions and those with the highest likelihood of inpatient admissions. In addition, we improved our process to closely manage our daily census, including educating providers on criteria we were using. We also built better relationships with our providers, implemented face-to-face CM visits, and worked with them more effectively on discharge planning.
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

* Last available contact information

** Contract ended in 2013.

Tennessee

Table 3.2.7-59. Amerigroup Tennessee – TennCare Contractor Risk Agreement

Amerigroup Tennessee, Inc. – TennCare Contractor Risk Agreement	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating at-risk MCO in Tennessee’s Medicaid managed care program for the Middle Grand Region counties of Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson, Rutherford, Davidson, Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln, Moore, Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren, and Van Buren; expands to a statewide program in 2015 Responsible for the provision of physical health services, behavioral health services, LTSS, vision, and non-emergency medical transportation
b. Duration of Contract	Nine years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 8/15/06 – 12/31/16 Original Contract Start: 04/01/07* *First enrollment on 4/1/07. Contract Term started on 8/15/06. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s)	CONTAINS CONFIDENTIAL INFORMATION

for alteration(s)					
e. Contact name and phone number	Keith Gaither Director, Managed Care Operations 615-507-6414 keith.gaither@tn.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid No. of Members: 201,993	Population: Medicaid No. of Members: 202,207	Population: Medicaid No. of Members: 202,236	Population: Medicaid No. of Members: 200,000	Population: Medicaid No. of Members: 222,134
g. Annual Contract Payment:	Year: 2010 \$866.14 million	Year: 2011 \$896.91 million	Year: 2012 \$863.52 million	Year: 2013 \$866 million	Year: 2014 \$943.18 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	Amerigroup Tennessee has used all the typical managed care programs to help keep utilization trends below national norms over the past seven years, with our primary success stemming from behavioral services, which have experienced negative trends over the same period. We have also had some significant re-contracting projects over the past five years after evaluating rate reduction opportunities from the original provider agreements put in place back in 2007 (note that Tennessee does <u>not</u> have Medicaid rates set by the state). The decreased utilization trends for long-term care resulted from efforts to keep new enrollees in community settings and out of nursing facilities, reducing the percentage of these members in nursing facilities from more than 80 percent in 2010 to about 55 percent in 2014.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

Table 3.2.7-60. Amerigroup Tennessee – Medicare Advantage D-SNP Contract

Amerigroup Tennessee, Inc. – Medicare Advantage D-SNP Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Medicare Advantage SNP (dual eligible) coordination agreement with the state Medicaid agency. Under the agreement, Amerigroup Tennessee, Inc. coordinates services for dual eligible Members. Under a corresponding contract with CMS for Medicare Advantage, the plan covers Medicare Part A, Part B and Part D (prescription drug coverage) services. In 2014, Amerigroup Tennessee, Inc.'s D-SNP program is available in the counties of Bedford,



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

	Cannon, Cheatham, Clay, Cumberland, Davidson, DeKalb, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson.				
b. Duration of Contract	Five years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/10 Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Keith Gaither Director, Managed Care Operations 615-507-6414 keith.gaither@tn.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010** Population: N/A No. of Members: N/A	Year: 2011** Population: N/A No. of Members: N/A	Year: 2012** Population: N/A No. of Members: N/A	Year: 2013** Population: N/A No. of Members: N/A	Year: 2014** Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010** N/A	Year: 2011** N/A	Year: 2012** N/A	Year: 2013** N/A	Year: 2014** N/A
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A – contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A -- Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

**Not applicable – contract started in 2010.*

***Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H7200.*

Table 3.2.7-61. Amerigroup Tennessee – Medicare Advantage SNP Contract H7200

Amerigroup Tennessee, Inc. – Medicare Advantage SNP Contract H7200					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating Medicare Advantage MCO offering an SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health services and behavioral health services</p>				
b. Duration of Contract	Seven years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 – 12/31/15</p> <p>Original Contract Start: 1/1/08</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010</p> <p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 1,389</p>	<p>Year: 2011</p> <p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 1,979</p>	<p>Year: 2012</p> <p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 3,744</p>	<p>Year: 2013</p> <p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 4,000</p>	<p>Year: 2014</p> <p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 5,669</p>
g. Annual Contract Payment:	<p>Year: 2010</p> <p>\$16.75 million</p>	<p>Year: 2011</p> <p>\$23.22 million</p>	<p>Year: 2012</p> <p>\$41.36 million</p>	<p>Year: 2013</p> <p>\$51 million</p>	<p>Year: 2014</p> <p>\$63.96 million</p>
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If No, describe: N/A</p>				
h. Improvements in utilization trends and quality indicators	<p>Central Region Medical Management initiatives include inpatient admission reviews to assure the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting as well as promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions per 1000 members also decreased year-over-year 2013 to 2014 by 24 percent. This reduction was achieved through an increased utilization of outpatient observation status. This confirms that members receive the care they need at the most appropriate level. Through our stabilization case management, we reduced our 30 day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p>				

	We have also implemented focused areas of clinical intervention, including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Texas

Table 3.2.7-62. Amerigroup Insurance Company – Managed Care Contract to Serve Members in the Medicaid RSA

Amerigroup Insurance Company – Managed Care Contract to Serve Members in the Medicaid RSA	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the state's Medicaid managed care program for the counties of Anderson, Andrews, Angelina, Archer, Armstrong, Bailey, Baylor, Bell, Blanco, Borden, Bosque, Bowie, Brazos, Brewster, Briscoe, Brown, Burleson, Callahan, Camp, Cass, Castro, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Colorado, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Delta, DeWitt, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Erath, Falls, Fannin, Fisher, Foard, Franklin, Freestone, Frio, Gaines, Gillespie, Glasscock, Gonzales, Gray, Grayson, Gregg, Grimes, Hall, Hamilton, Hansford, Hardeman, Harrison, Hartley, Haskell, Hemphill, Henderson, Hill, Hopkins, Houston, Howard, Irion, Jack, Jackson, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lamar, Lampasas, Lavaca, Leon, Limestone, Lipscomb, Llano, Loving, Madison, Marion, Martin, Mason, McCulloch, McLennan, Menard, Midland, Milam, Mills, Mitchell, Montague, Moore, Morris, Motley, Nacogdoches, Nolan, Ochiltree, Oldham, Palo Pinto, Panola, Parmer, Pecos, Presidio, Rains, Reagan, Real, Red River, Reeves, Roberts, Robertson, Runnels, Rusk, Sabine, San Augustine, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Titus, Tom Green, Trinity, Upshur, Upton, Uvalde, Val Verde, Van Zandt, Ward, Washington, Wheeler, Wichita, Willbarger, Winkler, Wood, Yoakum, Young, and Zavala</p> <p>Responsible for the provision of physical health services, behavioral health services, dental, vision, pharmacy, and non-emergency medical transportation</p>
b. Duration of Contract	Four years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 9/11/11 – 8/31/15 Original Start Date: 9/1/11</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d. Total value of the Contract at execution and	CONTAINS CONFIDENTIAL INFORMATION

any alteration(s) to that amount. Provide reason(s) for alteration(s)					
e. Contact name and phone number	LaTrese Jones, Manager Texas Health and Human Services Commission 512-462-6350 latrese.jones@hhsc.state.tx.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: N/A	Population: Unavailable	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: N/A	No. of Members: N/A	No. of Members: 118,951	No. of Members: 107,000	No. of Members: 109,762
g. Annual Contract Payment:	Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	N/A	N/A	\$326.11 million	\$394 million	\$342.3 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>We implemented two recent clinical initiatives in Texas to improve the care delivered to our pediatric Medicaid populations: Improving Care for Members with Asthma and Improving Access to Preventive Care for Physical and Behavioral Health.</p> <p>In 2011, 3,688 STAR members were identified as having persistent asthma, according to the Medication Management for People with Asthma measure. We also noted that only half of the members were adherent with controller medications.</p> <p>We instituted a Post-Emergency room Program to prevent further emergency room visits and inpatient admissions. Our interventions were successful in improving the care for our STAR members with asthma. We achieved a statistically significant 15.28-percent reduction in the asthma-related admission rate from 2012 to 2013, exceeding our goal of a 10-percent reduction in asthma-related admissions. We also achieved a statistically significant improvement for the percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period, increasing the rate by 3.39 percentage points.</p> <p>Amerigroup developed an initiative to improve access to preventive care for our members. Our HEDIS 2012 scores for Adolescent Well-Care Visits exceeded the NCQA 2012 Quality Compass[®] 75th percentiles. In an effort to reach the 90th percentile, we employed the following strategies as part of this initiative:</p> <ul style="list-style-type: none"> • Conducted outreach calls to members who had not had adolescent well-care visits and provided assistance with identifying a doctor in their area, scheduling the appointment, and arranging transportation • Enhanced provider communication by sending quarterly reports to PCPs indicating which members on their panel required preventive care visits (Texas Health Steps visits) in 2013 • Initiating electronic appointment scheduling—specialized software loads provider appointments along with a list of members assigned to that PCP, which is then used when Amerigroup calls, members to set up appointments (from October 2013 to May 2014, Amerigroup scheduled 1,066 appointments.) • Implementing provider incentives to encourage delivery of preventive care with their members <p>We achieved statistically significant improvement in our Adolescent Well-Care measure:</p> <ul style="list-style-type: none"> • Adolescent Well-Care Visit Rate decreased to 60.47 percent in 2013 from 62.77 percent in 2011 • Pediatric Asthma Admission Rate decreased 92.03 percent/100,000 in 2012 to 77.97 				

	<p>percent/100,000percent in 2013</p> <ul style="list-style-type: none"> Medication Management for People With Asthma (HEDIS 50 percent controller rate) improved from 40.72 percent in 2012 to 44.11 percent in 2013
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable – contract started in 2011.

Table 3.2.7-63. Amerigroup Insurance Company – Managed Care Contract to Serve STAR+PLUS members in the Medicaid RSA West

Amerigroup Insurance Company – Managed Care Contract to Serve STAR+PLUS members in the Medicaid RSA West	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the State’s Medicaid managed care program for the counties of Andrews, Archer, Armstrong, Bailey, Baylor, Brewster, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Gray, Hall Hansford, Hardeman, Hartley, Haskell, Hemphill, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, LaSalle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltrie, Oldham, Palo Pinto, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, and Zavala</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, pharmacy, and non-emergency medical transportation</p>
b. Duration of Contract	Four years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 12/15/13 – 8/31/17 Original Start Date: 12/15/13. Membership effective date: 9/1/14</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION
e. Contact name and phone number	<p>LaTrese Jones Texas Health and Human Services Commission</p>

	512-462-6350 latrese.jones@hhsc.state.tx.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	Population: N/A	Population: N/A	Population: N/A	Population: Medicaid	Population: Medicaid
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: 15,883
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 N/A	Year: 2014 \$39.1 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>We implemented two recent clinical initiatives in Texas to improve the care delivered to our pediatric Medicaid populations: Improving Care for Members with Asthma and Improving Access to Preventive Care for Physical and Behavioral Health.</p> <p>In 2011, 3,688 STAR members were identified as having persistent asthma, according to the Medication Management for People with Asthma measure. We also noted that only half of the members were adherent with controller medications.</p> <p>We instituted a Post-Emergency room Program to prevent further ER visits and inpatient admissions. Our interventions were successful in improving the care for our STAR members with asthma. We achieved a statistically significant 15.28-percent reduction in the asthma-related admission rate from 2012 to 2013, exceeding our goal of a 10-percent reduction in asthma-related admissions. We also achieved a statistically significant improvement for the percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period, increasing the rate by 3.39 percentage points.</p> <p>Amerigroup developed an initiative to improve access to preventive care for our members. Our HEDIS 2012 scores for Adolescent Well-Care Visits exceeded the NCQA 2012 Quality Compass[®] 75th percentiles. In an effort to reach the 90th percentile, we employed the following strategies as part of this initiative:</p> <ul style="list-style-type: none"> • Conducted outreach calls to members who had not had adolescent well-care visits and provided assistance with identifying a doctor in their area, scheduling the appointment, and arranging transportation • Enhanced provider communication by sending quarterly reports to PCPs indicating which members on their panel required preventive care visits (Texas Health Steps visits) in 2013 • Initiating electronic appointment scheduling—specialized software loads provider appointments along with a list of members assigned to that PCP, which is then used when Amerigroup calls members to set up appointments (from October 2013 to May 2014, Amerigroup scheduled 1,066 appointments.) • Implementing provider incentives to encourage delivery of preventive care with their members <p>We achieved statistically significant improvement in our Adolescent Well-Care measure:</p> <ul style="list-style-type: none"> • Adolescent Well-Care Visit Rate decreased to 60.47 percent in 2013 from 62.77 percent in 2011 • Pediatric Asthma Admission Rate decreased 92.03 percent/100,000 in 2012 to 77.97 percent/100,000percent in 2013 • Medication Management for People With Asthma (HEDIS 50 percent controller rate) improved from 40.72 percent in 2012 to 44.11 percent in 2013 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis				

	on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

*Not applicable – contract started in 2013.

Table 3.2.7-64. Amerigroup Texas – Managed Care Contract to Serve STAR, STAR+PLUS, and CHIP members across Texas Service Areas

Amerigroup Texas, Inc. – Managed Care Contract to Serve STAR, STAR+PLUS, and CHIP members across Texas Service Areas					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in the State’s Medicaid managed care program for the counties of Atascosa, Austin, Bandera, Bastrop, Bexar, Brazoria, Brown, Burnet, Butler, Caldwell, Carson, Chambers, Collin, Comal, Crosby, Dallas, Deaf Smith, El Paso, Ellis, Fayette, Floyd, Fort Bend, Galveston, Garza, Guadalupe, Hale, Hardin, Harris, Hays, Hockley, Hudspeth, Hurt, Hutchinson, Jasper, Jefferson, Kaufman, Kendall, Lamb, Lee, Liberty, Lubbock, Lynn, Matagorda, Medina, Montgomery, Navarro, Newton, Orange, Polk, Potter, Randall, Rockwall, San Jacinto, Swisher, Terry, Travis, Tyler, Walker, Waller, Wharton, Williamson, and Wilson</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, pharmacy, and non-emergency medical transportation</p>				
b. Duration of Contract	19 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 3/1/11 – 8/31/15 Original Start Date: 9/1/96</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>LaTrese Jones Texas Health and Human Services Commission 512-462-6350 latrese.jones@hhsc.state.tx.us</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 551,297</p>	<p>Year: 2011</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 592,837</p>	<p>Year: 2012</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 617,667</p>	<p>Year: 2013</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 569,000</p>	<p>Year: 2014</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 628,034</p>
g. Annual Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014



Payment:	\$1.36 billion	\$1.43 billion	\$1.70 billion	\$2.07 billion	\$2.06 billion
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	House Call Doctors (HCD) originated in Austin/San Antonio markets in late 2011. This is an in-home medical care program, primarily implemented to make sure our homebound and complex chronically ill members receive adequate medical attention and service. From the utilization prospective, the goal of this pilot program was to pursue home-based interventions that would ultimately improve ER services and inpatient admission rates. Under the HCD program, not only have we delivered quality medical interventions and improved member satisfaction, but we have also decreased unnecessary medical care. Under the Austin Health Plan, overall inpatient admissions decreased 23 percent, while utilization of ER services improved 48 percent. Similarly, under the San Antonio Health Plan, overall inpatient admissions decreased 49 percent, while ER utilization improved 15 percent.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

Table 3.2.7-65. Amerigroup Texas – Managed Care Contract to Serve STAR+PLUS members in Tarrant Service Area

Amerigroup Texas, Inc. – Managed Care Contract to Serve STAR+PLUS members in Tarrant Service Area	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating at-risk MCO in the State's Medicaid managed care program for the counties of Denton, Hood, Johnson, Parker, Tarrant, and Wise Responsible for the provision of physical health services, behavioral health services, LTSS, dental, vision, pharmacy, and non-emergency medical transportation
b. Duration of Contract	19 years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 6/30/11 – 8/31/15 Original Start Date: 9/1/96 This region of Texas was managed through a separate procurement in 2010; however, it is the same program and population as the Managed Care Contract to Serve STAR, STAR+PLUS, and CHIP members across Texas Service Areas. Before 2010, the contract was for STAR and CHIP. After 2010, STAR+PLUS was implemented in this SDA. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s)	CONTAINS CONFIDENTIAL INFORMATION



for alteration(s)																
e. Contact name and phone number	<p>LaTrese Jones Texas Health and Human Services Commission 512-462-6350 latrese.jones@hhsc.state.tx.us</p>															
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<table border="1"> <thead> <tr> <th>Year: 2010*</th> <th>Year: 2011</th> <th>Year: 2012</th> <th>Year: 2013</th> <th>Year: 2014</th> </tr> </thead> <tbody> <tr> <td>Population: N/A</td> <td>Population: Medicaid</td> <td>Population: Medicaid</td> <td>Population: Medicaid</td> <td>Population: Medicaid</td> </tr> <tr> <td>No. of Members: N/A</td> <td>No. of Members: 26,384</td> <td>No. of Members: 27,224</td> <td>No. of Members: 27,000</td> <td>No. of Members: 28,676</td> </tr> </tbody> </table>	Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014	Population: N/A	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	No. of Members: N/A	No. of Members: 26,384	No. of Members: 27,224	No. of Members: 27,000	No. of Members: 28,676
Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014												
Population: N/A	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid												
No. of Members: N/A	No. of Members: 26,384	No. of Members: 27,224	No. of Members: 27,000	No. of Members: 28,676												
g. Annual Contract Payment:	<table border="1"> <thead> <tr> <th>Year: 2010*</th> <th>Year: 2011</th> <th>Year: 2012</th> <th>Year: 2013</th> <th>Year: 2014</th> </tr> </thead> <tbody> <tr> <td>N/A</td> <td>\$120.41 million</td> <td>\$481.65 million</td> <td>\$258 million</td> <td>\$294.8 million</td> </tr> </tbody> </table>	Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014	N/A	\$120.41 million	\$481.65 million	\$258 million	\$294.8 million					
Year: 2010*	Year: 2011	Year: 2012	Year: 2013	Year: 2014												
N/A	\$120.41 million	\$481.65 million	\$258 million	\$294.8 million												
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>															
h. Improvements in utilization trends and quality indicators	<p>Stabilization Program. Amerigroup established a stabilization program to augment our UM team’s discharge planning efforts and to prevent unnecessary readmissions. Members who are at risk receive intensive outreach and individual coaching until they are stabilized at home or in a community setting.</p> <p>The program also targets Members with behavioral health diagnoses with specialized supports. The effectiveness of the program is demonstrated by a 51.8 percent decrease in readmission during the first nine months of the program for STAR+PLUS in the Tarrant service area.</p> <p>Initiative to Reduce Readmission Rates for STAR+PLUS through a Stabilization Program. In 2012, Amerigroup launched our advanced Stabilization Program to augment our Utilization Management team’s discharge planning efforts for STAR+PLUS Members in the Tarrant service area. The goal of the Stabilization Program is to reduce overall 30-day re-admission rates and to facilitate a smooth transition</p> <ul style="list-style-type: none"> • between inpatient settings and the home or other community settings by providing intensive, short-term support. Members who are at risk receive intensive outreach and individual coaching until they are stabilized at home or in a community setting. <i>As a result of the Stabilization Program, we achieved a statistically significant reduction in 30-day readmission rates from 14.9 percent to 7.2 percent.</i> 															
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>															
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>															

*Not applicable – contract started in 2010, enrollment started in 2011.

Table 3.2.7-66. UNICARE – Medicaid Managed Care Contract (STAR and CHIP)

UNICARE Health Plans of Texas, Inc. – Medicaid Managed Care Contract (STAR and CHIP)					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	Participating at-risk MCO in the state's CHIP managed care program Responsible for the provision of physical health services, behavioral health services, vision, and pharmacy				
b. Duration of Contract	Six years				
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 9/1/06 – 2/29/12 Original Start Date: 9/1/06 Contract has ended. Unicare decided not to re-bid this contract.				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	Lisa Neal Texas Health and Human Services Commission 512-491-1313 Lisa.Neal@hhsc.state.tx.us				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012*	Year: 2013*	Year: 2014*
	Population: Medicaid, CHIP No. of Members: 22,579	Population: Medicaid, CHIP No. of Members: 23,409	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A	Population: N/A No. of Members: N/A
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012*	Year: 2013*	Year: 2014*
Capitated Payment:	\$56.61 million \$48.79 million N/A N/A N/A <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	This contract ended in 2012.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a person centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line				

administration and translation services.

*Not applicable – contract ended in 2012.

Table 3.2.7-67. Amerigroup Texas – Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Contract

Amerigroup Texas, Inc. – Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Medicare Advantage SNP (dual eligible) coordination agreement with HHSC. Amerigroup Texas offers a Medicare Advantage D-SNP in the counties of Bexar, Brazoria, Denton, El Paso, Fort Bend, Harris, Hudspeth, Lubbock, Medina, Montgomery, and Tarrant</p> <p>The Texas SNP coordination agreement covers Medicare cost sharing, but no Medicaid benefits. Additional information provided in corresponding CMS contract listing (H5817).</p>				
b. Duration of Contract	Seven years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 1/1/2008</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Sandra Faske, CTCM Medicaid/CHIP 512-462-6372 Sandra.Faske@hhsc.state.tx.us</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	Population: N/A	Population: N/A	Population: N/A	Population: N/A	Population: N/A
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A
g. Annual Contract Payment:	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	N/A	N/A	N/A	N/A	N/A
Capitated Payment:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, describe: N/A Contract is a coordination agreement.				
h. Improvements in utilization trends and quality indicators	N/A – Contract is a coordination agreement.				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	N/A -- Contract is a coordination agreement.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract is a coordination agreement. Membership and contract payments are included under CMS contract listing H5817.

Table 3.2.7-68. Amerigroup Texas – Medicare Advantage SNP Contract H5817

Amerigroup Texas, Inc. – Medicare Advantage SNP Contract H5817					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating Medicare Advantage MCO offering a SNP for dual eligible enrollees and traditional Medicare Advantage plans; responsible for care coordination activities and the provision of Medicare covered services through a contracted network of providers in multiple areas across the state</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health services and behavioral health services</p>				
b. Duration of Contract	Nine years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/15 – 12/31/15 (Contract renews annually) Original Contract Start: 1/1/06</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 7,272</p>	<p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 11,384</p>	<p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 17,427</p>	<p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 28,000</p>	<p>Population: Medicare, including Dual Eligibles</p> <p>No. of Members: 35,009</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>				
h. Improvements in utilization trends and quality indicators	<p>West Region Medical Management initiatives include inpatient admission reviews to verify the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting, and promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year 2013 to 2014 by 24 percent. We achieved the reduction by increased utilization of outpatient observation status. This confirms that members receive the care they need at the most appropriate level. Through our stabilization case management, we reduced our 30-day all cause readmission</p>				

	<p>rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with ESRD.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Virginia

Table 3.2.7-69. HealthKeepers – Managed Care Services Contract for the FAMIS Program

Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. – Contract to Provide Managed Care Services for the Family Access to Medical Insurance Security (FAMIS) Program					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Virginia’s FAMIS (CHIP) program</p> <p>Responsible for the provision of physical health services, behavioral health services, vision, pharmacy, and non-emergency medical transportation</p>				
b. Duration of Contract	17 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/14 – 6/30/15</p> <p>Original Contract Start: 10/1/98 (Contract renews annually)</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Todd Clark</p> <p>Department of Medical Assistance Services</p> <p>804-786-3594</p> <p>todd.clarks@dmas.virginia.gov</p>				
f. Number of Members and	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2013*	Year: 2014*

Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP	Population: CHIP
	No. of Members: 228,994	No. of Members: 251,774	No. of Members: 255,303	No. of Members: 255,303	No. of Members: 260,109
g. Annual Contract Payment:	Year: 2011* \$709.02 million	Year: 2012* \$790.38 million	Year: 2013* \$891 million	Year: 2013* \$891 million	Year: 2014* \$983.17 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Anthem's HealthKeepers Plus Quality Management and Improvement Program is essential to making sure our members' medical and service needs are being met, and that the quality of care and services are continuously improved. Twenty-six measures and/or sub-measures increased in 2014 in comparison to 2013. We maintained commendable NCQA status with a final HEDIS Effectiveness of Care score of 17.3293 for MY 2013. In March 2015, Virginia underwent its NCQA Resurvey and scored 49.94/50.00 points on standards – or 99 percent. The Virginia Market was in its infancy in 2014; therefore, it was a year of recruitment of staff, defining processes and policy and workflow development. The Clinic Day Program, a Quality Program highlight, was not implemented until fourth quarter 2014. It was specifically designed to enhance provider relationships with the Plan and close member HEDIS gaps. On the provider side, we started building a collaborative, quality network strategy through more quality-PR outreach, clinical detailing, and a quality bonus payment program (PQIP). PQIP has led to a partnership with one of the largest provider groups in the State, which encompasses every Federally Qualified Health Center and serves more than 18,000 members. New and/or ongoing quality interventions include:</p> <ul style="list-style-type: none"> • Leveraging technology to further expand the Clinic Day Program at large provider practices • Implementing an Maternal Postpartum Outreach Program • Reporting (Provider Gaps in Care) to identify those who are missing recommended care and services • Implementing member incentives for immunizations, well-child, prenatal, postpartum, and diabetic care and services. <p>The mission of the Health Care Management (HCM) Department is to coordinate timely, cost-effective, integrated services that promote positive clinical outcomes for individual members. The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring, and follow up. Virginia Anthem HealthKeepers Plus assesses member case management experience via a telephone satisfaction survey and by monitoring member complaint data. Quantitative analysis of survey and case management complaint data shows consistently high performance year-over-year. During 2014, Anthem's performance goal of 80 percent Member Very Satisfied/Satisfied was met with our Complex Care Management Program. Survey results showed a 90 percent member overall satisfaction with the program. Member satisfaction scores on the remaining measures ranged from 88 to 92 percent. Sixty one percent of members gained more confidence in their ability to take their medication after participating in the program. Forty-six percent of members indicate that their ability to talk with their PCP about their health has improved.</p> <p>The HCM Utilization Department of HealthKeepersPlus sees that members receive the right care at the right time in the right setting. In 2014, admission trends rose two percent, reflecting greater than anticipated growth for both TANF and SSI populations via transition from the loosely managed State FFS program. Recognizing the challenge, the HCM Utilization Management (UM) unit moved to a regional integrative care "pod" structure to improve</p>				

	<p>relationships with providers, address our members’ medical and behavioral needs, and improve coordination/reconciliation of hospital and outpatient pharmacy prescriptions. Pods are composed of UM nurses, CM nurses, behavioral health nurses, a pharmacist, and a medical director. For this past year, the department focused pods on:</p> <ol style="list-style-type: none"> 1. Expanding our successful 2013 initiative that focused on whether requests for admissions that are typically one day and under Milliman Care Guidelines can be managed under observation care 2. Reducing hospital length of stay for members with complex admissions through improved discharge and care transition plans. <p>In 2014, these programs were very successful, resulting in an aggregate savings of approximately \$1million.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

**Data provided are combined totals for several contracts in Virginia: Medallion 3.0 Managed Care (formerly Medallion II Managed Care) Contract and Contract to Provide Managed Care Services for the Family Access to Medical Insurance Security (FAMIS) Program.*

Table 3.2.7-70. HealthKeepers – Medallion 3.0 Managed Care Contract

Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. – Medallion 3.0 Managed Care Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Virginia’s Medicaid managed care program</p> <p>Responsible for the provision of physical health services, behavioral health services, vision, pharmacy, and non-emergency medical transportation</p>
b. Duration of Contract	19 years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/15 – 6/30/15</p> <p>Original Contract Start: 07/01/96 (Contract renews annually).</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION
e. Contact name and phone number	Todd Clark Department of Medical Assistance Services

	804-786-3594 todd.clarks@dmas.virginia.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013*	Year: 2014*
	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: 221,530	No. of Members: 228,994	No. of Members: 251,774	No. of Members: 255,303	No. of Members: 260,109
g. Annual Contract Payment:	Year: 2010* \$583.20 million	Year: 2011* \$709.02 million	Year: 2012* \$790.38 million	Year: 2013* \$891 million	Year: 2014* \$983.17 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Anthem’s HealthKeepers Plus Quality Management and Improvement Program is essential to making sure our members’ medical and service needs are being met, and that the quality of care and services are continuously improved. Twenty six measures and/or sub-measures increased in 2014 over 2013. We maintained commendable NCQA status with a final HEDIS Effectiveness of Care score of 17.3293 for MY 2013. In March 2015, Virginia underwent its NCQA resurvey and scored 49.94/50.00 points on standards – or 99 percent.</p> <p>The Virginia market was in its infancy in 2014; therefore, it was a year of staff recruitment, defining processes and policy, and workflow development. The Clinic Day Program, a Quality Program highlight, was not implemented until fourth quarter 2014. It was specifically designed to enhance provider relationships with the Plan and close member HEDIS gaps. On the provider side, we started building a collaborative, quality network strategy through more quality-PR outreach, clinical detailing, and a quality bonus payment program (PQIP). PQIP has led to a partnership with one of the largest provider groups in the State, which encompasses every Federally Qualified Health Center and serves more than 18,000 members.</p> <p>New and/or on-going quality interventions include:</p> <ul style="list-style-type: none"> Leveraging technology to further expand the Clinic Day Program at large provider practices Implementing a Maternal Postpartum Outreach Program Reporting (Provider Gaps in Care) to identify those who are missing recommended care and services Implementing member incentives for immunizations, well-child, prenatal, postpartum, and diabetic care and services. <p>The mission of the Case Management Department is to coordinate timely, cost-effective, integrated services to promote positive clinical outcomes for individual members. The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring, and follow up.</p> <p>Virginia Anthem HealthKeepers Plus assesses member case management experience via a telephone satisfaction survey and by monitoring member complaint data. Quantitative analysis of survey and case management complaint data shows consistently high performance year-over-year. During 2014, Anthem’s performance goal of 80 percent Member Very Satisfied/Satisfied was met by our Complex Care Management Program. Survey results showed 90 percent member overall satisfaction with the program. Member satisfaction scores on the remaining measures ranged from 88 to 92 percent. Sixty one percent of members gained more confidence in their ability to take their medication after participating in the program. Forty six percent indicate that their ability to talk with their PCP about their health has improved.</p> <p>The HCM UM unit of HealthKeepersPlus assures that members receive the right care at the right time in the right setting. In 2014, admission trends rose two percent, reflecting greater than anticipated growth for both TANF and SSI populations via transition from the loosely</p>				

	<p>managed State FFS program. Recognizing this challenge, the HCM UM unit moved to a regional integrative care “pod” structure to improve relationships with providers, address member medical and behavioral needs, and improve coordination/reconciliation of hospital and outpatient pharmacy prescriptions. Pods are composed of UM nurses, CM nurses, behavioral health nurses, a pharmacist and a medical director. For this past year, the department focused pods on:</p> <ol style="list-style-type: none"> 1. Expanding our successful 2013 initiative that focused on whether requests for admissions that are typically one day and under Milliman Care Guidelines can be managed under observation care 2. Reducing hospital length of stay for members with complex admissions through improved discharge and care transition plans <p>In 2014, these programs were very successful, resulting in an aggregate savings of approximately \$1million.</p>
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

**Data provided are combined totals for several contracts in Virginia: Medallion 3.0 Managed Care (formerly Medallion II Managed Care) Contract and Contract to Provide Managed Care Services for the Family Access to Medical Insurance Security (FAMIS) Program.*

Table 3.2.7-71. HealthKeepers – Medicare Advantage SNP Contract H3447

Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. – Medicare Advantage SNP Contract H3447	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	<p>Medicare Advantage, Prescription Drug Plan HMO and HMO SNP in Richmond City, Henrico, Chesterfield, Goochland, Hanover, and Powhatan Counties</p> <p>Covered services include Medicare Part A, Part B, and Part D (prescription drug coverage); responsible for the provision of physical health services and behavioral health services</p>
b. Duration of Contract	Two years
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 –12/31/15 Original Contract Start: 1/1/13 (Contract renews annually).</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION

e. Contact name and phone number	CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010*	Year: 2011*	Year: 2012*	Year: 2013	Year: 2014
	Population: N/A	Population: N/A	Population: N/A	Population: Medicare SNP	Population: Medicare SNP
	No. of Members: N/A	No. of Members: N/A	No. of Members: N/A	No. of Members: 1,773	No. of Members: 2,146
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013 \$13.92 million	Year: 2014 \$19.15 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>East Region Medical Management initiatives include inpatient admission reviews to verify the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting, and promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year 2013 to 2014 by 24 percent. We achieved the reduction by increased utilization of outpatient observation status. This confirms that members receive the care they need at the most appropriate level. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.				
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.				

*Not applicable – contract started in 2013.

Table 3.2.7-72. HealthKeepers – Commonwealth Coordinated Care Contract H0147

Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. – Commonwealth Coordinated Care Contract H0147					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk managed care organization in the state and CMS Medicaid and Medicare managed care program. Program is statewide except for Tangier Island.</p> <p>Responsible for the provision of physical health services, behavioral health services, LTSS, vision, and pharmacy</p>				
b. Duration of Contract	Two years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/4/14 – 6/30/15 Original Contract Start: 12/4/13 (Contract renews annually)</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Emily Carr Virginia Department of Medical Assistance Services 804-588-4888 Emily.Carr@DMAS.Virginia.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010* Population: N/A No. of Members: N/A	Year: 2011* Population: N/A No. of Members: N/A	Year: 2012* Population: N/A No. of Members: N/A	Year: 2013* Population: Dual Eligible No. of Members: N/A	Year: 2014** Population: Dual Eligible No. of Members: 4,273
g. Annual Contract Payment:	Year: 2010* N/A	Year: 2011* N/A	Year: 2012* N/A	Year: 2013* N/A	Year: 2014 \$100.3 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>Anthem’s HealthKeepers Plus Quality Management and Improvement Program is essential to making sure our members’ medical and service needs are being met, and that the quality of care and services are continuously improved. Twenty six measures and/or sub-measures increased in 2014 over 2013. We maintained commendable NCQA status with a final HEDIS Effectiveness of Care score of 17.3293 for MY 2013. In March 2015, Virginia underwent its NCQA resurvey and scored 49.94/50.00 points on standards – or 99 percent.</p> <p>The Virginia market was in its infancy in 2014; therefore, it was a year of staff recruitment, defining processes and policy, and workflow development. The Clinic Day Program, a Quality Program highlight, was not implemented until fourth quarter 2014. It was specifically designed to enhance provider relationships with the Plan and close member HEDIS gaps. On the provider side, we started building a collaborative, quality network strategy through more quality-PR outreach, clinical detailing, and a quality bonus payment program (PQIP). PQIP has led to a partnership with one of the largest provider groups in the State, which encompasses every Federally Qualified Health</p>				

	<p>Center and serves more than 18,000 members. New and/or ongoing quality interventions include:</p> <ul style="list-style-type: none"> • Leveraging technology to further expand the Clinic Day Program at large provider practices • Implementing a Maternal Postpartum Outreach Program • Reporting (Provider Gaps in Care) to identify those who are missing recommended care and services • Implementing member incentives for immunizations, well-child, prenatal, postpartum, and diabetic care and services. <p>The mission of the HCM Department is to coordinate timely, cost-effective, integrated services to promote positive clinical outcomes for individual members. The goal of complex case management is to help members regain optimum health or improved functional capability in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring, and follow up.</p> <p>Virginia Anthem HealthKeepers Plus assesses member case management experience via a telephone satisfaction survey and by monitoring member complaint data. Quantitative analysis of survey and case management complaint data shows consistently high performance year-over-year. During 2014, Anthem's performance goal of 80 percent Member Very Satisfied/Satisfied was met by our Complex Care Management Program. Survey results showed 90 percent member overall satisfaction with the program. Member satisfaction scores on the remaining measures ranged from 88 to 92 percent. Sixty one percent of members gained more confidence in their ability to take their medication after participating in the program. Forty-six percent indicate that their ability to talk with their PCP about their health has improved.</p> <p>The HCM UM Department of HealthKeepersPlus assures that members receive the right care at the right time in the right setting. In 2014, admission trends rose two percent, reflecting greater than anticipated growth for both TANF and SSI populations via transition from the loosely managed State FFS program. Recognizing this challenge, The HCM UM unit moved to a regional integrative care "pod" structure to improve relationships with providers, address member medical and behavioral needs, and improve coordination/reconciliation of hospital and outpatient pharmacy prescriptions. Pods are composed of UM nurses, CM nurses, behavioral health nurses, a pharmacist and a medical director. For this past year, the department focused pods on:</p> <ol style="list-style-type: none"> 1. Expanding our successful 2013 initiative that focused on whether requests for admissions that are typically one day and under Milliman Care Guidelines can be managed under observation care 2. Reducing hospital length of stay for members with complex admissions through improved discharge and care transition plans <p>In 2014, these programs were very successful, resulting in an aggregate savings of approximately \$1million.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable – contract started in 2013.

** Not applicable – enrollment started in 2014.

Washington

Table 3.2.7-73. Amerigroup Washington – Managed Care Contract — Apple Health

Amerigroup Washington, Inc. – Managed Care Contract: Apple Health					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Washington’s Medicaid and CHIP managed care programs in the counties of Asotin, Benton, Columbia, Ferry, Franklin, Garfield, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Whitman, and Yakima</p> <p>Covered services include acute care, behavioral health, LTSS, vision, and pharmacy</p>				
b. Duration of Contract	Three years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/15 – 12/31/15 Original Contract Start: 07/01/12</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Alison Robbins Supervisor, Quality and Care Management 360-725-1634 Alison.Robbins@hca.wa.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	<p>Year: 2010*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2011*</p> <p>Population: N/A</p> <p>No. of Members: N/A</p>	<p>Year: 2012</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 25,418</p>	<p>Year: 2013</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 35,000</p>	<p>Year: 2014</p> <p>Population: Medicaid, CHIP</p> <p>No. of Members: 129,180</p>
g. Annual Contract Payment:	<p>Year: 2010 N/A</p>	<p>Year: 2011* N/A</p>	<p>Year: 2012 \$45.53 million</p>	<p>Year: 2013 \$134 million</p>	<p>Year: 2014 \$387 million</p>
Capitated Payment:	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>				
h. Improvements in utilization trends and quality indicators	<p>Amerigroup Washington develops an annual quality work plan, including objectives for serving individuals with special health care needs and enrollees from diverse communities. It comprises goals and objectives for the year, including patient safety, and serving a culturally and linguistically diverse membership that includes individuals with special health care needs. Admissions per 1000 demonstrated a positive, declining trend since the fourth quarter of 2013. Throughout 2014, we worked to standardize UM processes and provide focused training to concurrent review staff. In addition, we strengthened UM/Case Management collaboration, thereby enabling members who would benefit from case management to be identified and promptly referred by the UM team. Decreases in utilization for TANF and Expansion are attributable to standardization of UM processes and UM/Case Management collaboration.</p> <p>The ABD membership showed an increase for first quarter 2014 and again in the third quarter of 2014. Admissions in this group had a significant decline in the second quarter. ER visits also demonstrated slight to moderate decreases for TANF and the Expansion</p>				

	<p>populations. ABD ER visits have been fairly stable over three quarters of 2014 with a more significant decrease from the fourth quarter of 2013. We put a program into place to address ER utilization with a vendor, Consistent Care Choice Network, to engage members with high utilization in three specific metropolitan areas to provide support and information on the use of an established PCP/Specialist network. We will expand this program in 2015.</p> <p>Amerigroup Washington participated in a collaborative project with all participating Medicaid health plans to address early term C-section rates. The project involved measurement of rates and interventions with specific outlier providers to achieve the target rate established by the State Health Care Authority. The target was exceeded and further work on this topic ceased.</p>
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

*Not applicable – contract started in 2012.

Table 3.2.7-74. Amerigroup Washington – Medicare Advantage SNP Contract H1894

Amerigroup Washington, Inc. – Medicare Advantage SNP Contract H1894	
Reference Information (Current/Prior Services Performed For:)	
<p>a. Scope of work and covered benefits</p>	<p>Medicare Advantage, Prescription Drug Plan, HMO and Special Needs Plan</p> <p>Responsible for the provision of physical health services and behavioral health services</p>
<p>b. Duration of Contract</p>	<p>One year</p>
<p>c. Contract start/end dates, alterations to timeframe, and reason</p>	<p>Contract Start and End Dates: 1/1/15 – 12/31/15</p> <p>Original Contract Start: 1/1/14</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>
<p>d.Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)</p>	<p>CONTAINS CONFIDENTIAL INFORMATION</p>
<p>e. Contact name and phone number</p>	<p>CDR Anne McMillan MSN, FNP-BC, CLNC Centers for Medicare and Medicaid Services 312-353-1668 Anne.McMillan@cms.hhs.gov</p>



Tab 6: RFP Forms, Financial Statements, Resumes, and Contract Lists

3.2.7.4 Contract Lists

<p>f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract</p>	<p>Year: 2010* Population: N/A No. of Members: N/A</p>	<p>Year: 2011* Population: N/A No. of Members: N/A</p>	<p>Year: 2012 * Population: N/A No. of Members: N/A</p>	<p>Year: 2013* Population: N/A No. of Members: N/A</p>	<p>Year: 2014 Population: Medicare SNP No. of Members: 368</p>
<p>g. Annual Contract Payment:</p>	<p>Year: 2010* N/A</p>	<p>Year: 2011* N/A</p>	<p>Year: 2012* N/A</p>	<p>Year: 2013 N/A</p>	<p>Year: 2014 \$2.90 million</p>
<p>Capitated Payment:</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A</p>				
<p>h. Improvements in utilization trends and quality indicators</p>	<p>West Region Medical Management initiatives include inpatient admission reviews to verify the right level of care for each member's diagnosis, concurrent inpatient case management, post-hospitalization discharge planning, comprehensive complex case management to support optimal engagement in the outpatient setting, and promotion of recommended screenings and testing based on each member's clinical conditions.</p> <p>We have improved our ALOS in the SNF setting with improved outcomes for this population. ALOS in 2013 was 16.1 and we achieved an ALOS of 15 in 2014. Our hospital inpatient admissions/1000 members also decreased year-over-year 2013 to 2014 by 24 percent. We achieved the reduction by increased utilization of outpatient observation status. This confirms that members receive the care they need at the most appropriate level. Through our stabilization case management, we reduced our 30-day all cause readmission rate from 15 percent in 2013 to 13 percent in 2014.</p> <p>We have also implemented focused areas of clinical intervention, including enhanced management of members with frequent ER utilization, health education for our members with chronic diseases, opportunities to redirect outpatient surgical procedures to ambulatory surgical centers as well as focused care management for our members with end stage renal disease.</p>				
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation's leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

*Contract began in 2014.

West Virginia

Table 3.2.7-75. UNICARE – Mountain Health Trust Contract

UNICARE Health Plan of West Virginia, Inc. – Mountain Health Trust Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in West Virginia’s Medicaid managed care program for the counties of Barbour, Hancock, Mineral, Ritchie, Berkeley, Hardy, Mingo, Roane, Boone, Harrison, Monongalia, Summers, Braxton, Jackson, Monroe, Taylor, Brooke, Jefferson, Morgan, Tucker, Kanawha, Nicholas, Tyler, Calhoun, Lewis, Ohio, Upshur, Clay, Lincoln, Pendleton, Doddridge, Logan, Pleasants, Webster, Fayette, Marion, Pocahontas, Wetzell, Gilmer, Marshall, Preston, Wirt, Grant, Mason, Putnam, Wood, Greenbrier, McDowell, Raleigh, Wyoming, Hampshire, Mercer, and Randolph</p> <p>Responsible for the provision of physical health services, dental, vision, and pharmacy</p>				
b. Duration of Contract	12 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 7/1/14 – 6/30/15 Original Contract Start: 01/01/03</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Brandy Spaulding West Virginia Bureau for Medical Services 304-356-4912 Brandy.J.Spaulding@wv.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	<p>Population: Medicaid</p> <p>No. of Members: 80,555</p>	<p>Population: Medicaid</p> <p>No. of Members: 83,753</p>	<p>Population: Medicaid</p> <p>No. of Members: 82,234</p>	<p>Population: Medicaid</p> <p>No. of Members: 86,911</p>	<p>Population: Medicaid</p> <p>No. of Members: 92,450</p>
g. Annual Contract Payment:	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	\$154.55 million	\$160.47 million	\$167.13 million	\$216.51 million	\$275.46 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>UniCare’s Utilization Management Program includes activities related to inpatient and ambulatory care and collaborates with other departments within health care management services to meet the physical and behavioral healthcare needs of its members. The program adopts an integrated medical management model based on the physical, behavioral, and social needs of eligible members by evaluating medical necessity, appropriateness, and efficiency against nationally accepted clinical review criteria and medical policy guidelines, UniCare has successfully reduced admission days per thousand by 1.17 percent and has decreased total inpatient admits per thousand 1.26 percent in 2014. Our Short Length of Stay Initiative analyzes inpatient admissions versus observations for appropriate payment levels, which has resulted in a \$1.7 million savings in 2013. For 2015, UniCare has dedicated</p>				

	<p>additional resources for Intensive Case Management outreach and Care Planning to impact ER use. A report based on predictive modeling (the Chronic Illness Intensity Index) is generated monthly. UniCare is accredited by NCQA and has met rigorous requirements for service and clinical quality standards.</p> <p>Unicare has implemented initiatives to improve quality scores based on standard HEDIS measures, and has achieved a number of successes. Specifically, adolescent immunizations rates (Combo 1) increased 36 percentage points between 2012 and 2014. Contributing to this increase were improved access to adolescent immunization data through collaborative partnership with the state immunization registry, outreach educating members on the importance of recommended immunizations, and provider education on the immunization periodicity schedule.</p> <p>Adult BMI assessment rates increased 13.49 percentage points between 2012 and 2014. Provider education efforts and increased data capture enabled by electronic health records contributed to the increase in the adult BMI rate.</p> <p>The postpartum rate has remained stable over the past three years with UniCare exceeding the National Medicaid Average for each year. Increased, ongoing member outreach is expected to increase the rate of women receiving recommended postpartum care. Collaborative partnerships with pediatric and adolescent providers/providers groups are underway to increase well-child visit for three- to six-year-olds and adolescent well-care visits.</p> <p>Ongoing interventions designed to impact quality indicators include:</p> <ul style="list-style-type: none"> • Well-child and adolescent clinic days at large provider practices • Maternal Postpartum Outreach Program • Partnership with targeted school-based health centers to increase completed well-child and adolescent well-care visits • Technology to establish secure sites for providers to upload medical records for evidence of compliance with recommended care • Provider panel Gaps in Care reporting to identify those who are missing recommended care and services • Provider pharmacy reporting that alerts providers to members with asthma who have ER visits and claims for asthma rescue medications but lack maintenance medications • Member incentives for well-baby, well-child, prenatal, postpartum, and diabetic care and services • Provider incentive program focusing on access to care and specific HEDIS performance measures and quality indicators
<p>i. Contract emphasis on member choice, access, safety, independence, and responsibility</p>	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>
<p>j. Role of any Subcontractors:</p>	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>

Wisconsin

Table 3.2.7-76. *CompCare – BadgerCare Plus and SSI Medicaid (Western Service Area) Contract*

CompCare Health Services Insurance Corporation (dba CompCare) – BadgerCare Plus and SSI Medicaid (Western Service Area) Contract					
Reference Information (Current/Prior Services Performed For:)					
a. Scope of work and covered benefits	<p>Participating at-risk MCO in Wisconsin’s Medicaid managed care program; Group Health Cooperative assumes full risk as a delegated entity for the Western Service Area</p> <p>Responsible for the provision of physical health services, behavioral health services, and vision</p>				
b. Duration of Contract	10 years				
c. Contract start/end dates, alterations to timeframe, and reason	<p>Contract Start and End Dates: 1/1/14 – 12/31/15</p> <p>Original Contract Start: 5/1/05</p> <p>Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.</p>				
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION				
e. Contact name and phone number	<p>Makalah Wagner Department of Health Services Bureau of Benefits Management 608-266-9248 Makalah.Wagner@dhs.wisconsin.gov</p>				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals. ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: 30,648	No. of Members: 23,924	No. of Members: 21,988	No. of Members: 21,413	No. of Members: 20,001
g. Annual Contract Payment:	Year: 2010 \$47.60 million	Year: 2011 \$36.12 million	Year: 2012 \$36.44 million	Year: 2013 \$31.51 million	Year: 2014 \$35.53 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>The UM process provides Anthem Blue Cross and Blue Shield of Wisconsin Medicaid with the opportunity to identify UM processes, which are successful, and those that may present the opportunity for improvement. The annual evaluation of member satisfaction assures continuous improvement in the quality of care and services provided to Anthem Blue Cross Blue Shield, Medicaid HMO members. Anthem monitors member satisfaction, provider satisfaction, and a litany of quality scores annually, then identifies and prioritizes potential areas for improvement.</p> <ul style="list-style-type: none"> The plan’s State-specific quality scores have increased each year from 2012 through 2014 – from 65 percent in 2012 to 70 percent in 2013 and 77 percent of measured in 2014. During the period of 7/1/14 through 12/31/14 (post-claims system migration), Anthem Blue Cross and Blue Shield Wisconsin Medicaid did not receive any official member or provider complaints regarding the UM process. 				

	<ul style="list-style-type: none"> • Response to the CAHPS question “Getting an appointment with a specialist was easy,” showed a statistically significant increase (8.9 percent) in member satisfaction between the 2013 average rates and 2014 survey results for the Child w/ccc population. • Member response to the CAHPS question regarding the ease of getting needed care, tests, or treatment in all categories of 2014 improved as compared to 2013, with the exception of the adult, which decreased five percent. All categories, including the adult, are above the Medicaid National Average. <p>Anthem Blue Cross and Blue Shield of Wisconsin Medicaid presents reports to the UM Committee and the Quality Oversight Committee meetings. The following actions will continue to be accomplished with input from the members of those committees:</p> <ul style="list-style-type: none"> • Identification of potential barriers and actions to be taken to decrease these barriers. • Identification of additional opportunities for improvement.
i. Contract emphasis on member choice, access, safety, independence, and responsibility	As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.
j. Role of any Subcontractors:	Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.

Table 3.2.7-77. *Compcare – BadgerCare Plus Contract*

Compcare Health Services Insurance Corporation (dba Anthem BCBS) – BadgerCare Plus Contract	
Reference Information (Current/Prior Services Performed For:)	
a. Scope of work and covered benefits	Participating at-risk MCO in Wisconsin’s Medicaid managed care program for regions 1–6 Responsible for the provision of physical health services, behavioral health services, dental (in regions 5 and 6 only), and vision
b. Duration of Contract	10 years
c. Contract start/end dates, alterations to timeframe, and reason	Contract Start and End Dates: 1/1/14 – 12/31/15 Original Contract Start: 5/1/05 This contract was managed through a separate contract application process in 2010; however, it is the same program and population as the BadgerCare Plus and SSI Medicaid (Western Service Area) contract. Time frame may be altered from time to time in the normal course of contract terms and conditions through extensions.
d. Total value of the Contract at execution and any alteration(s) to that amount. Provide reason(s) for alteration(s)	CONTAINS CONFIDENTIAL INFORMATION
e. Contact name and phone number	Makalah Wagner Department of Health Services Bureau of Benefits Management

	608-266-9248 Makalah.Wagner@dhs.wisconsin.gov				
f. Number of Members and Population Type (e.g., Medicaid, CHIP, Other Low Income Individuals, ABD, BH, TANF, Foster Care Children, SNP, publicly funded) for each Year of the Contract	Year: 2010	Year: 2011	Year: 2012	Year: 2013	Year: 2014
	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid	Population: Medicaid
	No. of Members: unavailable	No. of Members: 11,802	No. of Members: 14,506	No. of Members: 47,172	No. of Members: 51,690
g. Annual Contract Payment:	Year: 2010 \$7.98 million	Year: 2011 \$11.74 million	Year: 2012 \$23.62 million	Year: 2013 \$70.54 million	Year: 2014 \$98.35 million
Capitated Payment:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If No, describe: N/A				
h. Improvements in utilization trends and quality indicators	<p>The utilization management process provides Anthem Blue Cross and Blue Shield of Wisconsin Medicaid with the opportunity to identify UM processes, which are successful, and those that may present the opportunity for improvement. The annual evaluation of member satisfaction assures continuous improvement in the quality of care and services provided to Anthem Blue Cross Blue Shield, Medicaid HMO members. Anthem monitors member satisfaction, provider satisfaction, and a litany of quality scores annually, then identifies and prioritizes potential areas for improvement.</p> <ul style="list-style-type: none"> • The plan’s State-specific quality scores have increased each year from 2012 through 2014 – from 65 percent in 2012 to 70 percent in 2013 and 77 percent of measured in 2014. • During the period of 7/1/14 through 12/31/14 (post-claims system migration), Anthem Blue Cross and Blue Shield Wisconsin Medicaid did not receive any official member or provider complaints regarding the UM process. • Response to the CAHPS question “Getting an appointment with a specialist was easy,” showed a statistically significant increase (8.9 percent) in member satisfaction between the 2013 average rates and 2014 survey results for the Child w/CCC population. • Member response to the CAHPS question regarding the ease of getting needed care, tests, or treatment in all categories of 2014 improved as compared to 2013, with the exception of the adult, which decreased five percent. All categories, including the adult, are above the Medicaid National Average. <p>Anthem Blue Cross and Blue Shield of Wisconsin Medicaid presents reports to the UM Committee and the Quality Oversight Committee meetings. The following actions will continue to be accomplished with input from the members of those committees:</p> <ul style="list-style-type: none"> • Identification of potential barriers and actions to be taken to decrease these barriers. • Identification of additional opportunities for improvement. 				
i. Contract emphasis on member choice, access, safety, independence, and responsibility	<p>As the nation’s leader in state-sponsored and other publicly funded health programs, Amerigroup and its affiliate health plans embrace and promote a healthcare delivery system that emphasizes member choice, independence, and engagement in all aspects of care through a member-centered care model that is at the core of all we do. Through this model, an emphasis on member responsibility permeates our programs in everything from our most basic of member communications and outreach through our selection of value-added services and member incentive programs. We deliver member access to care through development and maintenance of robust provider networks that reflect the diversity, geographic location, and preferences of our membership. Our quality programs and provider collaboration programs incorporate monitoring and oversight of patient safety measures.</p>				
j. Role of any Subcontractors:	<p>Each of our affiliate health plans uses subcontractors to deliver certain specialized covered services applicable for each individual state program. Some examples of these specialized services are pharmacy, vision, and dental services. Our affiliate health plans also use subcontractors for select applicable administrative services, such as nurse advice line administration and translation services.</p>				

2. Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five (5) years.

Amerigroup, our parent company Anthem, and our affiliate health plans have never been debarred, suspended, or otherwise prohibited from participating in federal or state health programs. Our affiliate health plans support commercial, federal, and state-sponsored contracts.

In our response to this question, we address regulatory actions, or sanctions, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity within the last five years for our commercial affiliate health plans.

In our response to Question 3, we provide information on regulatory actions, sanctions, letters of deficiency, and corrective actions requested or required by any federal or state regulatory entity within the last five years that relate to Medicare, Medicaid, or CHIP contracts, or the Substance Abuse Use Prevention and Treatment Block Grant.

Regulatory Actions or Sanctions

Amerigroup's affiliates provide commercial services across the country, including integrated health care plans and related services; a wide range of specialty products such as life and disability insurance benefits, dental, vision, and behavioral health benefit services; and long-term care insurance and flexible spending accounts. Medical membership is currently more than 30 million. None of these commercial affiliates will be providing services under the Iowa Initiative Contract.

Attachment 3.2.7.4.2-1 Commercial Affiliate Regulatory Actions and Sanctions, describes the regulatory actions and fines imposed on these commercial affiliates by state regulatory entities (primarily, the states' departments of insurance) in the last five years.

3. Identify and describe any letter of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicare, Medicaid, or CHIP contracts, or the Substance Abuse Use Prevention and Treatment Block Grant.

In our response to this section, we provide information about regulatory actions, sanctions, letters of deficiency, and corrective actions requested or required by any federal or state regulatory entity within the last five years that relate to Medicare, Medicaid, or CHIP contracts or the Substance Abuse Use Prevention and Treatment Block Grant for any of our affiliate health plans.

We believe that regulatory actions support a meaningful dialogue with our state partners and help strengthen our programs through efficiency of administration and oversight. Amerigroup will educate employees, develop policies and procedures, implement monitoring and audit mechanisms, and enforce strict guidelines to comply with all of the Iowa Initiative program requirements.

Parent Company and Affiliate Regulatory Actions, Sanctions, Letters of Deficiency, and Corrective Actions

Amerigroup has operational affiliates in 19 other states delivering services to Medicare, Medicaid, CHIP, and other state-sponsored program enrollees. In the regular course of business, these affiliates have received notices, sanctions, and other regulatory actions related to the numerous requirements of any public program contract. We provide information about these actions in Attachment 3.2.7.4.2-2, Affiliate Regulatory Actions and Sanctions. None of these affiliates will provide services for the Iowa Initiative program.

Our Investment in Compliance

Our National Medicaid Division and affiliate health plans operating state-sponsored health programs across the country have one of the most proactive regulatory compliance programs in the industry. Amerigroup will implement this program for our Iowa operations.

The program maintains a robust system of processes and controls to prevent, identify, and mitigate potential risks, which is founded on the principles of the U.S. Department of Justice's (USDOJ) Seven Fundamental Elements of an Effective Compliance Program:

- Implementing written policies, procedures, and standards of conduct
- Designating a compliance officer and compliance committee
- Conducting effective training and education
- Conducting internal monitoring and auditing
- Reporting and investigating
- Enforcing standards through well-publicized disciplinary guidelines
- Responding promptly to detected offenses and undertaking corrective action



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Our commitment to compliance and establishing a culture that encourages our employees to embrace this commitment is reflected in one of our company's core values: **Trustworthy**. We believe that being *trustworthy* and fostering open communication and dialogue across our health plan and with our state partners is at the core of our ability to meet the expectations and goals of the state, our providers, and our members.

In support of our commitment to being trustworthy, our Iowa health plan will invest in dedicated compliance resources that maintain a singular focus on not only contract compliance, but education, monitoring and oversight, and risk identification and mitigation. Our Iowa compliance resources will be supported by national compliance resources that provide oversight, guidance, and the sharing of best practices across all affiliate health plans. The components of our Iowa compliance program and national support resources are outlined below using the USDOJ framework.

1. Implementing Written Policies, Procedures, and Standards of Conduct

Policies and Procedures. Amerigroup will maintain a robust library of policies and procedures that address our regulatory, contractual, and other program obligations and requirements. Functional managers throughout the organization will develop our policies, in consultation with our dedicated Regulatory Oversight Manager and the Iowa Plan Compliance Officer. These policies will play a major role in guiding Iowa health plan activities and operations. We monitor and review policies and procedures regularly and publish them on an internal website accessible to all employees.

Standards of Ethical Business Conduct (Code). All Amerigroup employees must acknowledge and agree to comply with the Code as a condition of employment. The Code is applicable to Amerigroup and all of our affiliates and is designed to help employees understand and comply with our legal, regulatory, and contractual responsibilities and act in a way that supports our national principles.

2. Designating a Compliance Officer and Compliance Committee

Iowa Plan Compliance Officer. Amerigroup will maintain a full-time, dedicated Plan Compliance Officer. This individual partners with our health plan leadership to provide more extensive and focused engagement across the Iowa health plan on issues, including compliance education and training, risk identification and mitigation, and the development and oversight of corrective actions. The Plan

Compliance Officer provides Amerigroup with executive-level compliance oversight and management and works collaboratively across all functional areas to infuse compliance into everything we do.

Iowa Regulatory Oversight Manager. We will maintain a dedicated Regulatory Oversight Manager for the Iowa Initiative. This individual will be our primary liaison with DHS for day-to-day contract management and oversight issues, will manage the submission of all required regulatory reporting, and will serve as our internal subject matter expert and resource regarding Amerigroup’s contractual and regulatory obligations under the Iowa Initiative.

Iowa Medicaid Health Plan Compliance Committee. Chaired by our Plan Compliance Officer, our local Iowa Medicaid Compliance Committee will comprise our executive-level leadership, including our Contract Administrator/CEO and the Regulatory Oversight Manager. The Compliance Committee will meet monthly and provide a forum for health plan leadership to review and discuss emerging issues and upcoming activities, assess potential compliance risks, and provide input into mitigation activities and corrective action plans. The Compliance Committee receives and reviews reporting about compliance monitoring activities and provides necessary oversight for our Iowa Compliance Program.

3. Conducting Effective Training and Education

Extensive Compliance Training. All employees within the Anthem family of companies receive mandatory compliance training, including two hours of initial compliance training and annual required compliance training, which cover education on the requirements of any current agreements or corrective action; fraud, abuse, and waste; HIPAA; and other aspects of the compliance program (including the Code and policies and procedures). Additionally, Iowa health plan employees must participate in annual Medicaid-specific compliance training. We track and monitor completion of all required training through our online learning systems.

On-going Education and Awareness. We will conduct additional education and awareness activities throughout the year to reinforce the role that all Iowa health plan employees play in compliance. Our national Medicaid Compliance Program Services Department sponsors an annual “Ethics and Compliance Week” celebration that includes activities and information that highlight how employee commitment to compliance supports overall success.

4. Conducting Internal Monitoring and Auditing

Iowa Medicaid Compliance Program and Work Plan. Our Plan Compliance Officer will develop and maintain an Iowa Medicaid Compliance Program and Work Plan. The Compliance Committee will review and approve the Work Plan each year and receive regular progress updates. The core functions of the Work Plan track the seven elements of an effective compliance program: written standards, structured compliance program, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention.

National Medicaid Compliance Officer. As part of Anthem’s National Medicaid Division, Amerigroup can access the resources of our national Medicaid Compliance Officer and the Medicaid Compliance Program Services Department. Collectively, this team manages and assures the ongoing operation and effectiveness of national Medicaid Compliance Program initiatives, including compliance program effectiveness reviews, standardized risk identification, prioritization and mitigation framework, and overall direction and guidance through the sharing of best practices to local Medicaid health plan compliance officers and committees.

Partnership with Internal Audit. Our compliance resources and national Internal Audit Department work together to help ensure that master audit plans include key compliance issues and risks for detailed review, evaluation, monitoring, and corrective action as needed.

5. Reporting and Investigating

Speaking Up. In our Iowa health plan and nationally across our affiliate companies, we work to establish a culture that encourages employees to “speak up” to identify any potential compliance concerns or issues through multiple reporting avenues. We maintain a strict and highly publicized policy of nonretaliation for any employee who proactively comes forward to identify potential compliance risks and/or concerns.

Confidential Compliance Hotline. Our national Compliance Hotline supports confidential (anonymous as requested) and secure reporting of potential violations. All hotline reports are investigated and results reported to the national Medicaid Compliance Officer.

6. Enforcing Standards through Well-publicized Disciplinary Guidelines

National Ethics and Compliance Office. The national Ethics and Compliance Office administers and advises employees on the Standards of Ethical Business Conduct (described previously), serves as an independent resource to receive and investigate allegations of employee misconduct, provides employees with training on ethics and compliance issues, and provides high-level oversight of compliance programs across the Anthem enterprise.

7. Responding Promptly to Detected Offenses and Undertaking Corrective Action

Corrective Action. When we learn of any deficiency, whether identified by the State, by a provider, or internally, our Plan Compliance Officer, in collaboration with other internal stakeholders and business owners, investigates the root cause of the problem and develops an action plan to prevent a recurrence.

Taken together, these Iowa compliance program components and national support resources represent a comprehensive and proactive approach to program monitoring and enforcement that helps promote full compliance with all state and federal requirements, provides the fullest protection of our members’ rights, and fully supports the goals and objectives of DHS’s mission in providing high-quality health care services at a reasonable and predictable cost.

Compliance 360

Amerigroup is committed to maintaining high performance and compliance with the State’s expectations and requirements under the Iowa Initiative Contract. To augment our compliance program and activities, Amerigroup will use the Compliance 360 application to comply with new or revised regulatory requirements. Whenever there is a new or revised regulatory or contractual requirement, such as a health plan advisory or informational bulletin issued by DHS, our Iowa Regulatory Oversight Manager will create an alert and disseminate it to all affected employees and stakeholders who serve as “assessors.” Assessors must evaluate alerts to determine whether the regulatory content affects their unit. If the alert content affects the assessor’s unit, the assessor must list planned tasks to comply and document the completion of such tasks. Our Plan Compliance Officer will monitor timely assessments and task completion. Assistance from a dedicated project management team within our National Medicaid Division is available for medium- to large-scope Compliance 360 alerts such as large, cross-functional Contract amendments.

4. Description of all contracts and projects currently undertaken by the bidder. This shall include all contracts that have not expired, have not been completed, or have not been terminated. Descriptions of similar services (above) do not need to be repeated again in this section. If a Bidder does not have current contracts and projects, it may include those of its parent company if it includes a parent guarantee with its proposal.

Please see the response provided in Q3.2.7.4.2 for a table listing all publicly funded contracts and projects currently undertaken by Anthem and its affiliate health plans. A parent guarantee is included on the following page.

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Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
2/2015	CA	Enrollment Process	Failure to follow notification procedures before cancelling for nonpayment of premiums.	No	5,000
2/2015	CA	Grievance Process	Failure to follow grievance process.	No	15,000
2/2015	CA	Enrollment Process	Failure to give sufficient notice before a premium increase.	No	10,000
1/2015	CA	Grievance Process	Failure to follow grievance process.	No	15,000
1/2015	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
1/2015	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
1/2015	CA	Grievance Process	Failure to follow grievance process.	No	5,000
1/2015	CA	Reporting Requirement	EOBs contained inaccurate information.	No	50,000
12/2014	GA	Insurance Department Finding	Targeted examination of Medicare Supplement business.	No	718,540
11/2014	CA	Grievance Process	Failure to follow grievance process.	No	50,000
10/2014	CA	Grievance Process	Failure to provide timely information to Department.	No	5,000
10/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
8/2014	CA	Grievance Process	Incomplete grievance response.	No	5,000
8/2014	KY	Reporting Requirement	Failure to submit timely reports.	No	10,000
7/2014	CA	Grievance Process	Untimely grievance resolution.	No	5,000
6/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
6/2014	CA	Grievance Process	Failure to follow grievance process.	No	12,000
6/2014	CA	Grievance Process	Failure to follow grievance process.	No	10,000
6/2014	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
6/2014	CA	Grievance Process	Untimely grievance resolution.	No	7,000
6/2014	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
5/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
5/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
5/2014	CA	Grievance Process	Failure to follow grievance process.	No	14,000
5/2014	CA	Grievance Process	Failure to follow grievance process.	No	10,000
5/2014	CA	Grievance Process	Untimely acknowledgement of grievance.	No	3,000
3/2014	CA	Grievance Process	Failure to follow grievance process.	No	12,500
3/2014	CA	Claims Process	Improper adjudication of claim.	No	5,000
3/2014	CA	Claims Process	Untimely claims payment and failed to include interest.	No	2,500
3/2014	CO	Insurance Department Finding	Market conduct examination findings.	No	20,900
2/2014	CA	Grievance Process	Failure to follow grievance process.	No	10,000
2/2014	CA	Grievance Process	Failure to follow grievance process.	No	10,000
1/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
1/2014	CA	Grievance Process	Failure to follow grievance process.	No	15,000
12/2013	CA	Grievance Process	Incomplete information on grievance response.	No	15,000
12/2013	CA	Grievance Process	Failure to follow grievance process.	No	10,000
12/2013	CA	Grievance Process	Failure to provide timely information to Department.	No	5,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
12/2013	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	5,000
12/2013	KY	Insurance Department Finding	Market conduct examination findings.	No	300,000
10/2013	CA	Grievance Process	Failure to follow grievance process.	No	15,000
10/2013	CA	Grievance Process	Failure to follow grievance process.	No	7,500
10/2013	CA	Grievance Process	Failure to provide timely information to Department.	No	5,000
10/2013	CA	Authorization Process	Failed to timely notify provider of authorization denial.	No	1,000
9/2013	CO	Insurance Department Finding	Market conduct examination findings.	No	49,500
8/2013	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	5,000
8/2013	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	5,000
7/2013	CA	Miscellaneous Operations	Printed prohibited information on member materials.	No	15,000
7/2013	CA	Grievance Process	Failure to follow grievance process.	No	7,500
7/2013	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
7/2013	CA	Grievance Process	Incomplete grievance response.	No	5,000
7/2013	CA	Grievance Process	Incomplete grievance response.	No	5,000
7/2013	CA	Grievance Process	Untimely grievance resolution.	No	5,000
7/2013	CA	Grievance Process	Failure to provide timely information to Department.	No	5,000
7/2013	CA	Grievance Process	Failure to follow grievance process.	No	2,500
7/2013	CA	Grievance Process	Untimely grievance resolution.	No	2,500
7/2013	CA	Grievance Process	Incomplete response regarding enrollee grievance.	No	2,500
7/2013	CA	Grievance Process	Untimely acknowledgement of grievance.	No	2,500
7/2013	CA	Grievance Process	Incomplete grievance response.	No	2,500
7/2013	Multiple	Miscellaneous Operations	Self-reported security weakness in online application database containing protected health information from 10/23/2009 to 3/7/2010.	No	1,700,000
6/2013	CA	Grievance Process	Failure to follow grievance process.	No	10,000
6/2013	CA	Grievance Process	Incomplete grievance response.	No	10,000
6/2013	CA	Miscellaneous Operations	Use of outdated evidence of coverage.	No	7,500
6/2013	CA	Grievance Process	Failure to follow grievance process.	No	7,500
6/2013	CA	Grievance Process	Incomplete response regarding enrollee grievance.	No	5,000
6/2013	CA	Miscellaneous Operations	Failure to disclose information regarding basis for service denial.	No	5,000
6/2013	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	5,000
6/2013	CA	Grievance Process	Untimely response to Department request for information.	No	2,500
5/2013	CA	Grievance Process	Inadequate explanation for grievance response.	No	2,500
4/2013	CA	Grievance Process	Grievance process not followed.	No	7,500
4/2013	CA	Claims Process	Claims payment untimely.	No	7,500
4/2013	CA	Grievance Process	Grievance not acknowledged and late resolution.	No	5,000
4/2013	CA	Grievance Process	Grievance not acknowledged.	No	5,000
4/2013	KY	Insurance Department Finding	Market conduct examination findings.	No	200,000
1/2013	CA	Grievance Process	Grievance not given adequate consideration.	No	5,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
1/2013	CA	Grievance Process	Grievance resolution untimely.	No	2,500
12/2012	CA	Grievance Process	Grievance resolution untimely.	No	2,500
12/2012	CA	Reporting Requirement	Untimely response to request for information.	No	2,500
11/2012	CA	Grievance Process	Grievance process not followed.	No	5,000
11/2012	CA	Grievance Process	Grievance resolution untimely.	No	5,000
11/2012	CA	Grievance Process	Untimely response to the Department.	No	5,000
11/2012	CA	Grievance Process	Grievance process not followed.	No	5,000
11/2012	MO	Insurance Department Finding	Market conduct examination findings.	No	5,000
10/2012	CA	Reporting Requirement	Failure to provide correct response.	No	2,500
9/2012	CA	Grievance Process	Failure to follow grievance process.	No	5,000
8/2012	CA	Grievance Process and Claims Process	Grievance resolution untimely and untimely claims processing.	No	20,000
8/2012	CA	Grievance Process	Failure to follow grievance process.	No	5,000
8/2012	CA	Grievance Process	Incomplete response to the Department.	No	2,500
8/2012	CA	Grievance Process	Grievance resolution untimely.	No	2,500
8/2012	CA	Grievance Process	Grievance resolution untimely.	No	2,500
8/2012	SC	Claims Process	Failure to meet standards for completeness of claims.	No	155,768
8/2012	VA	Insurance Department Finding	Market conduct examination findings.	No	129,000
8/2012	VA	Insurance Department Finding	Market conduct examination findings.	No	52,000
8/2012	VA	Insurance Department Finding	Market conduct examination findings.	No	40,000
8/2012	VA	Insurance Department Finding	Market conduct examination findings.	No	40,000
7/2012	CA	Grievance Process	Untimely and unclear grievance resolution.	No	7,500
7/2012	CA	Grievance Process	Failure to follow grievance process.	No	5,000
7/2012	CA	Grievance Process	Untimely grievance resolution.	No	2,500
6/2012	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
6/2012	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
5/2012	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
5/2012	CA	Grievance Process	Untimely grievance resolution.	No	7,500
5/2012	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	5,000
5/2012	CA	Grievance Process	Untimely grievance resolution.	No	5,000
4/2012	CT	Insurance Department Finding	Examination of utilization review practices.	No	6,000
3/2012	CA	Grievance Process	Failure to follow grievance process.	No	15,000
2/2012	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
2/2012	NV	Reporting Requirement	Untimely report filing.	No	500
2/2012	NY	Insurance Department Finding	Did not tell small business of option to purchase extended mental health benefits.	No	296,200
2/2012	NY	Provider Data Integrity	Accuracy of online provider directories.	No	30,000
2/2012	NY	Insurance Department Finding	Did not tell small business of option to purchase extended mental health benefits.	No	184,240
1/2012	CA	Grievance Process	Failure to follow grievance process.	No	15,000
1/2012	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	15,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
1/2012	CA	Grievance Process	Untimely grievance resolution.	No	10,000
1/2012	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
1/2012	CA	Grievance Process	Incomplete response to the Department.	No	5,000
1/2012	CA	Grievance Process	Untimely grievance resolution.	No	5,000
12/2011	WA	Insurance Department Finding	Violations regarding marketing/sales of student health products.	No	100,000
11/2011	CA	Reporting Requirement	Failure to include required information in enrollee cancellation notice.	No	5,000
11/2011	CA	Reporting Requirement	Untimely response to Department request for information.	No	5,000
11/2011	CA	Grievance Process	Failure to provide correct response.	No	2,500
11/2011	WI	Miscellaneous Operations	Affiliate agreement approval and quarterly financial results review issues.	No	500
11/2011	WI	Miscellaneous Operations	Affiliate agreement approval and quarterly financial results review issues.	No	500
10/2011	CA	Grievance Process	Failure to follow grievance process.	No	20,000
10/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
10/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
10/2011	CA	Grievance Process	Incomplete grievance response.	No	5,000
10/2011	CA	Grievance Process	Incomplete grievance response.	No	5,000
10/2011	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
9/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
9/2011	CA	Grievance Process	Failure to follow grievance process.	No	10,000
9/2011	CA	Grievance Process	Incomplete grievance response.	No	5,000
9/2011	CA	Grievance Process	Incomplete grievance response.	No	5,000
9/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
9/2011	CA	Grievance Process	Failure to timely acknowledge grievance.	No	5,000
9/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
9/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
9/2011	CA	Grievance Process	Failure to timely acknowledge grievance.	No	5,000
9/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
9/2011	CA	Grievance Process	Untimely response to complaint.	No	2,500
8/2011	CA	Grievance Process	Failure to follow grievance process.	No	20,000
8/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
8/2011	CA	Grievance Process	Grievance resolution untimely.	No	10,000
8/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	10,000
8/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
8/2011	CA	Grievance Process	Incomplete information on grievance provided to the Department.	No	5,000
8/2011	CA	Grievance Process	Failure to follow grievance process.	No	5,000
8/2011	CA	Grievance Process	Grievance resolution untimely.	No	5,000
8/2011	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
8/2011	CA	Grievance Process	Provided incomplete reason for denial.	No	5,000
8/2011	CA	Grievance Process	Failure to timely acknowledge grievance.	No	5,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
8/2011	CA	Grievance Process	Untimely response to Department request for information.	No	5,000
8/2011	CA	Grievance Process	Failure to follow grievance process.	No	5,000
8/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
8/2011	GA	Insurance Department Finding	Targeted market conduct examination findings (July 2008).	No	—
7/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
7/2011	CA	Grievance Process	Untimely grievance resolution.	No	5,000
6/2011	IN	Insurance Department Finding	Security breach.	No	100,000
5/2011	CA	Grievance Process	Failure to follow grievance process.	No	7,500
5/2011	IL	Insurance Department Finding	Market conduct examination findings.	No	105,000
5/2011	IL	Insurance Department Finding	Market conduct examination findings.	No	75,000
5/2011	IL	Insurance Department Finding	Market conduct examination findings.	No	30,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	3,000
3/2011	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	3,000
3/2011	CA	Grievance Process	Untimely notification of expedited grievance disposition and failure to provide information to Department.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete explanation of grievance response.	No	3,000
3/2011	CA	Grievance Process	Incomplete grievance response.	No	5,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Incomplete and untimely response to grievance.	No	3,000
3/2011	CA	Grievance Process	Untimely response to request for information.	No	3,000
3/2011	CA	Grievance Process	Untimely response to request for information.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to provide timely information to Department.	No	3,000
3/2011	CA	Grievance Process	Failure to provide timely information to Department.	No	3,000
3/2011	CA	Grievance Process	Failure to provide timely information to Department.	No	3,000
3/2011	CA	Grievance Process	Failure to provide Department with timely information.	No	3,000
3/2011	CA	Grievance Process	Failure to provide Department with timely information.	No	3,000
3/2011	CA	Grievance Process	Failure to provide Department with timely information.	No	3,000
3/2011	CA	Grievance Process	Failure to provide Department with timely information.	No	3,000
3/2011	CA	Grievance Process	Failure to provide timely information to Department.	No	3,000
3/2011	CA	Grievance Process	Untimely acknowledgement of grievance.	No	3,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Untimely grievance resolution.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Late grievance resolution and failure to provide requested information.	No	3,000
3/2011	CA	Grievance Process	Untimely acknowledgement and resolution of grievance.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Prolonged independent review process or implementation of decision.	No	3,000
3/2011	CA	Grievance Process	Prolonged independent review process or implementation of decision.	No	3,000
3/2011	CA	Grievance Process	Prolonged independent review process or implementation of decision.	No	3,000
3/2011	CA	Grievance Process	Prolonged independent review process or implementation of decision.	No	3,000
3/2011	CA	Grievance Process	Prolonged independent review process or implementation of decision.	No	3,000

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
3/2011	CA	Grievance Process	Failure to follow grievance process.	No	3,000
1/2011	CA	Grievance Process	Untimely acknowledgement of grievance.	No	2,500
1/2011	CA	Grievance Process	Untimely acknowledgement of grievance.	No	2,500
1/2011	CA	Grievance Process	Untimely acknowledgement of grievance.	No	2,500
1/2011	CA	Grievance Process	Untimely acknowledgement of grievance.	No	2,500
1/2011	UT	Reporting Requirement	Failure to timely pay certificate of authority renewal fee.	No	4,000
12/2010	CA	Grievance Process	Failure to follow grievance process.	No	45,000
12/2010	CA	Grievance Process	Incomplete grievance response.	No	15,000
12/2010	CA	Grievance Process	Failure to follow grievance process.	No	15,000
12/2010	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	10,000
12/2010	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	5,000
12/2010	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
12/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
11/2010	CA	Claims Process	Failure to pay claims timely.	No	500,000
11/2010	CA	Grievance Process	Failure to follow grievance process.	No	7,500
11/2010	CA	Grievance Process	Untimely notification of expedited grievance disposition.	No	5,000
11/2010	CA	Grievance Process	Incomplete and untimely response to grievance.	No	5,000
11/2010	CA	Grievance Process	Untimely acknowledgement of grievance.	No	5,000
11/2010	CA	Grievance Process	Incomplete and untimely response to grievance.	No	5,000
11/2010	CA	Grievance Process	Incomplete and untimely response to grievance.	No	2,500
8/2010	CA	Claims Process	Failure to follow claims process.	No	20,000
8/2010	CA	Grievance Process	Failure to provide Department with information.	No	5,000
8/2010	CA	Grievance Process	Incomplete grievance response.	No	5,000
8/2010	CA	Grievance Process	Failure to provide clear denial reason.	No	5,000
8/2010	CA	Grievance Process	Failure to provide Department with information.	No	2,500
6/2010	OH	Insurance Department Finding	Refund or credit to policyholders charged rates not consistent with those filed.	No	5,900,000
5/2010	VT	Insurance Department Finding	Out of state groups with state subscribers.	No	100,000
4/2010	CA	Reporting Requirement	Failure to provide timely documents to the Division of Licensing.	No	100,000
4/2010	CA	Grievance Process	Failure to follow grievance process.	No	20,000
4/2010	CA	Grievance Process	Untimely and incomplete grievance resolution.	No	15,000
4/2010	CA	Grievance Process	Failure to follow grievance process.	No	15,000
4/2010	CA	Claims Process	Failure to properly execute claims process.	No	10,000
4/2010	CA	Authorization Process	Untimely medical necessity response.	No	2,500

Commercial Affiliate Regulatory Actions and Sanctions

Date	State	Regulatory Action Category	Description of Regulatory Action	Corrective Action Plan	Financial Penalty
4/2010	NV	Insurance Department Finding	Market conduct examination findings.	No	5,100
3/2010	CA	Grievance Process	Failure to provide Department with timely information.	No	2,500
3/2010	CA	Grievance Process	Failure to provide Department with timely information.	No	2,500

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
Medicaid - Operational Affiliates					
2/24/15	NJ	2014 IPRO Annual Assessment identified deficiencies.	Yes	The CAP included activities to: 1) develop network recruitment work plan for deficient counties; 2) work internally to develop reporting and with IPRO on data discrepancies; 3) develop new care management reporting; and 4) implement new staff education.	–
2/23/15	TN	Claims payment accuracy for NF did not meet standard in Jan 2015.	Yes	Corrective action included 1) auditing nursing facility price configuration to validate current rates and 2) adding a step to check current rates before moving the configuration into production.	–
2/19/15	TN	Untimely submission of a level of care assessment.	No		1,000
2/19/15	TN	Untimely submission of a level of care assessment.	No		1,500
2/18/15	KY	Encounter data was not timely and above the threshold error percentage.	No		13,500
2/9/15	TN	Late response to adhoc report request.	No		300
2/4/15	TN	Untimely submission of a level of care assessment.	No		1,500
1/30/15	TX	Q4SFY14 pharmacy encounters not within variance threshold.	No		12,500
1/30/15	TX	Report submitted using the wrong template.	No		100
1/30/15	TX	Did not meet 30 day member complaint resolution percentage.	No		–
1/29/15	TN	Aug 2014 - Jan 2015 care coordination did not meet timeliness measures.	No		2,000
1/29/15	TN	Untimely submission of a level of care assessment.	No		3,000
1/29/15	TN	Untimely submission of a level of care assessment.	No		2,000
1/29/15	TN	Untimely submission of a level of care assessment.	No		3,500
1/27/15	FL	Failure to submit provider network file that meets specifications (specific to occupational therapy).	No		–
1/27/15	FL	Failure to submit provider network file that meets specifications (specific to occupational therapy).	No		–
1/22/15	TN	Failure to comply with pick up and delivery standards.	No		500
1/22/15	TN	Failure to comply with pick up and delivery standards.	No		500
1/22/15	TN	Failure to comply with pick up and delivery standards.	No		500
1/21/15	TN	Failed to meet 2013 and 2014 transition benchmark.	Yes	Action plan included 1) implementing a new staffing model with new positions; 2) staff refresher training and education sessions regarding transitions; 3) community and stakeholder involvement activities.	–

Note: Medicaid affiliates operate three health plans in Florida and two in Texas

Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
1/20/15	CA	Did not meet the quality and timeliness encounter metrics for inpatient encounters.	Yes	The CAP included implementing an edit to check for potential duplicate encounters and carefully reviewing rejections from the state. The Provider Network Relations team is working with providers on timely submission of encounters, particularly inpatient encounters.	-
1/20/15	TN	Data file submitted with incorrect data.	Yes	Corrective action included 1) correcting file logic and re-running files; 2) changing file posting format; 3) adding additional monitoring steps to verify compliance.	-
1/20/15	TN	Data file submitted with incorrect data.	Yes	Corrective action included 1) correcting file logic and re-running files; 2) changing file posting format; 3) adding additional monitoring steps to verify compliance.	-
1/16/15	FL	Failure to submit Critical Incident Reporting within 24 hours of notification.	No		4,500
1/14/15	NY	Member Services Survey encountered Incorrect responses.	No		-
1/12/15	TN	4Q14 - failed to achieve accuracy rates for provider enrollment file.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, research using vendor to improve provider data, and continued provider visits to validate provider information and educate.	-
12/5/14	VA	Health assessment forms did not contain all required elements.	Yes	The CAP provided the state with flowcharts outlining current and revised assessment processes and recommended contract alternations to consider governing assessments.	-
12/4/14	LA	Encounter data file submission errors.	No		150,000
10/31/14	FL	Failure to comply with claims processing requirements. The fine was appealed and is pending state response.	No		30,000
10/31/14	FL	Failure to comply with claims processing requirements. The fine was appealed and is pending state response.	No		30,000
10/27/14	FL	Claims for Assistive Care Services did not process correctly. The sanction is under appeal as of November 17, 2014.	No		40,000
10/24/14	TX	Failure to attend Fair Hearing.	No		7,500
10/24/14	TX	Pharmacy encounters not within 2% variance.	No		35,000
10/24/14	TX	Submission of late and inaccurate report.	No		4,100
10/24/14	TX	Failure to timely notification of a privacy breach.	Yes	Actions taken included modifying the claims system search feature to ensure that member social security numbers are masked and prevented from being viewable in future search results.	105,000
10/24/14	TX	Untimely initiation of services after nursing facility discharge.	No		5,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
10/20/14	WI	Encounters did not meet the quality and timeliness standards.	Yes	The CAP included actions to: 1) review/update detailed process for submitting accurate, complete, and timely encounters, 2) create a plan to submit missing data, and 3) describe process to identify quality issues moving forward.	–
10/15/14	LA	Non-compliance with encounter submission standards.	No		90,000
10/13/14	TN	Transportation vendor was late for member drop off.	No		500
9/25/14	TN	Transportation vendor failed to comply with pick up and delivery standards.	No		500
9/23/14	FL	Review of records for two members identified continuity of care deficiencies.	No		2,500
9/22/14	TX	Desk audit identified delays in completing reassessments, interest list release assessments, and upgrades for waiver members which resulted in untimely delivery of needed services for several members.	Yes	Enhanced the member service coordination workflow process to include: outreach to members to ensure dental appointments are scheduled and services received; and follow-up with members to encourage treatment plan adherence. Additionally, service coordinator re-education emphasized the need ensure the completion of all identified services	–
9/17/14	NY	Q42013 provider network submission included sanctioned providers.	No		–
9/15/14	CA	Failure to follow member grievance process appropriately.	No		50,000
9/15/14	NY	Failure to provide adequate adverse determination notices to members.	Yes	The deficiencies noted were sent by a vendor that is no longer providing services members. The current notice and policy were submitted to provide evidence that current exception requests are handled correctly with appropriate noticing and are in compliance with current state regulations.	–
9/11/14	FL	Failure to comply with network adequacy requirements for adolescent medicine providers. The fine was appealed and is pending response from the state.	No		3,000
9/11/14	FL	Failure to comply with network adequacy requirements. The fine was appealed and is pending response from the state.	No		21,000
9/4/14	FL	Untimely report submission.	No		18,000
8/25/14	FL	Use of unapproved banner at marketing event.	No		2,500
8/25/14	NY	Deficiencies found in the 2013 Phase 2 Provider Directory Survey.	No		–
8/22/14	TN	Untimely member level of care assessment.	No		3,000
8/22/14	TN	Untimely member level of care assessment.	No		4,500
8/22/14	TN	Untimely member level of care assessment.	No		3,500

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
8/22/14	TN	Insufficient documentation for transition request.	No		2,000
8/22/14	TN	Insufficient documentation for transition request.	No		2,000
8/22/14	TN	Insufficient documentation for transition request.	No		2,000
8/22/14	TN	Untimely member level of care assessment.	No		3,000
8/22/14	TN	Untimely member level of care assessment.	No		3,000
8/22/14	TN	Insufficient documentation for transition request.	No		2,000
8/22/14	TN	Untimely member level of care assessment.	No		1,500
8/21/14	NJ	Grievance and appeal non-compliance with 30 day resolution requirement.	Yes	The CAP included activities to: add coaching tip prompts for call center employees; develop unified verbiage and documentation requirements for complaint input; and develop a report to proactively identify complaints that may not have been processed correctly.	–
8/13/14	TN	Untimely member level of care assessment.	No		1,000
8/7/14	NY	Failure to ensure member was reimbursed for financial liability after PCP referral.	No		–
8/7/14	NY	Failure to ensure member was reimbursed for financial liability after PCP referral.	No		–
8/5/14	FL	Untimely submission of provider network file.	No		250
8/5/14	FL	Untimely submission of provider network file.	No		250
8/5/14	FL	Untimely submission of provider network file.	No		250
8/1/14	TN	Untimely member level of care assessment.	No		1,000
7/29/14	FL	Ad hoc report submitted one day late.	No		500
7/18/14	NJ	Failure to refer tort and casualty cases to the state.	Yes	CAP submitted to the State on 8/18/14 pending approval. Amerigroup disputed this allegation and submitted evidence of past tort referrals. Proposed a more streamlined submission process that will deliver better communication with the State unit handling tort cases.	–
7/18/14	NY	Member Services Survey found Incorrect response given to member services questions.	No		–
7/8/14	TN	Incomplete response to a reconsideration of a denied service.	No		1,000
7/7/14	NJ	Failure to appoint dental director.	Yes	Evidence was submitted to the State on 8/1/14 that a dental director had been hired.	–
7/3/14	TN	Untimely member notification of a UM denial.	Yes	The CAP included root clause analysis leading to the revision of a job aid tool and employee re-training.	–
6/30/14	TN	Submission of incorrect quarterly transportation report.	No		3,500
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/30/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/26/14	WA	Deficiencies found in multiple operational areas during 2014 site visit.	Yes	The CAP included activities to address: care coordination oversight; authorizations of services; compensation for utilization directions; outpatient mental health; enrollee rights (format, alternative formats); adoption of practice guidelines; detecting over- and under-utilization of services; assess care furnished to enrollees with special health care needs; and health home health action plans.	–
6/5/14	TN	Failure to timely disenroll member.	No		3,000
6/5/14	TN	Late submission of a level of care assessment.	No		2,500
6/5/14	TN	Insufficient information submitted for member reassessment and transition.	No		2,000
6/5/14	TN	Untimely forwarding of an appeal response.	No		3,500
6/2/14	TX	Failure to meet performance standards in several areas for SFY 2013: claims, encounter, member appeals and fair hearings, out-of-network services; and inaccurate reporting.	Yes	A CAP was requested for the Member appeals area. Steps included refresher training and coaching employees regarding appeal processing and workflow and timeliness standards. Established monitoring and collection of monthly appeal report detail for quarterly report submission to confirm two consecutive quarters of compliance.	132,125
5/22/14	NJ	Plan D behavioral health co-payment error.	Yes	Implemented process to verify that member ID cards are accurate and contractually compliant during an internal audit review twice a year.	–
5/14/14	CA	Incomplete response to an enrollee grievance.	Yes	We reviewed this incident with the responsible employees and their supervisors, including applicable requirements.	10,000
5/12/14	CA	Incomplete response to an enrollee grievance and failure to provide timely information to the state.	Yes	We reviewed this incident with the responsible employees and their supervisors, including applicable requirements.	15,000
5/9/14	TN	Failed to execute prompt notification of an accident/incident.	No		1,000
5/9/14	TN	Failure to meet complaint deadline.	No		100
5/9/14	TN	Late submission of a level of care assessment.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/7/14	TN	External review of EPSDT services found deficiency in health education documentation.	Yes	The CAP included implementation and distribution of a Provider Tool Kit that addressed EPSDT periodicity, performing targeted education to providers who were non-compliant, and adding EPSDT education to provider orientation materials.	–
4/21/14	FL	Failed to achieve performance measures.	Yes	Activities included: member and provider outreach and education; appointment reminder notifications; reporting and data analysis; use of Text4Baby program; partnership with other associations; provider training; coordination with CM/DM; and notification of Healthy Behaviors program.	50,500
4/21/14	FL	Failed to achieve performance measures.	Yes	Activities included: member and provider outreach and education; appointment reminder notifications; reporting and data analysis; use of Text4Baby program; partnership with other associations; provider training; coordination with CM/DM; and notification of Healthy Behaviors program.	20,000
4/21/14	FL	Did not meet 2012 prenatal/postpartum performance measure.	No		7,500
4/17/14	FL	Failure to meet encounter data accuracy standards.	Yes	Reviewed health plan data against state data to identify cases of issues. Working with the state on the issues related to the state Master File. Delivering monthly status reports until the CAP is closed.	–
4/17/14	FL	Untimely report submission.	No		500
4/17/14	NJ	2013 annual assessment by IPRO found deficiencies in 8 elements.	Yes	Implemented a work plan to address elements identified as Not Met, including increased dental recruiting in deficient counties, improved appointment availability studies, development of a community needs assessment, development of additional member educational materials, and improved internal monitoring and reporting.	–
4/10/14	WV	Annual External Quality Review audit found deficiencies.	Yes	CAP actions included activities to: improve member notification of right to request financial statement; improve appointment availability and after hours care; clarify policies and procedures for credentialing and disenrollment; and making sure that verification of services letters are mailed quarterly.	–
4/8/14	TN	Telephone number accuracy failed to meet benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	–
4/3/14	TN	Deficiencies in network for SNF, dermatology, and pest control.	Yes	The CAP included outreach efforts to contract with providers to join the network and correction of data sufficiency errors that caused a false deficiency in these categories.	–
3/31/14	FL	Format error in provider network file.	No		1,750

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/28/14	NY	2014 Article 44 Operational Survey - Deficiencies found in pharmacy decision letter.	No		–
3/25/14	TN	Defective notice of action.	No		500
3/18/14	TN	PIP for CAHPS - member response to smoking cessation did not achieve validation status of met.	Yes	The CAP included revised verbiage to the CAHPS member survey and correction of measurement values.	–
3/11/14	KY	Network deficiency for urban hospitals, dermatologists, psychiatrists, and cardiologists.	Yes	Expedited provider file loading so provider network files would be more accurate. Plan outreached to several dermatologist groups.	–
3/7/14	NJ	A vendor conducted an unapproved post call survey after being told not to by the health plan.	Yes	Implemented an additional internal control to remove NJ members from the data file sent to the vendor who made non-compliant survey calls. The vendor implemented an additional control to review for and remove any NJ members from call samples.	–
3/4/14	WV	Dental vendor paid claims late and did not submit encounter data.	Yes	Worked with dental vendor to resolve claims payment issues. Implemented increased monitoring of dental vendor claims timeliness and encounter submission.	–
2/27/14	FL	Failed to meet child health check-up program 80% participation ratio.	Yes	Activities included: member education and outreach; appointment reminders and scheduling assistance; non-compliant member reports for providers and education; distribution of data to impacted plan departments; and compliance monitoring.	50,000
2/24/14	TN	Documentation failed to demonstrate review of care plan within required timeframes.	No		1,000
2/24/14	TN	Failed to meet reprocess claims within 60 days after rate update.	Yes	The CAP included revising the rate update policy and procedure and implementation of a tracking tool to monitor rate updates.	–
2/21/14	NY	Accuracy rates for 2013 provider directory survey failed to meet threshold.	No		–
2/20/14	TX	Failed to meet timely checkup program requirement.	Yes	The CAP outlined actions to bring checkup rates to required participation rates, including new call strategies with our Health Promotion team to increase appointment scheduling assistance and using a vendor to schedule appointments with provider offices in real-time. The health plan also partnered with 6 select physician offices/groups to deliver PCP level services on a Saturday for our members. Also created new reports for Provider Relations staff to use with provider offices to increase various measures.	–
2/7/14	FL	Failed to meet child health check-up program 80% participation ratio.	Yes	Activities included: member education and outreach; appointment reminders and scheduling assistance; non-compliant member reports for providers and education; distribution of data to impacted plan departments; and compliance monitoring.	25,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
2/7/14	FL	Failed to meet child health check-up program 80% participation ratio.	Yes	Activities included: member education and outreach; appointment reminders and scheduling assistance; non-compliant member reports for providers and education; distribution of data to impacted plan departments; and compliance monitoring.	25,000
1/31/14	TN	Failure to complete level of care assessment.	No		2,000
1/29/14	NJ	Enrollee appeal acknowledgement letters failed to meet required timeframe.	Yes	Implemented additional quality assurance checks to ensure that member acknowledgement letters are consistently generated and issued to members.	–
1/29/14	TN	Failure to initiate disenrollment for member.	No		1,000
1/14/14	TN	4Q13 provider data survey results did not meet the telephone number benchmark.	No		5,000
12/30/13	NJ	Deficiencies found in 2013 CAHPS.	Yes	Implemented additional provider and member outreach to increase member satisfaction and utilization measures. The CAP also outlined work with dental vendor on provider recruitment and access issues.	–
12/26/13	TN	Failure to meet provider enrollment file accuracy rates for telephone numbers.	Yes	The CAP included outreach to identified providers to confirm participation and demographic information. Additionally, engaged vendor to improve data accuracy.	5,000
12/26/13	TN	Subcontractor failed to provide approved supplies in a timely manner.	No		7,570
12/23/13	NY	2012 member services telephone survey found questions answered incorrectly.	No		–
12/5/13	NY	Inaccurate response to three complaint investigations.	No		–
12/4/13	TN	Audit for Oct 2012 found failure to issue notice of adverse action. (24 instances)	No		500
12/3/13	NJ	Untimely appeal resolution.	Yes	Determined non-compliance was caused by a staffing transition. To address the issue, provided ongoing education through weekly meetings and reeducation. Also increased member complaints and grievances staff.	–
11/27/13	TN	Late response to adhoc report request.	No		2,500
11/26/13	TN	Failure to issue notice of adverse action.	No		500
11/26/13	TN	Failure to issue notice of adverse action.	No		500
11/19/13	FL	Incorrect name on the claims aging report.	No		1,000
11/8/13	NY	Member services survey found representative gave incorrect response to a request for information.	No		–
10/8/13	CA	Untimely response to a request for documentation.	No		5,000
9/19/13	TN	Required benchmark for prompt pay rate not met.	No		10,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
9/17/13	NJ	Appeal acknowledgement letter not sent within 10 business days.	Yes	Because deficiencies occurred just prior to implementation of a new appeals system, CAP actions included training staff in the new system processes. Also started standing monitoring meetings to review compliance with appeal requirements.	–
9/17/13	NJ	Untimely provider grievance/appeal resolution.	Yes	Actions included a number of steps to improve overall provider complaint tracking process, including applying internal deadlines to various steps in the complaint processing, designating one lead provider relations designee, and improving the internal documentation system and tools.	–
9/16/13	VA	Deficiencies in appeal processing.	Yes	The CAP included actions to verify that proper review is conducted and have the Chief Medical Director conduct monthly case audits to ensure compliance.	–
9/4/13	TN	Program audit identified deficiencies.	No		7,500
9/4/13	TN	Required benchmark for claims payment accuracy for nursing facilities not met.	No		35,000
9/4/13	TN	Required benchmark for claims payment accuracy for nursing facilities not met.	No		25,000
9/4/13	TN	Monthly transportation utilization report submitted late.	No		1,300
8/29/13	NY	Deficiencies found in the 2011 Access & Availability survey.	No		–
8/22/13	FL	Improper format for Q2 claims aging report.	No		500
8/22/13	FL	Incorrect name on quarterly financial report.	No		500
8/5/13	FL	Medical loss ration report filed late.	No		500
7/25/13	TN	Semi-annual critical incidents audit identified two late notifications.	Yes	The CAP included provider education regarding timely reporting and corrective measures for non-compliant providers. Also revised the Critical Incident reporting policy.	–
7/22/13	MD	Primary care network appeared inadequate after the network directory clean-up.	Yes	Enacted protocols to ensure provider data submitted was complete and in a format to be accepted into the State's database.	–
7/16/13	NY	Claims payments for October 1, 2010-September 30, 2012 untimely.	No		27,300
7/9/13	TN	2Q13 provider data survey results did not meet telephone number accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
7/3/13	MD	Preauthorization decisions and adverse determination notifications late.	Yes	CAP addressed 3 areas. Preauthorization Determinations: Recruited management staff; review and tracking of pre-service timeframes. Adverse Determination Notification: Improved correspondence workflows. UM Timeliness Audit Policy: Revised policy to review preauthorization decisions and notifications to monitor compliance. Report the results to the QM committee quarterly.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
6/24/13	TN	Audit of deficit reduction act compliance identified several instances of non-compliance with provider education.	Yes	The CAP included provider communication on the deficit reduction act using provider visits, town hall sessions, and a provider newsletter article. Also revised the DRA monitoring process.	–
6/17/13	TN	Face-to-face care coordination standard for members admitted to a NF not met for Oct and Nov 2012.	No		1,000
6/17/13	TN	Adhoc report on a member appeal submitted late.	No		2,000
6/14/13	NJ	Excess denied capitation encounters.	No		104,559
5/29/13	TX	4Q12 performance standards not met.	Yes	The CAP addressed a number of areas, including: retraining staff on invalid naming conventions on a report; reviewing case details prior to report submission to address errors on a member complaints report; improving member appeals processing; actively participating in a project with HHSC regarding reconciliation of encounter data to FSRs; improving BH claims processing; and improving process for addressing report follow-up requests.	62,775
5/24/13	CA	Documentation for denial of services incomplete.	Yes	The CAP included coaching and counseling employees. In addition, created new processes for drug service requests that are exclusive to medical benefit coverage rules and not pharmacy medical necessity. We will also modify the letter generation capability ensure that we generate benefit denial letters with correct language.	5,000
5/23/13	NJ	2012 provider satisfaction survey deficiencies identified.	Yes	Initiated multiple provider education, member education, and pharmacy education initiatives to increase overall provider satisfaction as measured by the annual provider satisfaction survey.	–
5/21/13	TN	Submission of the fraud plan and policies and procedures was late and insufficient.	No		400
5/15/13	CA	Benchmark for inpatient quality not met.	Yes	Continued to focus on potential duplicate edits from capitated hospital groups. Worked with Claims IT to identify solutions that would not affect volume and timeliness factors. Continued provider education efforts. Met with encounter team to discuss solutions.	–
5/1/13	TN	Required benchmark for post discharge services report not met.	Yes	The CAP included activities to conduct barrier analysis, identify trends associated with missed appointments, and identify interventions to increase adherence. Also assessed member outreach materials and reviewed member incentive program.	–
4/18/13	FL	Report submitted to state did not include a complete signed jurat page.	No		500
4/17/13	NY	Article 44/49 targeted survey found one inaccurate physician file.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/12/13	NY	2012 provider directory survey did not meet benchmark for provider participation and accuracy of web and printed directories.	No		–
4/8/13	TN	1Q13 provider data survey results did not meet the benchmark for accuracy.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
3/27/13	WA	Deficiencies found in multiple operational areas during 2013 site visit.	Yes	CAP actions included: developing network reports; enrollee rights to access women's health; reports and analysis to assess member demographics; staff responsibilities related to program integrity; provider payment suspensions notification; developing case management program policies and procedures; process and procedure for patient review and coordination activities; behavioral policy; employee and provider training on enrollee rights and advance directives; organizing a diversity council to evaluate the needs of the membership served; defining a significant change and providing notification as required; quarterly reporting to the quality management program; more detailed meeting minutes; grievance system and process; documenting and reporting of Clinical Practice Guidelines; developing a provider watch list; and delegation oversight	–
3/21/13	TN	Adhoc report about a member appeal submitted late.	No		1,000
3/21/13	TN	Adverse action notice did not include reference to the exclusion rule.	No		500
3/21/13	TN	Adhoc report for a member appeal submitted late.	No		500
3/14/13	TX	Performance bond was not filed with the Department of Insurance.	No		–
3/8/13	FL	Marketing used a billboard not previously approved.	Yes	The health plan submitted billboards and Community Outreach policies and procedures to the state for review and approval. Gave refresher training to the marketing team and submitted confirmation of training to the state.	1,000
3/8/13	FL	Marketing used a banner not previously approved at a marketing event.	Yes	The health plan removed the unapproved banner and submitted the creative to the state for approval. Medicaid Compliance met with the Senior Director of Marketing to review approvals and discuss process and Marketing team was reminded of marketing policies pertaining to materials.	1,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/6/13	CA	Benchmark for outpatient timeliness, and Inpatient quality and timeliness not met.	Yes	Continued to monitor group submissions to ensure ongoing timeliness of receipt. Worked with its Claims IT area to determine if edits can be invoked to identify and suppress potential duplicate claims. In addition we are reached out to providers to ensure appropriate billing patterns. Conducted group outreach to ensure capitated group submissions are timely.	–
3/5/13	FL	Untimely filing of required corrective action plan.	Yes	Activities included: member education and outreach; appointment reminders and scheduling assistance; non-compliant member reports for providers and education; distribution of data to impacted plan departments; and compliance monitoring.	2,500
2/27/13	FL	Financial report for 4Q submitted with inaccurate information.	No		1,000
2/26/13	FL	Late report filing and failed to meet claims performance measures in Q4 2012.	No		1,500
2/26/13	FL	Late report filing and failed to meet claims performance measures in Q4 2012.	No		1,500
2/26/13	FL	Q4 2012 claims aging report filed late.	No		500
2/26/13	FL	Failed to meet Q4 2012 claims performance measures.	No		1,500
2/26/13	LA	Benchmark for clean claims in 3Q12 and 4Q12 not met.	Yes	Developed prompt payment reports at the provider type level to proactively identify variances and reinforced standards with internal business leads and subcontracted vendors. Vendor hired and trained additional staff and implemented additional monitoring.	–
2/26/13	NJ	Excessive duplicate encounters in December 2012.	No		4,733
2/19/13	FL	Failure to meet HEDIS performance measures in 3 areas: mental health/substance abuse, prenatal/postpartum, and chronic care.	Yes	Activities included: member and provider outreach and education; appointment reminder notifications; reporting and data analysis; use of Text4Baby program; partnership with other associations; provider training; coordination with CM/DM; and notification of Healthy Behaviors program.	20,000
2/19/13	FL	Failure to meet HEDIS performance measures in 3 areas: mental health/substance abuse, prenatal/postpartum, and chronic care.	Yes	Activities included: member and provider outreach and education; appointment reminder notifications; reporting and data analysis; use of Text4Baby program; partnership with other associations; provider training; coordination with CM/DM; and notification of Healthy Behaviors program.	–
2/15/13	NJ	Deficiencies identified in 2012 IPRO annual assessment categories.	Yes	Overall, the health plan scored 98% on this audit and demonstrated strong performance. Addressed actions needed to address low measures were minimal in the HEDIS work plan, including interventions and a monitoring and oversight plan.	–
2/1/13	TN	Annual quality audit requested CAP that was not submitted timely.	No		6,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
1/14/13	LA	Changes to supplemental data file required to address deficiencies between encounters and cash disbursement journal.	Yes	Reviewed audit report against our internal monitoring and reconciliation data. Worked with auditor to understand reconciliation data requirements and process and provided a revised data file. Confirmed in next report that encounters were no longer dropped	–
1/10/13	TN	4Q12 provider data survey results did not meet telephone number accuracy benchmark.	Yes	The CAP included provider outreach to providers refusing to participate, general provider communication to reinforce their obligation to participate in provider surveys, correction and resubmission of the provider enrollment, and use of a data vendor to improve the accuracy of missing and/or incomplete information.	–
12/20/12	TX	Failure to meet performance standards for: timely appealed claims adjudication, state pharmacy audit deficiencies, timely member appeal resolution, and late, incomplete, or inaccurate reporting.	Yes	The CAP addressed the timely processing of appealed claims. The health plan continued increased oversight of the appealed claims and submitted monthly detail to the state, though non-compliance is primarily due to extremely low denominators for some measures.	2,955
12/6/12	TN	Adhoc weekly deliverable regarding: BH CPT codes submitted late.	No		100
12/1/12	GA	Errors in network adequacy report.	Yes	The CAP included first determining the cause of the report error. After modifying the program, the reporting logic was locked-down to prevent changes without specific approval.	–
11/27/12	TN	2012 Quality and UM program descriptions, evaluations, and work plans deficient.	Yes	Revised the QI/QM Program Description template to address each of the required elements and detail the system/processes that support each item. Also modified the program evaluation template to add a barrier analysis section.	–
11/20/12	FL	Submission of non-compliant pharmacy encounter data.	No		25,000
11/15/12	CA	Encounter submission metrics for outpatient timeliness and inpatient quantity not met.	Yes	Continued monitoring of encounter submission timeliness and backlog. Monitoring inpatient volumes both by DOR and DOS.	–
11/13/12	TN	Oct 12 GeoAccess report indicated provider network deficiencies.	Yes	Continued contracting efforts to meet geo access requirements for identified services in two counties and corrected a system configuration error.	–
11/2/12	WA	Findings at 2012 monitoring visit identified areas requiring correction.	Yes	We took action to address: initial health screening completion timeliness; reports with analysis and opportunities for action; standardized reporting activities; notifications sent to incorrect locations; balance billing issues; clear reasons for grievance determination.	–
10/31/12	IN	2Q12 performance requirements for claims processing and call center timeliness not met.	Yes	Trained additional staff to assist with claims inventories. Trained additional call center resources and instituted an ongoing hiring strategy to address attrition trends and provide resources in a timely manner.	9,457

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
10/24/12	NV	Audit in policies and procedures and the member handbook identified deficiencies.	Yes	CAP activities included adding additional information to the member handbook regarding requirements of a written Notice of Action, continuation of benefits, and continuation of benefits while appeal is pending.	–
10/23/12	TN	Transportation vendor did not meet prompt pay standards for June 2012.	No		10,000
10/19/12	GA	Deficiencies in GeoAccess report, primarily due to programming errors.	Yes	The CAP included first determining the cause of the report error. After modifying the program, the reporting logic was locked-down to prevent changes without specific approval.	–
10/17/12	NY	Access and availability survey benchmark for routine appointments, non-urgent sick appointments, and after hours access not met.	No		–
10/11/12	NY	Benchmark for provider participation rate not met.	Yes	Made verification calls to providers and updated files to create accurate provider directories.	–
10/8/12	TN	3Q12 GeoAccess report indicated provider network deficiencies.	Yes	Continued contracting efforts to meet geo access requirements for identified services in one county and corrected a system configuration error.	–
10/5/12	NJ	Excessive duplicate encounters for September 2012.	No		82,843
10/5/12	TN	3Q12 provider data survey results did not meet telephone number accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
9/25/12	TN	Transportation vendor policy deficiency regarding weekend/evening hours.	Yes	Our transportation vendor implemented a live response to all calls for after-hours service and hired and trained staff to answer and take immediate action on all after-hours calls.	–
9/11/12	TN	Transportation vendor submitted response to a request for information late.	No		100
9/5/12	TN	Transportation vendor did not have current vehicle inspections on file for one of its vendors.	No		6,000
9/5/12	TN	2Q12 care coordination did not meet timeliness measures.	No		5,000
9/5/12	TN	July 2012 nonemergency transportation vehicle listing identified vehicles with overdue inspections.	Yes	Our transportation vendor updated the vehicle inspection listing, instituted an electronic tracking mechanism for vehicle information and documentation, and provided proof of inspection for two vehicles.	–
9/4/12	FL	Late filing of report. The fine was appealed and pending response from the state.	No		32,000
9/4/12	FL	Untimely filing of annual anti-fraud plan.	No		32,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
9/4/12	TN	1Q12 care coordination did not meet timeliness measures.	No		39,500
8/27/12	CA	Response to request for additional information submitted late.	Yes	Reviewed incident with the responsible plan employees and their supervisor and provide the state with written notification of completion.	2,500
8/22/12	FL	Late filing of report. The fine was appealed and is pending response from the state.	No		32,000
8/21/12	TN	Transportation vendor submitted a deficient monthly status report.	No		2,400
8/19/12	TN	July 2012 GeoAccess report indicated provider network deficiencies.	Yes	Continued contracting efforts to meet geo access requirements for identified services in one county and corrected a system configuration error.	–
8/17/12	TX	1Q12 member appeals processing timeframe not met.	No		250
8/8/12	TN	An approved service was not provided timely.	No		18,000
8/6/12	IN	1Q12 performance requirements for claims processing and call center timeliness not met.	Yes	Trained additional staff to assist with claims inventories and corrected system issues. Trained additional call center resources and enhanced the call routing system to route calls at a designated time threshold to the back up site that has additional trained capacity.	10,421
7/25/12	CA	Delay in delivering provider contracts related to a member complaint.	No		2,500
7/17/12	TN	Score for overall provider satisfaction decreased from 2010.	Yes	Training for call center staff, continued provider face-to-face contact efforts through town hall and onsite visits, and increased provider communication efforts via newsletters.	–
7/11/12	LA	Concurrent review and authorization reporting deficiencies.	Yes	Hired and trained new staff and educated/re-educated existing staff on turnaround process and metrics. Developed an automated turnaround time report. Implemented monthly validation of results and weekly audits to measure adherence.	–
7/10/12	TN	June 2012 provider file identified provider network deficiencies.	Yes	The CAP included contracting efforts with a residential abuse treatment facility and transportation availability for any remaining GeoAccess deficiencies.	–
7/9/12	NJ	Excessive duplicate encounters in June 2012.	No		2,831
7/9/12	TN	There were missed shifts for a member's care.	No		4,282
7/9/12	TN	2Q12 provider data survey results did not meet telephone number accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
7/5/12	TN	Pertinent medical records in response to a reconsideration request not included.	No		500

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
7/5/12	TN	Response to a reconsideration request was incomplete.	No		500
7/3/12	IN	4Q11 performance requirements for claims processing and call center timeliness not met.	Yes	Corrected system issues and worked overtime to address the backlog of claims. Hired additional call center resources, cross trained current employees to handle member calls, and hired an additional manager.	9,457
6/29/12	GA	Deficiencies in Q1 2012 GeoAccess, primarily due to programming errors.	Yes	The CAP included first determining the cause of the report error. After modifying the program, the reporting logic was locked-down to prevent changes without specific approval.	–
6/12/12	TX	1Q12 member appeals processing timeframe not met.	Yes	The health plan continued increased oversight of the appealed claims and submitted monthly detail to the state, though non-compliance is primarily due to extremely low denominators for some measures.	–
6/8/12	NJ	Technical error in a 5010 file format submission resulted in duplicate rejections.	No		248,522
6/8/12	TN	May 2012 provider file identified provider network deficiencies in specialty areas.	Yes	CAP included contracting efforts with a residential abuse treatment facility, transportation availability for any remaining GeoAccess deficiencies, and reconfiguration of a provider enrollment file.	–
6/7/12	TN	Member's request to change MCOs not addressed.	No		8,000
6/7/12	TN	Copy of medical criteria not included in the response to a member appeal request.	No		1,000
6/7/12	TN	Late member reconsideration request response.	No		1,000
6/7/12	TN	Late member reconsideration request response.	No		500
6/7/12	TN	Late member reconsideration request response.	No		1,000
6/7/12	TN	Late member reconsideration request response.	No		1,000
6/7/12	TN	Late member reconsideration request response.	No		500
6/7/12	TN	Adverse action letter issued without the official legal citation.	No		500
6/4/12	TN	Response to a request for medical reconsideration incomplete.	No		1,000
5/31/12	FL	Late filing of Q1 2012 financial report.	No		200
5/25/12	TN	Critical incidents audit identified deficiencies regarding management and reporting.	Yes	The CAP included new management processes to more properly categorize critical incidents, internal staff education and training, and provider education and training.	–
5/23/12	FL	Member materials not submitted to the state for approval prior to use.	Yes	Re-educated internal employees on the plan's internal process to review and approve written materials by including this as a re-occurring agenda item during compliance meetings as well as Operational Executive Team meetings.	–
5/22/12	NY	Q1 network submission incomplete and inaccurate.	No		–
5/18/12	FL	Late filing of Q1 2012 claims aging report.	No		400

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/18/12	FL	Failure to meet standards established in 2011 child health check up CAP.	No		36,500
5/17/12	TN	Performance standard for post discharge services not met.	Yes	The CAP included the development of a subcommittee to review adherence rates and monitor trends and outreach to providers to identify barriers. It also included the development of tracking mechanisms.	–
5/15/12	CA	Encounter metrics for outpatient timeliness and inpatient quantity not met.	Yes	Resolved 5010 issues and all backlogged encounter were transmitted. Continued to work to stabilize month to month volume. Implemented provider submission of institutional encounters directly to health plan.	–
5/9/12	TN	April 2012 GeoAccess report indicated provider network deficiencies.	Yes	Continued contracting efforts to meet geo access requirements for identified services in one county and corrected a system configuration error.	–
5/8/12	NY	Article 44/49 Operational Survey - governing authority did not demonstrate responsibility for establishment and oversight of policies, management, and operations.	No		–
5/8/12	NY	Article 44/49 Survey - did not correct hospital contract language; contract not submitted for review and approval.	No		–
5/8/12	NY	Article 44/49 Survey - cooling off language in hospital contract not approved by state.	No		–
5/8/12	NY	Article 44/49 Survey - Hospital contract termed without notice to state.	No		–
5/8/12	NY	Approval from state to continue to provide management services without a current and state approved agreement not requested.	No		–
5/8/12	NY	Provider license not board certified and not addressed during recertification process.	No		–
5/8/12	NY	Approval letter could not be produced for a 2011/2002 and 2010/2003 contract and a base contract was not fully executed.	No		–
5/8/12	NY	Final adverse determination letters for dental did not include enrollee coverage type.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/2/12	WA	2012 readiness review site visit identified multiple operational areas that were not fully met.	Yes	The CAP included actions to: revise policy and procedure language related to out-of-network providers; process to monitor and report the provider network; addressing language barriers to care; tracking and monitoring EPLS; missing compliance committee information; revisions to case management program; changes in P&P language for the patient review and coordination program; language insert in member mailings; and written description of the grievance system.	–
5/1/12	MD	Annual audit found deficiencies in: subcontractor oversight, appeal processing, claims payment, and over/under utilization reports.	Yes	Modified appeals tracking mechanism to identify appeals based on medical urgency and retrained staff.	–
4/30/12	NJ	Annual provider satisfaction survey identified deficiencies.	Yes	The CAP included: EPSDT member outreach activities; reviewing and updating Clinical Practice Guidelines and notifying providers of updates; using several methods to improve members' understanding of their benefits and preventive care/wellness programs; improving formulary information and pharmacy prior authorization response time; and improving disease management provider engagement.	–
4/26/12	FL	Untimely filing of report due to delay in getting complete data from vendor.	No		7,930
4/25/12	TN	Rejected encounters resubmitted late.	No		300
4/23/12	TN	Audited 2011 Disclosure of Ownership forms deficient.	Yes	The CAP included the submission of new and corrected provider disclosure forms.	–
4/19/12	FL	Failed to meet claims payment ratio for Q4 2011.	No		175,000
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/16/12	TN	Annual report submitted late.	No		300
4/11/12	TN	1Q12 provider data survey results did not meet telephone number and address accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and use of a data vendor to improve data accuracy.	5,000
4/5/12	TN	1Q12 GeoAccess report identified provider network deficiencies.	Yes	The CAP included contracting efforts with residential abuse treatment facility, transportation availability for any remaining GeoAccess deficiencies and reconfiguration of a provider enrollment file.	–

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/5/12	TN	Transportation accident involving a member not reported timely.	Yes	Our transportation vendor changed its reporting policies to require notice to Amerigroup within 4 hours of any accident or incident with claimed injuries.	–
3/30/12	TN	2011 ASH Audit identified noncompliant records.	Yes	The CAP included outreach to providers explaining appropriate use of ASH forms, revision of claims processing policies and procedures, and recoupment of improperly paid ASH claims.	6,000
3/28/12	NJ	2011 annual assessment identified deficiencies in credentialing/recredentialing.	Yes	The CAP included making changes to the recredentialing process to ensure timely recredentialing of providers and the inclusion of the required documentation.	–
3/26/12	TX	4Q11 member appeals processing timeframe not met.	No		250
3/26/12	TX	4Q11 member appeals processing timeframe not met.	Yes	Failure to meet performance standards in several areas: encounters, timely member appeal resolution, and out-of-network standards.	17,750
3/22/12	TN	Rejected encounters resubmitted late.	No		300
3/15/12	TN	Feb 2012 GeoAccess report identified provider network deficiencies.	Yes	The CAP included reconfiguration of the provider enrollment file.	–
3/14/12	TX	2011 quality audit found areas of non-compliance.	Yes	The CAP included actions to address deficiencies in several areas: conducted member advocate training focused on member complaints processes; reviewed procedures around utilization review/adverse determinations, including working with UM vendors and monitoring refresher training effectiveness; developed a reminder process for annual network submissions access plans.	–
3/7/12	NY	Approval from state to continue to provide management services without a current and state approved agreement not requested.	No		–
3/1/12	CA	Encounter submission metrics not met for inpatient quantity and timeliness	Yes	CAP actions included: working closely with our internal systems area to ensure we are notified in a timely manner of any delays they may face in processing files so that we can notify in a timely manner; reached out to 4 groups for direct submissions; established monthly delivery dates for all of our Dual-Risk groups.	–
3/1/12	FL	Untimely filing of report.	No		1,000
2/28/12	FL	Untimely filing of report.	No		1,000
2/27/12	FL	Financial report for 4Q submitted with inaccurate information.	No		1,600
2/23/12	FL	Vendor placed a hold on transfers to/from a specific hospital without notifying anyone. Hospital notified the state and the state assessed sanction on all plans contracting with the vendor.	Yes	Health plan implemented a CAP for the vendor that required plan approval of significant network changes and related communications. Plan and vendor policies and procedures were updated and a new vendor report required. Delegation oversight to review ongoing compliance during annual vendor audit.	10,000

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
2/23/12	FL	Vendor placed a hold on transfers to/from a specific hospital without notifying anyone. Hospital notified the state and the state assessed sanction on all plans contracting with the vendor.	Yes	Health plan implemented a CAP for the vendor that required plan approval of significant network changes and related communications. Plan and vendor policies and procedures were updated and a new vendor report required. Delegation oversight to review ongoing compliance during annual vendor audit.	10,000
2/17/12	FL	Q4 2012 claims aging report filed late.	No		200
2/17/12	TN	Jan 2012 GeoAccess report identified provider network deficiencies.	Yes	CAP included 1) contracting efforts with an adult day care facility and two residential treatment centers for child and adolescent services and 2) transportation availability for any remaining deficiencies.	–
2/10/12	NY	Request for clinical review criteria not responded to appropriately.	No		–
2/8/12	NJ	EPSDT and lead screening standards for CY 2009 not met.	No		18,129
1/26/12	FL	Claims processing 30 and 90 day standards not met for Q3 2011.	No		12,500
1/25/12	FL	Late filing of Q4 2011 grievance and appeals report.	No		200
1/25/12	FL	Late filing of Q4 2011 grievance and appeals report.	No		200
1/19/12	TN	3Q11 pharmacy report submitted late.	No		3,200
1/18/12	NY	Stipulation and report required for performance measures not met.	No		41,750
1/18/12	TN	Late request for reconsideration of a medical appeal.	No		500
1/18/12	TN	Late prior authorization request response.	No		5,000
1/12/12	TN	5010 not implemented by Jan 2012.	Yes	The CAP included the effective date in which 4010 claims would no longer be accepted and submission of weekly reports of claims accepted/rejected for both 4010 and 5010 claims.	–
1/12/12	TN	4Q11 provider data survey results did not meet telephone number accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
1/12/12	TX	Benchmarks established for medical checkup participation not met.	Yes	Closely monitored claims processing performance to better manage even the categories of claims with very small volume.	–
1/10/12	TN	Extension for the quarterly cost and utilization summary requested late.	No		100
1/10/12	TN	Extension for the quarterly cost and utilization summary requested late.	Yes	CAP included 1) contracting efforts with an adult day care facility and two residential treatment centers for child and adolescent services and 2) transportation availability for any remaining deficiencies.	–
1/9/12	TN	Review of provider file identified information deficiencies for assisted living facilities.	Yes	The CAP included reconfiguration of the provider enrollment file.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
1/5/12	TN	New member and referral processes compliance level of 90% not met.	Yes	The CAP included tracking mechanisms to ensure timely completion of face-to-face visit requirements and education of enrollment and care coordination staff.	–
1/4/12	TN	Enrollee record review identified deficiencies.	Yes	The CAP included monthly management review of care coordinator chart documentation against standards and issuance of employee corrections as necessary. The CAP also included care coordinator staff education and training.	–
12/19/11	TX	Grievance record review identified deficiencies.	Yes	Revised the complaint process to have a single point of control process. Revised 'Your Rights' language to include a complete description of the appeal process and started a daily review of the complaint and appeal log to ensure timeliness. Revised provider and member notification processes. Filed executed delegation contract agreements with the state's Department of Insurance.	–
12/15/11	TN	Audit identified deficiencies regarding management and notifications of critical incidents.	Yes	The CAP included a new management concurrent review process to ensure proper categorization of critical incidents, implementation of new tracking tool, and staff training/education.	–
12/14/11	TN	Nov 2011 GeoAccess report identified provider network deficiencies.	Yes	The CAP included contracting efforts with two residential treatment centers for child and adolescent services and reconfiguration of the Provider Enrollment File. Also included transportation availability for any remaining deficiencies.	–
12/7/11	GA	Low performance of timely access standards for adult PCP visits.	Yes	The CAP included the following actions: education and re-education with vendor on adult primary care sick access standards; reviewed survey questions with survey vendor; conducted quality assurance on random vendor calls; ran a parallel survey process to measure vendor outcomes and compliance for adult sick primary care.	–
12/7/11	TX	Performance standards deficiencies.	No		32,500
12/6/11	TN	Quarterly report submitted late.	No		100
12/6/11	TN	Weekly report submitted late.	No		100
12/6/11	TN	Weekly report submitted late.	No		100
11/30/11	TN	Weekly report submitted late.	No		800
11/30/11	TN	Quarterly report submitted late.	No		800
11/22/11	CA	Encounter submission metrics not met for inpatient quantity	Yes	CAP activities included: meeting and working with the groups to track the rejected encounter and verify that they have been successfully submitted; following up with each MSO; reviewing agreements and developing formal service Level language; and continuing close monitoring activities.	–
11/22/11	NY	3Q11 network submission did not include any physician, nurse, dental or therapy providers for certain counties.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
11/16/11	TN	Quarterly report submitted late.	No		1,000
11/15/11	FL	Late filing of Q3 2010 grievance and appeals report.	No		1,000
11/15/11	GA	Low levels of dental utilization.	Yes	Directed the dental vendor to outreach to providers to determine their participation status and then generate a GeoAccess report to confirm network compliance. Began targeted recruitment campaign. Dental vendor distributed an educational piece and newsletter stressing the importance of providing changes to provider participation. Performed a directory verification project.	-
11/7/11	TN	Approved private duty nursing services provided late.	No		576
11/4/11	NY	Printed and electronic provider directory deficiencies.	No		-
11/4/11	TN	Quarterly report submitted late.	No		100
11/4/11	TN	Approved home health aide and private duty nursing services provided late.	No		21,343
10/31/11	TX	Provider network deficiencies.	Yes	The CAP was issued during the readiness review prior to go-live for new service areas. Submitted the specific status of provider types and outlined recruitment strategies to meet adequacy standards. The health plan did pass the readiness review.	-
10/24/11	FL	Failed to meet claims payment ratio for Q2 2011.	No		7,500
10/13/11	TN	3Q11 provider data survey results did not meet two benchmarks.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
10/7/11	TN	3Q11 GeoAccess reports identified provider network deficiencies.	Yes	The CAP included contracting efforts with two residential treatment centers for child and adolescent services. It also included transportation availability for any remaining deficiencies.	-
9/24/11	NJ	EPSDT requirements regarding medical necessity and state directives not met.	Yes	Engaged the dental vendor to resolve deficiencies. Monitored the dental vendor to ensure that the following actions were taken: modified denial letter to address "medical necessity" and implemented a process to contact dentists when a lack of required documentation would impact the determination.	-
9/20/11	CA	Response to request for additional information submitted late.	No		5,000
9/20/11	FL	2011 onsite audit identified documentation deficiencies.	Yes	Configured system to pend and manually process claims that required a consent form. Implemented the Vaccines for Children (VFC) attestation process. Implemented a process to ensure that notices are sent to members pursuant to contract requirements	-
9/14/11	FL	Behavioral health performance improvement project filed late.	No		8,600

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
9/2/11	GA	Network access requirements not met and duplications in provider listing files.	Yes	Instituted a program with a telehealth vendor to support rural areas that do not have sufficient provider specialties. Also working to address data quality.	–
9/2/11	TX	Out-of-network standards not met.	No		25,000
9/2/11	TX	PCP open panel benchmark not met.	Yes	Recruited new PCPs and reviewed all PCP closed panels to determine the reason for closure. Provider network education representative outreached to numerous PCPs during monthly routine visits with a goal of re-opening the panels.	25,000
9/2/11	TX	Performance requirements for acute appealed claims processing not met.	No		250
9/2/11	TX	PCP error report benchmark not met.	No		500
9/2/11	TX	Performance requirements for the member complaint and appeal process not met.	No		500
9/1/11	TX	2Q11 benchmarks for timeliness and accuracy of member complaints reporting not met.	Yes	Reprogrammed the regulatory report deliverable for complaints and retrained staff on appropriate coding of complaints.	17,000
9/1/11	TX	2Q11 benchmark standard for claims processing not met.	No		10,000
9/1/11	TX	2Q11 member complaint response and provider complaint response delinquency.	No		1,500
8/31/11	FL	Q2 2011 claims aging report filed late.	No		1,400
8/31/11	FL	Late and inaccurate Q2 2011 financial report.	No		1,600
8/31/11	FL	Late and inaccurate Q2 2011 financial report.	No		2,200
8/25/11	TN	Approved skilled nursing services not provided to a member.	No		32,300
8/24/11	CA	Documentation for denial of services incomplete.	No		20,000
8/24/11	TN	Transportation vendor did not meet claims prompt pay standard for June 2011.	No		10,000
8/15/11	TN	Annual quality survey audit - submitted insufficient corrective action plan.	No		27,500
8/12/11	CA	Encounter submission metrics not met for inpatient quantity and quality	Yes	The CAP included activities to: revert two Dual Risk arrangements back to Shared Risk; meet with each Dual Risk Hospital to discuss error reports to ensure timely correction and resubmission; in a timely manner; meet regularly (at least weekly), with vendor to improve their turn-around time; and ensure the appropriate management is aware of encounters submission performance and obligations.	–
8/12/11	CA	Resolution of a member's grievance not timely or adequate.	No		5,000
8/11/11	TN	Approved home health care services not provided.	No		4,534
8/11/11	TN	March 2011 claims payment accuracy not met.	No		20,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
8/10/11	FL	June 2011 provider termination report filed late.	No		4,400
8/10/11	FL	June 2011 provider termination report filed late.	No		4,400
8/8/11	TN	Response to the state on a member appeal submitted late.	No		4,000
8/8/11	TX	Failure to secure approval prior to issuing a media release related to award announcements.	No		5,000
8/8/11	TX	Failure to secure approval prior to issuing a media release related to award announcements.	No		5,000
8/4/11	TN	Chart reviews showed deficient provider records in vision and hearing screening documentation.	Yes	The CAP included: letters to deficient providers soliciting information on any barriers to documenting EPSDT service delivery; distribution of educational materials; provider alert educational communications; and adding EPSDT information to provider website.	–
8/2/11	GA	Timely access requirements not met.	Yes	Reviewed situation and identified a human error in the report submission process. Corrected and resubmitted the report and implemented business owner review of report accuracy. Newly received provider information will be verified.	–
8/2/11	TN	Completed reconsideration form not provided in response to a member appeal.	No		500
7/28/11	FL	Report was filed 3 days late.	No		600
7/22/11	TN	Notice of action regarding a service denial was deficient.	No		500
7/12/11	TN	2Q11 provider data survey results did not meet telephone number accuracy benchmark.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and data vendor to improve data accuracy.	5,000
7/7/11	GA	Report load to state FTP site did not complete correctly.	Yes	The files were uploaded on the day they were due, but the file names were too long and they failed at the FTP process. When discovered the next day, the file names were corrected and resubmitted. Retrained employee to prevent a recurrence.	–
7/7/11	GA	Failed to meet performance measure targets and performance improvement project annual reports submitted late.	Yes	The CAP included steps to improve metrics through provider and member communications; member outreach activities by our Health Promotions team through preventive service events at provider offices as well as community events; and incentives to encourage members to receive services.	–
7/7/11	NY	Marketing monitoring identified lack of presentation at scheduled site and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
7/7/11	TN	2Q11 GeoAccess review identified provider network deficiencies.	Yes	Corrected a configuration error in the provider enrollment file; began contracting efforts with a rural hospital; and added surrounding county prenatal providers. Also addressed transportation availability for any remaining deficiencies.	–
7/1/11	GA	Provider network adequacy deficiencies.	Yes	Conducted active outreach and recruitment efforts with providers in needed counties. Made a configuration change to address seemingly duplicate records created for providers working under separate TINs and educated provider data management on how to identify these providers and adjust reporting. Provider representatives continued to work in the field to learn about changes in the network and submit timely changes.	–
6/23/11	NJ	Encounter data submission monitoring evaluation for May 2011 and November 2010 found deficiencies.	No		16,673
6/23/11	NJ	Encounter data submission monitoring evaluation for May 2011 and November 2010 found deficiencies.	No		17,919
6/22/11	TN	Notice of action regarding a service denial was deficient.	No		500
6/16/11	TN	Notice of action regarding a service denial was deficient.	No		500
6/14/11	TN	May 2011 Geo Access Report identified provider network deficiencies.	Yes	The CAP included outreach to providers for contracting purposes and transportation availability for any remaining deficiencies.	–
6/8/11	TN	Sep 2010 claims payment benchmark not met.	No		10,000
6/7/11	NY	Marketing monitoring identified failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
6/3/11	TN	Payment benchmark for claims in Oct 2010 not met.	No		20,000
6/3/11	TN	Payment benchmark for claims in Nov 2010 not met.	No		10,000
6/3/11	TN	Claims payment accuracy standard for Oct 2010 not met.	No		10,000
6/3/11	TN	Approved private duty nursing and home health aide service not provided.	No		3,567
6/3/11	TN	Prompt pay benchmark for claims in Sep 2010 not met.	No		10,000
6/2/11	TN	Approved home health services not provided.	No		4,943
5/31/11	TN	Annual quality audit identified deficiencies.	Yes	The CAP included tracking tools, monitoring policy, provider and member outreach communication, securing a braille member handbook for availability, and internal staff training.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/25/11	TN	Notice of action regarding a service denial was deficient.	No		500
5/25/11	TN	Response to a request for reconsideration of a medical appeal incomplete.	No		500
5/24/11	NJ	Encounter data submission for April 2011 and October 2010 insufficient.	No		16,705
5/24/11	NJ	Encounter data submission for April 2011 and October 2010 insufficient.	No		2,194
5/18/11	TN	Approval for psychiatric nursing services not completed.	No		3,900
5/10/11	NY	Marketing monitoring identified failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
5/9/11	TX	1Q11 benchmark for timely adjudicated claims not met.	No		20,000
5/9/11	TX	1Q11 response to provider complaints untimely and insufficient.	No		55,325
5/9/11	TX	Performance requirements for acute appealed claims processing not met.	No		500
5/9/11	TX	PCP open panel benchmark not met.	Yes	Reviewed all PCP closed panels to determine reason for closure. Provider network education representatives outreached to numerous PCPs during monthly routine visits with a goal of re-opening panels.	10,000
5/9/11	TX	Out-of-network standards not met.	No		25,000
5/9/11	TX	1Q11 response to provider complaints untimely and insufficient.	No		500
5/4/11	TN	3Q09-4Q09 audit identified lack of accurate or requested provider disclosures on file.	Yes	Delivered five corrected provider disclosures.	–
5/1/11	MD	Annual audit found deficiencies in: subcontractor oversight, credentialing, and UM.	Yes	Improved utilization management reporting detail to better detect opportunities for improvement. Added additional UM staff and reorganized department. Continued efforts with appeals to shift responsibilities to local teams. Credentialing activities included enhanced reporting, adding staff, and improving termination process for providers non-responsive to recredentialing.	–
4/28/11	FL	Claims processing 90 day standard not met for Q4 2010.	No		2,500
4/21/11	FL	Quarterly complaints, grievance, and appeals report was submitted late.	No		600
4/21/11	TN	Jan 2011 audit identified improvement needed in documentation and timeliness.	Yes	Implemented a member confirmation screening process, added a field to tracking process, conducted internal training to reiterate referral requirements, and implemented an internal quality auditing process.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/20/11	NJ	Encounter data submission for March 2011 and September 2010 insufficient.	No		5,390
4/18/11	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
4/14/11	FL	Report was filed 4 days late.	No		800
4/13/11	CA	Consistent downward trend in HEDIS scores.	Yes	The CAP focused on interventions in four areas: organizational and structure; data and reporting; provider; and member. Developed a strategy to identify members with gaps in care and provided incentives to receive appropriate care. Implemented two new provider incentive programs to assist in the early identification of pregnant women for timely outreach.	–
4/13/11	TN	Information in response to a state request regarding an appeal incomplete.	No		500
4/13/11	TN	Notice of action regarding a service denial was deficient.	No		500
4/13/11	TN	Benchmark for claims payment accuracy for LTC for Dec 2010 not met.	No		25,000
4/13/11	TN	Copy of denial for home health services not included in an appeal response.	No		500
4/13/11	TN	Notice of action regarding a service denial was deficient.	No		500
4/13/11	TN	Claims payment accuracy rates for 1Q11 not met.	No		5,000
4/12/11	FL	2010 behavioral health report was late.	No		2,000
4/12/11	TN	1Q11 GeoAccess analysis identified provider network deficiencies.	Yes	The CAP included contracting efforts with surrounding county providers to service member needs.	–
4/6/11	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
4/6/11	TN	Timely correction of encounters not met.	No		2,500
4/5/11	NY	Inappropriate final adverse determination notice was issued.	No		–
4/5/11	NY	Responsibility for establishment and oversight of the policies, management and overall operation demonstrated deficiencies.	No		–
4/5/11	NY	Provider contract guidelines and standard clause appendix noncompliance.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/4/11	TN	1Q11 provider data survey results identified deficiencies.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, correction and resubmission of the provider enrollment, and provider website change to facilitate provider update of demographic information.	5,000
3/30/11	TN	Reconsideration response submitted late.	No		3,000
3/25/11	NY	Responsibility for establishment and oversight of the policies, management and overall operation demonstrated deficiencies.	No		–
3/25/11	NY	Printed and electronic provider directory deficiencies.	No		–
3/17/11	NJ	Encounter data processing benchmarks for February 2011 and August 2010 not met.	No		17,126
3/15/11	GA	GeoAccess report identified provider network inadequacies.	Yes	The CAP addressed multiple issues including: resolving GeoAccess reporting changes; adding workflow steps for management review for accuracy, and resubmitting the report. Adjusted report logic to address USPS change in zip code and conducted outreach. Worked to resolve issues with providers associated with multiple TINs. Conducting quarterly wait time reviews and taking steps to update provider information and verify demographics.	–
3/10/11	TN	Response to a request for information submitted late.	No		500
3/10/11	TN	Reconsideration response issued late.	No		1,000
3/10/11	TN	Response to a request for information incomplete.	No		500
3/10/11	TN	Appointment for enrollee not provided.	No		1,000
3/10/11	TN	Reconsideration response incomplete.	No		500
3/10/11	TN	Reconsideration response incomplete.	No		500
3/9/11	FL	Submission of the fraud plan and policies and procedures was late and insufficient.	Yes	Re-iterated use of the report tracking spreadsheet to ensure reporting requirements are met; implemented a control to make sure attestations include the appropriate signatures; and updated the Compliance Plan in accordance with the state's request.	–
2/24/11	FL	Late filing of Q4 2010 unaudited financials.	No		400
2/22/11	TX	Failure to apply appropriate guidelines and/or language in medical necessity determinations and denial notices.	Yes	Health plan staff attended state-sponsored training and made changes to member and provider notifications to comply with the requirements. Staff received additional training on the regulations and in responding to requests for Fair Hearings.	–
2/18/11	CA	Benchmark for Inpatient timeliness not met.	Yes	Completed an analysis of the inpatient data and to bring this measure within acceptable timeframes, we took the following steps: engaged a cross functional team of employees; calculated lag time by hospital and collaborated to address barriers; began reaching out to groups to determine their ability and willingness to submit encounters directly.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
2/18/11	NJ	Additional information requested by state not provided.	Yes	Provided the state with internal audit sample sizes, screen shots of the care management system, and a description of how the health plan will conduct outreach to members.	–
2/17/11	NJ	Encounter data submission for January 2011 and July 2010 insufficient.	No		34,463
2/17/11	NJ	Encounter data submission for January 2011 and July 2010 insufficient.	No		7,763
2/17/11	TN	Jan 2011 GeoAccess analysis identified provider network deficiencies.	Yes	Conducted outreach to 24 hour residential treatment (substance abuse) adult providers that do not currently provide services to children and adolescents to add the service. The plan also included credentialing hierarchy for classification of adult day cares and transportation availability for any remaining deficiencies.	–
2/15/11	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
2/11/11	NY	External appeal filing information deficiencies.	No		–
2/10/11	TN	Reconsideration response incomplete.	No		500
2/10/11	TN	Reconsideration response submitted late.	No		1,500
2/8/11	TN	Notice of action regarding a service denial was deficient.	No		500
2/3/11	TX	Q410 complaints processing untimely.	No		34,000
2/3/11	TX	Q410 processing appealed claims not meeting 30 days standard.	Yes	The health plan continued increased oversight of the appealed claims and submitted monthly detail to the state, though non-compliance is primarily due to extremely low denominators for some measures.	5,000
2/3/11	TX	Q410 late regulatory reports.	No		375
2/3/11	TX	4Q10 collaborative efforts with community based organizations insufficient.	Yes	Identified additional organizations to collaborate with regarding children of migrant farmworkers and established target dates for contact. Delivered quarterly logs of the contacts to the state.	–
2/3/11	TX	Performance requirements for acute appealed claims processing not met.	No		10,000
2/3/11	TX	Q410 complaints processing untimely.	No		500
2/3/11	TX	Reconciliation standard not met for encounters to paid claims.	No		5,000
2/3/11	TX	PCP open panel benchmark not met.	Yes	Reviewed all PCP closed panels to identify closure reason. Provider network education representatives outreached to numerous PCPs during monthly routine visits with a goal of re-opening the panels.	–
2/3/11	TX	Administrative services for Spanish translation services not performed.	Yes	Key activities included identifying existing letters that required Spanish language translation. Versions of each translated letter were verified so that no altered letters are sent to members.	80,000

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
2/3/11	TX	Member complaint report submitted late.	No		1,500
2/3/11	TX	Failed to meet out of network standards.	No		25,000
2/2/11	GA	Deficiencies with dental vendor included Q3 2010 GeoAccess reports, appointment wait times, and online provider directory.	Yes	The CAP identified the dental vendor's success in significantly increasing the number of participating providers, thereby resulting in full (100%) access to health plan membership within required access standards. The increased number of participating providers (over 100 new providers and 100 new locations) resolved the concern with appointment wait time.	–
2/2/11	NJ	Benchmark for EPSDT Screenings and lead screening in 2008 not met.	No		36,616
1/31/11	TN	Nov 2010 enrollee record review benchmarks not met.	Yes	Implemented a member confirmation screening process, added a field to tracking process, conducted internal training to reiterate referral requirements, and implemented an internal quality auditing process.	–
1/27/11	FL	Audit identified grievance and appeals process inadequacies.	Yes	Added the state's current approved letter in the plan's letter inventory. Created an Operational Guideline to ensure that notices regarding appeals are provided to both members and providers and distributed an internal memo to all appeal review nurses.	–
1/25/11	FL	Late filing of Q4 2010 grievance and appeals report.	No		200
1/25/11	FL	Late filing of Q4 2010 grievance and appeals report.	No		200
1/25/11	TN	Claims payment accuracy for Dec 2010 did not meet performance standard.	Yes	Implemented claims staff education and confirmed that incorrectly processed audit sample claims were correctly processed.	–
1/24/11	GA	Deficiencies in provider network listing with incorrect addresses, untimely appointment wait times, and non-par providers in provider directory.	Yes	Changed survey vendors and worked to ensure that the vendor and their survey teams are educated and modified the questions for clarity.	–
1/24/11	GA	Timey access 4Q10 indicated provider types that did not meet appoint request waiting time standards.	Yes	The CAP included the following actions: modify GeoAccess reports to differentiate members' access to dental providers by type and include total number of providers. Clarified information about the online provider directory. Provided secret shopper list to the state with written responses to each.	–
1/18/11	TN	4Q10 provider data survey results identified deficiencies.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, research using vendor to improve provider data, and provider website change to facilitate provider update of demographic information.	5,000
1/14/11	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
1/12/11	TN	Notice of action regarding a service denial was deficient.	No		500
1/12/11	TN	Notice of action regarding a service denial was deficient.	No		500
1/12/11	TN	Notice of action regarding a service denial was deficient.	No		500
1/12/11	TN	Reconsideration response submitted late.	No		500
1/12/11	TN	Reconsideration response submitted late.	No		500
1/12/11	TN	Response to an adhoc report submitted late.	No		500
1/12/11	TN	Reconsideration response incomplete.	No		2,000
1/12/11	TN	Response to reconsideration request submitted late.	No		500
1/12/11	TN	Notice of action regarding a service denial was deficient.	No		2,000
1/11/11	TN	4Q10 GeoAccess analysis identified provider network deficiencies.	Yes	The CAP included contracting efforts with a rural hospital, adding surrounding county prenatal providers, and transportation availability for any remaining deficiencies.	–
1/10/11	NJ	Additional information requested by state not provided.	Yes	Provided additional detail on how care managers assist in coordinating well visits, lead screenings, and vaccinations. Also provided information on how we develop care plans with input from the members, providers, and community agencies, when appropriate.	–
1/5/11	NY	Notification of board member resignation submitted late.	No		–
12/21/10	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
12/17/10	TN	Oct 2010 noncompliance for paid and processed claims.	Yes	Implemented a technical solution for pricing errors, changes to claims processing instructions, and claims staff training.	–
12/16/10	NJ	Return of previously withheld funds for failure to meet encounter data benchmarks for SFY10.	No		-36,110
12/16/10	NJ	Withhold assessed for failure to meet encounter data benchmarks for SFY11.	No		17,658
12/16/10	NJ	Encounter data benchmarks for SFY11 not met.	No		557
12/16/10	TN	Response to an adhoc report concerning reimbursement and billing submitted late.	No		2,000
12/16/10	TN	Response to an adhoc report concerning reimbursement and billing submitted late.	No		2,000
12/15/10	NJ	Failure to implement CAPs with providers as required.	No		–
12/15/10	TN	Nov 2010 GeoAccess analysis identified provider network deficiencies.	Yes	Corrected the provider enrollment file and implemented transportation availability for any remaining deficiencies.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
12/1/10	NV	Health care cost containment fee submitted late.	No		5,000
11/23/10	NY	External appeal filing information deficiencies and grievance procedure requested by not submitted.	No		–
11/23/10	TN	Claims payment accuracy for Oct 2010 did not meet performance standard.	Yes	Implemented a technical solution for pricing errors, changes to claims processing instructions, and claims staff training.	–
11/22/10	NJ	GeoAccess for hospital and FQHC networks in 1 county deficient.	Yes	The CAP included efforts to renew negotiations with the hospital. Hospital adequacy issues are complicated by just a single acute care hospital in the county who refuses to participate with the health plan.	–
11/22/10	NJ	EQRO on-site annual audit identified credentialing/recredentialing deficiencies.	Yes	The CAP included establishing a credentialing department at the health plan to track all aspects of the process, including follow-up activities with providers to correct deficient applications and establishing clear processing timeframes, and close coordination with Corporate Credentialing. Audit findings during subsequent review noted improvement in deficiencies.	–
11/19/10	NY	Marketing monitoring identified lack for presentations at scheduled sites.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
11/19/10	TN	Benchmarks for psychiatric hospital 30 day readmissions not met.	Yes	The CAP included explanatory factors that cause non-compliance with the readmission rate standard.	–
11/18/10	CA	Encounter submission metrics not met for inpatient quality and timeliness	Yes	Reviewed reports and determined that push to submit 2009 DOS encounters negatively impacted measures. Continued close monitoring of encounter performance.	–
11/16/10	TN	Response for a request for reconsideration of appeal submitted late and incomplete.	No		1,500
11/16/10	TN	Notice of action regarding a service denial was deficient.	No		500
11/16/10	TN	Response to state's request for medical records incomplete.	No		500
11/16/10	TN	Response to enrollee and state's request for provider information incomplete.	No		500
11/16/10	TN	Scheduled an appointment for enrollee over 90 miles from their home.	No		500

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
11/10/10	GA	Submitted PCP assignment report with missing NPI and duplicate Medicaid numbers.	Yes	Reviewed each provider and provided an updated listing to the state. Two providers received additional follow-up. As part of the Credentialing plan all new providers must submit their NPI and their Medicaid ID at the time of application and no provider will be loaded without NPI. Resubmitted the PCP assignment report and reconciled providers with duplicate Medicaid IDs. Re-educated provider data management on issue resolution.	–
11/10/10	NJ	Encounter data benchmarks in SFY11 not met.	No		35,825
11/9/10	GA	Benchmark for the PCP sick visit and mental health appointment wait times not met.	Yes	Sent corrective action letters to each provider and performed a follow up visit within 30 days to re-educate the provider and his/her staff on the contractual access standards. All providers not meeting the requirements were re-surveyed during the next quarter's survey.	–
11/8/10	MD	Performance improvement project did not meet PIP requirements.	Yes	The health plan performed detailed barrier and intervention analysis and resubmitted the PIP.	–
10/29/10	NY	Marketing monitoring identified lack of presentations at scheduled sites and failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
10/26/10	TN	3Q10 provider data survey results identified deficiencies.	Yes	Outreach to providers refusing to participate, communication about obligation to participate in surveys, research using vendor to improve provider data, and provider website change to facilitate provider update of demographic information.	15,000
10/22/10	TN	Outreach to provider to facilitate in application process not conducted.	Yes	The CAP included confirmation of outreach to the provider and an update that the provider's application was being processed.	–
10/19/10	TN	Reconsideration response incomplete.	No		500
10/19/10	TN	Sept 2010 prompt pay standards not met.	Yes	CAP included improved reporting for tracking and increased staff.	–
10/18/10	TN	Reporting tied to a member's appeal request submitted late.	No		200
10/18/10	TN	Notice of action regarding a service denial was deficient.	No		500
10/18/10	TN	Reconsideration response submitted late.	No		500
10/18/10	TN	Complete documentation in support of an adverse decision not provided.	No		2,000
10/18/10	TN	Rejected encounters resubmitted late.	No		17,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
10/14/10	GA	Access, provider network listing, appointment scheduling, and directory deficiencies.	Yes	Used a team of employees to work to contract with various providers within a given geographic area. Submitted an updated network deficiency report to address the areas noted. Worked with providers with various TINs to prevent duplicates. Outreaching to providers to address incomplete information. Initiated a large-scale project to validate all specialties in the network to verify access and demographic information.	-
10/13/10	NJ	Credit/Refund of withhold from March 2010 and September 2010.	No		-35,295
10/13/10	NJ	April 2010 EQRO care management and lead case management standard not met.	Yes	Analyzed member EPSDT services on a monthly basis and conducted outreach to members and their provider with overdue services. Sent reports to providers listing members on their panel missing EPSDT services. Established interdepartmental workgroup to coordinate activities. Modified process to create care plans for members in lower acuity groups.	-
10/12/10	NY	Provider network submission included providers with professional licenses revoked, surrendered, suspended or are listed as inactive.	Yes	Reviewed provider data and updated files, provided formal process for removal of sanctioned providers.	-
10/11/10	TN	3Q10 GeoAccess Report identified provider network deficiencies.	Yes	The CAP included credentialing hierarchy for the classification of adult day cares, correction of the Provider Enrollment File, and transportation availability for any remaining deficiencies.	-
10/7/10	GA	HEDIS measures fell below the national average.	Yes	The CAP included measures to improve HEDIS outcomes and state-required metrics through provider and member communications; member outreach activities through preventive service events at provider offices as well as community events; and incentives to encourage members to receive services.	-
10/7/10	TX	Call center and grievance and appeal staff additional training required.	Yes	Developed additional training for call center and grievance and appeal staff, including post-training assessments and quality reassessments to measure comprehension levels and identify retraining needs. Initiated project to produce all letters in bilingual format. Developed a complaint Log and received state approval. Developed a process flow and policy for the complaint log.	-
10/5/10	NY	Printed and electronic provider directory deficiencies.	No		-
10/4/10	NY	Marketing monitoring identified lack of presentations at scheduled sites.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	-

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
10/1/10	NY	Appointment availability survey identified failure to meet access benchmarks.	No		–
9/29/10	NY	Services arranged within the approved provider network not provided by approved network providers; and approval for contract implementation not requested.	Yes	The health plan resubmitted the contract for state approval.	–
9/24/10	TN	Response to an adhoc report submitted late.	No		200
9/24/10	TN	Response to a request for reconsideration of a medical denial submitted late.	No		3,000
9/23/10	TN	Incomplete response to the state's request for reconsideration of a medical service denial.	No		2,000
9/23/10	TN	Deficient notice of action regarding a service denial.	No		500
9/23/10	TN	Response to an adhoc report was incomplete.	No		400
9/22/10	TX	3Q10 untimely claims processing.	Yes	Began submitting monthly detail on appealed claims and oversight of the appealed claims queues was increased.	1,000
9/22/10	TX	3Q10 late report submission.	No		6,625
9/22/10	TX	3Q10 untimely resolution of complaints.	No		27,000
9/22/10	TX	Q310 member hotline closed on regular business day.	No		12,000
9/22/10	TX	Q310 failed to meet member complaint resolution timeliness standards and acute appealed claims processing.	No		10,000
9/22/10	TX	Q310 failed to meet member complaint resolution timeliness standards.	No		500
9/21/10	TN	Response to the state's request for reconsideration of a medical service denial was incomplete.	No		500
9/21/10	TN	Response to the state's request for reconsideration of a medical service denial was incomplete.	No		500
9/14/10	NJ	Encounter data submission for February 2010 insufficient.	No		78,966
9/8/10	TN	Annual essential hospital services report rejected due to inconsistency with provider enrollment file.	Yes	The CAP included a correction and resubmission of the Provider Enrollment File.	–
9/1/10	NY	Correspondence with members did not meet contract requirements.	Yes	Re-educated the team to ensure that approved letters are used during correspondence with members and the manager reviews all service request letters as appropriate.	–
8/25/10	TN	Claims payment accuracy for Jul 2010 failed to meet performance standard.	Yes	Implemented a technical solution for pricing errors, changes to claims processing instructions, and claims staff training.	–
8/24/10	NY	Provider network deficiencies and requirements not met.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
8/19/10	NY	Member with complaint determination not notified in timely manner.	Yes	The delegated vendor addressed missing demographic information in a member letter and the health plan monitored the process to prevent recurrence of issue.	–
8/18/10	TN	July 2010 prompt pay standards not met.	Yes	Implemented daily reporting to track claims volume and aging and created a new staffing model with updated production standards.	–
8/17/10	NJ	Encounter data submission for January 2010 insufficient.	No		28,883
8/13/10	TN	Annual EPSDT record review for 2009 identified deficiencies.	Yes	Implemented outreach and education to providers.	–
8/12/10	MD	New enrollments in 1 county discontinued because of OB/GYN access requirements.	No		–
8/10/10	GA	Failure to obtain approval of written material prior to distribution.	Yes	The CAP addressed Amerigroup's submission of the immunization schedule for agency review and approval, and tighter internal controls for member and provider communications prior to use.	–
8/9/10	NJ	Encounter data submission for December 2009 insufficient.	No		10,699
8/9/10	NY	Marketing monitoring identified failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
7/29/10	TN	Required notice to members regarding a provider termination not provided.	No		314,000
7/21/10	TN	2Q10 provider data survey results identified deficiencies.	Yes	The CAP included outreach and education to providers, specific outreach to providers refusing to participate in the survey, and correction of the provider file.	15,000
7/19/10	GA	Submitted requested HS&R reports late.	No		40,000
7/16/10	TN	Jul 2010 provider file identified provider network deficiencies.	Yes	The CAP included contracting efforts with a rural hospital and the addition of surrounding county prenatal providers, correction of the provider enrollment file, and transportation availability for any remaining deficiencies.	–
7/16/10	TN	2Q10 Geo Access report identified provider network deficiencies.	Yes	The CAP included contracting efforts with a rural hospital and the addition of surrounding county prenatal providers, correction of the provider enrollment file, and transportation availability for any remaining deficiencies.	–
7/14/10	NY	State telephone surveys resulted in Incorrect responses for the same question.	No		–
7/13/10	NY	Marketing monitoring identified failure to communicate all required information and marketing at an unscheduled site.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
7/13/10	TN	Notice of action regarding a service denial was deficient.	No		500
7/2/10	NJ	Return of previously withheld funds for failure to meet encounter data benchmarks.	No		-72,161
6/30/10	TN	Notice of action regarding a service denial was deficient.	No		500
6/30/10	TN	Notice of action regarding a service denial was deficient.	No		500
6/30/10	TN	Request for reconsideration of a medical service denial incomplete.	No		1,000
6/30/10	TN	Response to a request for reconsideration of a medical service denial incomplete.	No		500
6/30/10	TN	Appropriate Grievance Notice not provided.	No		500
6/24/10	TX	2Q10 report submission untimely.	No		450
6/24/10	TX	2Q10 complaint responses late.	No		600
6/24/10	TX	Provider complaint summary report submitted late.	Yes	Corrected the methodology for provider counts and resubmitted the report.	1,800
6/24/10	TX	Member and provider complaint summary reports inaccurately categorized complaints.	Yes	Audited 120 state-specific calls per month that were not initially determined to be complaints in order to help ensure the accuracy of the calls being categorized as inquiries. Staff also audited 10 state calls per agent per month until the corrective action was closed.	150,000
6/24/10	TX	Provider directory not formatted to be included in the enrollee handbook.	Yes	Received state approval of the most recent directory submission and the directory is available to existing members and providers.	6,850
6/24/10	TX	Provider files contain inaccurate information.	Yes	Conducted a complete audit of all PCP panel information and instituted process to complete the audit quarterly. Provider changes to panel information are captured during routine provider visits.	7,650
6/24/10	TX	Performance requirements for the member complaint and appeal process not met.	Yes	Developed additional training tools to ensure a comprehensive curriculum that integrate the functional areas, including complaint processing as well as appeals processing.	500
6/24/10	TX	Failure to meet PCP open panel performance requirements.	Yes	Reviewed all PCP closed panels to identify closure reason. Provider network education representatives outreached to numerous PCPs during monthly routine visits with a goal of re-opening the panels.	-
6/21/10	TN	May 2010 prompt pay standards not met.	Yes	Implemented daily reporting to track claims volume and aging and created a new staffing model with updated production standards.	-
6/10/10	NJ	Request for revised hospital network and Geo Access concerns.	Yes	The CAP included efforts to renew negotiations with the hospital. Hospital adequacy issues are routine due to the fact that there is a single acute care hospital in the county and it refuses to participate with the health plan.	-

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
6/10/10	TN	Notice of action regarding a service denial was deficient.	No		500
6/10/10	TN	Response to an adhoc report submitted late.	No		500
6/10/10	TN	Directed service provided late.	No		500
6/9/10	NY	Marketing monitoring identified failure to communicate all required information and lack of presentation by the representatives.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
6/7/10	TX	Provider directory weight limit benchmark not met.	No		14,931
6/4/10	NY	Claims from October 2008 to September 2009 paid late.	No		43,500
6/2/10	NJ	Encounter data submission for October 2009 insufficient.	No		43,468
5/28/10	NJ	Identification and monitoring of members needing care management insufficient.	Yes	Proposed new process to exchange full names and identification numbers to improve member match.	–
5/27/10	NV	Required revisions to submitted CAP regarding issues with dental provision.	Yes	The health plan terminated the plan's contract with the dental vendor and entered a contract with a new vendor to provide dental benefits to the plan's members.	–
5/26/10	NJ	Provider network deficiencies.	Yes	The CAP included a recruitment plan for the provider network.	–
5/26/10	NY	Marketing monitoring identified failure to make a presentation, failure to sign in and marketing at an unscheduled site.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
5/25/10	NJ	GeoAccess of PCPs and PCDs in multiple counties insufficient.	Yes	Implemented a comprehensive recruitment plan for primary care physicians and dentists.	–
5/21/10	NJ	GeoAccess concerns for hospital network and 1 county.	Yes	The CAP included efforts to renew negotiations with the hospital. Hospital adequacy issues are routine due to the fact that there is a single acute care hospital in the county and it refuses to participate with the health plan.	–
5/19/10	GA	Informed of requirement to adhere to 2010 encounter reconciliation schedule.	Yes	The health plan worked with the state's contractor to reconcile encounters and provider payments by identifying system and data metrics to achieve required metrics.	–
5/13/10	TX	Performance standards not met resulting in enrollment freeze.	No		–
5/12/10	GA	4Q network submission deficiencies.	Yes	Submitted a corrected network deficiency report showing the number of providers used to determine access levels. Initiated workflow for management accuracy review prior to submission; and modified report logic to remove duplicates where possible or document reason. Utilized secret shoppers to verify access availability and educated providers on requirements. Reviewed online provider directory for accuracy.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/11/10	MD	Minimum compliance level standards on delegated entity oversight, credentialing and recredentialing and utilization review not met.	Yes	Implemented significant process improvements for appeals, credentialing and recredentialing, and pre-authorizations. This included transitioning to handling these processes locally and improving audits and monitoring to better gauge performance over the year. Also improved documentation of the Quality Committee's activities to oversee its delegates.	–
5/11/10	NY	Provider network submittal did not reflect all signed contracts.	Yes	Resubmitted the provider network report to include all providers with signed contracts and established a report review process. The plan's Provider Relations department recruited additional specialists.	–
5/6/10	NJ	EPSDT and lead screening standards for CY 2007 not achieved.	No		81,150
5/4/10	FL	Child health check up report was submitted late.	No		400
4/29/10	TN	Scoring on elements of NCQA for accreditation insufficient.	Yes	The CAP included education of credentialing staff, revisions to the provider directory and member handbook, distribution of the Notice of Privacy Practices annually with member handbook, and revisions to the provider website.	–
4/28/10	TN	Notice of action regarding a service denial was deficient.	No		500
4/28/10	TN	Provider demographics in provider file inaccurate.	Yes	The CAP included outreach to providers and a provider website enhancement to allow providers to update demographic information.	–
4/27/10	NJ	Evaluation of encounter data submission for September 2009 inadequate.	No		–
4/27/10	TN	Response to a request for reconsideration of a medical service denial incomplete.	No		500
4/27/10	TN	Response to an adhoc report concerning reimbursement and billing submitted late.	No		3,000
4/26/10	TN	2010 annual quality survey identified process deficiencies.	Yes	The CAP included communication in the member newsletter, revisions to the provider orientation process, and revisions to reporting policies and procedures for adverse occurrence reporting.	–
4/22/10	GA	Benchmark for pharmacy calls answered within 30 seconds in Feb 2010 not met.	Yes	CAP actions included hiring additional staff to support PBM call center activities and an improved workflow to triage member and provider calls. Made training improvements to the health plan and PBM call centers.	–
4/22/10	TN	1Q10 provider data survey results identified deficiencies.	Yes	The CAP included contracting efforts with a rural hospital and the addition of surrounding county prenatal providers, correction of the provider enrollment file, and transportation availability for any remaining deficiencies.	15,000

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/21/10	NV	Required revisions to submitted CAP regarding issues with dental provision.	Yes	Information submitted to satisfy this CAP included items such as policies and procedures, quick reference guides for how to handle the special dental benefits for pregnant women, a provider office reference manual, training invites, the Utilization Management program description, and a call script.	–
4/15/10	NY	Marketing monitoring identified failure to communicate all required information and not being present at a marketing table.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	–
4/15/10	TN	April 2010 provider file review identified network deficiencies.	Yes	The CAP included contracting with a rural hospital; addressing provider file configurations; and requesting the application of community standards and where access standards were not met, provided transportation to members.	–
4/14/10	TN	Authorized DME services not provided.	No		50,500
4/14/10	TN	Annual transportation report submitted late.	No		700
4/14/10	TN	Annual transportation report submitted late.	No		500
4/13/10	IN	Performance requirements for encounter data submissions not met.	No		400
4/7/10	CA	Information to confirm provider network adequacy insufficient and submitted late.	No		50,000
4/7/10	CA	Information to confirm provider network adequacy insufficient and submitted late.	No		50,000
4/1/10	TN	Response to a reimbursement and billing adhoc report submitted late.	No		1,000
3/31/10	TN	Approved services not provided.	No		52,000
3/29/10	TN	Reconsideration response to a request to review a medical appeal incomplete.	No		500
3/25/10	NJ	Completeness benchmarks for encounters processing for August 2009 not met.	No		28,661
3/24/10	TX	1Q10 claims and claims appeals standards not met.	Yes	Made revisions to the monthly claims report to help better manage provider disputes.	20,000
3/24/10	TX	1Q10 benchmark for behavioral health services hotline abandonment rate not met.	No		100
3/24/10	TX	1Q10 report submitted late.	No		150
3/24/10	TX	1Q10 complaint response submitted late.	No		2,250
3/23/10	NY	Article 44/49 Operational survey statement identified deficiencies.	No		–
3/22/10	TN	Audit for ASH compliance identified incomplete consent form.	Yes	The CAP included recoupment of claims paid for incomplete ASH forms, review of policies and procedures, claims analyst re-training, implementation of a check-off process, and provider education.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/19/10	NV	Dental vendor issues with outreach, case management, and provider payment.	Yes	Created a refresher course for customer service and mailed a letter to all providers	-
3/19/10	TN	Response to a reimbursement and billing adhoc report submitted late.	No		500
3/19/10	TN	Complete response to an adhoc report submitted late.	No		2,500
3/18/10	GA	Submitted hospital statistical and reimbursement report late.	No		16,000
3/18/10	TN	Incomplete response to a reconsideration of a denied service.	No		500
3/18/10	TN	Incomplete response to a reconsideration of a denied service.	No		500
3/18/10	TN	Late adhoc report for reimbursement and billing.	No		500
3/18/10	TN	Late adhoc report for reimbursement and billing.	No		500
3/18/10	TN	Notice of action regarding a service denial was deficient.	No		500
3/17/10	GA	Call center standards for December, January, and February 2010 not met for calls answered within 30 seconds.	Yes	PBM hired and trained additional pharmacy call center staff and revised the call center skill workflow. Implemented process to transfer member related calls to the health plan call center. Continued process improvement efforts, including work groups to support prior authorization reviews and P&P reviews for the pharmacy call center.	-
3/17/10	NY	Marketing monitoring identified failure to communicate all required information.	Yes	Retrained and coached employee on marketing procedures. The compliance department conducted a secret shopper survey to confirm that the issue was corrected.	-
3/16/10	NY	Provider network directory participation rate benchmark not met.	Yes	Made verification calls to providers and updated files to create accurate provider directories.	-
3/4/10	FL	Q4 claims report was on wrong template and included inaccurate information.	No		600
3/3/10	NJ	Encounter data for January 2010 and June 2009 insufficient.	No		14,362
Medicaid - Non-operational Affiliates					
10/16/13	NM	Failure to pay claims timely and accurately.	No		25,000
9/20/13	NM	Personal care option processes for level of care closures and authorization for services not in compliance.	Yes	Ran authorization reports that included the LOC dates and delivered to each provider. Notified the providers that the new MCOs would honor the member's plan of care as noted on the report.	-
8/9/13	NM	Outstanding encounters from 2011 and 2012 not submitted per contract requirements.	Yes	Revised encounter tracking tool so that dollars were not overstated; corrected outpatient Medicare crossover claims issue; corrected duplicate edit rejection; and resolved errors for specific codes.	-

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/27/13	OH	Pharmacy claims edits incorrectly excluded drugs on Medicaid drug list.	Yes	Engaged the pharmacy department to draft and implement a CAP, which included validating the status of current edits and establishing a process to ensure future compliance.	–
3/5/13	OH	Failed to submit required delegation documentation within the required timeframes.	Yes	Implemented staff retraining and updated internal procedures.	–
2/20/13	OH	Q3 SFY12 clinical performance and access measures not met.	Yes	Took measures to target increased utilization during the next measurement period, including outreach to non-compliant members for the clinical quality measures, specifically working to improve access to care.	–
2/4/13	OH	Provider network deficiency.	No		1,000
1/10/13	OH	Failure to remove prior authorization denial language and adhere to CAP.	Yes	Engaged the pharmacy department to correct prior authorization denial language. Submitted language to the state on 2/6/13.	10,000
1/10/13	OH	Issuance of state hearing rights to non-members during the prior authorization denial process noncompliant.	Yes	The pharmacy department reviewed all denial reasons to confirm that the language indicates that the decision was based on a medical necessity review. Management reviewed all state prior authorization requests and drafted all specific member denial language until a full review of denial reasons was completed and changes implemented. In addition, the age edit for long acting stimulants was removed.	–
12/12/12	OH	High risk care management performance standard for July through September 2011 not met.	No		–
10/23/12	OH	Provider network deficiency.	No		–
8/3/12	OH	Medically-necessary Medicaid covered services to members not provided.	Yes	The pharmacy department reviewed all denial reasons to confirm that the language indicates that the decision was based on a medical necessity review. Management reviewed all state prior authorization requests and drafted all specific member denial language until a full review of denial reasons was completed and changes implemented. In addition, the age edit for long acting stimulants was removed.	10,000
6/22/12	OH	Grievance and appeals processing requirements non compliant.	Yes	Retrained staff and updated internal procedures.	5,000
4/27/12	OH	Provider panel deficiency.	No		2,000
3/5/12	OH	Associate provided inaccurate information to a member regarding the state hearing process.	Yes	Retrained staff and updated internal procedures.	5,000

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/1/12	OH	Exception to prior authorization requirements for psychiatrists practicing at community mental health centers non-adherence.	Yes	The pharmacy department enhanced the quality check on the community mental health center files to include a data file quality review process. Activities included file analyses, file provider quality assurance, pharmacy quality/compliance oversight, and a new daily antipsychotics and antidepressants denial report.	–
2/14/12	OH	Provision of prescribed medication delayed.	Yes	Enhanced pharmacy education to address TPL issues; issued Pharmacy Step-by-Step instructions to educate pharmacies on TPL overrides and billing procedures; instituted a PBM Help Desk Communication for any calls from pharmacies with TPL questions; and developed a system message screen to assist pharmacists with the billing/claim issues. Also added additional oversight of PBM processes via regularly scheduled meetings to address issues.	5,000
2/1/12	OH	Provider network deficiencies.	No		2,000
1/23/12	OH	Requirement to provide outpatient drugs within twenty-four hours of the initial request not met.	Yes	Received clarification of accurate turnaround time standards for calculation, and held follow-up discussions with the pharmacy vendor and staff to confirm turnaround time calculation compliance. Received turnaround time reports and held regular calls with the pharmacy vendor to ensure compliance.	–
1/18/12	OH	High risk care management performance measures for the April-June 2011 reporting period not met.	No		–
11/29/11	OH	Notification requirements for claims payment system errors not met.	Yes	Retrained staff and updated internal procedures.	5,000
11/7/11	OH	CY10 clinical performance measures noncompliant with state contract standards.	Yes	The CAP included process improvements to identify noncompliant members earlier, to work with members and enroll them into case management program as needed, and to work with providers to identify members who would qualify for these criteria.	–
11/4/11	OH	Provider panel deficiency.	No		1,000
8/26/11	OH	Notification requirements for claims payment system errors not met.	Yes	Retrained staff and updated internal procedures.	–
8/23/11	OH	Annual ASH audit resulted in deficiencies.	No		16,000
6/21/11	OH	4Q10 encounter data volume standard measurement not met.	Yes	Review determined that the issue is based on low utilization and not encounter data submission issues. Documented measures to increase utilization during the next measurement period.	–

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
5/16/11	OH	EPSDT review for medical necessity and use of form requirements not met.	Yes	Retrained staff and updated internal procedures.	–
5/9/11	OH	Access related grievances resolved untimely.	Yes	Retrained staff and updated internal procedures.	20,000
4/29/11	OH	CY09 Emergency department diversion regional statewide review results deficient.	No		–
4/29/11	OH	CY09 Emergency department diversion regional statewide review results deficient.	Yes	Improved case management processes to work with members identified as possible emergency department over-utilizers; hospital and provider outreach and processes to transfer daily information on emergency department utilizers; and follow-up with the case management team to identify alternatives to care.	–
4/14/11	OH	CY09 high risk care management performance measures were deficient.	No		–
4/14/11	OH	CY09 high risk care management performance measures were deficient.	No		–
3/16/11	OH	CY09 clinical performance measures noncompliant.	Yes	Took measures to target increased utilization during the next measurement period through process improvements to identify noncompliant members earlier; working with members to enroll them into case management program as needed, and working with providers to identify members who would qualify.	–
3/7/11	NM	Identification of unresolved claims issues for Indian Health Services and Tribal 638.	Yes	As requested, developed and submitted a response work plan on the State's template to resolve the corrective action. The work plan included sections for claims processes and system, staff information; information on inaccurately reimbursed claims; policies and procedures, and provider education.	–
2/10/11	OH	CY08 clinical performance measures noncompliant.	No		–
2/2/11	OH	Provider network deficiencies.	No		4,000
2/1/11	NM	Individual service plan template and various documentation deficiencies.	Yes	Actions including re-education of our staff and deployment of service needs assessments and data capture with new mobile technology.	–
1/25/11	OH	Assigned members to PCPs that had previously been identified as not accepting new members.	No		30,000
12/23/10	OH	Provider agreement signature page submitted late.	No		300
12/16/10	OH	Provider network deficiencies.	No		2,000
11/16/10	OH	EQRO comprehensive administrative review identified deficiencies.	Yes	Retrained staff and updated internal procedures.	–
11/12/10	OH	Resolution of claims-related grievances and appeals did not meet required timeframes.	Yes	Retrained staff and updated internal procedures.	–
8/18/10	OH	Grievance reporting activity including insufficient information and failure to report member grievances noncompliant.	Yes	Retrained staff and updated internal procedures.	20,000

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Date	State	Description	CAP?	Corrective Action Plan Description	Fine
7/16/10	OH	ASH documentation/claims processing noncompliant.	Yes	Reviewed ASH requirements with the claims department and educated staff.	34,000
6/30/10	OH	Member services representatives failed to adequately assist members in finding a needed provider.	Yes	Retrained staff and updated internal procedures.	20,000
6/29/10	OH	State hearing forms sent to members noncompliant.	Yes	The dental vendor implemented additional training and oversight to ensure that covered services are not denied and that the reason codes on complaint forms are compliant. Held routine meetings, at least monthly, for 6 months with the dental vendor to verify compliance.	10,000
6/14/10	OH	Generic provider number usage rate and the vision encounter data standard from October to December 2009 noncompliant.	No		–
6/14/10	OH	Corrective action plan not followed.	No		10,000
6/14/10	OH	Corrective action plan not followed.	No		10,000
6/2/10	OH	Corrective action plan not followed.	No		5,000
5/4/10	OH	Corrective action plan not followed.	Yes	Retrained staff and updated internal procedures.	5,000
4/26/10	OH	Provision of inaccurate information to health care providers, members, or any eligible individuals.	Yes	The dental vendor evaluated the eligibility data file exchange, updated internal processes to provide reconsideration of eligibility before denying claims, and retrained staff.	–
4/13/10	OH	Incorrect use of state hearing forms.	Yes	Retrained staff and updated internal procedures.	–
4/12/10	OH	Provider panel deficiency.	No		1,000
4/8/10	OH	Required copies of state hearing appeal summaries submitted late.	Yes	Retrained staff and updated internal procedures.	–
4/1/10	OH	Accreditation report submitted late.	No		200
3/30/10	OH	State hearing appeal summary submitted late.	No		700
3/30/10	OH	State hearing appeal summary submitted late.	No		800
3/4/10	OH	Delegation documentation requirements for vendor contract noncompliant.	Yes	Implemented a new internal automated contract processing system to track vendor agreements and trigger the State approval process.	–
1/22/10	NM	Claims processing, medical care credit/cost share reduction, and coordination of benefits/Medicare crossover payments deficiencies.	Yes	Claims monitors and reviews nursing facility claims volumes greater than 10 days old on a daily basis and sends reports to other functional areas for review.	–
Medicare Affiliates					
9/19/14	VA	Notice of Non-Compliance. Non-compliance with call center response to specific member enrollment scenario.	No		–
7/8/14	Multiple	Notice of Non-Compliance. Did not complete a monthly certification of enrollment and payment data for January 2014.	No		–

Note: Medicaid affiliates operate three health plans in Florida and two in Texas

Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
7/1/14	AZ, CA, NV	Corrective Action Plan. Display measures, low performance.	Yes	We work continuously with our operations teams to review and improve compliance with administrative and management requirements.	–
5/30/14	NY	Warning Letter. Inaccurate annual notice of change/evidence of coverage documents sent to enrollees.	No		–
5/1/14	Multiple	Corrective Action Plan. Notice of contract deficiencies for 2011 financial audit.	Yes	Conducted a detailed review of the audit findings and created an action plan to address deficiencies in the following areas: late plan to plan payments; late enrollment penalty issues; and Part D payment mapping areas.	–
4/29/14	NY	Notice of Non-Compliance. Failure to timely deliver payment to a non-contracted provider.	No		–
4/17/14	Multiple	Corrective Action Plan. Low plan ratings for 2014 for 4 contracts.	Yes	Our STAR team works continuously with our operations teams to review and improve compliance with administrative and management requirements. Efforts resulted in a 64% decrease from 2013 ratings.	–
4/16/14	Multiple	Notice of Non-Compliance. Telesales vendor failed to maintain enrollment recordings. (self reported)	No		–
2/28/14	Multiple	Notice of Non-Compliance. Did not meet automated true out-of-pocket balance transfer transactions requirements.	No		–
2/28/14	AZ, CA, NV, VA	Notice of Non-Compliance. Non-compliance with CY 2014 Part D formulary submission.	No		–
2/28/14	AZ, CA, NV, VA	Notice of Non-Compliance. Submitted July limited window with non-allowable/unsolicited changes.	No		–
2/18/14	Multiple	Notice of Non-Compliance. Failure to meet call center monitoring timeliness standards 4Q 2013.	No		–
2/10/14	CA	Warning Letter. Failure to meet Part D formulary update requirements involving prescription drugs.	No		–
12/3/13	NY	Notice of Non-Compliance. Failure to submit complete and accurate final bid.	No		–
11/20/13	GA, MD	Notice of Non-Compliance. Did not meet timely upload requirement for format and information marketing events.	No		–
9/17/13	Multiple	Notice of Non-Compliance. Non-compliance with Part D requirements for the coverage of Cialis.	No		–
8/19/13	Multiple	Notice of Non-Compliance. Non-compliance with pharmacy data submission resulted in suppression of plan finder information.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
8/12/13	AZ, CA, NV	Notice of Non-Compliance. Failure to effectively monitor captive agent state licensure	No		–
7/3/13	Multiple	Notice of Non-Compliance. Inaccurate annual notice of change/evidence of coverage documents sent to enrollees.	No		–
6/11/13	AZ, CA	Notice of Non-Compliance. Call center monitoring found deficiencies with TTY access.	No		–
4/12/13	Multiple	Notice of Non-Compliance. Failure to meet call center monitoring timeliness standards 1Q 2013.	No		–
4/1/13	Multiple	Notice of Non-Compliance. Telephone calls to 130 impacted members were not followed by enrollment verification letters.	No		–
4/1/13	AZ, CA, NV	Notice of Non-Compliance. Failure to send accurate outbound enrollment verification letters.	No		–
3/1/13	NY, VA	Notice of Non-Compliance. Drug formulary did not include at least one protected class drug.	No		–
2/28/13	Multiple	Notice of Non-Compliance. As part of its self-monitoring process, pharmacy vendor discovered that LIS-beneficiaries received erroneous refunds.	No		–
12/28/12	AZ	Notice of Non-Compliance. Failure to submit Best Available Evidence (BAE) for August 2012	No		–
12/21/12	All	Corrective Action Plan. Notice of operations deficiencies for 2012 CMS program audit.	Yes	Conducted a review of audit findings and created an action plans to address deficiencies in the following areas: formulary administration; part C and D organization determinations and appeals; compliance program; and enrollment/disenrollment.	–
12/21/12	AZ	Warning Letter. Failure to timely submit 4Rx data.	No		–
12/13/12	Multiple	Corrective Action Plan. Low plan ratings for 2013 for 11 contracts.	Yes	Our STAR team works continuously with our operations teams to review and improve compliance with administrative and management requirements. Efforts resulted in a 45% decrease from 2012 ratings.	–
12/13/12	FL, NJ, NY	Corrective Action Plan. Notice of contract deficiencies for 2010 financial audit.	Yes	Reviewed audit findings and created an action plan to address deficiencies in the following areas: fraudulent prescription and EOB retrieval.	–
12/10/12	Multiple	Notice of Non-Compliance. Untimely and inaccurate service area reduction and/or annual notice of change mailings.	No		–
12/7/12	Multiple	Notice of Non-Compliance. Issuance of inaccurate annual notice of change/evidence of coverage documents.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
11/30/12	OH, WI	Notice of Non-Compliance. Untimely submission of Service Area Reduction disenrollment transactions.	No		–
11/19/12	Multiple	Notice of Non-Compliance. Failed to correctly bill member cost share for visual field testing.	No		–
9/26/12	Multiple	Warning Letter. Non-compliance with TTY Part C and Part D requirements.	No		–
9/7/12	CA, CT, GA	Notice of Non-Compliance. Failure to submit monthly attestations of enrollment in May and June 2012.	No		–
8/16/12	Multiple	Warning Letter. Call center monitoring of Part C and Part D customer service call centers.	No		–
7/27/12	All	Notice of Non-Compliance. Failure to assess, bill, and collect late enrollment penalties. (self-reported)	No		–
7/18/12	CT, IN, KY, NY, OH	Notice of Non-Compliance. Did not meet upload requirement for scheduled marketing events.	No		–
6/12/12	Multiple	Notice of Non-Compliance. Failure to complete outbound enrollment and verification calls.	No		–
6/12/12	Multiple	Notice of Non-Compliance. Untimely processing and dismissal of grievances and appeals.	No		–
5/24/12	Multiple	Corrective Action Plan. Notice of contract deficiencies for 2009 financial audit.	Yes	Conducted detailed review of audit findings and developed an action plan to address deficiencies.	–
5/24/12	NY	Notice of Non-Compliance. Failure to submit timely broker compensation filing.	No		–
5/18/12	Multiple	Notice of Non-Compliance. Did not meet upload requirement for scheduled marketing events.	No		–
5/18/12	NY	Notice of Non-Compliance. Failure to submit timely payment.	No		–
4/27/12	Multiple	Notice of Non-Compliance. Failure to attest to the edits during the formulary submission process.	No		–
4/10/12	Multiple	Notice of Non-Compliance. Failure to meet call center monitoring timeliness standards 1Q 2012.	No		–
3/16/12	All	Corrective Action Plan. Notice of operations deficiencies for 2011 CMS program audit.	Yes	Conducted a detailed review of the audit findings. Created an action plan to address each area: Part D formulary and benefit administration; Part D coverage determinations and appeals; Part D grievances, agent/broker oversight, and compliance program effectiveness.	–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
2/29/12	Multiple	Corrective Action Plan. Actuary standards not met for 2012 bids.	Yes	Carefully reviewed findings and developed an internal action plan to meet actuarial standards. CMS reviewed the next year Bids and no issues were found, showing all corrective actions taken were effective.	–
2/17/12	Multiple	Notice of Non-Compliance. Secret shopping deficiencies at marketing events.	No		–
1/30/12	Multiple	Notice of Non-Compliance. Secret shopping deficiencies at marketing events.	No		–
1/20/12	Multiple	Notice of Non-Compliance. Non-compliance with payment of local sales tax on prescription drug transactions.	No		–
1/12/12	AZ, CA, NV	Notice of Non-Compliance. Failure to submit third quarter payment information.	No		–
11/30/11	Multiple	Corrective Action Plan. Low plan ratings for 2012 for 20 contracts..	Yes	Our STAR team works continuously with our operations teams to review and improve compliance with administrative and management requirements. Improvement measured as fewer contracts have been identified with having Low Plan Ratings.	–
11/30/11	Multiple	Notice of Non-Compliance. Pharmacy vendor missed transition fill. Issued notices to members and self-disclosed to CMS.	No		–
11/3/11	CT, NY	Notice of Non-Compliance. Failure to meet call center monitoring timeliness standards 3Q 2011.	No		–
10/18/11	IN, KY, MO, NV, OH, WI	Corrective Action Plan. Notice of contract deficiencies for 2008 financial audit.	Yes	Conducted detailed review of audit findings and developed an action plan to address deficiencies.	–
9/15/11	Multiple	Notice of Non-Compliance. Did not meet the 98% compliance threshold for grievance and appeal processing.	No		–
7/19/11	Multiple	Warning Letter. Call center monitoring of Part C and Part D customer service call centers.	No		–
7/5/11	Multiple	Corrective Action Plan. Low plan ratings for 2011.	Yes	Our STAR team works continuously with our operations teams to review and improve compliance with administrative and management requirements. Improvement measured as fewer contracts have been identified with having Low Plan Ratings.	–
6/6/11	KY	Notice of Non-Compliance. Non-compliance with transmission of plan-generated beneficiary enrollments to CMS.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
3/30/11	Multiple	Notice of Non-Compliance. Incorrect processing of Part B prescription drug claims through Part D during 2010, resulting in member underpayments and overpayments for prescription drugs.	No		–
2/11/11	NM	Notice of Non-Compliance. Submission error caused a high number of duplicate encounters.	No		–
1/7/11	OH	Corrective Action Plan. Notice of contract deficiencies for 20078 financial audit.	Yes	Conducted detailed review of audit findings and developed an action plan to address deficiencies.	–
1/5/11	All	Corrective Action Plan. Notice of contract deficiencies for 2010 compliance audit.	Yes	Conducted detailed review of audit findings and developed an action plan to address deficiencies.	–
12/23/10	Multiple	Notice of Non-Compliance. Non-compliance with pharmacy data submission resulted in suppression of plan finder information.	No		–
12/22/10	Multiple	Notice of Non-Compliance. Erroneous statement in the emergency services section of the 2011 pre-sales kits.	No		–
11/17/10	Multiple	Notice of Non-Compliance. Secret shopping deficiencies at marketing events.	No		–
9/23/10	Multiple	Notice of Non-Compliance. Results of 2010 call center accuracy and accessibility study for Part C and Part D.	No		–
8/25/10	CA	Warning Letter. Low plan ratings.	No		–
8/18/10	Multiple	Notice of Non-Compliance. Failure to meet Part D program website requirements.	No		–
8/4/10	Multiple	Corrective Action Plan. Notice of contract deficiencies for 2006 audit.	Yes	Conducted detailed review of audit findings and developed an action plan to address deficiencies.	–
7/7/10	Multiple	Corrective Action Plan. Noncompliance with CMS requirements for submitting risk adjustment data.	Yes	Reviewed risk adjustment data submissions and created an action plan to address deficiencies.	–
5/28/10	All	Warning Letter. Non-compliance with program requirements related to protecting the confidentiality of member information.	No		–
5/20/10	All	Notice of Non-Compliance. Advised of concerns identified during post sanction monitoring activities.	No		–
5/10/10	TX	Corrective Action Plan. CMS requested a CAP on seven findings from a 2008 financial audit.	Yes	Conducted a detailed review of the audit findings and created an action plan to address deficiencies.	–
4/26/10	All	Notice of Non-Compliance. Advised of concerns identified during post sanction monitoring activities.	No		–
4/19/10	Multiple	Notice of Non-Compliance. Untimely submission of Part C and D data.	No		–
4/12/10	All	Notice of Non-Compliance. Advised of concerns identified during post sanction monitoring activities.	No		–

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Affiliate Regulatory Actions and Sanctions

Date	State	Description	CAP?	Corrective Action Plan Description	Fine
4/19/10	Multiple	Notice of Non-Compliance. Untimely submission of Part C and D data.	No		-
4/12/10	All	Notice of Non-Compliance. Advised of concerns identified during post sanction monitoring activities.	No		-
4/2/10	Multiple	Warning Letter. Deficiencies identified during secret shopper review of marketing events.	No		-
3/30/10	VA	Corrective Action Plan. Not in compliance with CMS requirements for submitting risk adjustment data.	Yes	Reviewed risk adjustment data submissions and created an action plan to address deficiencies.	-
3/22/10	Multiple	Notice of Non-Compliance. Call center disconnect rate is over 5 percent.	No		-
3/3/10	Multiple	Corrective Action Plan. Noncompliance with CMS requirements for submitting risk adjustment data.	Yes	Reviewed risk adjustment data submissions and created an action plan to address deficiencies.	-
3/2/10	KY	Warning Letter. Failure to comply with requirement to submit medication therapy management program data.	No		-

Damages, Penalties, Disincentives and Withholds	
State	Contract and Comments
GA	Georgia Families 360 - The contract includes a quality program implemented in 2014, the outcome of which will not be known until sometime in 2015
IN	Hoosier Healthwise - From 2009 to 2013, we retained over 1/3 of withhold or premium at risk. Losses or disincentives range from approximately \$1.3 to \$3.5 M.*
IN	Healthy Indiana Plan - From 2011 to 2013, we retained on average 60% of the withhold or premium at risk under the quality program with the exception of 2012 at lower %. Losses or disincentives range from approximately \$500K to \$750K.*
KS	KanCare - Since the contract began in 2013, we retained over 2/3 of the withhold program. The disincentive was approximately \$7.5M.*
LA	CCN - 2013 was the first year of the quality program. We retained 80% of the withhold or premium at risk. The disincentive was approximately \$152K.*
MD	For 2009 and 2011-2013, we earned a net incentive under the quality program of our Maryland contracts. In 2010, our performance resulted in a net disincentive resulting in a loss of approximately \$1.4M
NY	TANF/SSI/LTSS - The quality program is administered through a bonus inside the premium rates. Additional premium is awarded based on a tiered structure, with no inherent disincentive. In 2010, we were in the 4th tier out of 4; in 2011, in the 4th tier out of 5; in 2012, in 3rd tier out of 5; and 2013, in 3rd tier out of 6.*
SC	Blue Choice - the quality incentive program began in 2012. Losses or disincentives for 2012 and 2013 were approximately \$845K and \$2.7M, respectively.*
TX	STAR, STAR+PLUS, CHIP - The quality program began in 2013 (prior, significant incentives/disincentives were not available under the program). We achieved a net incentive in 2013.*
WA	Apple Health - the quality incentive program began in 2014. Results are provided quarterly. We achieved a full incentive.
WV	The quality incentive for all of our contracts began in 2014. The outcome of 2014 will not be known until sometime in 2015.
WI	Community Connect - the quality incentive program began in 2011. From 2011-2013, we earned 75-95% of the withhold or premium at risk. Losses or disincentives range from approximately \$52-\$273K. The outcome of 2014 will not be known until sometime in 2015.

* the outcome of 2014 will not be known until sometime in 2015.

Note: Medicaid affiliates operate three health plans in Florida and two in Texas

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CAPITAL AND SURPLUS GUARANTEE

THIS CAPITAL AND SURPLUS GUARANTEE (hereinafter the "Guarantee") is made on the 18th day of May, 2015 by Anthem, Inc., a corporation formed under the laws of the State of Indiana (hereinafter "Anthem").

WHEREAS, Amerigroup Iowa, Inc., a corporation formed under the laws of the State of Iowa (hereinafter the "Company"), is an indirect, wholly-owned subsidiary of, and controlled by, Anthem;

WHEREAS, the Company is applying to the Iowa Insurance Division (hereinafter the "Division") for a certificate of authority to establish and operate a health maintenance organization;

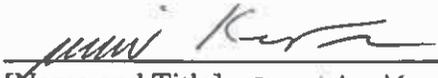
WHEREAS, Anthem desires that the Division exercise its discretion to, and continue to, grant the certificate of authority; and

WHEREAS, Anthem desires to give legal assurances to the Division that at all times its control of the Company will be or will have been exercised so that Company's capital and surplus meets or exceeds the requirements of the State of Iowa, as amended at any time.

WHEREFORE, Anthem guarantees that the Company shall have and maintain capital and surplus at no less than the minimum amount required, from time to time, by the applicable provisions of the Insurance Code of the State of Iowa, and Anthem agrees that this Guarantee shall remain in force until Anthem obtains a written release from the Division, which release shall not be unreasonably withheld.

Executed at Indianapolis, Indiana as of the date first set forth above.

ANTHEM, INC.

By: 
[Name and Title] David Kretschmer
SVP, Treasurer and CIO

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Select Attachments Not Included in Page Count (3.2.7.5)

Per RFP Section 3.2.7.5 Select Attachments Not Included in Page Count, we have included the following documents:

- Attachment 3.2.7.5-1 TX Medicaid Managed Care and CHIP EQRO Report
- Attachment 3.2.7.5-2 Implementation Plan
- Attachment 3.2.7.5-3 HEDIS Measures
- Attachment 3.2.7.5-4 Sample Provider Agreements

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Texas Medicaid Managed Care and Children's Health Insurance Program

EQRO Summary of Activities and Trends in Healthcare Quality

Contract Year 2012

Measurement Period:

September 1, 2009 through December 31, 2011

**The Institute for Child Health Policy
University of Florida**

**The External Quality Review Organization
for Texas Medicaid Managed Care and CHIP**

Final Submitted: March 28, 2014

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Executive Summary

Introduction

This report summarizes the evaluation activities conducted by the Institute for Child Health Policy (IHP) at the University of Florida to meet federal requirements for external quality review of Texas Medicaid Managed Care and the Children's Health Insurance Program (CHIP). IHP has been the external quality review organization (EQRO) for the Texas Health and Human Services Commission (HHSC) since 2002. The findings discussed in this report are based on EQRO activities conducted in Fiscal Year (FY) 2011 – September 1, 2010 to August 31, 2011. This report also presents trends in healthcare quality in Texas Medicaid and CHIP between FY 2009 and FY 2011.

The review is structured to comply with the Centers for Medicare and Medicaid Services (CMS) federal guidelines and protocols, and addresses care and services provided by managed care organizations (MCOs) participating in STAR, STAR+PLUS, STAR Health, NorthSTAR, and CHIP. The EQRO conducts ongoing evaluation of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

The findings presented in this summary are based on previously approved EQRO reports to HHSC. The summary concludes with a listing of the most relevant recommendations made by the EQRO in FY 2011 for improving quality of care in Texas Medicaid and CHIP.

Summary of Findings

Demographic Characteristics

- *Enrollment.* In 2011, the STAR program had the largest number of members (1,746,595), followed by Primary Care Case Management (PCCM) (804,327) and CHIP (562,647). The membership in STAR, STAR+PLUS, and NorthSTAR increased by at least 20 percent over the three-year period. STAR+PLUS Medicaid-only enrollment increased by more than three-fourths from 2009 to 2011 (76 percent), following the Medicaid managed care expansion in September 2011.
- *Member age.* The average age of members in Texas Medicaid and CHIP ranged from 8 to 14 years old, with the exception of STAR+PLUS, in which the average age of the Medicaid-only population was 43 years old and the average age of dual-eligible members was 65 years old.
- *Member race/ethnicity.* Hispanic members were the largest group in every program, with the exception of STAR+PLUS, ranging from 43 percent in STAR Health to 65 percent in CHIP. In STAR+PLUS, Black, non-Hispanics represented the largest racial/ethnic group, at 38 percent in December 2011.

Health Status

- Child members with special health care needs (MSHCN) prevalence (administrative).* The prevalence of child MSHCN was determined using the Clinical Risk Group (CRG) classification system in STAR, CHIP, and PCCM in 2011. The PCCM program had the highest percentage of child MSHCN across all programs, at 27 percent in 2011. STAR and CHIP both had similar rates (16 percent and 15 percent, respectively), with the percentage in STAR remaining constant over the three-year period and the percentage in CHIP increasing marginally.
- Child MSHCN prevalence (survey).* The prevalence of child MSHCN was also determined by parent-report using the CSHCN screener in STAR, CHIP, and PCCM in 2011, and in STAR Health in 2012. The rates in STAR (18 percent) and CHIP (20 percent) were comparable to the national average (reported by the National Survey of CSHCN), while the rate in STAR Health was considerably higher (48 percent).
- Child MSHCN characteristics (survey).* The characteristics of child MSHCN were determined using the parent-report CSHCN screener in STAR, CHIP, and PCCM in 2011 and in STAR Health in 2012. The most common special health care need among child MSHCN was dependence on prescription medications in STAR (15 percent), CHIP (16 percent), and PCCM (18 percent). In STAR Health, the most common special health care needs were dependence on medications (35 percent) and problems that require mental health treatment or counseling (36 percent). The distribution of special needs among child MSHCN was relatively constant in STAR and CHIP across the three-year period.
- Caregiver-reported child member health status.* Approximately 70 percent of caregivers rated their child's health status as excellent or very good for all programs. Both STAR and CHIP had an increase in reported child health status from 2009 to 2011.
- Childhood obesity.* The PCCM and STAR Health programs had the highest reported obesity rates, with nearly one-third of members classified as obese (31 percent and 30 percent, respectively). STAR and CHIP both showed a decrease in the rate of child/adolescent obesity from 2009 to 2011, with CHIP having the lowest obesity rate at 25 percent.
- Member-reported health status in STAR+PLUS.* Overall, member self-rated health status in STAR+PLUS was low, with over 60 percent of Medicaid-only and dual-eligible members reporting being in "fair" or "poor" health. Only 15 percent of Medicaid-only STAR+PLUS members and 16 percent of STAR+PLUS dual-eligible members rated their health as "excellent" or "very good". Self-reported mental health status was generally higher, with more than one-quarter of members in both eligibility groups reporting their mental health as "excellent" or "very good".

- *Activities of daily living in STAR+PLUS.* Approximately two-thirds of STAR+PLUS members in both eligibility groups reported having a condition that interferes with their quality of life. Approximately half of STAR+PLUS members reported needing assistance with *routine needs*, and approximately one-third of members reported needing assistance with *personal needs*.
- *Obesity in STAR+PLUS.* For the STAR+PLUS Medicaid-only and dual-eligible populations, nearly one-half of all members were considered obese, and one-fourth of all members were considered overweight.

Pediatric Preventive Care

- *Access to primary care.* Across programs, child and adolescent members had good access to primary care practitioners, with over 90 percent of members visiting a PCP during the measurement period.
- *Well-care visits.* Rates of well-child and well-care visits increased slightly over the three-year period for all programs. Rates of increase were especially pronounced in STAR Health. All programs met HHSC Dashboard standards for well-child/well-care visits in all age groups across the three-year period.
- *Childhood immunization.* Less than one-half of two-year-olds in STAR received the appropriate vaccinations by their second birthday (45 percent), exceeding the 2011 HEDIS[®] national mean of 32 percent. The rate in CHIP was 39 percent.
- *Access to dental care.* Overall, the rate of annual dental visits in CHIP Dental increased from 59 percent in 2009 to 66 percent in 2011, exceeding the 2011 HEDIS[®] national average of 48 percent.

Adult Preventive Care

- *Access to ambulatory health services.* STAR+PLUS members over 45 years of age generally had good access to preventive care. Eighty-seven percent of members in both older age cohorts (45 to 64 years and 65 years and older) had an ambulatory or preventive care visit in CY 2011. Preventive care was lower among 20- to 44-year-old STAR+PLUS members than among older members (72 percent).
- *Prenatal care.* The rate of timely prenatal care in STAR (83 percent) was comparable to the national HEDIS[®] mean of 84 percent. It should be noted that this sub-measure follows HEDIS[®] specifications with the exception of provider constraints; therefore, comparisons to the HEDIS[®] national means are approximate and for illustrative purposes only. Rates of timely prenatal care increased in STAR, STAR+PLUS and STAR Health between 2009 and 2011. Despite the increase in STAR+PLUS, the 2011 rate remained below the HHSC Dashboard standard. Nearly two-thirds of deliveries in STAR had ≥ 81 percent of the expected number of prenatal visits (63 percent), which is slightly higher than the HEDIS[®] mean of 61 percent for this performance threshold. This rate was lower in CHIP (40 percent) and STAR Health (47 percent).

- *Postpartum care.* Fifty-nine percent of deliveries in STAR received a postpartum visit, which is lower than the national HEDIS® mean of 64 percent. The percentage of deliveries receiving a postpartum visit in STAR+PLUS increased slightly across the three-year period, while remaining fairly consistent in STAR and STAR Health. The rate in STAR+PLUS was below the HHSC Dashboard standard, despite increasing between 2009 and 2011.
- *Breast cancer screening.* Forty-six percent of eligible women in STAR+PLUS had a mammogram to screen for breast cancer during the measurement period.
- *Cervical cancer screening.* Rates of cervical cancer screening increased very slightly during the three-year period in STAR (to 59 percent in 2011), but were still lower than the 2011 HEDIS® national mean of 67 percent. Rates in STAR+PLUS also showed a very slight increase over the three-year period (to 40 percent in 2011).
- *Chlamydia screening in women.* Approximately half of eligible women in STAR (51 percent) and one-third in CHIP (31 percent) received Chlamydia screening in CY 2011. Fifty-eight percent of eligible female members in STAR Health received Chlamydia screening in CY 2011.

Ambulatory Care

- *Emergency department visits.* The rate of emergency department visits per 1,000 member-months ranged from 21 in CHIP to 114 in STAR+PLUS.
- *Outpatient visits.* The rate of outpatient visits per 1,000 member-months ranged from 231 in CHIP to 565 in STAR+PLUS.

Pediatric Quality Indicators

- *Asthma PDI.* Over the three-year period, pediatric inpatient admissions (PDIs) for asthma declined in STAR, CHIP, and STAR Health, and fluctuated considerably in STAR+PLUS.
- *Diabetes short-term complications PDI.* Pediatric inpatient admissions for diabetes short-term complications remained fairly constant in STAR, CHIP, and STAR+PLUS, and declined considerably in STAR Health.
- *Gastroenteritis PDI.* Pediatric inpatient admissions for gastroenteritis declined for all programs during the three-year period, particularly in STAR+PLUS.
- *Urinary tract infection PDI.* Pediatric inpatient admissions for UTI decreased slightly in STAR and CHIP, fluctuated in STAR+PLUS, and increased in STAR Health.

Prevention Quality Indicators

- *Diabetes short-term complications PQI.* Over the three-year period, adult inpatient admissions for diabetes short-term complications remained relatively constant in STAR and declined in STAR+PLUS.

- *Diabetes long-term complications PQL.* Adult inpatient admissions for diabetes long-term complications remained constant in STAR and declined in STAR+PLUS.
- *Bacterial pneumonia PQL.* Adult inpatient admissions for bacterial pneumonia remained fairly constant in STAR and declined in STAR+PLUS.
- *Urinary tract infection PQL.* Adult inpatient admissions for UTI remained constant in STAR and decreased in STAR+PLUS.

Potentially Preventable Readmissions (3M)

- In CY 2011, rates of potentially preventable readmissions were 2 percent in STAR, 5 percent in CHIP, 13 percent in STAR+PLUS, and 16 percent in STAR Health.

Behavioral Health Service Utilization

- *Use of mental health services.* Use of outpatient or ED mental health services was considerably greater in STAR Health (78 percent) than in STAR (9 percent), STAR+PLUS (32 percent), or NorthSTAR (9 percent).
- *Use of alcohol and other drug (AOD) services.* Use of ambulatory AOD services was higher in STAR+PLUS (11 percent) than in STAR (1 percent) or NorthSTAR (2 percent).

Health Plan Information

- *Encounter data validation.* Match rates for date of service, diagnosis, and procedure were over 90 percent for all programs. Match rates for date of service and procedure were over the desired 95 percent in the STAR, CHIP, STAR+PLUS, and STAR Health programs.
- *Electronic health records.* Nine out of 18 health plans monitored whether providers implemented electronic health records (EHR) during FY 2011. ValueOptions reported the highest percentage of providers implementing EHR (70 percent). Evercare and UnitedHealthcare-Texas reported that none of their providers had implemented EHR during FY 2011.
- *Data certification.* The EQRO conducted the following analyses to certify claims data for all programs: (1) Volume analysis based on service category; (2) Data validity and completeness analysis; (3) Consistency analysis between encounter data and financial summary reports provided by the MCOs; and (4) Validity and completeness analysis of provider information. Volume data were found to be consistent for all plan codes based on overall volumes. All critical fields were found to be present in the data. Overall, the results of these analyses were positive and suggest that completeness of MCO administrative data has improved.

Disease Management (DM) Programs

- *Asthma DM participation rates.* In 2011, rates of participation in MCO asthma DM programs in STAR, CHIP, and STAR+PLUS were 59 percent, 69 percent, and 90 percent, respectively.

- *Diabetes DM participation rates.* In 2011, rates of participation in MCO diabetes DM programs were 43 percent in STAR, 74 percent in CHIP, and 86 percent in STAR+PLUS.

Quality Assessment and Performance Improvement (QAPI) Evaluation Summaries

- *Overall QAPI scores.* The average score for all MCOs was 92 percent. A majority of health plans scored above average, with the exception of five MCOs scoring below average. Delta Dental and Seton were the only two health plans that scored significantly lower than average.

Performance Improvement Projects (PIPs)

- *Overall PIP scores.* The average score of the year-end review of all the PIPs was 57 percent. Eight of the 15 MCOs scored above average. HealthSpring was the only health plan that scored below 50 percent, with a score of 14 percent. The “Real” Improvement Activity of the PIPs had the greatest opportunity for improvement, with only 15 percent of the PIPs resulting in a statistically significant improvement in the baseline rate.

Satisfaction with Timeliness of Care

- *CAHPS® Getting Care Quickly.* Scores for *Getting Care Quickly* among child members ranged from 83 percent in STAR to 90 percent in STAR Health, and were similar to those reported for children in Medicaid and CHIP nationally. Scores for this measure among adult members ranged from 71 percent in STAR to 80 percent among STAR+PLUS dual-eligible members, falling below the applicable national averages.
- *Good Access to Urgent Care.* Performance on this HHSC Dashboard indicator was fairly good for children, ranging from 86 percent in STAR to 96 percent in STAR Health. Among adults, performance ranged from 74 percent in STAR (below standard) to 81 percent among STAR+PLUS dual-eligible members (equal to standard).
- *Good Access to Routine Care.* Performance on this HHSC Dashboard indicator among children ranged from 78 percent in CHIP to 84 percent in STAR Health (above standard). Among adults, performance ranged from 67 percent in STAR (below standard) to 80 percent among STAR+PLUS dual-eligible members (equal to standard).
- *No Delays for Health Plan Approval.* Performance on this HHSC Dashboard indicator was below the standard for all programs, with the exception of STAR Health, which had a rate equal to its Dashboard standard. Scores ranged from 63 percent to 69 percent among children and from 38 percent to 50 percent among adults.
- *No Wait to be Taken to the Exam Room Greater than 15 Minutes.* Performance on this HHSC Dashboard indicator was considerably below the standard for all members, ranging from 24 percent to 30 percent among children and from 21 percent to 33 percent among adults.

Satisfaction with Primary and Specialist Care

- *CAHPS® Getting Needed Care.* Scores for *Getting Needed Care* among child members ranged from 72 percent in STAR to 80 percent in STAR Health, and were lower than those reported for children in Medicaid and SCHIP nationally. Scores for this measure among adult members ranged from 60 percent for STAR+PLUS Medicaid-only members to 74 percent for STAR+PLUS dual-eligible members, also below the national averages.
- *Good Access to Specialist Referral.* Performance on this HHSC Dashboard indicator among children ranged from 69 percent in STAR (below standard) to 84 percent in STAR Health (above standard). The rate in STAR Health increased notably between 2009 and 2012. Among adults, performance ranged from 61 percent for STAR+PLUS Medicaid-only members (below standard) to 78 percent for STAR+PLUS dual-eligible members (above standard).
- *Good Access to Special Therapies.* Performance on this HHSC Dashboard indicator among adults in STAR was 62 percent (above standard). Rates were lower in STAR+PLUS, for both Medicaid-only members (52 percent) and dual-eligible members (53 percent) – both below the HHSC Dashboard standard. Furthermore, rates of good access to special therapies in STAR+PLUS dropped notably over the period between 2009 and 2012 – particularly in Molina (by 20 percentage points) and Superior (by 15 percentage points).

Satisfaction with the Patient-Centered Medical Home

- The percentage of members who had a personal doctor ranged from 68 percent among adults in STAR to 93 percent among children in STAR Health. Member ratings of their personal doctor generally exceeded the national averages.
- *CAHPS® How Well Doctors Communicate.* Scores for *How Well Doctors Communicate* were high among child members, ranging from 88 percent in STAR to 94 percent in STAR Health. Scores among adult members were also high, ranging from 82 percent for STAR+PLUS Medicaid-only members to 90 percent for STAR+PLUS dual-eligible members.
- *Good Access to Service Coordination.* Performance on this HHSC Dashboard indicator for STAR+PLUS was slightly above standard for Medicaid-only members (67 percent). The rate among dual-eligible members was 64 percent.

Satisfaction with Customer Service

- *CAHPS® Health Plan Information and Customer Service.* Scores for *Health Plan Information and Customer Service* among child members ranged from 75 percent in STAR Health to 84 percent in STAR. The rate in STAR Health dropped from 85 percent in 2010 to 75 percent in 2012. Scores among adult members were slightly lower, ranging from 69 percent for STAR+PLUS Medicaid-only members to 78 percent for STAR members.

Acute Respiratory Care

- *Appropriate treatment for children with URI.* The percentage of children in STAR who received appropriate treatment for URI was 83 percent, which is lower than the national HEDIS[®] mean of 87 percent. In all eligible programs, performance on this measure showed slight increases from 2009 to 2011; however, rates for this measure are generally low and have changed little over the three-year period.
- *Appropriate testing for children with pharyngitis.* Rates of appropriate testing for pediatric pharyngitis were low for all eligible programs from 2009 to 2011. Furthermore, rates in STAR were lower than the HEDIS[®] mean across all three years. In 2011, the rate for STAR was 58 percent, compared to 65 percent of children in Medicaid nationally.
- *Avoidance of antibiotic treatment in adults with acute bronchitis.* In STAR+PLUS, the rate of members with bronchitis who were not dispensed an antibiotic increased slightly from 18 percent in 2010 to 20 percent in 2011.

Care for Chronic Conditions

- *Use of appropriate medications for people with asthma.* For members 5 to 11 years old, rates of appropriate asthma medication use in STAR exceeded the HEDIS[®] national mean of 92 percent. In addition, rates in all programs exceeded the HHSC Dashboard standard of 92 percent for this age group. For members 12 to 50 years old, the rate in STAR (93 percent) also exceeded the national HEDIS[®] mean of 86 percent. For this age group, STAR+PLUS was the only program that fell below the HHSC Dashboard standard of 86 percent. In addition, the rate among adults in STAR+PLUS has declined from 91 percent in 2009 to 80 percent in 2011.
- *Comprehensive diabetes care.* For adults with diabetes in STAR, CY 2011 results for all sub-measures were below their respective HEDIS[®] national means and HHSC Dashboard standards – suggesting a general need for improvement in diabetes care for this population. The rates for eye exams (36 percent), LDL-C control (18 percent), and HbA1c control (29 percent) were particularly low in comparison to the national means. For adults in STAR+PLUS, rates on all sub-measures were generally higher than in STAR, but also indicated need for improvement – particularly for eye exams (37 percent) and HbA1c control (26 percent). For both programs, three-year trends among sub-measures saw a net increase in rates from 2009 to 2011.
- *Controlling high blood pressure.* Rates of adequate blood pressure control for the STAR program (44 percent) and STAR+PLUS program (40 percent) were lower than the HHSC Dashboard standard of 54 percent for both programs. The rates for STAR and STAR+PLUS were also lower than the national HEDIS[®] mean of 56 percent.
- *Annual monitoring for patients on persistent medications.* The vast majority of eligible STAR+PLUS members received annual medication monitoring, with a rate of 88 percent for all medications combined.

Behavioral Health Care

- *Follow-up after hospitalization for mental illness.* STAR results were similar to the national HEDIS[®] means for 7-day and 30-day follow-up. It should be noted that this measure follows HEDIS[®] specifications with the exception of provider constraints; therefore, comparisons to the HEDIS[®] national means are approximate and for illustrative purposes only. All programs performed well in comparison to their respective HHSC Dashboard standards, STAR Health in particular. Rates for STAR+PLUS and STAR Health increased consistently from 2009 to 2011.
- *Follow-up for children prescribed ADHD medication.* Results among programs for the initiation phase ranged from 29 percent in NorthSTAR to 86 percent in STAR Health. Results among programs for the continuation and maintenance phase ranged from 42 percent in NorthSTAR to 90 percent in STAR Health. For the initiation phase, the STAR rate (50 percent) was higher than the HEDIS[®] mean of 38 percent. For the continuation and maintenance phase, the STAR rate (66 percent) was higher than the HEDIS[®] mean of 44 percent. It should be noted that this measure follows HEDIS[®] specifications with the exception of provider constraints; therefore, comparisons to the HEDIS[®] national means are approximate and for illustrative purposes only.
- *Antidepressant medication management.* In STAR+PLUS, the rate for the acute phase of treatment was 53 percent, which is higher than the HHSC Dashboard standard of 43 percent. The rate for the continuation phase of treatment was 36 percent, which is higher than the HHSC Dashboard standard of 24 percent. In NorthSTAR, the rate for the acute phase of treatment was 58 percent, and the rate for the continuation phase of treatment was 42 percent. Overall, rates for NorthSTAR decreased from 2010 to 2011.
- *Initiation and engagement of alcohol and other drug dependence treatment.* Results for treatment initiation ranged from 25 percent in NorthSTAR to 39 percent in STAR, and results for treatment engagement ranged from five percent in NorthSTAR to 11 percent in STAR. The STAR rates for treatment initiation and engagement were lower than their respective HEDIS[®] means (43 percent and 14 percent, respectively).

Preventive Care

- *Adult BMI assessment.* In 2011, 57 percent of STAR+PLUS members had their BMI documented. From 2010 to 2011, the rate of BMI assessment increased by 11 percentage points.
- *Weight assessment and counseling for nutrition and physical activity for children/adolescents.* Approximately one-third of STAR and CHIP members had their BMI percentile documented. Regarding counseling for children in STAR and CHIP, about half received counseling for nutrition, and about 42 percent received counseling for physical activity. STAR performed below the HEDIS[®] mean of 38 percent for the BMI percentile documentation sub-measure, above the HEDIS[®] mean of 46 percent for counseling for nutrition, and above the HEDIS[®] mean of 37 percent for counseling for physical activity. STAR performance across all three measures increased from 2010 to 2011.

EQRO Recommendations for FY 2011

This report concludes with a list of recommendations made by the EQRO in FY 2011 and FY 2012, compiled from quality of care reports and member survey reports to improve the quality of care delivered to Texas Medicaid and CHIP members. The list of recommendations focuses on those that address common issues in quality of care across programs, and HHSC's overarching goals for STAR, STAR+PLUS, CHIP, and STAR Health. Recommendations are reported in the following domains:

- 1) Effectiveness of outpatient/ambulatory care for chronic conditions;
- 2) Acute respiratory care for children;
- 3) Obesity screening and management; and
- 4) Service coordination in STAR+PLUS.

Moving forward, the EQRO, in consultation with HHSC, will be conducting more in-depth analyses on a subset of quality of care indicators, which will be the focus of the pay-for-quality initiatives in Texas.

Introduction

The delivery of affordable, high-quality health care is a challenge the U.S. health care system has faced for decades, and has become increasingly important in a political climate that seeks to address federal and state budget deficits while also improving access to health care. A recent study by the Commonwealth Fund found that the United States spends more on health care per capita than 12 other industrialized countries, yet at the same time performs poorly on many quality indicators, including cervical cancer survival rates, asthma-related deaths, and amputations resulting from diabetes.¹

Much of the effort to improve the affordability and quality of healthcare focuses on services delivered through state public insurance programs, such as Medicaid and the Children's Health Insurance Program (CHIP), which will expand in some states in 2014 through the Patient Protection and Affordable Care Act.² Concerns about the efficiency of health services have led many states to turn to managed care as the predominant delivery model for these programs. In contrast to the fee-for-service model, managed care is distinguished by a number of practices intended to improve access to care and control health care costs, including:³

- 1) Ensuring that members have a *medical home* – a primary care provider (PCP) or team of professionals that follows a person-based approach to provide comprehensive and continuous preventive and primary care.
- 2) Establishing a network of providers under contract with the managed care organization (MCO), which is obligated to maintain access standards established by the state.
- 3) Conducting utilization review and utilization management to monitor and evaluate the appropriateness, necessity, and efficacy of health services.
- 4) Implementing quality assessment and performance improvement (QAPI) programs, which assess performance using objective standards to lead to improvements in the structure and functioning of health services delivery.

Currently, about 66 percent of Medicaid beneficiaries receive services through managed care nationally.⁴ This proportion is expected to rise as more states expand their Medicaid managed care programs. In 2012, all states except Alaska, New Hampshire, and Wyoming operated comprehensive Medicaid managed care programs, either through MCOs or Primary Care Case Management (PCCM) programs.⁵ Many of these states also had risk-based PHP arrangements or other "limited benefit plans" for services such as behavioral health, dental care, or non-emergency medical transportation. Cost-containment continued to be a strong emphasis in state Medicaid programs, although small improvements in the economy allowed many states to implement targeted program improvements, such as continued expansion of community-based long-term care options. These program improvements are part of a larger initiative by many Medicaid programs to reform managed care practices and care coordination strategies.

The state of Texas conducted its first Medicaid managed care pilot programs in 1991, and passed legislation in 1995 to enact a comprehensive restructuring of the Medicaid program, incorporating a managed care delivery system.⁶ In 2011, the number of Texas Medicaid

members enrolled in a managed care program had reached 71 percent.⁷ During the summer of 2011 the Texas Legislature passed Senate Bill 7, mandating a statewide expansion of Medicaid managed care, which previously was limited to large urban areas.⁸ In August 2011, the state awarded \$10 billion in Medicaid managed care contracts, following the largest request for proposals in the history of such contracting.⁹ Since this time, the following managed care expansions have occurred:

- February 2011: Due to the termination of operations of the Integrated Care Management (ICM) program in the Dallas and Tarrant service areas, the STAR+PLUS program expanded into these service areas in February 2011 to provide acute and long-term services to blind, aged, and disabled Medicaid members.
- September 2011: The STAR program expanded into 28 counties contiguous to six of the current Medicaid managed care service areas. The expansion of STAR included combining the Harris and Harris Expansion Service Areas into one service area, and forming the new Jefferson Service Area. The STAR+PLUS program expanded into 21 counties contiguous to six of the current Medicaid managed care service areas. The expansion of STAR+PLUS included combining the Harris and Harris Expansion Service Areas into one service area, expanding most of the existing service areas to cover new counties, and forming the Jefferson Service Area.
- March 2012: A major expansion of Medicaid managed care included the addition of one county to the El Paso service area and six counties to the Lubbock service area; creation of the new Hidalgo service area, which covers ten counties; and the expansion of STAR into 164 counties in the Rural Service Area (RSA), previously served by PCCM.¹⁰ In addition, members in STAR, STAR+PLUS, and CHIP began receiving pharmacy benefits through managed care, and most children and young adults in Medicaid began receiving dental benefits through managed care. Previously only CHIP members received their dental services through managed care; Medicaid enrollees received fee-for-service (FFS) dental services.

External Quality Review in Texas Medicaid and CHIP

When states and health plans make changes to the structure of health care delivery to control spending, the result can compromise the quality of health care. The Institute of Medicine defines health care *quality* as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹¹ High quality of care requires that health care delivery be safe, effective, patient-centered, timely, efficient, and equitable. Given the recent cost-containment and managed care expansion strategies being implemented nationwide, evaluation research into the quality of care delivered to Medicaid members is of particular and timely importance.

Federal regulations require external quality review of Medicaid managed care programs to ensure compliance of state programs and their contracted MCOs with established standards.¹² States are required to validate MCO performance improvement projects (PIPs), validate MCO performance measures, and assess MCO compliance with member access to care and quality

of care standards. In addition to these required activities, states may also validate member-level data; conduct consumer surveys, provider surveys, or focus studies; assess performance improvement projects; and calculate performance measures. The Centers for Medicare and Medicaid Services (CMS) provides guidance for these mandatory and optional activities through protocols for evaluating the state's quality assessment and improvement strategy.¹³

Through a contract with the Texas Health and Human Services Commission (HHSC), the Institute for Child Health Policy (IHP) at the University of Florida has served as the Texas External Quality Review Organization (EQRO) since 2002. Following CMS protocols, IHP measures access, utilization, and quality of care for members in Texas Medicaid and CHIP, and produces an annual summary of evaluation activities conducted during the prior year. This report summarizes the findings of EQRO activities conducted during fiscal year (FY) 2011 (September 1, 2010 to August 31, 2011), as well as activities using FY 2011 or calendar year (CY) 2011 data, providing an annual profile of Texas Medicaid and CHIP MCO performance.¹⁴

To further assist Texas HHSC and participating MCOs in the development and implementation of future quality improvement strategies, this report shows performance trends for selected quality of care measures from 2009 through 2011. Most of the trends presented in this report are at the program level (e.g., STAR, CHIP). The report includes a separate appendix of profiles of each MCO participating in Texas Medicaid and CHIP during FY 2011, showing each MCO's available FY/CY 2011 results on HHSC Performance Indicator Dashboard measures and presenting the MCO's three-year trends for selected performance measures.

A summary of the EQRO's recommendations to Texas HHSC in its FY 2011 activities is listed in **Appendix A**. The recommendations for Texas Medicaid and CHIP should be considered for future quality improvement initiatives in the coming year.

Managed Care Programs and Participating MCOs

In FY 2011, Texas Medicaid and CHIP benefits were administered through the following programs:

- **STAR** – The State of Texas Access Reform (STAR) program is a managed care program established to reduce service fragmentation, increase access to care, reduce costs, and promote more appropriate use of services. In FY 2011, services were provided to STAR members through 14 MCOs and in nine service areas, as listed in **Table 1**.
- **PCCM** – The Primary Care Case Management (PCCM) program combined elements of fee-for-service and managed care models, consisting of a non-capitated network of PCPs and hospitals under contract with HHSC. In FY 2011, services were provided to PCCM members in 202 Texas counties, primarily in rural areas. As part of the Texas Medicaid managed care expansion, PCCM was phased out in FY 2012, and members in these counties began receiving care through STAR and STAR+PLUS. In light of this change, the CY 2011 findings and trends presented for PCCM in this report provide

needed information for quality improvement in STAR and STAR+PLUS MCOs that have moved into former PCCM areas.

- **STAR+PLUS** – The STAR+PLUS program integrates acute health services with long-term care services using a managed care delivery system. STAR+PLUS serves members who are elderly or who have a physical or mental disability, and who qualify for Supplemental Security Income (SSI) benefits or for Medicaid due to low income. The program also serves non-SSI adults who qualify for Medicaid because they receive home and community-based services. In FY 2011, services were provided to STAR+PLUS members through five MCOs operating in seven service areas (**Table 1**). The HealthSpring MCO began operation in STAR+PLUS in May 2011. As many of the quality measures presented in this report require at least one full year of data, HealthSpring is not represented in all results.
- **STAR Health** – STAR Health is a managed care program for children in state conservatorship and young adults previously in state conservatorship. Implemented in April 2008, the program offers an integrated medical home where each member has access to PCPs, dentists, behavioral health clinicians, and other specialists. In FY 2011, the exclusive MCO for STAR Health was Superior HealthPlan Network.
- **NorthSTAR** – NorthSTAR is a carve-out program available to STAR and STAR+PLUS members living in the Dallas service area who need behavioral health services. These members receive behavioral health services through ValueOptions, which is contracted with the Texas Department of State Health Services (DSHS) as the exclusive behavioral health organization for NorthSTAR. This contract is separate from the direct contracts between HHSC and the STAR and STAR+PLUS health plans. NorthSTAR provides an innovative approach to behavioral health service delivery, including: (1) blended funding from state and local agencies; (2) integrated treatment in a single system of care; (3) care management; (4) data warehouse and decision support for evaluation and management; and (5) services provided through a fully capitated contract with a licensed behavioral health organization (BHO).
- **CHIP** – The Children's Health Insurance Program is designed for families whose income is too high to qualify for Medicaid but who cannot afford private insurance for their children. CHIP provides eligible children with coverage for a full range of health services, including regular checkups, hospital visits, immunizations, prescription drugs, lab tests, and X-rays. In FY 2011, services were provided to CHIP members through 15 health plans operating in nine service areas – including the CHIP Rural Service Area (RSA) (**Table 1**).
 - *CHIP Dental* – CHIP Dental provides dental services to members through a single, state-wide managed care plan. In FY 2011, the sole dental benefit contractor for CHIP Dental was Delta Dental Insurance Company.
 - *CHIP Perinate* – CHIP Perinate expands CHIP services to unborn children of low-income women who earn too much money to qualify for Medicaid. Benefits

and eligible services are limited to prenatal care, labor and delivery, and postpartum care associated with the birth of the child. After birth, the newborn receives full CHIP benefits.

Table 1. Texas Medicaid and CHIP MCOs and Service Areas in FY 2011^a

Health Plan	STAR	STAR+PLUS	CHIP
Aetna	✓		✓
Amerigroup	✓	✓	✓
Community First	✓		✓
Community Health Choice (CHC)	✓		✓
Cook Children's	✓		✓
Driscoll	✓		✓
El Paso First	✓		✓
FirstCare	✓		✓
HealthSpring		✓	
Molina	✓	✓	✓
Parkland Community	✓		✓
Seton			✓
Superior	✓	✓	✓
Texas Children's	✓		✓
UniCare	✓		✓
UnitedHealthcare-Texas (UHC-TX) ^b	✓	✓	✓
Service Area	STAR	STAR+PLUS	CHIP
Bexar	✓	✓	✓
Dallas ^c	✓	✓	✓
El Paso	✓		✓
Harris	✓	✓	✓
Jefferson	✓	✓	
Lubbock	✓		✓
Nueces	✓	✓	✓
Rural service area (RSA)			✓
Tarrant ^c	✓	✓	✓
Travis	✓	✓	✓

^a STAR Health was served by one MCO – Superior HealthPlan Network – and operated statewide. NorthSTAR was served by ValueOptions (a BHO), and operated in the Dallas service area. CHIP Dental was served by Delta Dental, and operated statewide.

^b Throughout certain sections of the report, the UnitedHealthcare-Texas MCO is referred to as Evercare in the context of its performance in STAR+PLUS.

^c STAR+PLUS expanded into the Dallas and Tarrant service areas in February 2011.

The listed service areas account for the merging of the Harris and Harris Expansion service areas, as well as the creation of the Jefferson service area in September 2011. As many of the quality measures discussed in this report require at least one full year of data, the Jefferson service area is not represented in all results.

EQRO Activities

The EQRO annually conducts the following activities to address the mandatory and optional external quality review functions for evaluating Medicaid Managed Care and CHIP:

1. Ongoing Monitoring and Improvement of Data Quality
 - a. MCO Data Submission
 - b. Claims and Encounter Data Quality Certification
 - c. Encounter Data Validation (EDV)
2. Evaluation of MCO Structure and Processes
 - a. MCO Administrative Interviews
 - b. Evaluation of MCO QAPI Programs
 - c. Evaluation of MCO PIPs
 - d. Provider Office Surveys
3. Quality of Care Assessment
 - a. Member Satisfaction Surveys
 - b. Calculation of Performance Measures
 - c. Focus Studies
4. Health-Based Risk Analysis
5. Resources and Guidance for MCOs
 - a. Training/Continuing Education Sessions
 - b. Tools for Disseminating Quality of Care Results

EQRO survey projects are specific to particular populations, and their content can vary from year to year. Member satisfaction surveys conducted in FY 2012 for adults in STAR and STAR+PLUS and for children in STAR Health were completed prior to the publication of this report; therefore, results from these studies are available and summarized where appropriate. In FY 2011, the EQRO conducted member surveys with parents of children enrolled in CHIP, STAR, and PCCM, and with adults enrolled in STAR+PLUS. In addition, behavioral health surveys were conducted in FY 2012 with adults in STAR, and in FY 2011 with parents of

children in STAR and with adults in STAR+PLUS. Results are also available for dual-eligible members in STAR+PLUS from surveys conducted in FY 2011 and 2010. Changes in survey results were assessed across the four-year period from 2009 through 2012.

Results of administrative measures, such as the Healthcare Effectiveness Data and Information Set (HEDIS[®]), were reported using CY 2011 data for STAR, CHIP, STAR+PLUS, STAR Health, NorthSTAR, and CHIP Dental. The set of measures for each program varies, with measures being selected according to the demographic and health profile of the program's members. There are a number of measures specific to adults (e.g., HEDIS[®] Comprehensive Diabetes Care, HEDIS[®] Antidepressant Management, and others) that were not calculated for CHIP or STAR Health because the vast majority of members in these programs do not meet the age criteria for the adult measures. For CHIP Dental, the EQRO calculated a single administrative measure – HEDIS[®] Annual Dental Visit. In addition, the measure set for STAR Health was more limited than the measure sets for STAR and CHIP.¹⁵ For more information, readers can consult the EQRO's Quality of Care reports for these programs.¹⁶

It is important to note that, while the STAR Health program includes young adults (up to age 23), only six percent of STAR Health members were 19 years or older in CY 2011 (n = 1,792). Due to the relatively small group of adult members in STAR Health, HEDIS[®] measures specific to adults were not run for STAR Health, and no adult surveys in STAR Health were conducted.

The EQRO conducted one focus study in FY 2011 (the STAR+PLUS Long-Term Care Focus Study), which used member survey data to assess the health and functional status of STAR+PLUS dual-eligible members who need long-term services and supports. Baseline data for this study were collected using the Medicare Health Outcomes Survey (MHOS), and will be compared with data to be collected from the same members in the coming year. The EQRO also conducts special quarterly studies on health care quality topics of importance to the state (the Quarterly Topic Reports). In FY 2011 and FY 2012, the EQRO's Quarterly Topic Reports used 3M Health Information Systems (HIS) measures to calculate rates and expenditures associated with potentially preventable events (PPEs), such as potentially preventable hospital admissions (PPAs) and readmissions (PPRs).

To promote continued improvements in quality of care for Texas Medicaid and CHIP members, the EQRO also provides resources and guidance for MCOs, such as training and continuing education sessions, and the development of tools to assist in the dissemination of quality of care results to health plans and members. In FY 2011, the EQRO held two MCO Quality Forums in Austin, Texas, which were attended by state and MCO stakeholders, including health plan quality improvement staff. In FY 2012, the EQRO began two initiatives to develop tools for disseminating quality of care information: (1) the Texas Healthcare Learning Collaborative web portal – an online resource for health plans to access and analyze their results on important quality of care measures, including PPE measures; and (2) the MCO Report Cards, which

summarize quality of care information in a way that is accessible to Medicaid members, allowing members to make informed decisions when selecting their health plans.

Detailed methodologies for the EQRO activities are available in previous reports approved by HHSC, many of which are available online through the HHSC publications website.¹⁷

Conceptual Framework

Quality is defined, measured, and improved across three elements of health care: (1) *structure* – the organization of health care; (2) *process* – the clinical and non-clinical practices that comprise health care; and (3) *outcomes* – the effects of health care on the health and well-being of the population.^{18,19} Within this framework, structure and process can affect outcomes of care independently, and measurement of one element can lead to quality improvements in another. To these three aspects are added individual-level factors (e.g., demographic characteristics) and environmental factors (e.g., neighborhood poverty) that are not part of the health care system, but which nevertheless have an important impact on outcomes of care.

Following the aims for quality improvement outlined by the Institute of Medicine, improvements in structure, process, and outcomes are realized through addressing six general characteristics of quality health care: (1) efficiency; (2) effectiveness; (3) equity; (4) patient-centeredness; (5) timeliness; and (6) safety.²⁰ Furthermore, in evaluating quality of care in Texas Medicaid and CHIP, the EQRO assesses a number of more specific dimensions of care, including access and utilization, member satisfaction, and health plan and provider compliance with evidence-based practices.

This report follows a framework based on these concepts to present findings in a way that is both useful and meaningful for readers. The report is divided into six sections:

Section 1 addresses the demographic and health characteristics of Texas Medicaid and CHIP members using data from MCO claims and encounters, as well as from member surveys.

Section 2 addresses access and utilization of care in Texas Medicaid and CHIP. Using administrative measures from the Healthcare Effectiveness Data and Information Set (HEDIS[®]) and the Agency for Healthcare Research and Quality (AHRQ), the EQRO assesses access to and utilization of pediatric and adult preventive care, ambulatory care, inpatient services, and mental health services.

Section 3 addresses the structure and process of Medicaid managed care in Texas. Using encounter data validation studies, administrative interviews with MCOs, data certification, and evaluation of MCO QAPI programs and PIPs, the EQRO assesses MCO data management capabilities and data quality, disease management programs, and quality improvement practices.

Section 4 addresses Texas Medicaid and CHIP member satisfaction with care. Findings include results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey and the Experience of Care and Health Outcomes (ECHO) behavioral health survey, assessing members' experiences and satisfaction with timeliness of care, access to primary and specialist care, the patient-centered medical home, customer service, and care coordination.

Section 5 addresses the effectiveness of care in Texas Medicaid and CHIP. Using a number of HEDIS[®] and HEDIS[®]-based administrative measures, the EQRO assesses provider compliance with evidence-based practices and member compliance with treatment regimens regarding acute respiratory care, care for chronic conditions, behavioral health care, and preventive care.

Section 6 summarizes special studies and projects conducted by the EQRO in FY 2011 or using FY/CY 2011 data, including the STAR+PLUS Long-Term Care Focus Study, development of the Texas Healthcare Learning Collaborative web portal, and development of MCO Report Cards.

Each of the sections presents CY 2011 results for all Texas programs for which the measures were calculated. Although the report shows results for these programs together, it is important to note that each program serves a different population with unique demographic and health status characteristics. Therefore, in many cases differences in process and outcome measures between the programs are to be expected. Readers should exercise caution when comparing results across the programs.

In addition, for many of the administrative HEDIS[®] measures, the 2011 HEDIS[®] national means for state Medicaid programs are available for comparison with results for the Texas STAR program. All other programs discussed in this report represent populations that are not directly comparable with the national HEDIS[®] means. For measures where HHSC Performance Indicator Dashboard standards are available, these standards are the preferred benchmarks for assessing performance, as they more closely reflect the Texas Medicaid and CHIP populations.

Percentages shown in most figures and tables in this report are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

1 – The Texas Medicaid and CHIP Populations

1.1 – Demographic Characteristics

Assessing demographic characteristics of Medicaid and CHIP members is crucial for defining health service needs and targeting appropriate interventions that are population-specific.

Table 2 shows enrollment trends in Texas Medicaid and CHIP using MCO administrative data for the months of August 2009, August 2010, and December 2011. All programs increased in membership each year, with the exception of PCCM, which declined in membership from 2010 to 2011, following the Medicaid managed care expansion in September 2011. A slight decrease in STAR Health membership was also seen between 2010 and 2011.

Table 2. Enrollment Trends in Texas Medicaid and CHIP, 2009-2011

Number of Members	2009	2010	2011	3-year trend
STAR	1,264,763	1,477,897	1,746,595	+38.1%
PCCM	742,144	849,444	804,327	+8.4%
CHIP	490,646	522,769	562,647	+14.7%
STAR+PLUS (Medicaid-only)	78,245	80,259	137,372	+75.6%
STAR+PLUS (Dual-eligible)	NR	89,152	144,092	+61.6% ^a
STAR Health	30,251	32,523	32,242	+6.6%
NorthSTAR	372,434	421,202	454,565	+22.1%

^a STAR+PLUS enrollment for dual-eligible members was not reported in 2009; therefore the reported trend represents the change in enrollment since 2010.

STAR, STAR+PLUS, and NorthSTAR had the greatest increases in membership over the three-year period, with each program showing an increase of at least 20 percent:

- STAR enrollment increased by more than one-third between 2009 and 2011 (38 percent), to 1,746,595 members in December 2011. Among the programs, STAR had the highest overall increase in enrollment, by more than 480,000 members.
- STAR+PLUS Medicaid-only enrollment increased by more than three-fourths between 2009 and 2011 (76 percent), to 137,372 members in December 2011. Among the programs, STAR+PLUS had the highest increase in relation to its 2009 membership; most of this increase occurred following the Medicaid managed care expansions in February and September 2011.
- STAR+PLUS dual-eligible enrollment increased by nearly two-thirds between 2010 and 2011 (62 percent), to 144,092 in December 2011. Most of this increase also occurred following the Medicaid managed care expansions in February and September 2011.
- NorthSTAR enrollment increased by more than one-fifth between 2009 and 2011 (22 percent), to 454,565 members in December 2011.

Table 3 shows the sex and age distribution of members for each program in December 2011. All programs exhibited a fairly even distribution of male and female members, with the exception of dual-eligible members in STAR+PLUS, among whom nearly two-thirds were female (65 percent).

Table 3. Sex and Age Distribution in Texas Medicaid and CHIP, December 2011

Distribution of Members	Mean Age (yrs.)	Male	Female
STAR	9 (SD=8.0)	47%	53%
PCCM	11 (SD=12.1)	47%	53%
CHIP	10 (SD=4.6)	51%	49%
STAR+PLUS (Medicaid-only)	43 (SD=15.5)	47%	53%
STAR+PLUS (Dual-eligible)	65 (SD=17.0)	35%	65%
STAR Health	8 (SD=6.1)	51%	49%
NorthSTAR	14 (SD=17.8)	48%	52%

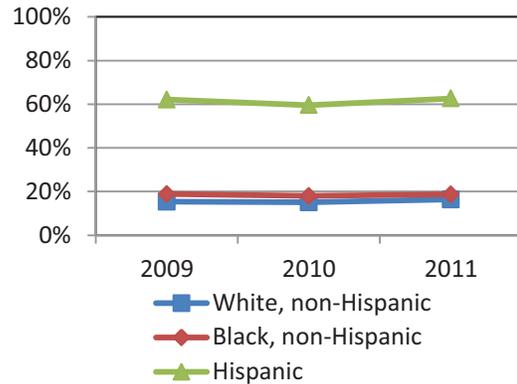
- The mean age in STAR was nine years old, with 36 percent of the population below four years of age and 27 percent of the population between five and nine years old.
- The mean age in PCCM was 11 years old, with 75 percent of the population below 15 years of age.
- The mean age in CHIP was ten years old, with 17 percent of the population below the age of five and 61 percent of the population between 6 and 14 years old.
- The mean age of STAR+PLUS Medicaid-only members, was 43 years old, with 53 percent of the population between 45 and 64 years old. Among dual-eligible members in STAR+PLUS, the mean age was 65 years old, with 53 percent of the population between 45 and 74 years old.
- The mean age in STAR Health was eight years old, with 37 percent of the population between one and five years old and 37 percent between 6 and 14 years old.
- The mean age in NorthSTAR was 14 years old, with 55 percent below the age of ten and 25 percent between 10 and 17 years old.

Figures 1 through 6 present three-year trends in the distribution of members by race/ethnicity in each program. Trends are shown for White, non-Hispanics; Black, non-Hispanics; and Hispanic members (the three most populous groups). Hispanic members were the largest group in every program across all three years, with the exception of STAR+PLUS, where the Hispanic member population dropped below the White, non-Hispanic and Black, non-Hispanic populations following the Medicaid managed care expansion in September 2011. Asian and American Indian members accounted for less than five percent of members in all programs during the

three-year period and are not shown in the figures. Percentages exclude members listed as “unknown” race/ethnicity in the enrollment data.

In STAR, the distribution of members by race/ethnicity was constant from 2009 to 2011. In December 2011, Hispanic members represented 63 percent of the STAR population, followed by Black, non-Hispanic members (19 percent), and White, non-Hispanic members (16 percent). Asian members accounted for about two percent, and American Indian members accounted for less than one percent of the STAR population.

Figure 1. STAR Members by Race/Ethnicity, 2009-2011



In CHIP, the distribution of members by race/ethnicity changed slightly from 2009 to 2011. In December 2011, Hispanic members represented 61 percent of the CHIP population, which decreased from 65 percent in 2009. The next largest group was White, non-Hispanic members, who increased minimally from 20 percent in 2009 to 23 percent in 2011. The percentage of Black, non-Hispanic members remained at about 12 percent across the three-year period. Asian members accounted for about four percent, and American Indian members accounted for less than one percent of all CHIP members during the three-year period.

In STAR+PLUS, the distribution of Medicaid-only members by race/ethnicity changed considerably following the Medicaid managed care expansion in September 2011. In December 2011, Black, non-Hispanics represented 38 percent of the STAR+PLUS population, following an increase from 31 percent in 2010. The next largest group was White, non-Hispanic members, with an increase from 26 percent in 2010 to 33 percent in 2011. The proportion of Hispanic members decreased from 33 percent in 2010 to 26 percent in 2011. Asian members accounted for about three percent, and American Indian members accounted for less than one percent of all STAR+PLUS Medicaid-only members during the three-year period.

Figure 2. CHIP Members by Race/Ethnicity, 2009-2011

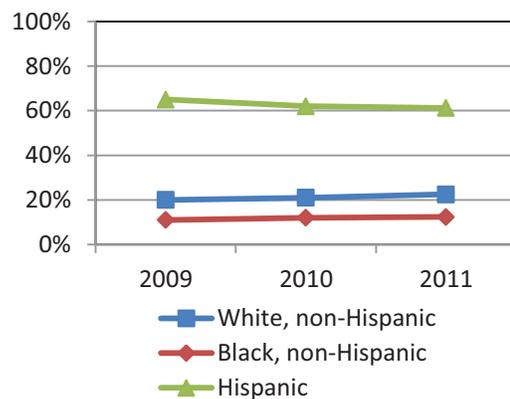


Figure 3. STAR+PLUS Medicaid-only Members by Race/Ethnicity, 2009-2011

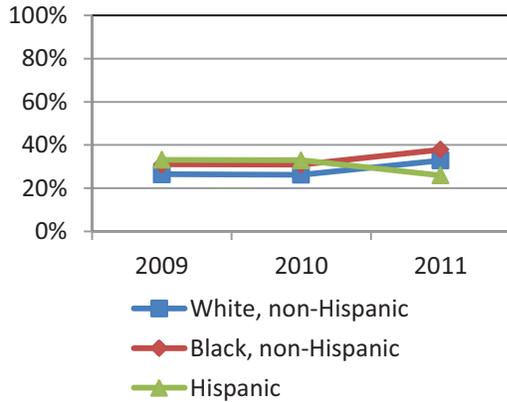
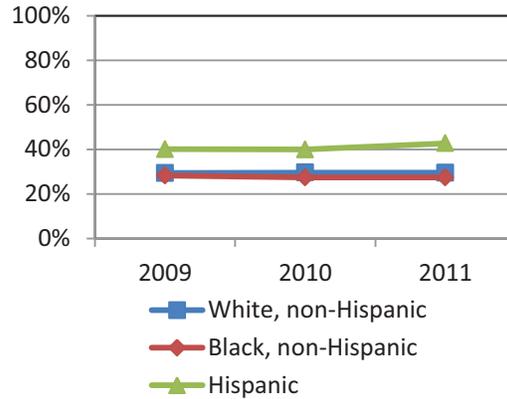


Figure 4. STAR Health Members by Race/Ethnicity, 2009-2011



In STAR Health, the distribution of members by race/ethnicity was primarily constant from 2009 to 2011, with Hispanic membership increasing slightly from 40 percent to 43 percent during the three-year period. The next largest group was White, non-Hispanic members (29 percent), followed by Black, non-Hispanic members (27 percent). Asian and American Indian members together accounted for less than one percent of all STAR Health members.

In NorthSTAR, the distribution of members by race/ethnicity remained constant from 2009 to 2011. In December 2011, Hispanic members accounted for 51 percent of the NorthSTAR population, following a slight increase from 48 percent in 2009. The next largest group was Black, non-Hispanic members (29 percent), followed by White, non-Hispanic members (16 percent). Asian members accounted for about three percent, and American Indian members accounted for less than one percent of all NorthSTAR members.

Figure 5. NorthSTAR Members by Race/Ethnicity, 2009-2011

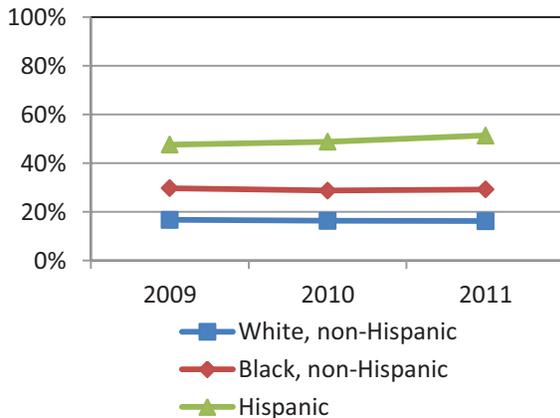
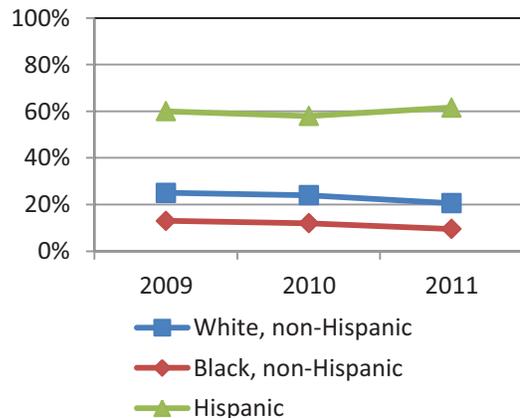


Figure 6. PCCM Members by Race/Ethnicity, 2009-2011



In PCCM, the distribution of members by race/ethnicity changed slightly for all groups following the Medicaid managed care expansion in September 2011. In December 2011, Hispanic members represented 62 percent of the PCCM population, following a slight increase from 58 percent in 2010. The next largest group was White, non-Hispanic members, who decreased from 24 percent in 2010 to 21 percent in 2011, followed by Black, non-Hispanic members, who also decreased slightly from 12 percent in 2010 to 10 percent in 2011. Asian and American Indian members together accounted for less than one percent of all PCCM members during the three-year period.

1.2 – Health Status

Health is a multi-dimensional concept that includes the absence of physical conditions, the absence of pain and/or disability, emotional well-being, and satisfactory social functioning. There is no single standard measurement of health status for individuals or population groups; methods used to assess health can draw from administrative data on health care claims and encounters or from member-reported health status collected in surveys.

Rating health status is important for several reasons. First, knowing the health of a member population allows the program or health plan to determine its health care needs and anticipated utilization. Second, the regular monitoring of health status measurements over time helps to inform an MCO's efforts toward quality improvement (QI), allowing QI staff to determine the effects of interventions on the health outcomes of its members.

This section examines member health status in STAR, CHIP, STAR+PLUS, and PCCM using administrative and survey data collected between SFY 2009 and 2011, and in STAR Health using survey data collected in 2012. Specifically, this section presents findings on: (1) the percentage of child members with special health care needs (MSHCN) in STAR, CHIP, and PCCM, using both Clinical Risk Groups (CRGs) and surveys, and the most common types of special needs among child MSHCN in STAR, CHIP, PCCM, and STAR Health (using surveys); (2) caregiver-reported health status of child members in STAR, CHIP, PCCM, and STAR Health; (3) self-reported health status and activities of daily living (ADL) of adult members in STAR+PLUS; and (4) obesity rates among children in STAR, CHIP, PCCM, and STAR Health, and adults in STAR+PLUS.

Child Member Health Status

To ensure quality of care for children in Medicaid and CHIP, it is important to identify children with special health care needs (CSHCN) in programs and health plans.

The Federal Maternal and Child Health Bureau defines *CSHCN* as:²¹

- children who have or are at an 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 children generally.

In this report, CSHCN are referred to as child “MSHCN” – “members with special health care needs” – to be consistent with terminology used in the Texas Medicaid program.

The EQRO uses two methods for identifying child MSHCN: (1) CRG classification using International Classification of Diseases, 9th Revision (ICD-9-CM) and Current Procedural Terminology (CPT) codes from health care claims and encounter data;^{22,23} and (2) survey-based classification using the CSHCN Screener[®].²⁴

Clinical Risk Group (CRG) categories

- 1) Healthy
- 2) Significant Acute Conditions
- 3) Minor Chronic Conditions
- 4) Moderate Chronic Conditions
- 5) Major Chronic Conditions

This report presents findings on the percentage of child MSHCN in STAR, CHIP, and PCCM using the CRG classification system. Five CRG categories are reported, ranging from healthy children to children with major chronic conditions. The *Significant Acute Conditions* category includes

illnesses or injuries, such as head injury with coma or meningitis, which could place a child at risk for developing a chronic condition. *Minor Chronic Conditions* include illnesses that can usually be managed effectively with few complications, such as hearing loss or attention deficit/hyperactive disorder (ADHD). *Moderate Chronic Conditions* include illnesses that vary in their severity and progression, can be complicated, and require extensive care, such as asthma, epilepsy, or major depression. *Major Chronic Conditions* are serious illnesses that often result in progressive deterioration, debilitation, and death, such as active malignancies or cystic fibrosis. Children in the three chronic conditions categories together are classified as MSHCN.

Percentage of Child MSHCN

Table 4 presents the percentage of child MSHCN in the STAR, CHIP, and PCCM populations in 2011 (assessed using both CRGs and surveys), and in STAR Health in 2012 (assessed by survey only). STAR Health had a considerably higher percentage of child MSHCN than the other programs (48 percent), at more than double the rates observed in STAR (18 percent) or CHIP (20 percent) using the survey.

- When CRGs were used to classify children, the PCCM program showed an increase in the percentage of child MSHCN from 23 percent in 2010 to 27 percent in 2011. Both STAR and CHIP members had similar rates of child MSHCN in 2011 (16 percent and 15 percent, respectively). Rates have remained constant for STAR and increased nominally for CHIP during the three-year period.
- Use of the survey-based CSHCN Screener produced slightly higher rates than CRG-based rates in STAR and CHIP, and a lower rate in PCCM. The proportion of child MSHCN in STAR and CHIP was slightly above the national average of 14 percent for the general population, estimated by the 2009/2010 National Survey of CSHCN.²⁵

Table 4. Percentage of Child Members with Special Health Care Needs, by Program

Program	Year of study	% MSHCN (CRG)	% MSHCN (survey)
STAR	2011	16%	18%
PCCM	2011	27%	23%
CHIP	2011	15%	20%
STAR Health	2012	-	48%

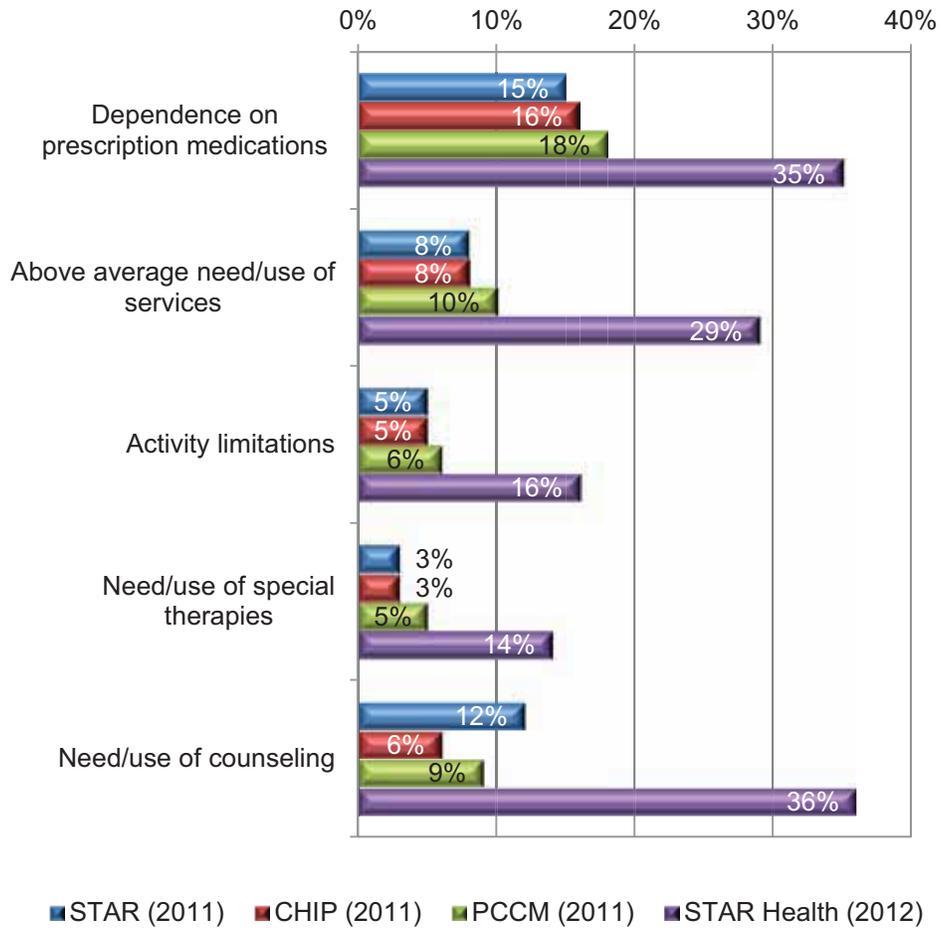
Child MSHCN Characteristics

Caregiver surveys administered by the EQRO include questions regarding five types of special needs among child MSHCN: (1) Dependence on medication; (2) Greater than routine use of health and educational services; (3) Functional/ability limitations (compared with other children their age); (4) Need for/use of special therapies; and (5) Need for/use of mental health treatment or counseling.

Figure 7 provides the percentage of members in STAR, CHIP, and PCCM who met the criteria for each of the five child MSHCN categories in FY 2011, and the percentage of members in STAR Health who met these criteria in FY 2012.²⁶ In STAR, CHIP, and PCCM, the most common special health care need was dependence on prescription medications (15 percent for STAR, 16 percent for CHIP, 18 percent for PCCM). The second most common special health care need varied across the programs. In STAR, need for/use of mental health treatment or counseling was the second-most common special health care need (12 percent). In CHIP and PCCM the second-most common special need was use of more medical care, mental health, or education services than is usual for most children (8 percent and 10 percent, respectively). Across the three-year period, the distribution of special needs among child MSHCN was relatively constant in STAR and CHIP, with STAR reporting an increase in need for counseling from seven percent in 2009 to 12 percent in 2011.

The prevalence of special needs was considerably higher in STAR Health, based on the FY 2012 STAR Health Caregiver Survey. In STAR Health, more than one-third of members were dependent on medications (35 percent) or had problems that required mental health treatment or counseling (36 percent). More than one-fourth of STAR Health members also had use of more medical care, mental health, or educational services than is usual for most children (29 percent). The percentage of STAR Health members who had functional/ability limitations or need/use of special therapies in 2012 was 16 percent and 14 percent, respectively. The higher rates of special needs in STAR Health are expected, as this program serves the population of children in foster care.

Figure 7. Characteristics of Child MSHCN in STAR, CHIP, PCCM, and STAR Health



Caregiver-Reported Child Member Health Status

Figure 8 shows parent-reported child member health status in STAR, CHIP, and PCCM for 2011, and in STAR Health in 2012. Both STAR and CHIP had an increase in child member health status from previous years. In STAR, parent-reported child health status (“excellent” or “very good”) increased from 65 percent in 2009 to 71 percent in 2011. In CHIP, this rate increased from 68 percent in 2010 to 73 percent in 2011.

Childhood Obesity Rate

BMI values were calculated using caregiver-reported height and weight data for children enrolled in STAR, CHIP, PCCM, and STAR Health. For children and adolescents less than 18 years old, BMI classification depends on the child's sex and age, and is determined using the CDC's BMI-for-age growth charts.²⁷ **Figure 9** displays the reported obesity rate in STAR, CHIP and PCCM. PCCM had the highest rate of child/adolescent obesity, with 31 percent of members classified as obese. STAR showed a decrease in the rate of child/adolescent obesity from 33 percent in 2009 to 28 percent in 2011. CHIP had the lowest child/adolescent obesity rate among the programs, and also showed a decrease over two years, from 28 percent in 2010 to 25 percent in 2011.

Figure 8. Percent of Caregivers who Reported Their Child's Health was "Excellent" or "Very Good" in STAR, CHIP, PCCM, and STAR Health

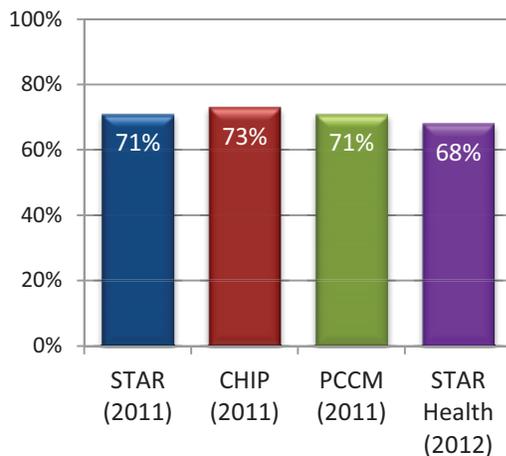
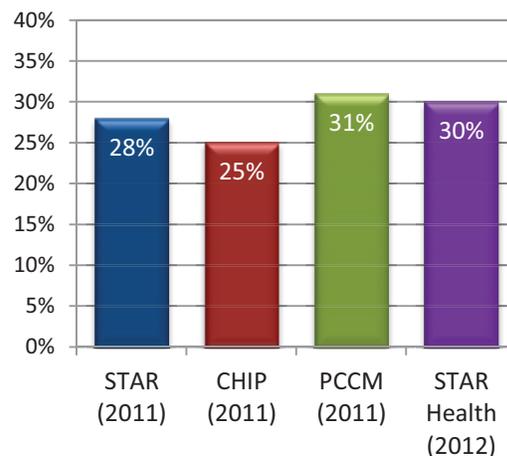


Figure 9. Reported Child/Adolescent Obesity Rates in STAR, CHIP, PCCM, and STAR Health



STAR+PLUS Member Health Status

Each year, STAR+PLUS members are asked a series of questions about their health status, ranging from general health to specific domains such as mental health and role and activity limitations due to physical or emotional problems. Rating health status is important for two major reasons. First, this information forms a baseline to track changes in health status over time. Second, such information can assist in program planning and financing. Assessing the percentage of members who are in poor health or who have chronic conditions is important to ensure adequate provider access, appropriate range of services, and financing for health services.

Member-Reported Health Status

Overall, STAR+PLUS member self-rated health status was low, with over 60 percent of Medicaid-only and dual-eligible members reporting “fair” or “poor” health across the three-year period. In 2009 and 2011, only 14 percent of Medicaid-only STAR+PLUS members rated their health as “excellent” or “very good”. This rate increased negligibly to 15 percent in 2012. Among STAR+PLUS dual-eligible members, 16 percent reported being in “excellent” or “very good” health in both 2010 and 2011. Low health status rates are generally expected for the STAR+PLUS population due to higher rates of chronic illness and disability in this program.

<u>STAR+PLUS Member Self-Reported Health Status</u>		
	STAR+PLUS Medicaid-only	STAR+PLUS Dual-eligible
	2012	2011
Overall health		
“Excellent” or “Very Good”	15%	16%
“Good”	22%	23%
“Fair or Poor”	64%	62%
Mental health		
“Excellent” or “Very Good”	26%	27%
“Good”	24%	29%
“Fair or Poor”	50%	44%

Note: Percentages shown in most figures and tables are rounded to the nearest whole number; therefore, percentages may not add up to 100 percent.

Self-reported mental health status among STAR+PLUS members was generally higher, with more than one-fourth of Medicaid-only members in 2012 and dual-eligible members in 2011 reporting their mental health as “excellent” or “very good” (26 percent and 27 percent, respectively).

Activities of Daily Living

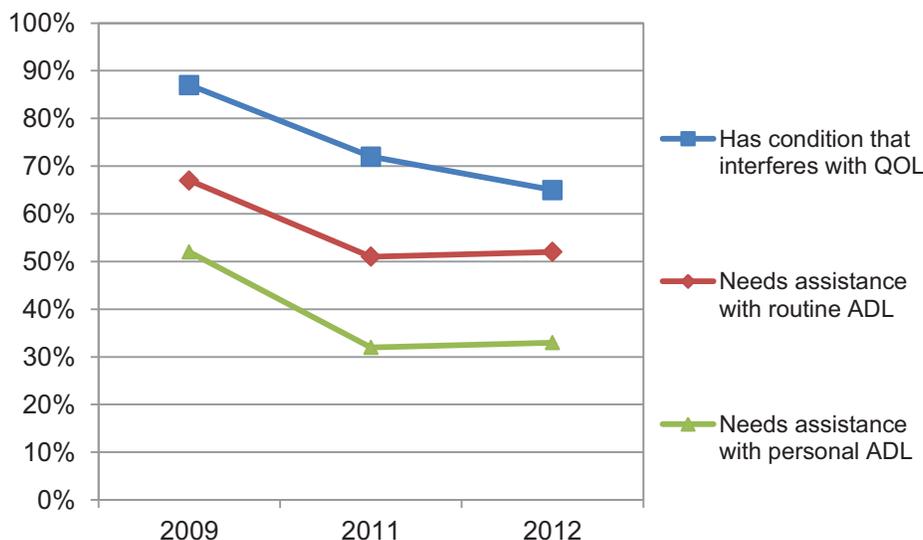
An important component of health status involves a person’s independence and ability to perform specific tasks of daily living, in which low levels of functioning indicate disability and dependence on others.

Medicaid-only and dual-eligible STAR+PLUS members generally had high levels of need for assistance with their activities of daily living (ADLs). Approximately two-thirds of members in both eligibility groups reported having a condition that interferes with their quality of life (QOL) – at 65 percent for Medicaid-only members in 2012, and 68 percent for dual-eligible members in

2011. During these same reporting years, 52 percent of Medicaid-only members and 53 percent of dual-eligible members reported needing assistance with *routine needs*, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes. Approximately one-third of members in both eligibility groups reported needing assistance with *personal needs*, such as eating, dressing, or getting around the house (33 percent and 37 percent, respectively).

In the STAR+PLUS Medicaid-only population, some changes were observed in the percentage of members needing assistance with ADLs following the Medicaid managed care expansion in September 2011. **Figure 10** displays the percentage of Medicaid-only members who had a condition that interfered with their QOL, needed assistance with routine ADL, and needed assistance with personal ADL in 2009, 2011, and 2012. For all three rates, a considerable decrease occurred between the 2009 and 2011 reporting periods, suggesting that the expansion that occurred in 2011 added members with higher functional status. It should be noted, however, that similar increases were not observed in self-reported overall or mental health status.

Figure 10. Activities of Daily Living for STAR+PLUS Medicaid-Only Members in 2009, 2011, and 2012



Obesity Rate

BMI values were calculated using self-reported height and weight data for members enrolled in STAR+PLUS. Men and women 18 years of age and older are grouped into one of four clinically relevant BMI categories, which are recognized by the Centers for Disease Control and Prevention (CDC): (1) Underweight (below 18.5); (2) Healthy weight (18.5 to 24.9); (3) Overweight (25.0 to 29.9); and Obese (30.0 and above).²⁸ For the STAR+PLUS Medicaid-only and dual-eligible populations, nearly one-half of all members were considered obese across the three years.

<u>STAR+PLUS Member BMI Classification</u>		
	STAR+PLUS Medicaid-only	STAR+PLUS Dual-eligible
	2012	2011
Underweight	3%	4%
Healthy weight	23%	26%
Overweight	25%	25%
Obese	50%	45%

These findings show a notably high rate of obesity among members in the STAR+PLUS program, suggesting that STAR+PLUS MCOs should continue efforts to monitor, document, and implement interventions for healthy weight.

2 – Access and Utilization of Care

The Institute of Medicine defines *access to health care* as “the timely use of personal health services to achieve the best possible outcomes.”²⁹ Many quality of care metrics evaluate quality only for individuals who actually interacted with the health care system, which can overstate the quality of care received by the general population. Measures of access are therefore critical for understanding whether *all* members in public insurance programs are receiving the care they need, and whether it is being delivered quickly enough to meet their health care needs. Similarly, monitoring the utilization of health services by program can reveal whether members are receiving appropriate levels of care.

2.1 – Preventive Care

Preventive services are crucial for both detecting early signs of disease and for addressing modifiable risk factors of disease. Without timely diagnosis and treatment, risk factors such as obesity, high blood pressure, and high blood glucose levels can lead to chronic diseases.³⁰ Lifestyle choices can also contribute to chronic disease; at least one-third of annual mortality in the United States can be linked to preventable factors such as poor diet, physical inactivity, and cigarette smoking.^{31,32} Regular and effective implementation of preventive efforts for these factors can limit the development of chronic diseases³³ and, in turn, reduce the incidence of preventable deaths.³⁴ Preventive services include screening patients for risk factors and counseling them on healthy lifestyle decisions.

Pediatric Preventive Care

The EQRO uses several measures that assess pediatric preventive care in Texas Medicaid and CHIP, including: (1) *Children and Adolescents’ Access to Primary Care Practitioners*; (2) *Well-Child Visits in the First 15 Months of Life*; (3) *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; (4) *Adolescent Well-Care Visits*; (5) HEDIS[®] *Childhood Immunization Status*; and (6) HEDIS[®] *Annual Dental Visit*.

Access to Primary Care Practitioners

Children and adolescents need access to primary care practitioners (PCPs) in order to receive the care that is necessary for their health and well-being.³⁵ However, at the national level many children do not have access to a PCP.^{36,37} (In Texas, Medicaid MCOs are required to provide a PCP to each of their members.) It is important to identify the children and adolescents who experience barriers to primary care to ensure that they receive the health care services they need.

The EQRO examines PCP accessibility in Texas Medicaid and CHIP using the HEDIS[®]-based measure: *Children and Adolescents’ Access to Primary Care Practitioners*. This measure reflects the percentage of members 12 months to 19 years of age who had a PCP visit during the measurement period (defined as one year for children up to six years old and two years for children and adolescents older than six). The EQRO calculates this measure for STAR, CHIP, and STAR Health. At HHSC’s request, the EQRO lifted provider constraints for this measure,

which may result in inflation of rates. The name “HEDIS®” was removed from discussion of this measure, as it does not conform precisely to NCQA specifications.

<u>Children and Adolescents’ Access to Primary Care Practitioners</u>				
	CY 2011 results 12 to 24 mo.	CY 2011 results 25 mo. to 6 yrs.	CY 2011 results 7 to 11 years	CY 2011 results 12 to 19 years
STAR	98 percent	93 percent	96 percent	95 percent
CHIP	95 percent	90 percent	93 percent	91 percent
STAR Health	99 percent	96 percent	98 percent	98 percent

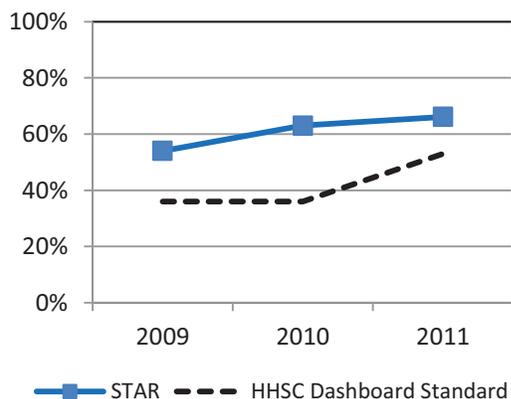
For each of the three programs, members in all age cohorts generally had good access to primary care in CY 2011. Access to PCPs is slightly lower among children 25 months to 6 years old than among members in other age groups. However, all rates were 90 percent or greater.

Well-Child Care

Pediatric well-child visits play an essential role in monitoring a child’s health and development.³⁸ Well-child visits facilitate the identification of childhood illnesses and developmental delays, and provide the opportunity for early intervention at a crucial point in the child’s life.³⁹ Standards regarding the frequency of such visits vary depending upon the age of the child. The American Academy of Pediatrics recommends six well-child visits in the first year of life, and an annual well-child visit for children three to six years of age.⁴⁰ The EQRO uses items that track well-care at three unique stages of development.

To assess whether infants received the recommended level of well-child care, the EQRO uses the HEDIS®-based measure: *Well-Child Visits in the First 15 Months of Life*. This measure reveals the percentage of members who turned 15 months old during the measurement year and who had at least six well-child visits during their first 15 months of life. At HHSC’s request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name “HEDIS®” was removed from discussion of this measure, as it does not conform precisely

Figure 11. Well-Child Visits in the First 15 Months of Life in STAR, 2009-2011



to NCQA specifications. In both STAR and STAR Health, performance on this measure improved from 2009 to 2011.

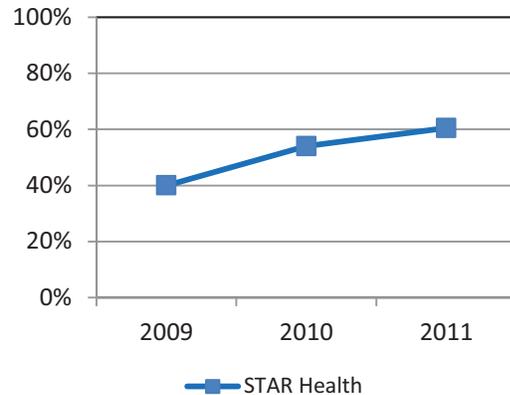
Figure 11 displays rates for this measure in STAR from 2009 to 2011, along with the corresponding HHSC Dashboard standards. The percentage of infants in the STAR program receiving the appropriate number of well-child visits surpassed the HHSC Dashboard standard during all three years. In 2011, two-thirds of eligible STAR members had six or more well-child visits within the first 15 months of life (66

7 – 2009 - 2011

percent), exceeding the HHSC Dashboard standard of 53 percent.

Figure 12 shows rates in STAR Health over the same three-year period. In 2011, 60 percent of eligible children received at least six well-child visits in the first 15 months of life, exceeding the HHSC Dashboard standard of 53 percent. (Note that STAR Health Dashboard standards for this measure were first established in 2011.) Between 2009 and 2011, the rate of well-child visits for infants in STAR Health increased by 20 percentage points.

Figure 12. Well-Child Visits in the First 15 Months of Life in STAR Health, 2009-2011



To measure access and utilization of well-child care among young children, the EQRO uses the HEDIS®-based measure:

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. This measure provides the percentage of members three to six years of age who received one or more well-child visits with a PCP during the measurement year. At HHSC’s request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name “HEDIS®” was removed from discussion of this measure, as it does not conform precisely to NCQA specifications.

Figure 13. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011

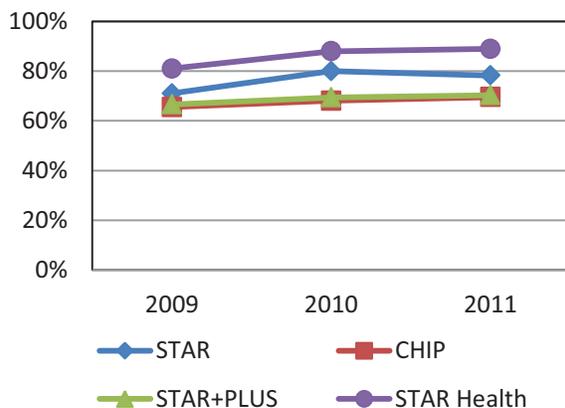


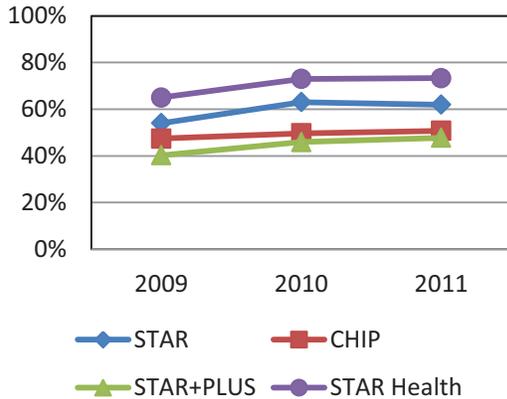
Figure 13 displays program-level results for this measure from 2009 to 2011 for STAR, CHIP, STAR+PLUS, and STAR Health. In general, all four programs demonstrated slight improvements over the three year period.

In 2011, 78 percent of STAR members in this age group had one or more well-child visits within the measurement year. This percentage exceeded both the national HEDIS® mean and HHSC Dashboard standard (72 percent and 71 percent, respectively). In addition, CHIP, STAR+PLUS, and STAR Health all outperformed the HHSC Dashboard standards associated with their programs by five percentage points each.

Well-care visits are also important for adolescents, whose health-related issues are often associated with lifestyle factors such as risky sexual behaviors, unhealthy diet, and use of

alcohol, tobacco, or recreational drugs.⁴¹ The American Medical Association recommends that adolescents have at least one well-care visit annually.⁴²

Figure 14. Adolescent Well-Care Visits in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011



The EQRO uses the HEDIS[®]-based measure *Adolescent Well-Care Visits*, which assesses the percentage of members 12 to 21 years of age who had at least one comprehensive well-care visit with either a PCP or an OB/GYN practitioner during the measurement year. At HHSC’s request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name “HEDIS[®]” was removed from discussion of this measure, as it does not conform precisely to NCQA specifications. **Figure 14** shows program-level trends in adolescent well-care from 2009 to 2011. Results for all four programs slightly improved over this time frame.

In 2011, 62 percent of adolescents in STAR had at least one comprehensive well-care visit within the measurement year. This percentage surpasses both the HHSC Dashboard standard of 51 percent and the national HEDIS[®] mean of 48 percent. Rates in CHIP (51 percent), STAR+PLUS (48 percent), and STAR Health (73 percent) also exceeded the HHSC Dashboard standards for these programs (42 percent, 42 percent, and 45 percent, respectively).

Childhood Immunization

Childhood vaccination is a basic method of disease prevention. Immunizations prevent the spreading of dangerous diseases and ultimately save billions of dollars in direct and societal costs.⁴³ Certain vaccine-preventable illnesses, such as hepatitis, measles, and pertussis, can lead to severe complications, including death.⁴⁴ Infants are especially vulnerable and often have a more severe reaction to infections because their immune systems are still developing.⁴⁵

The Centers for Disease Control and Prevention (CDC) recommends an immunization schedule in a child’s first two years of life against chickenpox, diphtheria, hepatitis (A and B), influenza, measles, mumps, pertussis, polio, pneumococcus, rotavirus, rubella, and tetanus.⁴⁶

The EQRO uses the HEDIS[®] *Childhood Immunization Status* measure to assess whether children in Medicaid and CHIP are receiving these vaccines. This measure represents the percent of two-year-old children who received the recommended series of vaccinations by their second birthday.⁴⁷ In both STAR and CHIP, less than one-half of eligible members had been given the recommended series of vaccinations by their second birthday in CY 2011. However, the STAR program rate for

<u>HEDIS[®] Childhood Immunization Status</u>	
CY 2011 results	
STAR	45 percent
CHIP	39 percent

Childhood Immunization Status exceeded the national HEDIS[®] mean of 32 percent. Among CHIP members, 39 percent of eligible two-year olds received the appropriate immunizations, an improvement of four percent over the previous year's rate.

Access to Dental Care

Good oral health is integral to a child's overall physical well-being. Inadequate dental care during childhood can have negative impacts on speech, growth and social development, nutrition, and quality of life.^{48,49} Yet, millions of children in the United States have insufficient access to needed dental treatment and preventive oral health care.⁵⁰ Children from impoverished families are particularly vulnerable to experiencing problems related to poor dental health, including oral disease and untreated tooth decay.^{51, 52} However, compared to the general population, children from low-income households receive fewer dental services^{53, 54} and are less likely to have routine dental checkups.⁵⁵

<u>HEDIS[®] Annual Dental Visit</u>	
CHIP Dental CY 2011 results	
2 to 3 years old	60 percent
4 to 6 years old	71 percent
7 to 10 years old	73 percent
11 to 14 years old	66 percent
15 to 18 years old	56 percent
19 to 21 years old	48 percent
All members	66 percent

The EQRO evaluates access to dental care and services among members enrolled in CHIP Dental using the HEDIS[®] *Annual Dental Visit* measure. This measure calculates the percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year. Specifications for this measure allow for the calculation of separate rates across six age cohorts, as well as an overall rate. Overall, the rate of annual dental visits in CHIP Dental rose from 59 percent in SFY 2009 to 66 percent in CY 2011, greatly exceeding the 2011 HEDIS[®] national average of 48 percent.

Adult Preventive Care

The EQRO uses six measures to assess adult preventive care in Texas Medicaid: (1) HEDIS[®] *Adults' Access to Preventative/Ambulatory Health Services*; (2) *Prenatal and Postpartum Care*; (3) *Frequency of Ongoing Prenatal Care*; (4) HEDIS[®] *Breast Cancer Screening*; (5) HEDIS[®] *Cervical Cancer Screening*; and (6) HEDIS[®] *Chlamydia Screening in Women*.

Adults' Access to Preventive/Ambulatory Health Services

<u>HEDIS[®] Adults' Access to Preventive/Ambulatory Health Services</u>
STAR+PLUS CY 2011 results

The HEDIS® *Adults' Access to Preventive/Ambulatory Health Services* measure examines the percentage of members who had an ambulatory or preventive care visit during the measurement year. In CY 2011, rates in STAR+PLUS were calculated separately for three age groups: 20 to 44 years old, 45 to 64 years old, and 65 years and older.

20 to 44 years old	72 percent
45 to 64 years old	87 percent
65 years and older	87 percent

In the STAR+PLUS program, members 45 years of age and older generally had good access to preventive care. Eighty-seven percent of members in both older age cohorts (45 to 64 years and 65 years and older) had an ambulatory or preventive care visit in CY 2011. Preventive care was lower among 20- to 44-year-old STAR+PLUS members than among older members. Seventy-two percent of members 20 to 44 years of age had an ambulatory or preventive care visit in CY 2011.

Prenatal and Postpartum Care

Timely prenatal and postpartum care provides the opportunity to screen for health conditions that affect mother and child during and after pregnancy. Depression, diabetes, and anemia are all prenatal and postpartum conditions that can lead to adverse consequences if they are not detected early.^{56,57} The American College of Obstetricians and Gynecologists recommends a prenatal evaluation within the first trimester and a postpartum evaluation on or between 21 days and 56 days after delivery.⁵⁸

<u>Prenatal and Postpartum Care</u>		
CY 2011 results	Prenatal Care	Postpartum Care
STAR	83 percent	59 percent
STAR+PLUS	68 percent	38 percent
STAR Health	72 percent	45 percent

The EQRO uses the *Prenatal and Postpartum Care* measure to analyze two aspects of perinatal care for live births that occurred during the measurement period: (1) *Timeliness of Prenatal Care*: the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment; and (2) *Postpartum*

Care: the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. This measure follows HEDIS® specifications with the exception of provider constraints for Prenatal Care; this should be taken under consideration when making comparisons to HEDIS® national means.

Eighty-three percent of STAR program deliveries received a prenatal visit, and 59 percent of deliveries received a postpartum visit within the specified time periods. These percentages fell slightly short of their corresponding national HEDIS® means (84 percent and 64 percent, respectively), but met their HHSC Dashboard standards (83 percent and 59 percent, respectively).

Figures 15 and 16 show results for the *Prenatal and Postpartum Care* measure from 2009 to 2011 in the STAR+PLUS program. Sixty-eight percent of STAR+PLUS deliveries received a prenatal visit in 2011. Although this rate represented an increase over previous years' performances, STAR+PLUS failed to meet the HHSC Dashboard standard for the third consecutive year.

A similar trend was observed in STAR+PLUS for the *Postpartum Care* sub-measure. The percentage of deliveries receiving a postpartum visit in STAR+PLUS increased slightly across the three-year period (from 31 percent in 2009 to 38 percent in 2011), but failed to meet the HHSC Dashboard standard during all three years.

Figure 15. Timeliness of Prenatal Care in STAR+PLUS, 2009-2011

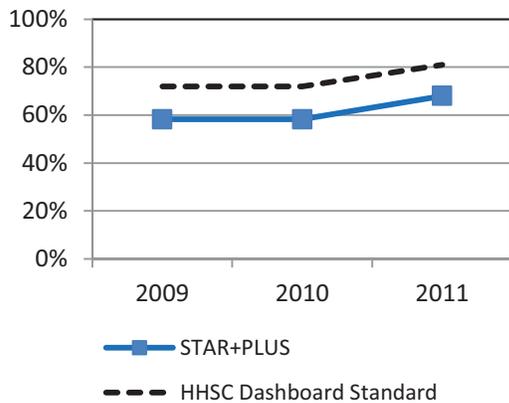


Figure 16. Postpartum Care in STAR+PLUS, 2009-2011

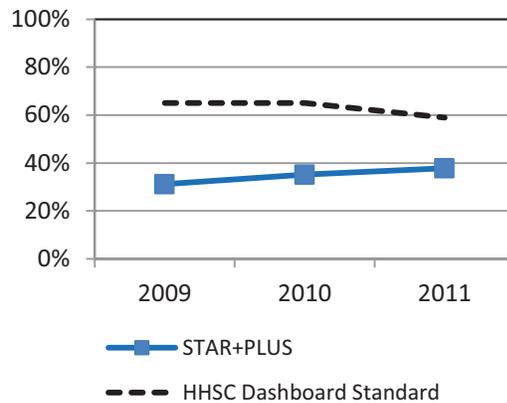


Figure 17. Timeliness of Prenatal Care in STAR Health, 2009-2011

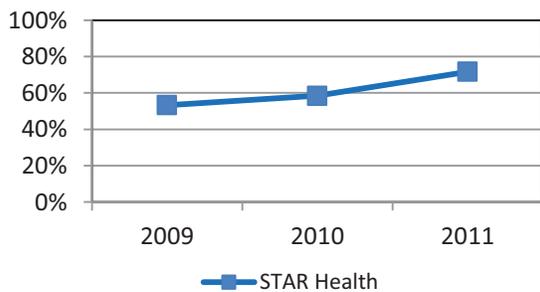


Figure 17 shows results for the *Timeliness of Prenatal Care* sub-measure from 2009 to 2011 in STAR Health. Seventy-two percent of deliveries in STAR Health received a prenatal visit in 2011, which was approximately a 20 percent increase over the 2009 outcome of 53 percent for this measure. Forty-five percent of STAR Health deliveries received a postpartum visit.

Frequency of Ongoing Prenatal Care

The EQRO uses the HEDIS[®]-based measure *Frequency of Ongoing Prenatal Care* to examine women's use of prenatal care services relative to the recommended guidelines of the American College of Obstetricians and Gynecologists for frequency/scheduling of prenatal care. This

measure represents the percentage of deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of prenatal visits (in reference to the recommended number of visits): (1) <21 percent of expected visits; (2) 21-40 percent of expected visits; (3) 41-60 percent of expected visits; (4) 61-80 percent of expected visits; and (5) ≥81 percent of expected visits. At HHSC’s request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name “HEDIS®” was removed from discussion of this measure, as it does not conform precisely to NCQA specifications.

Figure 18. Frequency of Ongoing Prenatal Care in STAR and STAR Health, 2009-2011

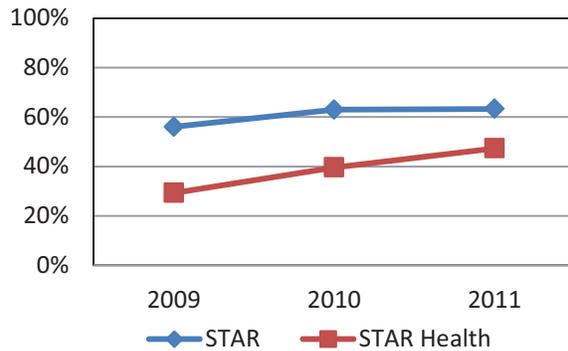


Figure 18 shows the percentage of deliveries in STAR and STAR Health that had greater than 80 percent of the expected prenatal care visits in CY 2011. Sixty-three percent of STAR deliveries had ≥81 percent of expected visits (representing good performance), which exceeded the HEDIS® mean of 61 percent. Forty-seven percent of STAR Health deliveries had ≥81 percent of expected visits, while 40 percent of CHIP deliveries had ≥81 percent of expected visits.

Breast Cancer Screening

Nearly one of every eight women in the U.S. will develop breast cancer during her lifetime.⁵⁹ Screening for breast cancer can reduce the risk for breast cancer mortality by about 20 percent,⁶⁰ and the American Academy of Family Physicians (AAFP) recommends that women between the ages of 50 and 74 get a mammogram every two years.⁶¹

<u>HEDIS® Breast Cancer Screening</u>	
CY 2011 results	
STAR+PLUS	46 percent

The EQRO examines breast cancer screening rates in STAR+PLUS using the HEDIS® *Breast Cancer Screening* measure, which assesses the percentage of women who received a mammogram during the measurement period.

In CY 2011, 46 percent of eligible women in STAR+PLUS had a mammogram to screen for breast cancer during the measurement period. This rate falls below the HEDIS® mean of 51 percent, but is six percentage points higher than the program-level results from 2009.

Cervical Cancer Screening

Pap tests are an effective way to detect cervical cancer, and have helped to reduce the prevalence of cervical cancer by 67 percent in the past 30 years.⁶² Women who receive Pap tests and detect cancer early have a survival rate of nearly 100 percent. Despite the effectiveness of screening for cervical cancer, approximately three out of four women with

<u>HEDIS[®] Cervical Cancer Screening</u>	
CY 2011 results	
STAR	59 percent
STAR+PLUS	40 percent

advanced cervical cancers have not had a Pap test in the past five years.⁶³

The EQRO assesses rates of cervical cancer screening in STAR and STAR+PLUS using the HEDIS[®] *Cervical Cancer Screening* measure, which provides the percentage of women between 21 and 64 years of age

who had at least one Pap test to screen for cervical cancer during the measurement year. In the STAR program, 59 percent of women eligible for this measure had a Pap test to screen for cervical cancer during the CY 2011 measurement period. Of the women eligible for this measure in STAR+PLUS, 40 percent had a Pap test to screen for cervical cancer. The results in both programs fell short of both the HEDIS[®] mean of 67 percent and the HHSC Dashboard standard of 65 percent.

Chlamydia Screening in Women

Over one million Americans are diagnosed with Chlamydia each year,⁶⁴ and an estimated two million additional cases go undiagnosed and untreated. Chlamydia can lead to a number of serious health problems if not treated properly, often causing irreversible damage to women's reproductive organs.^{65,66} The CDC recommends annual screening for Chlamydia in all women under the age of 25 who are sexually active.⁶⁷

The EQRO uses the HEDIS[®] *Chlamydia Screening in Women* measure for young women in STAR, CHIP, and STAR Health. This measure provides the percentage of sexually active female members between ages 16 and 24 who had at least one test for Chlamydia during the measurement period.

<u>HEDIS[®] Chlamydia Screening in Women</u>	
CY 2011 results	
STAR	51 percent
CHIP	31 percent
STAR Health	58 percent

In 2011, the percentage of eligible women in the STAR program who received Chlamydia screening during the measurement period (51 percent) was lower than the national HEDIS[®] mean of 58 percent. When STAR results were broken down by age group, program-level performance on this measure fell below the HEDIS[®] mean for members 16 to 20 years of age (49 percent, compared to the HEDIS[®] mean of 55 percent), while exceeding the HEDIS[®] mean for members 21 to 24 years of age (66 percent, compared to the HEDIS[®] mean of 62 percent).

In 2011, 58 percent of all eligible women in STAR Health received at least one test for Chlamydia during the measurement period, which was six percentage points higher than the

STAR Health rate reported in 2009. The rate among eligible members 16 to 20 years of age was also 58 percent. By contrast, the rate among eligible STAR Health members 21 to 24 years of age was 53 percent, which falls short of the HEDIS® mean of 62 percent for this age group.

Results for the CHIP program were reported only for the younger age cohort (16- to 20-year olds) because the older age cohort is not applicable to the CHIP population. In CY 2011, fewer than one in three eligible women in CHIP received Chlamydia screening (31 percent).

2.2 – Ambulatory Care and Inpatient Utilization

The HEDIS® *Ambulatory Care* measure summarizes utilization of two types of ambulatory care: (1) outpatient care, showing the rate of outpatient visits per 1,000 member months; and (2) emergency department (ED) visits, showing the rate of ED visits per 1,000 member months.

<u>HEDIS® Ambulatory Care</u>		
CY 2011 results	Outpatient visits per 1,000 member months	Emergency department visits per 1,000 member months
STAR	387	54
CHIP	231	21
STAR+PLUS	565	114
STAR Health	466	51

Potentially Avoidable Inpatient Use

Potentially avoidable health care events are costly and represent a particularly important challenge for the effective delivery of health services in state Medicaid programs. One way to evaluate the occurrence of potentially avoidable health care events is to analyze inpatient admissions for various ambulatory care sensitive conditions (ACSCs), which the Agency for Healthcare Research and Quality (AHRQ) defines as "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."⁶⁸

Emergency department visits and hospital admissions for ACSCs function as indicators of access to and quality of outpatient care. These healthcare events and their associated expenditures potentially could have been avoided with accessible, effective outpatient care. Thus, unlike most other performance measures referenced throughout this report, higher values represent poorer performance.

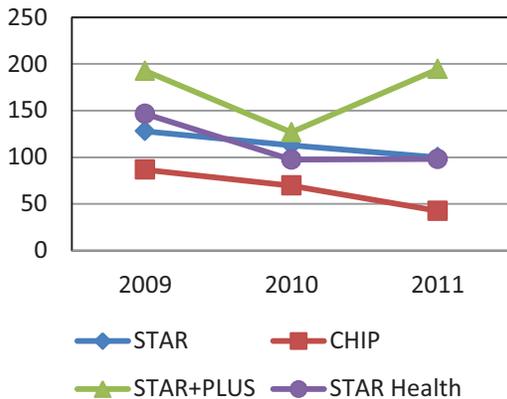
To assess potentially avoidable inpatient use, the EQRO uses the AHRQ Pediatric Quality Indicators (PDIs) and Prevention Quality Indicators (PQIs), as well as measures of potentially preventable readmissions (PPRs) developed by 3M.

Pediatric Quality Indicators (children)

The EQRO uses the Pediatric Quality Indicators (PDIs) to analyze pediatric admissions for five ambulatory care sensitive conditions among members 17 years of age and younger: (1) *Asthma*; (2) *Diabetes Short-Term Complications*; (3) *Gastroenteritis*; (4) *Perforated Appendix*; and (5) *Urinary Tract Infection*. **Figures 19 to 22** show trends in AHRQ PDIs for asthma, diabetes short-term complications, gastroenteritis, and urinary tract infection among children in STAR, CHIP, STAR+PLUS, and STAR Health, from 2009 to 2011. Rates are expressed per 100,000 eligible members. It should be noted that in smaller programs, such as STAR Health and STAR+PLUS, the number of pediatric admissions for a particular indicator is very small. For measures where the number of admissions in these programs was less than 20, observed year-to-year changes may not reflect true differences in quality of care. Changes in PDI rates in these cases should be interpreted with caution. Measures where the number of admissions

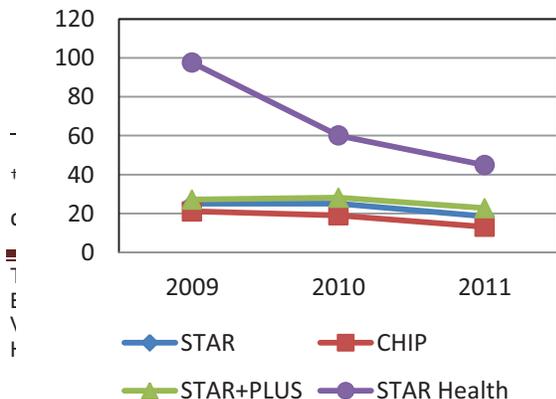
were below 20 have been noted with footnotes (e.g., “†”) in the narrative of this section.

Figure 19. AHRQ Asthma PDI Rates in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011



Asthma: Pediatric inpatient admissions for asthma showed a slight decline in STAR, CHIP, and STAR Health between 2009 and 2011. In 2011, *Asthma PDI* rates in STAR (100 per 100,000) were below both the HHSC Dashboard standard of 181 per 100,000 and the AHRQ national average of 147 per 100,000. As shown in **Figure 19** rates in STAR+PLUS fluctuated over the three-year period, decreasing from 193 to 127 per 100,000 between 2009 and 2010, and then returning to 194 per 100,000 in 2011.[†]

Figure 20. AHRQ Diabetes Short-Term Complications PDI Rates in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011



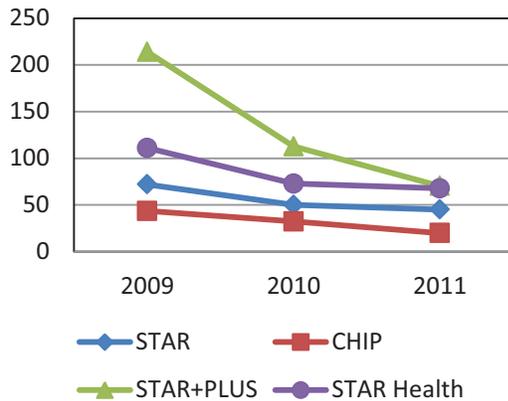
Diabetes: Inpatient admissions for diabetes short-term complications remained fairly consistent from 2009 to 2011 in STAR, CHIP, and STAR+PLUS. PDI rates for diabetes short-term complications declined in STAR Health during the three-year period, dropping from 98

asthma was 16 in 2009, 10 in 2010, and 19 in 2011. This rate and should be interpreted with caution.

– 2009 - 2011

per 100,000 in 2009 to 45 per 100,000 in 2011, as depicted in **Figure 20**.[‡]

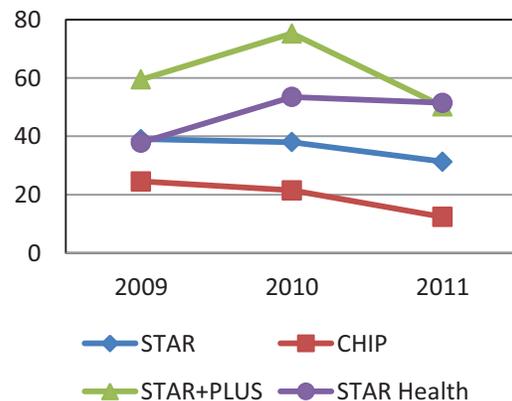
Figure 21. AHRQ Gastroenteritis PDI Rates in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011



Gastroenteritis: Pediatric inpatient admissions for gastroenteritis declined in all programs over the three-year period, particularly in STAR+PLUS (**Figure 21**). In 2011, PDI rates in STAR (45 per 100,000) and CHIP (20 per 100,000) were considerably lower than the HHSC Dashboard standards (146 and 42 per 100,000, respectively).[§]

Urinary tract infection: Pediatric inpatient admissions for urinary tract infection showed a slight decline in STAR and CHIP from 2009 to 2011, while fluctuating considerably in STAR+PLUS and increasing considerably in STAR Health (**Figure 22**).[†] Rates were lower than the HHSC Dashboard standard of 53 per 100,000 in STAR. In CHIP and STAR Health, rates were lower than the HHSC Dashboard

Figure 22. AHRQ Urinary Tract Infection PDI Rates in STAR, CHIP, STAR+PLUS, and STAR Health, 2009-2011



[‡] In STAR Health, the number of admissions for diabetes showed a slight increase in 2011. In STAR+PLUS, there were only two admissions for diabetes in 2011. These estimates may not represent true changes in quality of care.

[§] In STAR+PLUS, the number of admissions for gastroenteritis decreased from 20 in 2009 to 7 in 2011. This change may not represent true changes in quality of care and should be interpreted with caution.

[†] In STAR Health, the number of admissions for UTI increased from 15 in 2009 to 22 in 2011. In STAR+PLUS the number of admissions for UTI was 5 in 2009, 6 in 2010, and 5 in 2011. Due to the small numbers of admissions, these changes may not represent true changes in quality of care and should be interpreted with caution.

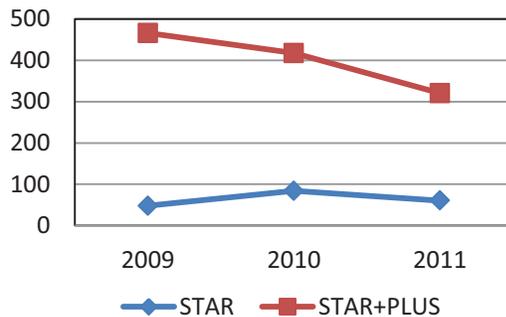
standards of 26 per 100,000 and 53 per 100,000, respectively.

Perforated appendix: PDI rates for perforated appendix were higher than the HHSC Dashboard standard of 31 per 100 admissions for appendicitis in STAR (43 per 100), CHIP (35 per 100), and STAR Health (59 per 100).

Prevention Quality Indicators (adults)

The EQRO uses the Prevention Quality Indicators (PQIs) to assess adult admissions for the following ambulatory care sensitive conditions: (1) *Diabetes Short-Term Complications*, (2) *Perforated Appendix*, (3) *Diabetes Long-Term Complications*, (4) *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults*, (5) *Low Birth Weight*, (6) *Hypertension*, (7) *Congestive Heart Failure*, (8) *Dehydration*, (9) *Bacterial Pneumonia*, (10) *Urinary Tract Infection*, (11) *Angina without Procedure*, (12) *Uncontrolled Diabetes*, (13) *Asthma in Younger Adults*, and (14) *Rate of Lower Extremity Amputation among Patients with Diabetes*. Members ages 18 or older are eligible for these measures.

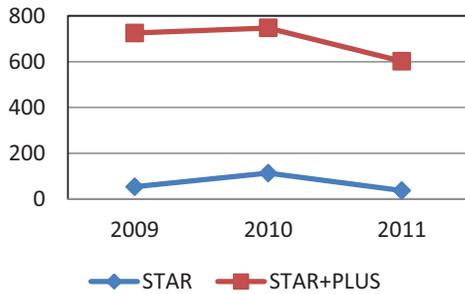
Figure 23. AHRQ Diabetes Short-Term Complications PQI Rates in STAR and STAR+PLUS, 2009-2011



The PQIs are calculated for adults in STAR and STAR+PLUS, with three-year trends available for most indicators.⁶⁹ **Figures 23 to 26** depict trends in AHRQ PQIs for diabetes short-term complications, diabetes long-term complications, bacterial pneumonia, and urinary tract infections among adults in STAR and STAR+PLUS, for 2009, 2010, and 2011. While other PQIs also exhibited dramatic shifts in rates over this time, some of these changes may have resulted from modifications to the methodological specifications that occurred with the release of version 4.3 of the AHRQ PQIs. This report focuses on PQIs for which

measurement specifications remained consistent over the three-year period. Rates are per 100,000 eligible members. While none of the rates presented here involved numerators less than 20 members (as for certain PDIs), these trends should still be interpreted with caution. In future reports, the EQRO will conduct statistical significance testing for the time trends.

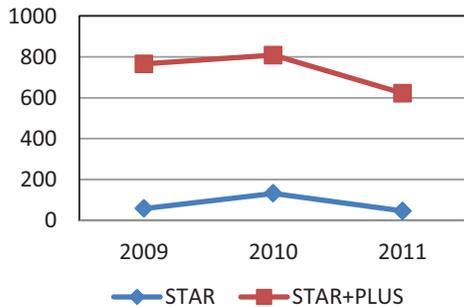
Figure 24. AHRQ Diabetes Long-Term Complications PQI Rates in STAR and STAR+PLUS, 2009-2011



Diabetes short-term complications: Adult inpatient admissions for diabetes short-term complications dropped considerably from 2009 to 2011 in STAR+PLUS (Figure 23). During this period, PQI rates for diabetes short-term complications showed a very slight net increase in the STAR program, rising from 48 per 100,000 in 2009 to 61 per 100,000 in 2011, which was roughly equivalent to both the AHRQ national average of 62 per 100,000 and the HHSC Dashboard standard of 56 per 100,000.

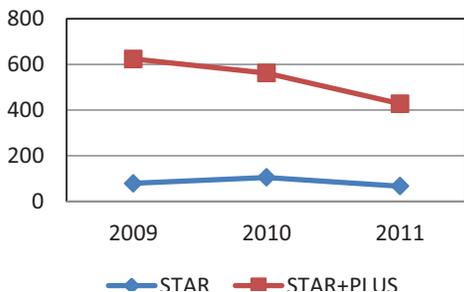
Diabetes long-term complications: Adult inpatient admissions for diabetes long-term complications dropped considerably from 2009 to 2011 in STAR+PLUS (Figure 24). Rates in STAR fluctuated over the three-year period, increasing from 53 to 113 per 100,000 between 2009 and 2010, before dropping back down to 36 per 100,000. In 2011, rates in STAR were noticeably better than the HHSC Dashboard standard of 64 per 100,000, and all MCOs had rates lower than the AHRQ national average of 122 per 100,000.

Figure 25. AHRQ Bacterial Pneumonia PQI Rates in STAR and STAR+PLUS, 2009-2011



Bacterial pneumonia: Adult inpatient admissions for bacterial pneumonia showed a net decline from 2009 to 2011 in both programs analyzed for this measure. *Bacterial Pneumonia* PQI rates in STAR+PLUS fell from 765 per 100,000 in 2009 to 622 per 100,000 in 2011, while STAR rates decreased from 58 to 46 per 100,000 (Figure 25). The STAR rates were also substantially lower than the HHSC Dashboard standard for this measure (174 per 100,000).

Figure 26. AHRQ Urinary Tract Infection PQI Rates in STAR and STAR+PLUS, 2009-2011



Urinary tract infection: Adult inpatient admissions for urinary tract infection showed a steady decline in STAR+PLUS from 2009 to 2011, while fluctuating somewhat in the STAR program during that timeframe where rates peaked in 2010 (Figure 26). In 2011, the STAR PQI rate of 67 per 100,000 for UTIs was far

- 2009 - 2011

below the HHSC Dashboard standard of 177 per 100,000 for the STAR program.

Potentially Preventable Readmissions (PPRs)

Potentially preventable readmissions (PPRs) are return hospitalizations that may arise from factors such as poor coordination of services at the time of discharge and during follow-up (such as incomplete discharge planning or inadequate access to care after discharge), or deficiencies in the process of care and treatment, including actions taken or omitted during the initial hospital stay.⁷⁰ Patient-level factors associated with readmissions include poor health status, co-morbidities, and increasing severity of illness.⁷¹ Some studies have also found associations between various health care structure and process factors and readmissions. As with other forms of avoidable health care events, potentially preventable readmissions tend to be more common among patients insured by Medicaid or self-pay.⁷² Possible reasons for these associations include greater financial barriers to medications and access barriers to primary care, as well as reliance on hospitals as the most convenient or preferred source of primary care by Medicaid and self-pay patients.^{73,74}

<i>3M Potentially Preventable Readmissions</i>				
CY 2011 results	Candidate admissions	Admissions that resulted in a PPR	PPR rate	PPR cost per 1,000 member-months
STAR	139,381	2,979	2.1%	\$1,127.32
CHIP	7,680	388	5.1%	\$494.67
STAR+PLUS	30,086	3,876	12.9%	\$26,661.17
STAR Health	4,536	703	15.5%	\$11,195.93

The EQRO calculated PPR rates and expenditures using the 3M Health Information Systems (HIS) software. The 3M measure for PPRs uses hospital inpatient discharge data to calculate rates of readmissions that could have been prevented with better outpatient care. PPRs are produced using a combination of All Patient Refined Diagnosis Related Groupings (APR-DRGs) and severity of illness categories within each APR-DRG. The 3M HIS software assigns APR-DRGs to every initial hospital admission and then compares APR-DRGs for all subsequent admissions for the same person within the measurement period to identify potentially preventable readmissions.

2.3 – Behavioral Health Service Utilization

Mental Health Service Utilization

Each year nearly 60 million people in the United States are diagnosed with mental disorders.⁷⁵ Patients with mental disorders utilize health care services less efficiently than those without mental health disorders. For example, patients with mental disorders visit the emergency department more frequently than those without mental disorders, which can lead to lower quality of care for those in need of urgent medical attention. Inappropriate health care utilization may indicate deficiencies in the health care system, including lack of care coordination.⁷⁶ Information on what types of services patients utilize can help identify areas of behavioral health care delivery that need improvement.⁷⁷

The EQRO uses a modified version of the HEDIS[®] *Mental Health Utilization* measure to assess utilization of mental health services in STAR, STAR+PLUS, NorthSTAR, and STAR Health.⁷⁸ This measure identifies the percentage of members who received a mental health service during the one-year measurement period, in the following categories: (1) inpatient services; (2) intensive outpatient or partial hospitalization services; and (3) outpatient or emergency department (ED) services. At HHSC's request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name "HEDIS[®]" was removed from discussion of this measure, as it does not conform precisely to NCQA specifications. For all programs in CY 2011, the vast majority of services utilized by members were outpatient mental health services.

<u><i>Mental Health Utilization</i></u>			
CY 2011 results	Inpatient services	Intensive outpatient or partial hospitalization services	Outpatient or ED services
STAR	0.3 percent	0.1 percent	8.7 percent
STAR+PLUS	3.9 percent	0.7 percent	32.3 percent
STAR Health	7.0 percent	1.6 percent	78.1 percent
NorthSTAR	0.5 percent	0.0 percent	9.4 percent

Utilization of Drug and Alcohol Services

In the United States, over 22 million people are classified as having a drug or alcohol disorder.⁷⁹ Each year nearly five million ED visits are drug- and alcohol-related visits that may be associated with decreased quality of care and indicate deficiencies in the health care system.⁸⁰

The HEDIS[®] *Identification of Alcohol and Other Drug (AOD) Services* measure represents the percentage of members receiving one of the following AOD-related services during the measurement period: (1) inpatient services; (2) intensive outpatient or partial hospitalization services; and (3) ambulatory services. The EQRO calculates this measure for STAR, STAR+PLUS, and NorthSTAR.⁸¹ In all three programs in CY 2011, the chemical dependency

services most utilized by members were ambulatory services, while intensive outpatient or partial hospitalization services were very rare.

Identification of Alcohol and Other Drug Services

CY 2011 results	Inpatient services	Intensive outpatient or partial hospitalization services	Ambulatory services
STAR	0.2 percent	0.0 percent	0.7 percent
STAR+PLUS	3.0 percent	0.2 percent	11.0 percent
NorthSTAR	0.3 percent	0.0 percent	1.6 percent

3 – Managed Care Organization Structure and Process

3.1 – Health Plan Information

Producing and maintaining valid, complete, and up-to-date health care claims and encounter data is critical for ensuring high quality of care in state Medicaid and CHIP MCOs. These data are necessary for: (1) implementing timely and comprehensive care coordination based on member diagnostic and health care use profiles; and (2) calculating and validating numerous quality of care measures that are based on administrative data. Following recommendations made by the Institute of Medicine (IOM) in 2001, MCOs have worked toward implementing electronic health records (EHRs), permitting the automation of clinical, financial, and administrative information, and the electronic sharing of this information.⁸² More recently, the American Recovery and Reinvestment Act of 2009 includes an incentive program to encourage Medicaid and Medicare providers to implement EHR technology, with incentive payments of up to \$63,750 over six years, beginning in 2011.^{83,84}

As part of its mandatory and optional review activities, the EQRO annually conducts:

- Encounter data validation (EDV) studies, in which elements of MCO claims and encounter data are validated using provider health records⁸⁵
- Studies of MCO data systems capabilities and processes, including MCO-reported electronic claims submission rates, using the annual MCO Administrative Interviews
- Data certification to assess the completeness and validity of claims and encounter data maintained by Texas Medicaid and CHIP MCOs
- Studies of MCO disease management (DM) programs, evaluating the elements of the DM programs using the annual MCO Administrative Interviews
- Evaluations of MCO Quality Improvement Programs through review of the annual MCO Quality Assessment and Performance Improvement (QAPI) Evaluation Summaries
- Evaluations of MCO Performance Improvement Projects (PIPs)

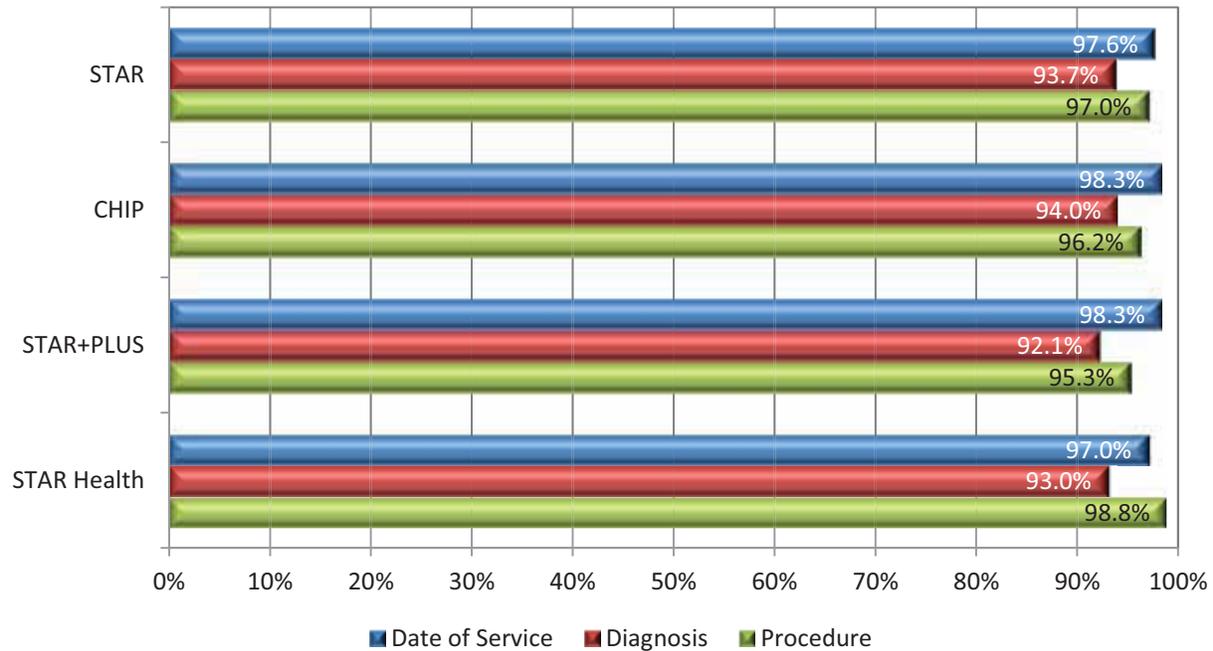
This section presents trends in EDV results, electronic claims submissions, and data certification findings at the program level from 2009 to 2011. In addition, the section provides a summary of the MCO DM programs, QAPIs, and PIPs for the FY 2011 measurement period.

Encounter Data Validation

According to CMS guidelines for Medicaid MCOs, states can set a targeted match rate between information found in an MCO's claims and encounter data and information found in the members' health records.⁸⁶ A match rate of 95 percent or greater between the two data sources is desired, and states are encouraged to work toward that goal. To determine Texas Medicaid and CHIP MCO compliance with standards for encounter data completeness and quality, the EQRO conducts biannual EDV studies using provider health records to calculate match rates for a random sample of encounters, focused on the validation of three data elements: (1) date of service; (2) diagnosis; and (3) procedure.

Figure 27 provides match rates for date of service, diagnosis, and procedure data elements in STAR, CHIP, STAR+PLUS, and STAR Health for CY 2011, with match rates for all programs and data elements exceeding 90 percent.

Figure 27. Encounter Data Validation Match Rates for CY 2011



Match rates in STAR, CHIP, STAR+PLUS, and STAR Health exceeded the desired rate of 95 percent for both the date of service and procedure data elements. The match rates for the diagnosis data element for all programs were below the desired 95 percent rate, but exceeded 90 percent.

Provider response rates for the EDV study ranged from 57 percent in the El Paso SA to 65 percent in the Travis SA. It is possible that various provider characteristics contributed to these differences in response rates. Therefore, results of the EDV study should be interpreted with the understanding that non-response bias may have occurred.

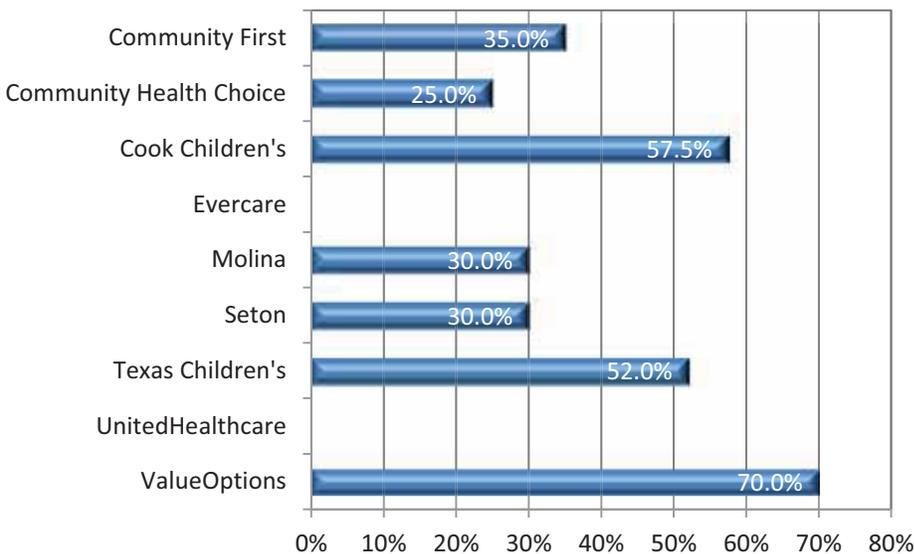
Electronic Health Records

Electronic health records are becoming more widespread in the United States. Changes in health care are requiring a shift in the medical record system from paper records to electronic health records (EHRs). The widespread use of EHRs will result in more accessible records for providers and improved outcomes for patients. In 2009, to overcome barriers to implementing an EHR system, Congress passed the Health Information Technology for Economic and Clinical Health Act (HITECH), which endorses incentive payments for the private and secure use of EHRs by Medicare and Medicaid providers and hospitals.⁸⁷ Efforts by the Centers for Medicare & Medicaid Services (CMS) to employ the concept of “meaningful use” of EHRs are based on improving health outcomes and the quality of care while engaging patients and their families in a secure, protected manner.

The CMS initiative to encourage utilization of certified EHRs is a three-phased approach: (1) data capture and sharing by 2011; (2) advanced clinical practices by 2013; and (3) improved health outcomes by 2015. Participation in the program is incentivized and voluntary. Eligible providers and hospitals, however, will receive negative adjustments in their Medicare/Medicaid payments if they do not adopt the initiative by 2015.⁸⁸

Only half of the MCOs monitored the percentage of their providers who implemented EHRs during FY 2011. **Figure 28** presents the percentage of providers who implemented EHRs during FY 2011 by health plan (for health plans that reported this information). ValueOptions had the highest percentage of providers who implemented EHR (70 percent). Evercare and UnitedHealthCare-Texas reported that none of their providers implemented EHRs. The remaining six health plans varied in the percentage of providers who implemented EHRs, ranging from 25 percent to 58 percent. None of the MCOs offered incentives to providers for implementing EHRs during FY 2011.⁸⁹

Figure 28. Percentage of Providers who Implemented EHRs during FY 2011



Data Certification

The EQRO annually certifies key data elements in claims and encounter data that the Texas Medicaid and CHIP MCOs maintain, and provides separate data certification reports for each Texas Medicaid program and CHIP. Annual data certification includes four types of analysis: (1) Volume analysis based on service category; (2) Data validity and completeness analysis; (3) Consistency analysis between encounter data and financial summary reports (FSRs); and (4) Validity and completeness analysis of provider information.

Key data elements assessed during data certification include those that are critical for proper care coordination and quality of care measurement, such as:

- Place of service code
- Admission date
- Primary diagnosis code
- Procedure code
- Discharge date
- Discharge status
- Billing provider National Provider Identifier (NPI)
- Billing provider taxonomy code
- Rendering provider NPI
- Rendering provider taxonomy code

For FY 2011 data certification, the EQRO's analysis was guided by: (1) Texas Government Code § 533.0131, Use of Encounter Data in Determining Premium Payment Rates; and (2) Department of Health and Human Services, CMS – *Validating Encounter Data: A Protocol for Use in Conducting External Quality Review Activities*.^{90,91} The EQRO used these documents to develop procedures for certifying the Texas STAR, STAR+PLUS, STAR Health, CHIP, CHIP Dental, CHIP Perinate, and NorthSTAR encounter data. For managed care programs served by multiple MCOs (e.g., STAR, CHIP, and STAR+PLUS), analyses were conducted at the plan code level (MCO and service area combined).

Volume analysis based on service category: For each plan code within each program, the EQRO determined the number of records for facility, physician, dental (where present), and total services for each month of FY 2011. The EQRO examined the monthly totals to determine whether the number of records for each of the service categories and the total number of records varied significantly from month to month. The results were found to be consistent for all plan codes based on overall volumes.

Data validity and completeness analysis: For each plan code, the EQRO examined the presence and validity of critical data elements in the claims extracts submitted by the MCOs. The EQRO derived data validity standards from accepted lists of valid information taken from a variety of sources, including data dictionaries supplied by HHSC, CPT manuals, and ICD-9-CM manuals.^{92,93} The EQRO performed the analysis on the final image of all FY 2011 claims it received from Texas Medicaid and Healthcare Partnership (TMHP) through December 2011. All critical fields were present in the data as specified in the CMS Data Validation Protocol.

Consistency analysis between encounter data and FSRs provided by the MCOs: The EQRO compared payment dollars documented in the claims data to payment dollars in the MCOs' self-reported FSRs, which HHSC provided to the EQRO for FY 2011. According to the standard set by HHSC, the claims data and the FSR must agree within three percent for the data to be certifiable.

Validity and completeness analysis of provider information: Adequate provider identification is critical to the EQRO's efforts to calculate HEDIS[®] measures, to conduct provider surveys, and to obtain medical records for the purposes of validating encounter data and calculating hybrid HEDIS[®] measures. When provider identification numbers and/or taxonomy (provider specialty) codes are missing in the encounter data, the EQRO is hindered in its ability

to provide HHSC with accurate and complete information about Texas Medicaid and CHIP. Overall, the results of these analyses are positive and suggest an improvement in the completeness of MCO administrative data.

3.2 – Disease Management Programs

Although approximately three-quarters of the national Medicaid population are children, parents, and pregnant women, about two-thirds of Medicaid expenditures go to care for elderly and disabled adults.⁹⁴ These members use more long-term care services, which account for more than one-third of Medicaid spending. Many states are adopting Medicaid disease management (DM) programs as a way to improve health care quality and reduce costs for these members.

HHSC requires that all MCOs participating in STAR, STAR+PLUS, CHIP, and STAR Health provide DM services covering asthma and diabetes.^{95,96} In addition to asthma and diabetes, HHSC requires MCOs participating in STAR+PLUS to offer DM services for chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and coronary artery disease (CAD). Finally, all MCOs are required by HHSC to provide DM services for other chronic diseases based upon an evaluation of disease prevalence within each MCO's membership.⁹⁷

This section presents findings from the FY 2011 MCO Administrative Interview on the structure and practices of DM programs operating in Texas Medicaid and CHIP MCOs, focusing on programs that are required by the state. All STAR and CHIP MCOs had the required asthma and diabetes DM programs, in addition to various DM programs focused on the needs of their populations. These included programs for depression, high-risk perinatal, HIV/AIDS, hypertension, and obesity. All STAR+PLUS MCOs had the required asthma, diabetes, COPD, CHF, and CAD DM programs.

In some cases, DM functions were administered through an externally contracted disease management organization. Four STAR MCOs delegated asthma and diabetes DM functions fully or in part to a DM organization in 2011.⁹⁸ In STAR+PLUS, only Superior delegated DM functions to a DM organization, while Amerigroup, Evercare, and Molina administered DM programs in-house. Across Medicaid and CHIP, Parkland and UnitedHealthcare-Texas consistently delegated all DM functions, and FirstCare, Seton, and Superior used a combination of in-house and delegated programs. Community Health Choice and Cook Children's delegated behavioral health DM functions. Behavioral health DM programs were the most common type of DM program to be delegated to a DM organization, with 7 out of the 13 MCOs delegating behavioral health DM programs.

Fourteen of 16 MCOs operating in Texas Medicaid and CHIP in FY 2011 assigned members participating in their DM programs to risk groups, which allowed for more appropriate care according to the members' health status, disease severity, and special needs.⁹⁹ **Table 5** shows details on asthma and diabetes DM program participation in STAR, CHIP, and STAR+PLUS. For asthma DM, STAR had both the highest number of eligible members (92,211) and the highest number of participating members (54,539). However, the resulting participation rate of 59 percent was the lowest among the programs. STAR also had the lowest participation rate for

diabetes DM (43 percent). In CHIP, more than two-thirds of eligible members were enrolled in asthma DM (69 percent) and three-fourths were enrolled in diabetes DM (74 percent). For diabetes DM, STAR+PLUS had the highest number of eligible members (30,852), the highest number of participating members (26,456), and the highest participation rate (86 percent).

Table 5. Member Participation in Asthma and Diabetes DM Programs in FY 2011

	Asthma DM			Diabetes DM		
	Members eligible	Members enrolled	Participation rate	Members eligible	Members enrolled	Participation rate
STAR	92,211	54,539	59.1%	5,355	2,295	42.9%
CHIP	21,602	14,833	68.7%	1,319	974	73.8%
STAR+PLUS	8,048	7,212	89.6%	30,852	26,456	85.8%

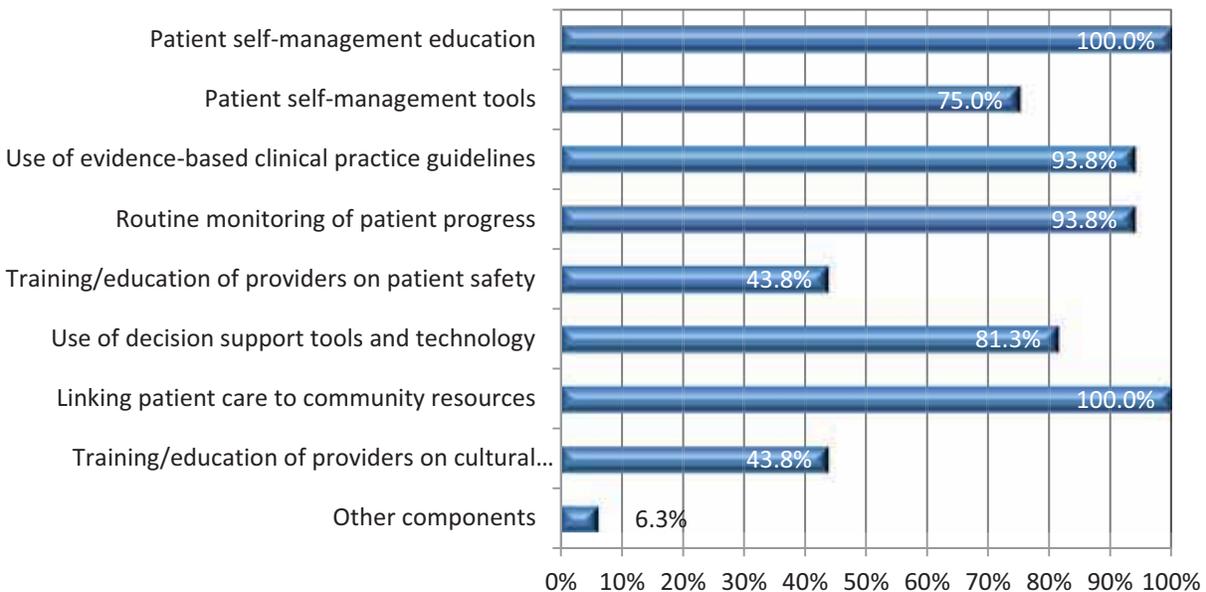
In STAR+PLUS, DM participation rates were high for CAD (89 percent), COPD (94 percent) and CHF (90 percent). It should be noted that these rates are calculated from MCO Administrative Interview responses from Amerigroup, Evercare, HealthSpring, Molina, and Superior.

Definitions for “participation” in DM programs vary among the MCOs, which limits interpretations that can be made when comparing participation rates. Four out of 15 health plans have ‘opt-in’ DM programs, where eligible members must agree to participate in the program to be considered enrolled.^{100,101} El Paso First and HealthSpring have ‘opt-out’ DM programs, although El Paso First requires a completed assessment for enrollment and HealthSpring does not enroll members who cannot be reached.

ICHHP identifies specific components of the health plans’ DM programs using the Administrative Interview tool. **Figure 29** presents the percentage of health plans that have incorporated the following as formal components of their DM programs: (1) Patient self-management education; (2) Patient self-management tools (e.g., glucose meter); (3) Use of evidence-based clinical practice guidelines; (4) Routine monitoring of patient progress; (5) Training/education of providers on patient safety; (6) Use of decision support tools and technology; (7) Linking patient care to community resources; (8) Training/education of providers on cultural competency; and (9) Other components.

All of the MCOs offer patient self-management education to members and link patient care to community resources as formal components of their DM programs. Only 44 percent, however, offer provider training/education on patient safety and cultural competency. Cook Children’s was the only MCO that indicated ‘other’ formal components are included in the DM programs. The additional components offered by Cook Children’s are geared toward improving health literacy.

Figure 29. Percentage of MCOs Incorporating Selected Formal Components of DM programs in FY 2011



3.3 – Quality Improvement

The EQRO annually reviews the Texas Medicaid MCO Quality Improvement Programs (QIPs) to evaluate aspects of structure and process that contribute to the success of these programs. This section discusses the EQRO's evaluation of FY 2011 MCO QAPI and PIP submissions.

Quality Assessment and Performance Improvement Evaluations

The QAPI evaluations follow CMS guidelines to evaluate both Quality Assurance and Quality Improvement practices of the Texas Medicaid MCOs. According to CMS, there are five essential elements to a QAPI program: (1) Design and Scope; (2) Governance and Leadership; (3) Feedback, Data Systems, and Monitoring; (4) Performance Improvement Projects (PIPs); and (5) Systematic Analysis.¹⁰² The EQRO QAPI evaluation reviews the first three elements and partially reviews the fifth element. The EQRO reviews the fourth and fifth elements as part of its annual PIP evaluation, which is discussed in the next section. The fifth element is reviewed in both the QAPI and PIP evaluations when determining whether a root cause analysis was conducted.

Using documentation submitted by the MCOs, the QAPI evaluation reviews the health plans' performance improvement structure and their assessment of the effectiveness of their QAPI program.

This evaluation captures the structure and process of the QIP and MCO quality activities through review of the following sections:

- **Documentation** (maximum 12 points) of the MCO's Work Plan, QI Organizational Chart, PIPs, and completed QAPI evaluation.
- **Assessment of QAPI Effectiveness** (maximum 16 points), including the MCO's statement of purpose, scope, goals and objectives, methodology (whether or not the MCO utilizes the Plan-Do-Study-Act model or something similar), the method by which MCOs identify and address barriers to implementation, and program effectiveness.
- **Global Quality Goals** (maximum 2 points), including the MCO's goals and objectives for FY 2011.
- **Role of the Governing Body** (maximum 8 points), covering the level and type of governance and leadership within the organization.
- **Structure of Quality Improvement Committee(s)** (maximum 14 points), including the role, structure, and function of the QI Committee(s), and level of provider and member representative involvement.
- **Identification of Adequate Resources** (maximum 4 points), including human and material resources available for the implementation of the QAPI program.
- **Provider Credentialing** (maximum 2 points), including the processes of credentialing and re-credentialing health plan providers.
- **Identification of Improvement Opportunities** (maximum 8 points), including actions taken to effect improvement at the system, process, and outcome levels.
- **Clinical Practice Guidelines** (maximum 12 points), including a review of current clinical practice guidelines to ensure they are evidence-based, relevant to member needs, and support care of members and services for members.
- **Availability and Accessibility** (maximum 12 points), including results of MCO monitoring of member access to care indicators, goals for all indicators, the MCO's actions to improve rates of accessibility and availability of care for members, and the effectiveness of actions taken.
- **QI Activities and Quality Indicators** (maximum 12 points), including results of MCO monitoring of clinical and service indicators, goals for all indicators, the MCO's actions to improve rates of clinical and service indicators, and the effectiveness of actions taken.
- **Credentialing** (maximum 16 points), summarizing the number of providers and facilities credentialed/re-credentialed, the number who requested or were denied credentialing, reasons for denials, the number of providers/facilities that were reduced, suspended, or had privileges terminated during FY 2011, and the reasons for these reductions, suspensions, or terminations.
- **Delegation** (maximum 10 points) of QAPI activities, including procedures for monitoring and evaluating delegated functions, results of evaluation of delegated activities, and how the results are incorporated into quality improvement.

- **Corrective Action Plans** (maximum 10 points), including any corrective actions required following a Texas Department of Insurance (DOI) audit and the MCO actions taken.

Each section includes different components that target key elements of quality improvement, as described above. The overall evaluation of health plan responses focuses on whether the MCO satisfied the requirements of a strong, comprehensive QIP and complied with specific Code of Federal Regulations (CFR) policies.^{103,104} Full credit is awarded when all components for each section are met, with a maximum achievable score of 138 points. The scoring system also allows for partial credit.

Figure 30 provides the overall score for each MCO, calculated as the percentage of maximum achievable points earned. The average score of all MCOs was 92 percent. Most health plans scored above average, with only five MCOs scoring below the average score. Delta Dental and Seton had scores that were significantly lower than the average (64 percent and 80 percent, respectively).¹⁰⁵ Scores were lower for both health plans due to the absence of necessary documentation needed for a thorough review of their QIPs.

The EQRO also evaluated the MCO QAPIs by section to identify areas of high performance and opportunities for improvement across all the health plans combined. **Figure 31** presents the average health plan score by QAPI section, calculated as the percentage of maximum achievable points earned. Overall, the health plans scored highest in the Documentation and Corrective Action Plan sections, at approximately 100 percent. The section with the greatest opportunity for improvement was the Assessment of QAPI Effectiveness, with an average score of 85 percent.

Figure 30. Overall QAPI Score by Health Plan in FY 2011

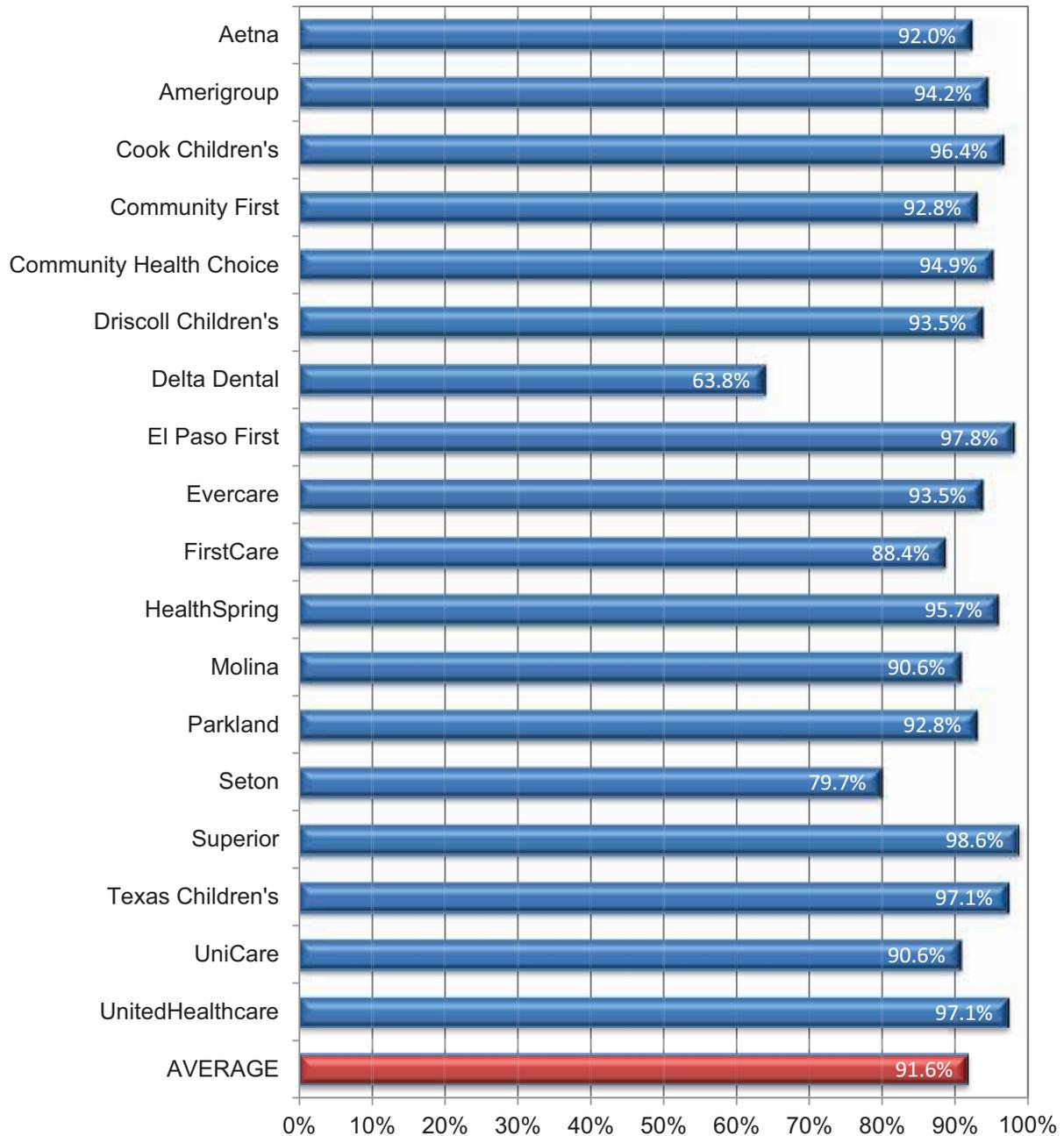
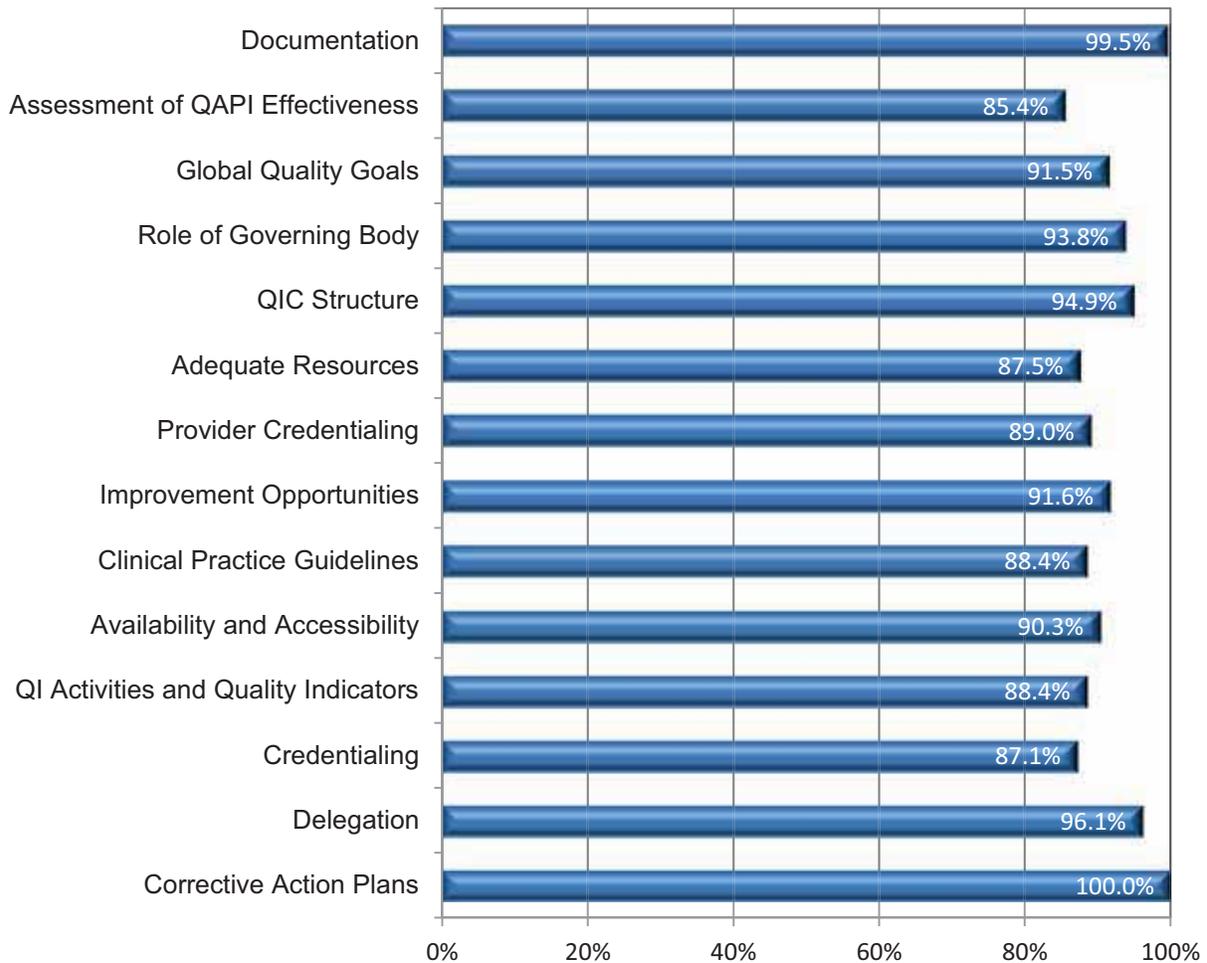


Figure 31. Overall QAPI Score by Section in FY 2011

Performance Improvement Projects

Performance Improvement Projects (PIPs) are the fourth essential element of a Quality Improvement Program. The purpose of a PIP is to develop a project with interventions that target a specific problem with the aim of improving quality of care and health outcomes.¹⁰⁶ Key components of a PIP include the topic, study indicators, and interventions. Topic selection should be based on the results of monitoring and evaluating clinical and service indicators. Once an opportunity for improvement is identified, health plans should conduct a root cause analysis in order to identify the underlying cause of the problem, and appropriate study indicators should be selected. Interventions should be developed to target the root cause of the problem at the member, provider, and system levels.

The EQRO's PIP evaluation addresses these three components and evaluates the following ten activities:

1. **Study Topic(s)** – In this section, health plans report the topic of the PIP and provide supporting evidence for why the topic was selected.
2. **Study Question(s)** – The MCOs pose the question they would like to answer with the PIP. For example, “does X result in Y?”
3. **Study Indicator(s)** – This section should include the measures or study indicators the health plan will use to measure change. Many health plans use HEDIS[®] measures with standardized numerators and denominators.
4. **Study Population** – This section should describe the population the PIP is targeting. For example, all STAR members, or only STAR members age 3 to 6 years. The study population should be representative and generalizable.
5. **Sampling Techniques (if sampling is used)** – This section describes the frequency of occurrence of the problem in the study population and the number of members needed in the sample in order to produce valid and reliable results. If HEDIS[®] measures are used, sampling is not required. (This does not apply to hybrid HEDIS[®] measures, which do require sampling.)
6. **Data Collection** – The data to be collected should be included in this section, in addition to identification of data sources, instruments used to collect data, and who will collect the data.
7. **Interventions and Improvement Strategies** – The MCO should describe the interventions and improvement strategies that will be taken to improve the measures indicated in Activity 3.
8. **Data Analysis and Interpretation of Results** – Baseline and follow-up measurements should be presented in this section. All data analyses should be summarized and supported by a test of statistical significance. The MCO should discuss factors that affect the comparability of baseline and follow-up measures and factors that threaten internal and external validity of the findings.
9. **“Real” Improvement** – This section summarizes whether or not the PIP resulted in a statistically significant improvement. The MCO should address how the interventions resulted in a statistically significant improvement.
10. **Sustained Improvement** – If there was a statistically significant improvement, this section should report whether the improvement was sustained over time.

The EQRO conducted a qualitative evaluation of PIP Activities 1-6 in July of 2011, and reported recommendations to the MCOs for strengthening study topics and designs. Following a full year of implementation, in November 2012 the EQRO conducted a quantitative analysis to score MCO performance on PIP Activities 7-10. This summary presents the results of the year-end review of the FY 2011 PIPs, focusing on Activities 7-10. Each section includes different

components that target key elements of a PIP, as described above. The overall evaluation of health plan responses focuses on whether the MCO: (1) described the interventions in detail; (2) developed and implemented interventions that were based on a root cause analysis; (3) implemented interventions that had adequate reach; (4) clearly presented baseline and follow-up measurements; (5) provided the level of statistical significance in the change in rates from baseline to follow-up; (6) accurately interpreted the results; (7) achieved statistically significant improvement; and (8) described sustained improvement and future plans, if applicable. Full credit is awarded when all components for each section are met, with a maximum achievable score of 14 points for Activities 7-10. The scoring system also allows for partial credit.

A variety of topics were selected by the health plans for the FY 2011 PIPs, based on state-specified Overarching Goals and goals specific to the MCOs. A total of 100 PIPs were reported by 15 health plans. **Figure 32** presents the percentage of PIPs conducted within each of seven common categories. PIPs that addressed issues related to access and utilization of care, such as preventive care, prenatal and postpartum care, and well-child visits were most common (35 percent). PIPs targeting the rate of emergency department (ED) visits were the second most common (29 percent). Among PIPs focused on the general category of ED visits, the most common topic was reduction of the rate of ED visits for ambulatory care sensitive conditions (ACSCs), such as otitis media, rash, and upper respiratory infections, comprising 18 percent of all topics in the FY 2011 PIPs.

Figure 32. FY 2011 PIPs, by Specific Topic Categories

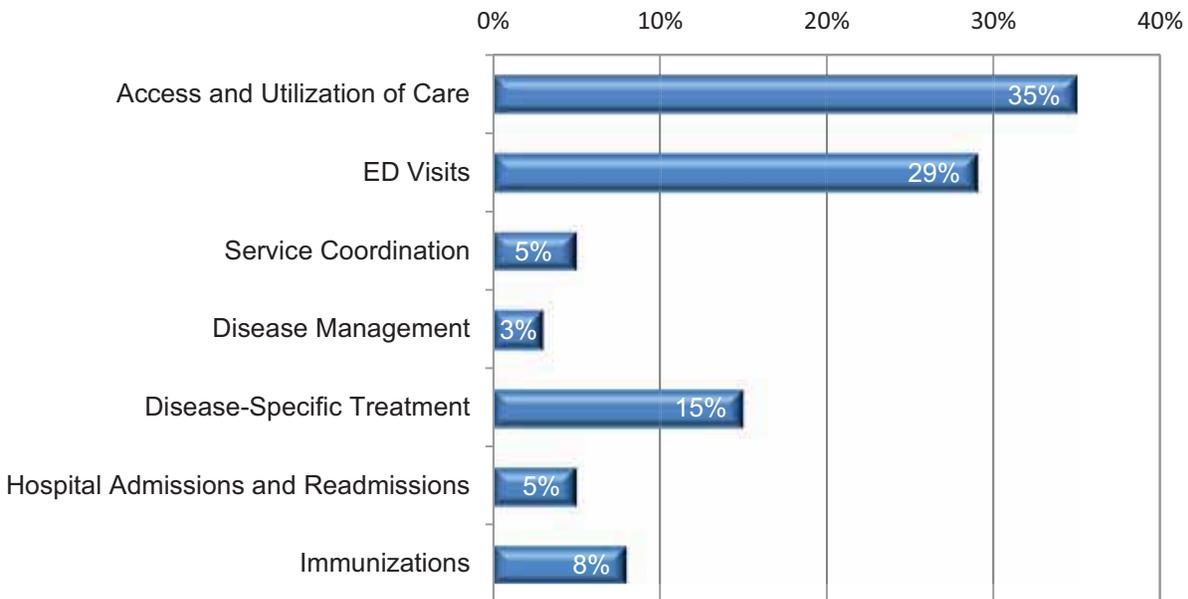
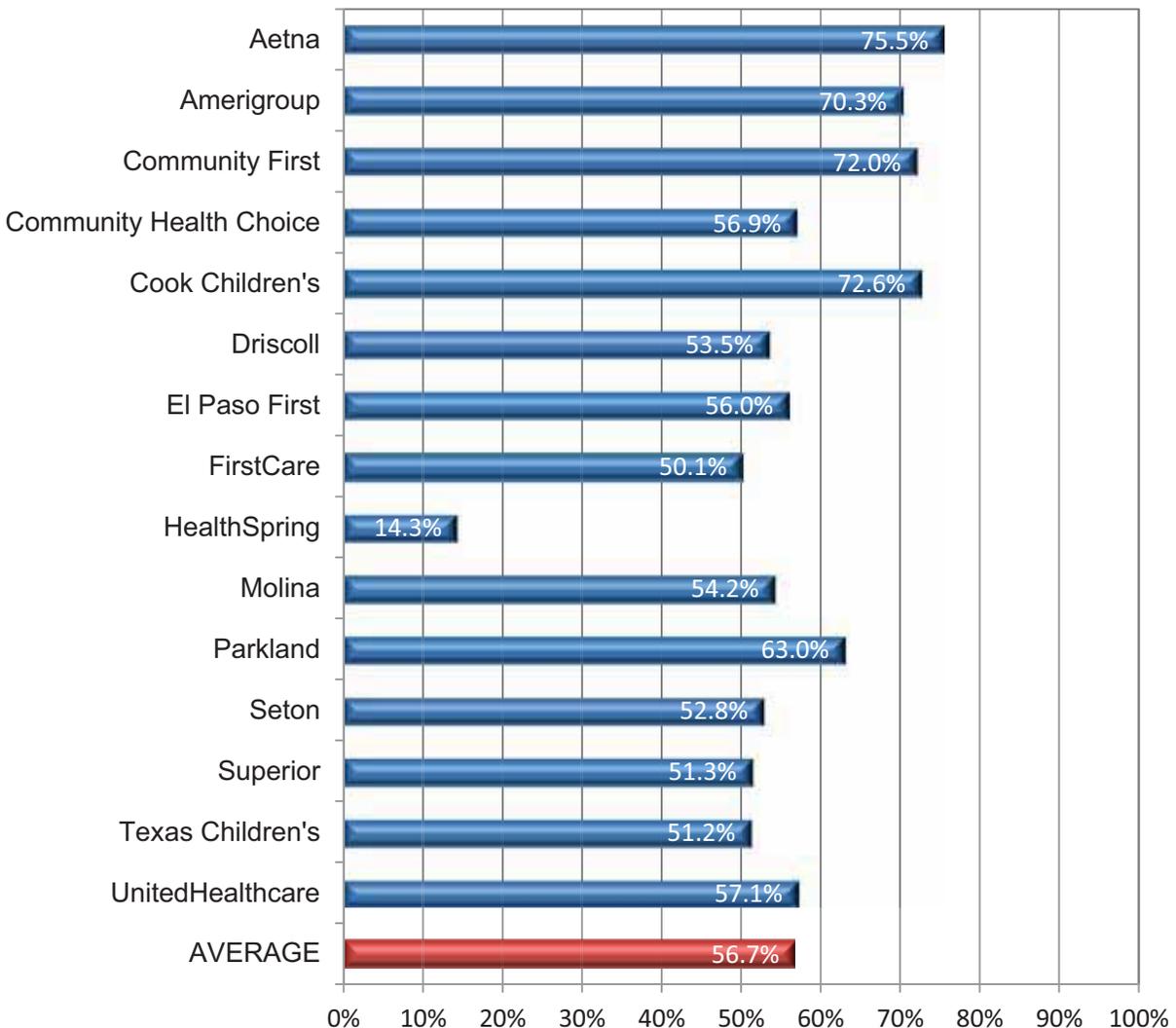


Figure 33 presents the overall year-end review scores for the FY 2011 PIPs, showing the percentage of maximum achievable points earned by each health plan across the different managed care programs. Aetna had the highest overall score (76 percent), and HealthSpring had the lowest score (14 percent). HealthSpring’s score was low because the MCO reported only baseline data, which affected the scores for Activities 8-10 (analyzing and interpreting results, improvement and sustained improvement); furthermore, the MCO’s interventions mostly consisted of mail-outs, which historically reach a small percentage of members and when used alone are not robust enough to effect change. The average score was 57 percent, with only 8 out of the 15 health plans scoring at or above the average. Aetna, Amerigroup, Community First, and Cook Children’s scored over 70 percent. Factors that contributed to higher scores included strong interventions that were described in detail and results of data analysis that were clearly presented.

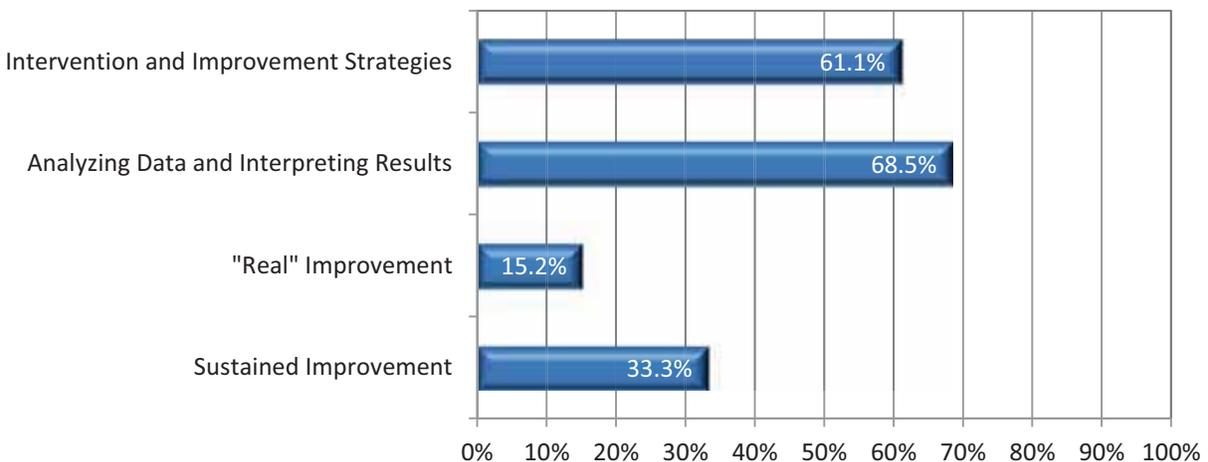
Figure 33. FY 2011 Performance Improvement Projects - Overall Score by MCO



Several health plans lost points on the evaluation for not describing how the cultural and linguistic needs of the members were addressed – a component included in the evaluation of PIP interventions. Points were also deducted for not reporting the level of statistical significance of the results. **Figure 34** presents the overall score for each activity (7-10) for all of the PIPs. The activity with the overall lowest score was the “Real” Improvement activity, with only 15 percent of the PIPs resulting in a statistically significant improvement in the baseline rate. Because the FY 2011 PIPs were the first in which MCOs fully implemented Activities 1-10, the evaluations were based on interventions that had been in place for only one year. Greater time is often needed for a new intervention to become fully implemented and show improvement in selected outcomes. The sustained improvement activity, which had the second-lowest overall score (33 percent), was not applicable to PIPs for which statistically significant improvement was not observed. Many of these cases involve longer-term PIPs that require greater than one year of implementation.

In cases where improvement is not observed, or where results on selected indicators demonstrate a reduction in quality, MCOs should conduct root cause analyses as part of their PIP assessment. For future PIP evaluations, the EQRO has modified reporting forms to assist the MCOs in measuring and reporting results of their interventions, including a section for reporting results of root cause analyses and instructions on the level of detail necessary for describing interventions.

Figure 34. FY 2011 Performance Improvement Projects - Overall Activity Scores



4 – Member Satisfaction with Care

Measuring patients' satisfaction with the health care they receive has long been an important component of health care quality evaluation. Positive patient satisfaction ratings have been associated with positive health outcomes and positive health behaviors, such as adherence to treatment plans and appropriate use of preventive health care services.^{107,108} Surveys with parents about the health care their children receive can also reveal deficiencies in access and utilization that may not otherwise be detected, as low parental satisfaction has been associated with shorter length of well-child visits and missed or delayed care.¹⁰⁹ Satisfaction measures provide implicit ratings of patients' judgments about the delivery of health services, and have been found to reflect parents' expectations of their children's health care.^{110,111,112,113}

The practice of assessing patient satisfaction has become even more relevant in recent years, with the increasing policy emphasis on patient-reported outcomes.¹¹⁴ There is evidence that individuals are more likely to have better health outcomes, higher satisfaction and well-being, and better treatment adherence when they are able to help define what is important to them.¹¹⁵ Therefore, decisions on the comparative effectiveness of treatment options should take into account the patient's perspective, reflecting the outcomes that patients care about.¹¹⁶

This section presents findings from the EQRO's telephone surveys with adult members and parents of child members in Texas Medicaid and CHIP, focusing on the most recent results from FY 2011 and FY 2012 surveys, and presenting trends in cases where satisfaction ratings have changed notably over the years.

4.1 – Timeliness of Care

One of the most important determinants of positive member satisfaction is timeliness of care. Long waits to receive care result in emotional distress for patients, and can increase the risk for physical harm when delays in diagnosis or treatment result in preventable complications.¹¹⁷ The EQRO assesses member-reported timeliness of care using items from the CAHPS[®] Health Plan Survey, which include the CAHPS[®] *Getting Care Quickly* composite, as well as questions regarding the timeliness of urgent care, routine care, health plan approval, and exam room visits that have been incorporated into the HHSC Performance Indicator Dashboard.

CAHPS[®] *Getting Care Quickly*

The CAHPS[®] *Getting Care Quickly* composite combines members' responses to questions about the timeliness of: (1) care needed right away for an illness, injury, or condition (urgent care); and (2) appointments for health care at a doctor's office (routine care). This core composite is calculated for adult members and parents of child members. Following AHRQ specifications, the score represents the percentage of members who "usually" or "always" had positive experiences with timeliness of care, which can be compared to national estimates for the Medicaid and CHIP populations reported by AHRQ.¹¹⁸ In addition, the EQRO follows a modified NCQA scoring methodology to calculate *Getting Care Quickly* scores on a 1- to 3-point scale, which allows for statistical comparisons between population sub-groups and reporting years.

Scores for *Getting Care Quickly* among child members are similar to those reported for children in Medicaid and SCHIP nationally. Scores for children on this composite were:

- 83 percent for children in STAR (in 2011), which is slightly lower than the Medicaid national average of 87 percent.
- 84 percent for children in CHIP (in 2011), which is slightly lower than the SCHIP national average of 86 percent.
- 90 percent for children in STAR Health (in 2012), which is higher than scores in STAR or CHIP.

CAHPS [®] <i>Getting Care Quickly</i>	
Child – 2011/2012	
STAR ^a	83%
CHIP ^a	84%
STAR Health ^b	90%
Adult – 2011/2012	
STAR ^b	71%
STAR+PLUS Medicaid-only ^b	75%
STAR+PLUS Dual-eligible ^a	80%

^a 2011, ^b 2012

Scores for *Getting Care Quickly* among adult members were generally lower than for children, and fell below the applicable national averages. Adult scores for this composite were:

- 71 percent for adults in STAR (in 2012), which is notably lower than the Medicaid national average of 81 percent.
- 75 percent for STAR+PLUS Medicaid-only members (in 2012).
- 80 percent for STAR+PLUS dual-eligible members (in 2011), which is higher than that reported for Medicaid-only adults in STAR+PLUS.

Since 2009, few observable trends were seen in scores for this composite. Children in CHIP had a moderate increase in *Getting Care Quickly*, from 79 percent in 2010 to 84 percent in 2011. Over the four-year period, STAR+PLUS Medicaid-only members had a moderate decrease for this measure, from 79 percent in 2009 to 75 percent in 2012.

HHSC Performance Indicator Dashboard – Survey-based Timeliness Measures

The HHSC Performance Indicator Dashboard includes the following four survey-based measures of timeliness of care, each with standards set by the state for Texas Medicaid and CHIP MCO performance:

- 1) *Good Access to Urgent Care* – based on responses to a CAHPS[®] 4.0 item assessing how often the member (or their child) received urgent care as soon as it was needed. Members who answer “usually” or “always” to this question are considered to have good access to urgent care.
- 2) *Good Access to Routine Care* – based on responses to a CAHPS[®] 4.0 item assessing how often the member (or their child) received an appointment for routine care as soon as it was needed. Members who answer “usually” or “always” to this question are considered to have good access to routine care.

- 3) *No Delays for Health Plan Approval* – based on responses to a modified CAHPS® 3.0 item assessing how often the member (or their child) experienced delays in their health care while waiting for approval from their health plan. Members who answer “never” to this question are considered to have no delays for health plan approval.
- 4) *No Wait to be Taken to the Exam Room Greater than 15 Minutes* – based on responses to a CAHPS® 3.0 item assessing how often the member (or their child) was taken to the exam room within 15 minutes of their appointment. Members who answer “always” to this question are considered to have no wait greater than 15 minutes.

HHSC Performance Dashboard Indicators – Timeliness of Care for Children						
	STAR 2011		CHIP 2011		STAR Health 2012	
	Rate	Dashboard standard	Rate	Dashboard standard	Rate	Dashboard standard
<i>Good Access to Urgent Care</i>	86%	88%	89%	89%	96%	88%
<i>Good Access to Routine care</i>	79%	84%	78%	86%	84%	76%
<i>No Delays for Health Plan Approval</i>	63%	65%	67%	91%	69%	69%
<i>No Wait to be Taken to Exam Room > 15 min.</i>	24%	35%	24%	68%	30%	50%

Program-level rates on timeliness indicators were generally below state-specified standards for children in STAR and CHIP, and met or exceeded standards for children in STAR Health (with the exception of waiting to be taken to the exam room):

- In 2011, children in STAR had rates slightly below the HHSC Dashboard standards for *Good Access to Urgent Care* (standard = 88 percent), *Good Access to Routine Care* (standard = 84 percent), and *No Delays for Health Plan Approval* (standard = 65 percent). The rate for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* was more than 10 percentage points below the HHSC Dashboard standard of 35 percent.
- In 2011, children in CHIP had rates equal to the HHSC Dashboard standard for *Good Access to Urgent Care* (standard = 89 percent), slightly below the standard for *Good Access to Routine Care* (standard = 86 percent), and considerably below the standards for *No Delays for Health Plan Approval* (standard = 91 percent) and *No Wait to be Taken to the Exam Room Greater than 15 Minutes* (standard = 68 percent).
- In 2012, children in STAR Health had rates that exceeded the HHSC Dashboard standards for *Good Access to Urgent Care* (standard = 88 percent) and *Good Access to Routine Care* (standard = 76 percent). The STAR Health rate for *No Delays for Health Plan Approval* was equal to the HHSC Dashboard standard of 69 percent, while the rate for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* was 20 percentage points below the standard of 50 percent.

HHSC Performance Dashboard Indicators – Timeliness of Care for Adults					
	STAR		STAR+PLUS		
	2012	Dashboard standard	Medicaid 2012	Dual 2011	Dashboard standard
<i>Good Access to Urgent Care</i>	74%	81%	77%	81%	81%
<i>Good Access to Routine care</i>	67%	80%	73%	80%	80%
<i>No Delays for Health Plan Approval</i>	50%	57%	38%	49%	57%
<i>No Wait to be Taken to the Exam Room > 15 Min.</i>	21%	42%	28%	33%	42%

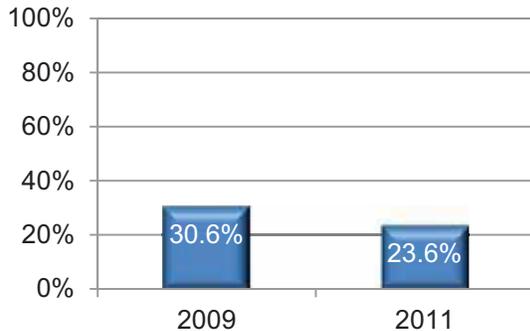
Program-level rates on timeliness indicators were below 2012 state-specified standards for adults in STAR and STAR+PLUS Medicaid-only members – particularly for delays in health plan approval and waiting to be taken to the exam room. STAR+PLUS dual-eligible members had rates equal to 2011 standards for timeliness of urgent and routine care, and rates below the standards for delays in health plan approval and waiting to be taken to the exam room:

- In 2012, adults in STAR had rates below the HHSC Dashboard standard for *Good Access to Urgent Care* (standard = 81 percent), and 13 percentage points below the standard for *Good Access to Routine Care* (standard = 80 percent). The rate for *No Delays for Health Plan Approval* was seven percentage points below the standard of 57 percent, while the rate for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* was more than 20 percentage points below the HHSC Dashboard standard of 42 percent.
- In 2012, STAR+PLUS Medicaid-only members had rates slightly below the HHSC Dashboard standard for *Good Access to Urgent Care* (standard = 81 percent) and seven percentage points below the standard for *Good Access to Routine Care* (standard = 80 percent). The rate for *No Delays for Health Plan Approval* was 19 percentage points below the standard of 57 percent, while the rate for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* was 14 percentage points below the standard of 42 percent.
- In 2011, STAR+PLUS dual-eligible members had rates that were equal to the HHSC Dashboard standards for *Good Access to Urgent Care* (standard = 81 percent) and *Good Access to Routine Care* (standard = 80 percent). The STAR+PLUS dual-eligible rate for *No Delays for Health Plan Approval* was eight percentage points below the standard of 57 percent, while the rate for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* was 9 percentage points below the standard of 42 percent.

Overall, the most recent survey findings on timeliness of care show that improvements in timeliness are warranted for health plan approval and waiting times at doctors' offices for both children and adults.

Few observable trends were seen for any of the HHSC Dashboard timeliness indicators. As shown in **Figure 35**, children in STAR had a notable decrease in performance for *No Wait to be Taken to the Exam Room Greater than 15 Minutes* between 2009 (31 percent) and 2011 (24 percent) – a change that was statistically significant.¹¹⁹ Most STAR MCOs saw a decrease in performance on this indicator between 2009 and 2011, with the greatest decreases observed for Amerigroup (-12 percent), Molina (-12 percent), and Unicare (-11 percent).¹²⁰ Based on this finding, STAR MCOs should explore possible reasons for this decline and implement focused efforts to improve the timeliness of care in clinical settings.

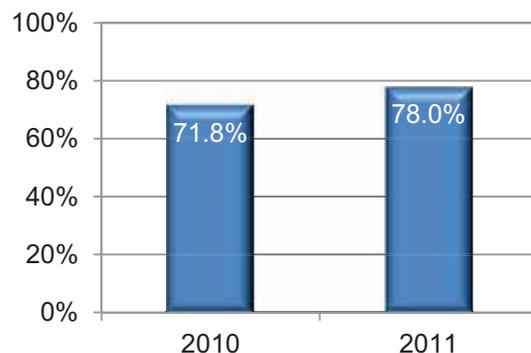
Figure 35. No Wait to be Taken to the Exam Room > 15 Minutes for Children in STAR, 2009-2011



Taken to the Exam Room Greater than 15 Minutes between 2009 (31 percent) and 2011 (24 percent) – a change that was statistically significant.¹¹⁹ Most STAR MCOs saw a decrease in performance on this indicator between 2009 and 2011, with the greatest decreases observed for Amerigroup (-12 percent), Molina (-12 percent), and Unicare (-11 percent).¹²⁰ Based on this finding, STAR MCOs should explore possible reasons for this decline and implement focused efforts to improve the timeliness of care in clinical settings.

As shown in **Figure 36**, children in CHIP had a notable increase in performance for *Good Access to Routine Care* between 2010 (72 percent) and 2011 (78 percent) – a change that was statistically significant.¹²¹ Most CHIP MCOs saw an increase in performance on this indicator over the two-year period, with the greatest increases observed in Molina (+20 percent), Parkland Community (+18 percent), and Aetna (+15 percent).¹²² Although this finding suggests that efficiencies may have been successfully implemented in CHIP provider offices during the one-year period, continued monitoring of this indicator is important to ensure that rates will continue to improve.

Figure 36. Good Access to Routine Care for Children in CHIP, 2010-2011



4.2 – Primary and Specialist Care

The EQRO uses a number of questions from the CAHPS® Health Plan Survey to assess member-reported access to primary and specialist care. These include: (1) three composite measures – *Getting Needed Care* (which is a core composite for adults and children), *Getting Specialized Services* and *Prescription Medicines* (which are composites specifically for children); and (2) three items dealing with access to specialist referrals, behavioral health treatment and counseling, and special therapies that have been incorporated into the HHSC Performance Indicator Dashboard.

Scores for the three CAHPS® composites follow AHRQ specifications, which represent the percentage of members who “usually” or “always” had positive experiences with access to care.

In addition, the EQRO follows a modified NCQA scoring methodology to calculate these scores on a 1- to 3-point scale, which allows for statistical comparisons between population sub-groups and reporting years.

Getting Needed Care

The CAHPS® *Getting Needed Care* composite combines responses to questions about how often it was easy for members to get: (1) appointments with specialists; and (2) care, tests, or treatment they needed through their health plan. For both adults and children, scores for *Getting Needed Care* can be compared to national estimates for the Medicaid and SCHIP populations reported by AHRQ.¹²³

Getting Needed Care scores for both child and adult members are below those reported for Medicaid and SCHIP nationally. Scores on this composite were:

- 72 percent for children in STAR (in 2011), which is lower than the Medicaid national average of 79 percent.
- 72 percent for children in CHIP (in 2011), which is lower than the SCHIP national average of 80 percent.
- 67 percent for adults in STAR (in 2012), which is notably lower than the Medicaid national average of 78 percent.

CAHPS® <i>Getting Needed Care</i>	
Child – 2011/2012	
STAR ^a	72%
CHIP ^a	72%
STAR Health ^b	80%
Adult – 2011/2012	
STAR ^b	67%
STAR+PLUS Medicaid-only ^b	60%
STAR+PLUS Dual-eligible ^a	74%

^a 2011, ^b 2012

The score for *Getting Needed Care* among members in STAR Health (80 percent) was greater than among child members in STAR or CHIP. STAR+PLUS Medicaid-only members had the lowest score for this composite (60 percent), although the score among STAR+PLUS dual-eligible members was notably higher (74 percent).

Since 2009, a negative trend was observed for this composite in STAR+PLUS (Medicaid-only), and a positive trend was observed in STAR Health. As shown in **Figure 37**, scores for *Getting Needed Care* in STAR+PLUS declined by almost nine percentage points over the four-year period, from 69 percent in 2009 to 60 percent in 2012. While scores in all STAR+PLUS MCOs declined during this period, these decreases were statistically significant in Molina and Superior.^{124,125} Furthermore, the program mean for this composite decreased with the addition of the HealthSpring MCO in 2012, which had a low NCQA-scaled score for *Getting Needed Care* (1.91). These findings suggest the need for improved access to primary and specialist care in STAR+PLUS, particularly for Medicaid-only members and those in the Molina and Superior health plans.

Figure 37. CAHPS® Getting Needed Care in STAR+PLUS, 2009-2012

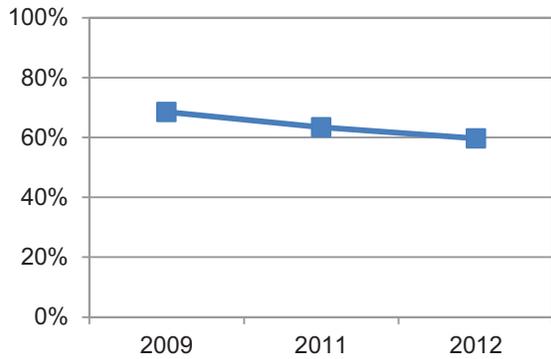
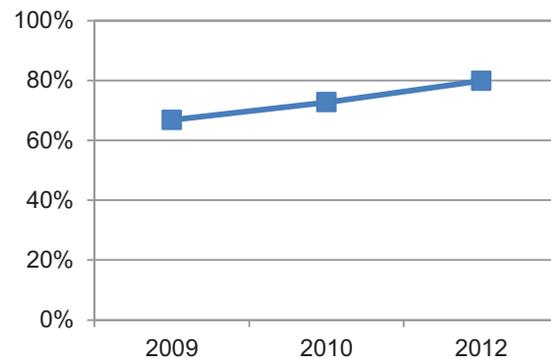


Figure 38. CAHPS® Getting Needed Care in STAR Health, 2009-2012



As shown in **Figure 38**, scores for *Getting Needed Care* in STAR Health increased by over 13 percentage points over the four-year period, from 67 percent in 2009 to 80 percent in 2012. Much of this increase may be explained by improvements in access to network providers in STAR Health since its implementation in 2008.

Getting Specialized Services

The CAHPS® *Getting Specialized Services* composite, which is calculated for children in Medicaid and CHIP, combines responses to questions about access to: (1) special medical equipment or devices; (2) special therapies such as physical, occupational, or speech therapy; and (3) treatment or counseling for emotional, developmental, or behavioral problems.

CAHPS® Getting Specialized Services	
Child – 2011/2012	
STAR ^a	66%
CHIP ^a	64%
STAR Health ^b	72%

^a 2011, ^b 2012

In 2011, approximately two-thirds of parents in STAR (66 percent) and CHIP (64 percent) usually or always had positive experiences getting specialized services for their child. Although no national standards are available for comparison, these scores are considered low, and suggest the need to improve access to specialized services for children in STAR and CHIP.

Among the three items in this composite, the lowest rates of access were observed for behavioral health treatment or counseling, with 61 percent of parents in STAR and 59 percent of parents in CHIP saying it was “usually” or “always” easy to get treatment or counseling for their child. When NCQA-scaled means were compared across the MCOs, the lowest rates in CHIP were seen in Aetna (1.87) and Texas Children’s (1.85), while the lowest rates in STAR were seen in Molina (1.86) and UnitedHealthcare-Texas (1.92).^{126,127}

No observable trends were seen in scores for *Getting Specialized Services* between 2009 and 2012.

Prescription Medicines

The CAHPS® *Prescription Medicines* measure is based on a single item that assesses how often it was easy for parents to get prescription medicines through their child’s health plan. Although no national comparisons are available for this measure, scores in STAR (88 percent), CHIP (88 percent), and STAR Health (93 percent) are considered high, indicative of good access to prescription medication for children. No observable trends were seen for this measure between 2009 and 2012

CAHPS® <i>Prescription Medicines</i>	
Child – 2011/2012	
STAR ^a	88%
CHIP ^a	88%
STAR Health ^b	93%

^a 2011, ^b 2012

HHSC Performance Indicator Dashboard – Survey-based Access Measures

The HHSC Performance Indicator Dashboard includes the following three survey-based measures of access to primary and specialist care, each with standards set by the state for Texas Medicaid and CHIP MCO performance:

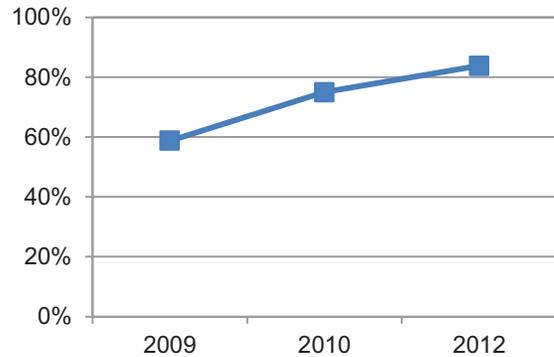
- 1) *Good Access to Specialist Referral* – based on responses to a CAHPS® 4.0 item assessing how often it was easy for the member (or their child) to get a specialist referral. Members who answer “usually” or “always” to this question are considered to have good access to specialist referrals.
- 2) *Good Access to Behavioral Health Treatment or Counseling* – based on responses to a CAHPS® 4.0 item assessing how often it was easy for the parent of a child member to get treatment or counseling for their child for a behavioral health problem. Parents who answer “usually” or “always” to this question are considered to have good access to behavioral health treatment or counseling for their child. This indicator is used only in child surveys.
- 3) *Good Access to Special Therapies* – based on responses to a CAHPS® 4.0 item assessing how often it was easy for the member to get special therapies, such as physical, speech, or occupational therapy. Members who answer “usually” or “always” to this question are considered to have good access to special therapies. This indicator is only used in adult surveys.

HHSC Performance Dashboard Indicators – Access to Care for Children						
	STAR 2011		CHIP 2011		STAR Health 2012	
	Rate	Dashboard standard	Rate	Dashboard standard	Rate	Dashboard standard
<i>Good Access to Specialist Referral</i>	69%	74%	73%	77%	84%	75%
<i>Good Access to BH Treatment/Counseling</i>	61%	76%	59%	76%	78%	79%

Program-level rates for *Good Access to Specialist Referral* were lower than 2011 HHSC Dashboard standards for children in STAR (standard = 74 percent) and CHIP (standard = 77 percent). Rates for *Good Access to Behavioral Treatment or Counseling* were notably lower than 2011 HHSC Dashboard standards for children in STAR (standard = 76 percent) and CHIP (standard = 76 percent). Denominators at the MCO-level for this measure were not sufficient for statistically comparing results among the health plans in STAR or CHIP.

The rate for *Good Access to Specialist Referral* in STAR Health notably exceeded the HHSC Dashboard standard of 75 percent, while the rate for *Good Access to Behavioral Treatment or Counseling* in STAR Health was approximately equal to the standard of 79 percent. Between 2009 and 2012, a considerable increase was observed in access to specialist referrals for members in STAR Health (**Figure 39**). The rate for this indicator increased by 25 percentage points over the four-year period, from 59 percent in 2009 to 84 percent in 2012 – potentially as a result of improvements in access to specialist network providers since the implementation of STAR Health in 2008.

Figure 39. Good Access to Specialist Referral in STAR Health, 2009-2012



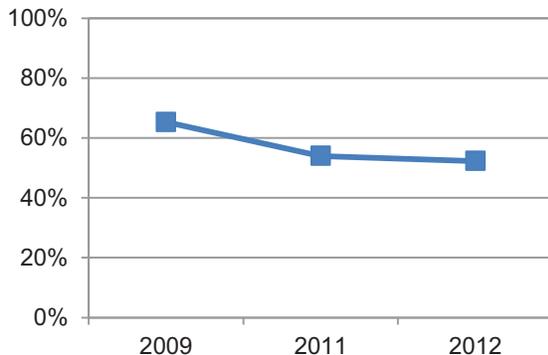
HHSC Performance Dashboard Indicators – Access to Care for Adults					
	STAR		STAR+PLUS		
	2012	Dashboard standard	Medicaid 2012	Dual 2011	Dashboard standard
<i>Good Access to Specialist Referral</i>	64%	73%	61%	78%	73%
<i>Good Access to Special Therapies</i>	62%	58%	52%	53%	66%

Program-level rates for *Good Access to Specialist Referral* were lower than 2012 HHSC Dashboard standards for adults in STAR and STAR+PLUS Medicaid-only members (standard = 73 percent for both programs). Among the STAR MCOs, the lowest rates for this indicator were observed in Parkland Community (48 percent) and Aetna (57 percent). Among the STAR+PLUS MCOs, the lowest rates were seen in Molina and HealthSpring (both at 57 percent). However, differences among the MCOs were not statistically significant in either program.

Among dual-eligibles in STAR+PLUS, access to specialist referrals was considerably better, having increased from 71 percent in 2010 to 78 percent in 2011, and exceeding the 2011 standard for this indicator by five percentage points.

The rate for *Good Access to Special Therapies* among adults in STAR exceeded the 2012 HHSC Dashboard standard of 58 percent. However, in STAR+PLUS, the rate for this indicator was considerably below the standard of 66 percent for both Medicaid-only members (by 14 percentage points) and dual-eligible members (by 13 percentage points).

Figure 40. Good Access to Special Therapies in STAR+PLUS (Medicaid-only), 2009-2012



Furthermore, both groups in STAR+PLUS saw considerable declines in access to special therapies. As shown in **Figure 40**, the rate among STAR+PLUS Medicaid-only members dropped from 65 percent in 2009 to 52 percent in 2012.¹²⁸ Most of this decrease occurred between 2009 and 2011, suggesting that the negative trend in access to special therapies is not explained by the Medicaid managed care expansion that occurred in September 2011. Rates in all STAR+PLUS MCOs declined during this period, particularly in Molina (by 20 percentage points) and Superior (by 15

percentage points).^{129,130} The program mean for this indicator also decreased with the addition of the HealthSpring MCO in 2012, which had a rate of 49 percent. A similar decline in access to special therapies was seen for STAR+PLUS dual-eligible members, from 66 percent in 2010 to 53 percent in 2011. To understand and correct these trends, STAR+PLUS MCOs should examine changes that may have occurred in their specialist provider networks during the period between 2009 and 2011.

4.3 – Patient-Centered Medical Home

The American Academy of Family Physicians defines the patient-centered medical home (PCMH) as a “system of comprehensive coordinated primary care for children, youth and adults.”¹³¹ In the PCMH model, patients have a personal physician who coordinates care within a team, ensures that patients’ needs are being met, and respects patients’ preferences. In a joint statement released in 2007, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association identified seven principles of the patient-centered medical home model:¹³²

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care that is coordinated and/or integrated across settings and providers
- Quality and safety
- Enhanced access (e.g., open scheduling, extended hours)
- Payment structure that promotes coordination, health information technology, and quality incentives

The PCMH may improve not only outcomes of care and patient satisfaction, but also utilization and costs of care. A demonstration project in Washington State found that after one year of implementation, use of the PCMH model in a health care system resulted in higher patient experience ratings, lower emotional exhaustion among staff, increased use of e-mail, phone, and specialist visits, and decreased emergency department visits.¹³³

The EQRO member satisfaction surveys include a number of CAHPS® core and supplemental items that address the presence and quality of the PCMH for members in Texas Medicaid and CHIP, including: (1) the percentage of members with a personal doctor; (2) member ratings of their personal doctor (on a scale of 0 to 10); and (3) CAHPS® composite scores for *How Well Doctors Communicate*; *Shared Decision-Making*; *Personal Doctor*; *Getting Needed Information*; and *Care Coordination*. In addition, STAR+PLUS members' experiences with care coordination are assessed using the HHSC Performance Dashboard indicator, *Good Access to Service Coordination*.

Presence of a Usual Source of Care

The majority of Texas Medicaid and CHIP members report having a personal doctor whom they see when they need a checkup, want advice about a health problem, or get sick or hurt (**Table 6**). Among children, rates of having a personal doctor were higher in the STAR Health program (93 percent) than in STAR (84 percent) or CHIP (85 percent). Among adults, rates were higher for STAR+PLUS Medicaid-only (82 percent) and dual-eligible members (85 percent) than for STAR members (68 percent). No observable trends were seen in the percent of members with a personal doctor over the four-year period.

Table 6. Percent of Members with a Personal Doctor in Texas Medicaid and CHIP

STAR Child 2011	CHIP 2011	STAR Health 2012	STAR Adult 2012	STAR+PLUS	
				Medicaid 2012	Dual-eligible 2011
84%	85%	93%	68%	82%	85%

Member Ratings of their Personal Doctor

For members who report having a personal doctor, the CAHPS® Health Plan Survey also asks them to rate their personal doctor on a scale from 0 to 10. **Figure 41** shows the percentage of parents of child members who gave their child's personal doctor a rating of "9" or "10", along with the corresponding national averages for 2011. Three-quarters of parents of children in STAR rated their child's personal doctor a "9" or "10" (75 percent), which is greater than the Medicaid national average of 70 percent. The rate for children in CHIP (72 percent) was also greater than the SCHIP national average of 69 percent, while the rate for children in STAR Health (74 percent) was comparable. Overall, these findings show that parents of children in Texas Medicaid and CHIP are satisfied with their children's personal doctors.

Between 2009 and 2012, a positive trend was observed in personal doctor ratings for caregivers of children in STAR Health. The percent of caregivers who gave their child’s personal doctor a rating of “9” or “10” increased by over ten percentage points, from 63 percent in 2009 to 74 percent in 2012.

Figure 41. Percent of Parents Rating their Child’s Personal Doctor a “9” or “10”

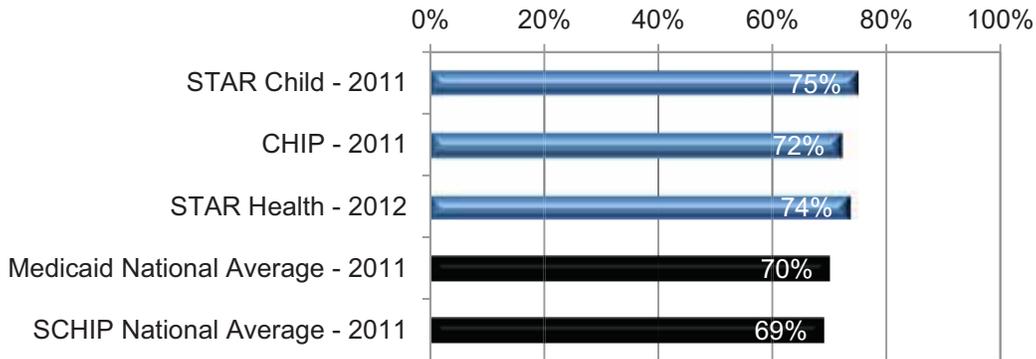
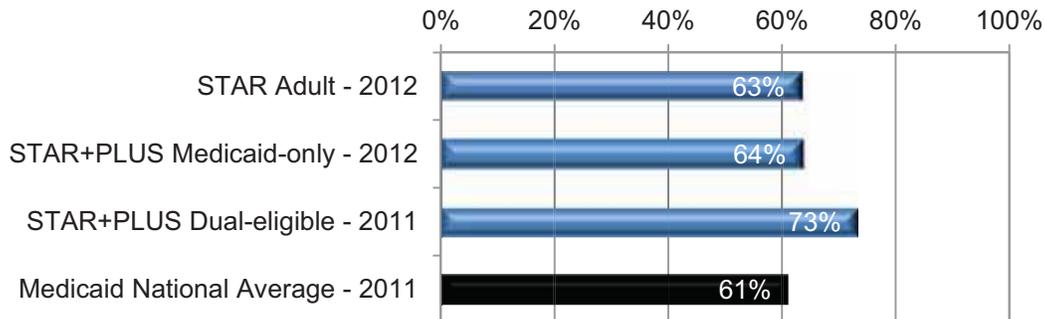


Figure 42 shows the percentage of adult members who rated their own personal doctor a “9” or “10”, along with the corresponding national averages for 2011. Although ratings for personal doctors among adult members were slightly lower than among parents of child members (with the exception of STAR+PLUS dual-eligible members), they generally exceeded the Medicaid national average of 63 percent. The percent of STAR+PLUS members who rated their personal doctor a “9” or “10” was considerably higher among dual-eligibles (73 percent) than among Medicaid-only members (64 percent).

Figure 42. Percent of Members Rating their Personal Doctor a “9” or “10”



How Well Doctors Communicate

Good doctor-patient communication is an important determinant of patient satisfaction and outcomes of care. Patients who report good communication with their doctors are more likely to be satisfied with their care, to share information for accurate diagnosis of their problems, and to adhere to prescribed treatment.¹³⁴ The EQRO uses the CAHPS® composite *How Well Doctors Communicate* to assess member- and parent-reported experiences and satisfaction communicating with their personal doctors. This composite combines responses to questions about how often personal doctors: (1) explained things in a way that was easy for members to

understand; (2) listened carefully to members; (3) showed respect for what members had to say; and (4) spent enough time with members. *How Well Doctors Communicate* is a core CAHPS® composite for both adults and children. Scores follow AHRQ specifications, representing the percentage of members who “usually” or “always” had positive experiences communicating with personal doctors.

The most recent EQRO surveys found that members and parents of child members are generally satisfied with communication with their personal doctors. The score for *How Well Doctors Communicate* among children in STAR (88 percent) was slightly lower than the Medicaid national average of 92 percent, while the score for children in CHIP (91 percent) was comparable to the SCHIP national average of 92 percent.

Eighty-nine percent of adults in STAR had positive experiences communicating with their personal doctors, which is equal to the Medicaid national average for 2011. In STAR+PLUS, *How Well Doctors Communicate* was lower among Medicaid-only members (82 percent) and higher among dual-eligible members (90 percent). No observable trends were seen in scores for this composite over the four-year period.

CAHPS® <i>How Well Doctors Communicate</i>	
Child – 2011/2012	
STAR ^a	88%
CHIP ^a	91%
STAR Health ^b	94%
Adult – 2011/2012	
STAR ^b	89%
STAR+PLUS Medicaid-only ^b	82%
STAR+PLUS Dual-eligible ^a	90%

^a 2011, ^b 2012

Shared Decision-Making

An important component of the patient-centered medical home is the involvement of patients in decisions about their health care. The process of shared decision-making, in which doctors inform patients of available options and elicit patients’ treatment preferences, is particularly suited for long-term decisions, such as those made in the context of chronic illness.¹³⁵

CAHPS® <i>Shared Decision-Making</i>	
Child – 2011/2012	
STAR ^a	88%
CHIP ^a	91%
STAR Health ^b	89%

^a 2011, ^b 2012

To assess parents’ experiences with this process for their children in Texas Medicaid and CHIP, the EQRO uses the CAHPS® composite *Shared Decision-Making*. This composite combines responses to questions about whether the child’s doctor or other health providers: (1) talked with the parent about the pros and cons for each choice for their child’s health care; and (2) asked the parent which choice they thought was best for their child.

Overall, parents reported positive experiences with shared decision-making for their child’s care. Although no national averages are available for comparison, the scores in STAR (88 percent), CHIP (91 percent), and STAR Health (89 percent) are considered high, and indicative of effective shared decision-making practices in the clinical setting. No observable trends were seen in scores for this composite over the four-year period.

Personal Doctor

The CAHPS® composite *Personal Doctor*, which is calculated for children in Medicaid and CHIP, combines responses to questions about whether the child’s personal doctor: (1) talked with the parent about how their child was feeling, growing, or behaving; and (2) understood how the child’s medical, behavioral, or other health conditions affected the child’s and family’s day-to-day life.

CAHPS® <i>Personal Doctor</i>	
Child – 2011/2012	
STAR ^a	86%
CHIP ^a	87%
STAR Health ^b	90%

^a 2011, ^b 2012

Overall, parents reported positive experiences with these aspects of their interactions with their child’s personal doctor. Although no national averages are available for comparison, the scores in STAR (86 percent), CHIP (87 percent), and STAR Health (90 percent) are considered high, and indicate that personal doctors in Medicaid and CHIP are attentive to the broader impacts associated with children’s physical and emotional development. No observable trends were seen in scores for this composite over the four-year period.

Getting Needed Information

CAHPS® <i>Getting Needed Information</i>	
Child – 2011/2012	
STAR ^a	92%
CHIP ^a	92%
STAR Health ^b	90%

^a 2011, ^b 2012

The CAHPS® composite *Getting Needed Information*, which the EQRO also calculates for children in Medicaid and CHIP, is based on a single item about how often parents had their questions answered by their child’s doctors or other health providers.

Although no national averages are available for comparison, scores for this composite in STAR (92 percent), CHIP (92 percent), and STAR Health (90 percent) are considered high, and indicate that parents are adequately having their questions answered by providers. A slight increase in the score for this measure was observed for children in STAR, from 86 percent in 2009 to 92 percent in 2011.

Care Coordination

To assess parents’ experiences with care coordination for their children in Texas Medicaid and CHIP, the EQRO uses the CAHPS® composite *Care Coordination*. This composite combines responses to questions asking: (1) whether the child’s doctors or other health providers helped the parent in contacting their child’s school or daycare; and (2) whether anyone from the child’s health plan, doctor’s office, or clinic helped the parent coordinate their child’s care among different providers and health care services.

CAHPS® <i>Care Coordination</i>	
Child – 2011/2012	
STAR ^a	71%
CHIP ^a	71%
STAR Health ^b	74%

^a 2011, ^b 2012

Although no national averages are available for comparison, scores for this composite in STAR (71 percent), CHIP (71 percent), and STAR Health (74 percent) suggest that there is room for improvement in care coordination practices for children in these programs. It should be noted that the *Care Coordination* score in STAR Health increased by approximately six percentage points, from 68 percent in 2010 to 74 percent in 2012.

HHSC Dashboard Indicator	
<i>Good Access to Service Coordination</i>	
STAR+PLUS – 2010/2012	
Medicaid-only ^b	67%
Dual-eligible ^a	64%
Dashboard standard ^b	63%

Members in STAR+PLUS have the option to receive assistance from a service coordinator through their health plan, who helps to arrange their care and find the services that they need. For these members, the HHSC Dashboard indicator, *Good Access to Service Coordination*, represents the percentage of members who “usually” or “always” received service coordination help as soon as they needed it.

^a 2010, ^b 2012

Results for this indicator are available for Medicaid-only members in 2012 and dual-eligible members in 2010.¹³⁶ Among Medicaid-only members who had a service coordinator, 67 percent had good access to service coordination, which exceeds the 2012 HHSC Dashboard standard of 63 percent. The result for this indicator among dual-eligible members was slightly lower (64 percent), although no 2010 HHSC Dashboard standard is available for comparison. No observable trends were seen for this indicator during the four-year period.

4.4 – Customer Service

Customer service is an important component of managed care that impacts member satisfaction, member compliance with treatment, performance improvement, and ultimately, the size of an MCO's overall membership. Better service translates to higher member satisfaction, which in turn means that members are more likely to return to the same providers, ensuring their continuity of care. Conversely, dissatisfaction with customer service generates potential new costs, lowers treatment compliance, and leads to worse health outcomes.

To assess member satisfaction with health plan customer service in Texas Medicaid and CHIP, the EQRO uses the CAHPS® composite *Health Plan Information and Customer Service*. This is a core composite for both adults and children, and combines responses to questions regarding how often health plan customer service staff: (1) gave members the information or help they needed; and (2) treated members with courtesy and respect. Scores follow AHRQ specifications, which represent the percentage of members who “usually” or “always” had positive experiences with health plan customer service. In addition, the EQRO follows a modified NCQA scoring methodology to calculate these scores on a 1- to 3-point scale, which allows for statistical comparisons between population sub-groups and reporting years.

CAHPS [®] Health Plan Information and Customer Service	
Child – 2011/2012	
STAR ^a	84%
CHIP ^a	82%
STAR Health ^b	75%
Adult – 2011/2012	
STAR ^b	78%
STAR+PLUS Medicaid-only ^b	69%
STAR+PLUS Dual-eligible ^a	74%

^a 2011, ^b 2012

Results for this composite reveal that Texas Medicaid and CHIP members have generally positive experiences with health plan customer service. The score for children in STAR (84 percent) was higher than the Medicaid national average of 80 percent, while the score for children in CHIP (82 percent) was comparable to the CHIP national average of 81 percent.

Among adults in STAR, the score for this composite (78 percent) was slightly below the Medicaid national average of 80 percent. Scores were generally lower in STAR+PLUS, for both Medicaid-only members (69 percent) and dual-eligible members (74 percent).

Among caregivers of children in STAR Health, 75 percent usually or always had positive experiences with health plan customer service. This score is lower than that reported for children in the other programs, and represents a considerable decline from 85 percent in 2010. This finding suggests that the STAR Health MCO (Superior Health Plan) should explore possible reasons for the lower ratings in customer service among caregivers of children in foster care.

4.5 – Behavioral Health Care

In response to recommendations made by the Texas Legislative Budget Board Staff, the EQRO began conducting behavioral health satisfaction surveys for Texas Medicaid members in FY 2010.¹³⁷ These surveys use the CAHPS[®] Experience of Care and Health Outcomes (ECHO) tool, which assesses members' experiences and satisfaction with the behavioral health services they receive through their managed care organization or behavioral health organization. The EQRO has conducted this survey twice for children in STAR (in 2010 and 2011), twice for adults in STAR (in 2010 and 2012), and once for adults in STAR+PLUS (in 2011).

The ECHO behavioral health survey includes four reporting composites that combine responses to closely related survey items:¹³⁸

- 1) *Getting Treatment Quickly*, which assesses how often members got professional counseling over the phone, urgent counseling and treatment, and routine counseling appointments. Scores are calculated on a scale ranging from 1.00 to 3.00.
- 2) *How Well Clinicians Communicate*, which assesses how often clinicians listened carefully to members, explained things in a way members could understand, showed respect for what members had to say, spent enough time with members, made members feel safe, and involved members as much as they wanted. Scores are calculated on a scale ranging from 1.00 to 3.00.

3) *Information About Treatment Options*, which assesses whether members were told about self-help or support groups, and whether they were given information about different kinds of counseling options available to them. Scores are calculated on a scale ranging from 0.00 to 1.00.

4) *Perceived Improvement*, which assesses how members would rate their ability to deal with daily problems, ability to deal with social situations, ability to accomplish things they want to, and their problems or symptoms compared to six months prior to the survey. Scores are calculated on a scale ranging from 1.00 to 4.00.

<u>ECHO Behavioral Health Survey Composites^a</u>						
	STAR Child 2011		STAR Adult 2012		STAR+PLUS 2011	
	Mean	95% CI	Mean	95% CI	Mean	95% CI
<i>Getting Treatment Quickly</i> (1.00 – 3.00)	2.15	2.05-2.24	1.96	1.86-2.07	2.15	2.06-2.23
<i>How Well Clinicians Communicate</i> (1.00 – 3.00)	2.52	2.47-2.56	2.26	2.18-2.29	2.47	2.43-2.51
<i>Information About Treatment Options</i> (0.00 – 1.00)	NR	NR	0.50	0.46-0.53	0.60	0.57-0.63
<i>Perceived Improvement</i> (1.00 – 4.00)	3.09	3.02-3.13	2.78	2.73-2.86	2.60	2.55-2.65

^a 95% CI = 95% Confidence Interval

Findings from the EQRO's most recent behavioral health surveys in STAR and STAR+PLUS showed adequate scores for *Getting Treatment Quickly* and *Perceived Improvement*, and good scores for *How Well Clinicians Communicate*. Scores for *Information About Treatment Options* among adults in STAR (0.50) and STAR+PLUS (0.60) suggest there is room for improvement in the quality of information that behavioral health providers give to members.

5 – Effectiveness of Care

The Institute of Medicine (IOM) defines *effectiveness* as a quality of care that uses “systematically acquired evidence to determine whether an intervention, such as a preventive service, diagnostic test, or therapy, produces better outcomes than alternatives – including the alternative of doing nothing.”¹³⁹ Ensuring that care is effective is one of six aims outlined by the IOM for improving the 21st-century health care system, and requires that services based on scientific knowledge are provided to all who could benefit.

To evaluate effectiveness of care in Texas Medicaid and CHIP, the EQRO uses HEDIS[®] process measures that assess: (1) provider compliance with evidence-based practices; and (2) patient compliance with follow-up and treatment regimens. These measures address the appropriate and effective management of a number of acute and chronic conditions, including pediatric upper respiratory tract infection and pharyngitis; bronchitis in adults; asthma; diabetes; hypertension; and behavioral conditions such as attention deficit-hyperactivity disorder (ADHD), depression, and alcohol or drug dependence. This section also presents preventive care measures related to the promotion of healthy weight and diet in children and adults. Many of these measures are also HHSC Dashboard indicators for STAR, CHIP, STAR Health, or STAR+PLUS.

5.1 – Acute Respiratory Care

Acute respiratory conditions, such as upper respiratory infections (URIs) in children and acute bronchitis in adults, account for a large proportion of outpatient visits in the United States. Children typically experience six to eight URIs each year, with common infections including laryngitis, pharyngitis, otitis media, and the common cold.^{140,141} Pharyngitis, in particular, results in more than seven million pediatric outpatient visits each year – approximately one-third of which are due to a bacterial infection caused by group A streptococcus, which can be treated with antibiotics.^{142,143} However, antibiotics are prescribed as a treatment in 68 percent of respiratory infection cases, which may lead to an increase in drug-resistant bacteria.^{144,145}

Acute bronchitis is a common reason for ambulatory care visits among adults in the United States, although its diagnostic requirements and treatment vary widely in clinical practices.¹⁴⁶ As with pediatric URIs, most cases of acute bronchitis in adults are caused by viruses; however, prescription of antibiotics is a frequent practice and has contributed to the emergence of antibiotic-resistant bacteria.¹⁴⁷

The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend against antibiotic prescriptions for most types of pediatric URIs, including otitis media, rhinitis, viral pharyngitis, cough, and bronchitis.¹⁴⁸ Evidence-based practice guidelines by the CDC also recommend against the routine use of antibiotics for cases of acute bronchitis in adults.¹⁴⁹ The EQRO uses three HEDIS[®] measures to assess the compliance of Texas Medicaid and CHIP providers with treatment guidelines for acute respiratory infections:

- HEDIS[®] *Appropriate Treatment for Children with Upper Respiratory Infection*
- HEDIS[®] *Appropriate Testing for Children with Pharyngitis*
- HEDIS[®] *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*

Appropriate Treatment for Children with Upper Respiratory Infection

The HEDIS® *Appropriate Treatment for Children with Upper Respiratory Infection* measure assesses the percentage of children three months to 18 years old who received a diagnosis of upper respiratory infection (URI) and who *were not* dispensed an antibiotic prescription. As pediatric clinical guidelines do not recommend antibiotic treatment for most URIs, high percentages on this measure indicate good performance. The EQRO calculates this measure annually for STAR, CHIP, and STAR Health.

<u>HEDIS® Appropriate Treatment for Children with URI</u>	
CY 2011 results	
STAR	83 percent
CHIP	76 percent
STAR Health	79 percent

In CY 2011, the percentage of children who received appropriate treatment for URI was 83 percent in STAR, which was lower than the national HEDIS® mean of 87 percent. Rates for this measure were lower in CHIP (76 percent) and STAR Health (79 percent).

Trends in performance on this measure showed very slight increases since 2009, with a net increase of 2.6

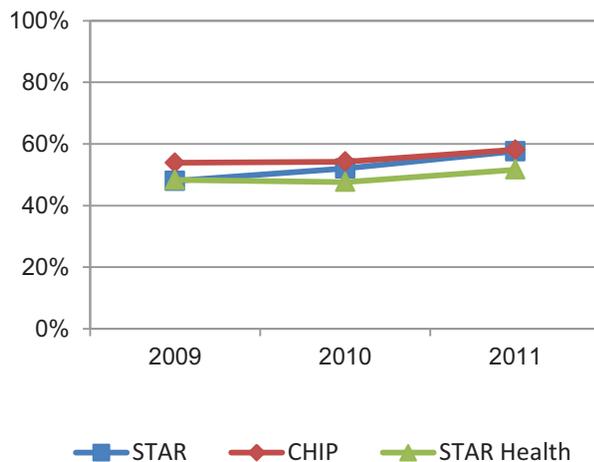
percent in STAR, 1.0 percent in CHIP, and 0.7 percent in STAR Health. Overall, rates of appropriate treatment for pediatric URI in Texas Medicaid and CHIP were generally low and changed little over the three-year period, highlighting the need for efforts to improve MCO network provider compliance with practice guidelines.

Appropriate Testing for Children with Pharyngitis

The HEDIS® *Appropriate Testing for Children with Pharyngitis* measure assesses the percentage of children 2 to 18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic, and who also received a group A streptococcus test for the episode. Because an antibiotic prescription for pharyngitis *without* a positive test for group A streptococcus is not recommended, high percentages on this measure indicate good performance. The EQRO calculates this measure annually for STAR, CHIP, and STAR Health.

Figure 43 shows trends in HEDIS® *Appropriate Testing for Children with Pharyngitis* in STAR, CHIP, and STAR Health from 2009 to 2011. Rates of appropriate testing for pediatric pharyngitis were low for all three programs, ranging from approximately 50 to 60 percent during the three-year period. Rates in STAR were lower than the HEDIS® national means in all three years.

Figure 43. HEDIS® Appropriate Testing for Children with Pharyngitis in STAR, CHIP, and STAR Health, 2009-2011



In 2011, 58 percent of children in STAR received appropriate testing for pharyngitis, compared to 65 percent of children in Medicaid nationally. Rates for this measure were approximately the same in CHIP (58 percent), and slightly lower in STAR Health (52 percent). However, rates of appropriate testing for pharyngitis did increase for all three programs over the three-year period, particularly for children in STAR (from 48 percent in 2009 to 58 percent in 2011). These findings suggest that performance on this measure has seen improvement in Texas Medicaid and CHIP. Health plans should continue efforts to encourage MCO network providers to follow the most up-to-date guidelines for the appropriate prescription of antibiotics in children.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

The HEDIS® *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure assesses the percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were *not* dispensed an antibiotic prescription. As with other measures in this section, high percentages represent good performance. The EQRO calculates this measure annually for STAR+PLUS.

HEDIS® *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* in STAR+PLUS

2010	18 percent
2011	20 percent

Results for this measure in STAR+PLUS are available for 2010 (18 percent) and 2011 (20 percent), showing a slight increase by two percentage points over the two-year period. Findings show low performance on this measure at the program level. Continued monitoring of this measure is important for adults in STAR+PLUS, who are more vulnerable to adverse outcomes related to antibiotic-resistant bacterial infections.

5.2 – Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

Asthma is one of the most common conditions that affect children and adults in Texas Medicaid and CHIP. When improperly managed, the condition can lead to asthma attacks that contribute to potentially avoidable emergency department and hospital admissions, missed school days for children, and missed work days for adults.¹⁵⁰ The National Asthma Education and Prevention Program (NAEPP) recommends that patients with persistent asthma be prescribed long-term control medications for daily use to maintain control of their symptoms and reduce the occurrence of adverse events due to asthma attacks.¹⁵¹

To assess the appropriateness of asthma medication use in Texas Medicaid and CHIP, the EQRO uses the HEDIS® *Use of Appropriate Medications for People with Asthma* measure, which is also an HHSC Performance Dashboard indicator. This measure assesses the percentage of members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period.

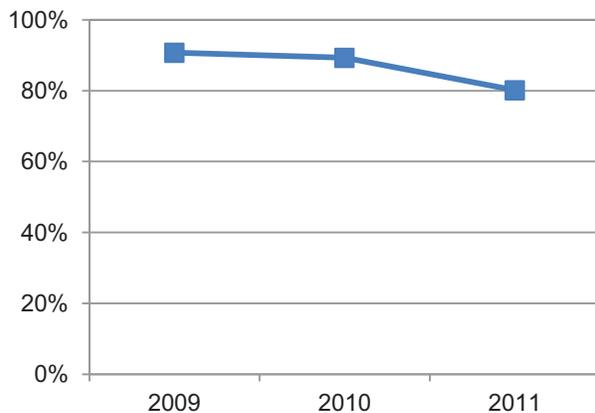
The 2012 HEDIS® specifications for this measure provide rates for four age cohorts: 5 to 11 years, 12 to 18 years, 19 to 50 years, and 51 to 64 years. Following the age cohorts specified in the 2011 HEDIS® specifications and the HHSC Performance Indicator Dashboard, this report

shows results for the 5- to 11-year age group in STAR, CHIP, and STAR Health; and for members 12 to 50 years old in STAR, STAR+PLUS, CHIP, and STAR Health (representing the 12- to 18-year and 19- to 50-year age groups combined).¹⁵²

HEDIS® Use of Appropriate Medications for People with Asthma					
Age 5 to 11 years			Age 12 to 50 years		
	CY 2011 results	Dashboard standard		CY 2011 results	Dashboard standard
STAR	95%	92%	STAR	93%	86%
CHIP	96%	92%	CHIP	93%	86%
STAR+PLUS	95%	None	STAR+PLUS	80%	86%
STAR Health	94%	92%	STAR Health	91%	86%

For members 5 to 11 years old, rates of appropriate asthma medication use exceeded the HHSC Dashboard standard of 92 percent for all programs, suggesting a high level of compliance on this measure for children in Texas Medicaid and CHIP.¹⁵³ The rate in STAR (95 percent) also exceeded the HEDIS® national mean of 92 percent. Although findings show good performance at the program level, continued monitoring of this measure for children is warranted, given the high prevalence of asthma in these populations and its association with potentially preventable hospital admissions and ED visits.

Figure 44. HEDIS® Use of Appropriate Medication for People with Asthma in STAR+PLUS, 2009-2011



For members 12 to 50 years old, rates exceeded the HHSC Dashboard standard of 86 percent in STAR, CHIP, and STAR Health. The rate in STAR (93 percent) also exceeded the national HEDIS® mean of 86 percent. In STAR+PLUS, 80 percent of eligible members in this age group had appropriate asthma medication, which is lower than the HHSC Dashboard standard. Furthermore, the rate of appropriate asthma medication use for adults in STAR+PLUS declined by over 10 percentage points over the three-year period, from 91 percent in 2009 to 80 percent in 2011 (**Figure 44**).¹⁵⁴

Among the five STAR+PLUS health plans, Superior had the highest rate (86 percent) – performing equal to the HHSC Dashboard standard. Rates were below the HHSC Dashboard standard in Evercare (72 percent), Molina (74 percent) and Amerigroup (82 percent). As this measure requires two years of continuous enrollment, a rate was not calculated for HealthSpring (for which only eight months of data were available in CY 2011).

Comprehensive Diabetes Care

Diabetes is a very prevalent chronic condition among adults in Texas Medicaid. Inappropriate management of diabetes can lead to serious complications, including blindness, kidney damage, and lower extremity amputation resulting from neuropathy. Diabetes also makes it difficult to control blood pressure and cholesterol, which can lead to heart attacks or strokes.¹⁵⁵ Complications resulting from the improper treatment of diabetes frequently result in potentially preventable emergency department and hospital admissions.

To prevent the development of these serious complications, the American Diabetes Association (ADA) recommends that people with diabetes receive: (1) an annual eye examination; (2) routine testing of their hemoglobin levels (HbA1c); (3) routine screening of low-density lipoprotein (LDL) cholesterol levels; and (4) routine screening and medical attention for kidney disease (nephropathy).¹⁵⁶ In addition, the ADA recommends that diabetes patients have adequate control of HbA1c levels and LDL-C levels. The monitoring and treatment of diabetes-related complications can reduce the adverse effects that arise from this disease.¹⁵⁷

To assess the effectiveness of diabetes care for adults in STAR and STAR+PLUS, the EQRO uses the HEDIS[®] *Comprehensive Diabetes Care* measure, which is also an HHSC Dashboard indicator for these programs. This measure provides the percentage of members 18 to 75 years of age with diabetes (type 1 or 2) who had HbA1c testing, eye exams, LDL-C screening, medical attention for diabetic nephropathy, adequate HbA1c control, and adequate LDL-C control during the measurement period. HEDIS[®] technical specifications for the *Comprehensive Diabetes Care* measures include the use of both administrative and medical record review data. The measures for adequate hemoglobin control and adequate cholesterol control are hybrid measures, assessed through medical record reviews.

HEDIS [®] <i>Comprehensive Diabetes Care</i>				
	STAR		STAR+PLUS	
	CY 2011 Results	Dashboard standard	CY 2011 Results	Dashboard standard
<i>HbA1c Testing</i>	73%	77%	78%	77%
<i>Eye Exam</i>	36%	50%	37%	50%
<i>LDL-C Screening</i>	70%	71%	76%	71%
<i>Medical Attention for Nephropathy</i>	73%	74%	81%	81%
<i>LDL-C Control < 100 mg/dL</i>	18%	37%	26%	37%
<i>HbA1c Control < 8%</i>	29%	48%	26%	48%

STAR: For adults with diabetes in STAR, CY 2011 results for all sub-measures were below their respective HEDIS[®] national means and HHSC Dashboard standards – suggesting a general need for improvement in diabetes care for this population. The rates for *Eye Exam* (36 percent), *LDL-C Control* (18 percent), and *HbA1c Control* (29 percent) were particularly low in comparison to the national means.

Specific comparisons of HEDIS® *Comprehensive Diabetes Care* results in STAR with the national HEDIS® means and HHSC Dashboard standards are shown below:

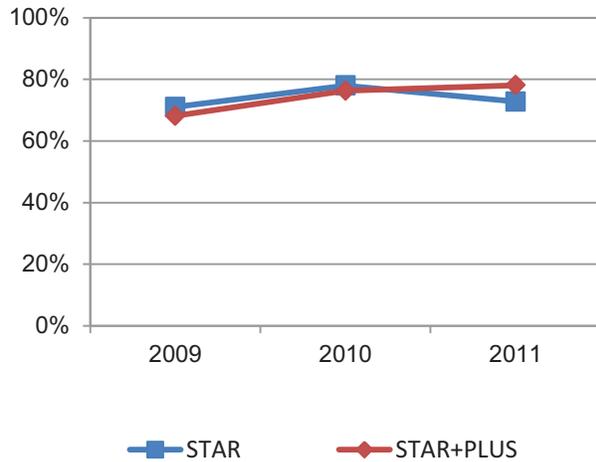
- For *HbA1c Testing*, STAR performed 9 percentage points below the national HEDIS® mean of 82 percent, and 4 percentage points below the HHSC Dashboard standard of 77 percent.
- For the diabetic *Eye Exam* measure, STAR performed 17 percentage points below the national HEDIS® mean of 53 percent, and 14 percentage points below the HHSC Dashboard standard of 50 percent.
- For *LDL-C Screening*, STAR performed 5 percentage points below the national HEDIS® mean of 75 percent, and 1 percentage point below the HHSC Dashboard standard of 71 percent.
- For *Medical Attention for Nephropathy*, STAR performed 5 percentage points below the national HEDIS® mean of 78 percent, and 1 percentage point below the HHSC Dashboard standard of 74 percent.
- For *LDL-C Control*, STAR performed 17 percentage points below the national HEDIS® mean of 35 percent, and 19 percentage points below the HHSC Dashboard standard of 37 percent.
- For *HbA1c Control*, STAR performed 18 percentage points below the national HEDIS® mean of 47 percent, and 19 percentage points below the HHSC Dashboard standard of 48 percent.

STAR+PLUS: For adults with diabetes in STAR+PLUS, rates on all sub-measures were generally higher, but also indicated need for improvement – particularly for *Eye Exam* (37 percent) and *HbA1c Control* (26 percent). Specific comparisons of HEDIS® *Comprehensive Diabetes Care* results in STAR+PLUS with the HHSC Dashboard standards are shown below:

- For *HbA1c Testing*, STAR+PLUS performed 1 percentage point above the HHSC Dashboard standard of 77 percent.
- For the diabetic *Eye Exam* measure, STAR+PLUS performed 13 percentage points below the HHSC Dashboard standard of 50 percent.
- For *LDL-C Screening*, STAR+PLUS performed 5 percentage points above the HHSC Dashboard standard of 71 percent.
- For *Medical Attention for Nephropathy*, performance in STAR+PLUS was equal to the HHSC Dashboard standard of 81 percent.
- For *LDL-C Control*, STAR+PLUS performed 11 percentage points below the HHSC Dashboard standard of 37 percent.
- For *HbA1c Control*, STAR+PLUS performed 22 percentage points below the HHSC Dashboard standard of 48 percent.

Three-year trends could be assessed for the four administrative sub-measures in both STAR and STAR+PLUS. For all four administrative sub-measures, both programs saw a net increase in rates between 2009 and 2011. These increases were most pronounced for *HbA1c Testing* (Figure 45) and *LDL-C Screening* (Figure 46).

Figure 45. HEDIS® Comprehensive Diabetes Care – HbA1c Testing in STAR and STAR+PLUS, 2009-2011

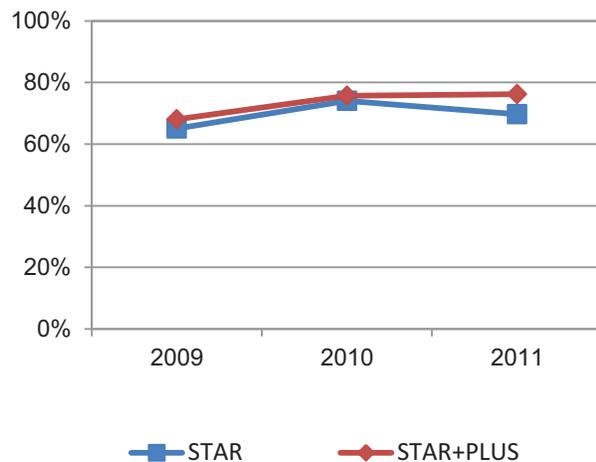


For *HbA1c Testing*, the rate in STAR+PLUS increased by 10.0 percentage points over the three-year period. In STAR, the rate increased notably in 2010 (by 7.0 percentage points), then dropped back to prior levels in 2011, for a net increase of only 1.8 percentage points.

For *LDL-C Screening*, the rate in STAR+PLUS increased by 8.2 percentage points over the three-year period. In STAR, the rate increased notably in 2010 (by 9.0 percentage points), then dropped back in 2011, for a net increase of 4.7 percentage points.

Based on these findings, the EQRO recommends that any MCO interventions to improve diabetes care implemented during this time frame be continued in the coming year, and improved upon using established quality improvement methodologies. Furthermore, STAR+PLUS MCOs should identify factors that contributed to success in increasing rates of *HbA1c Testing* and *LDL-C Screening* in particular, and increase the scope of their implementation to encourage further improvement.

Figure 46. HEDIS® Comprehensive Diabetes Care – LDL-C Screening in STAR and STAR+PLUS, 2009-2011



Controlling High Blood Pressure

The Mayo Clinic states that uncontrolled high blood pressure can result in disabilities and lower quality of life, as well as more life-threatening complications.¹⁵⁸ Consequently, uncontrolled hypertension could ultimately result in higher rates of potentially preventable events and health care costs for the community as a whole. The rate of controlled hypertension serves as an important indicator of quality of care and can reveal member or health plan sub-populations with room for improvement in this area.

The HEDIS[®] *Controlling High Blood Pressure* measure assesses the percentage of members 18 to 85 years old who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. This measure is used by the EQRO to assess blood pressure control in the STAR and STAR+PLUS populations and is also an HHSC Dashboard indicator. Adequate control is defined as having both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high-normal range), with the representative BP being the most recent reading during the measurement year. HEDIS[®] technical specifications for the *Controlling High Blood Pressure* measure allows for the use of both administrative and medical record review data. Results presented in this report are based on hybrid studies using medical record review. Results for the hybrid studies are not available at the service area level.

HEDIS[®] Controlling High Blood Pressure

CY 2011 results

STAR	44 percent
STAR+PLUS	40 percent
Dashboard standard	54 percent

In CY 2011, rates of adequate blood pressure control for the STAR program (44 percent) and STAR+PLUS program (40 percent) were lower than the HHSC Dashboard standard of 54 percent for both programs. In addition, STAR fell below the national HEDIS[®] mean of 56 percent.

In STAR+PLUS, the rate for Superior (62 percent) was substantially higher than that of the other MCOs; furthermore, Superior was the only MCO to meet the HHSC Dashboard standard for this measure.

A hybrid study for this measure was also conducted in 2009 for STAR+PLUS, with a rate of 37 percent for the program.. The increase from 2009 to 2011 was only 3.0 percentage points. However, at the MCO-level, the rate for Superior increased substantially, with a net increase of 18.2 percentage points.

Annual Monitoring for Patients on Persistent Medications

Long-term medication use is common among patients with chronic conditions, such as hypertension, congestive heart failure, kidney disease, and epilepsy. Patients who take persistent medications for these conditions are at increased risk of adverse drug events, requiring monitoring and follow-up by prescribing physicians to assess side-effects and modify pharmaceutical treatment decisions accordingly.¹⁵⁹

The HEDIS® *Annual Monitoring for Patients on Persistent Medications* measure assesses the percentage of members 18 years of age and older with at least 180 treatment days of ambulatory medication therapy who received at least one therapeutic monitoring event during the measurement year. The measure includes four rates, depending on the type of persistent medication, providing the percentage of members who received annual monitoring for:

- 1) *Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)*
- 2) *Digoxin*
- 3) *Diuretics*
- 4) *Anticonvulsants*

The EQRO calculates this measure for STAR+PLUS members because long-term medication use is common in this population. Overall, results for STAR+PLUS were good – 88 percent for all medications combined – indicating that the vast majority of eligible STAR+PLUS members received annual medication monitoring.

STAR+PLUS MCOs performed equally well on this measure. In addition, rates varied little among STAR+PLUS service areas.

HEDIS® Annual Monitoring for Patients on Persistent Medications

STAR+PLUS - CY 2011 results

<i>ACE or ARB</i>	92 percent
<i>Anticonvulsants</i>	67 percent
<i>Digoxin</i>	92 percent
<i>Diuretics</i>	92 percent
<i>Combined Rate</i>	88 percent

5.3 – Behavioral Health Care

Follow-up After Hospitalization for Mental Illness

Annually, approximately 600,000 youths and two million adults are hospitalized for mental health disorders.¹⁶⁰ Follow-up after hospitalization for mental illness is an important component of ongoing post-discharge care. Patients have a lower probability of being readmitted to the hospital if they are in contact with a mental health provider after being discharged from the hospital.¹⁶¹ However, one study found that only 16 percent of patients hospitalized for mental health disorders receive follow-up care, and 13 percent of patients are readmitted within six months of discharge.¹⁶²

The EQRO uses the *Follow-Up after Hospitalization for Mental Illness* measure to assess follow-up care in Texas STAR, CHIP, STAR+PLUS, STAR Health, and NorthSTAR. This measure provides the percentage of members six years of age or older who were hospitalized for treatment of mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a provider during the measurement period. This measure follows HEDIS® specifications with the exception of provider constraints; therefore, comparisons to the national HEDIS® means are approximate and are for illustrative purposes only. Two sub-measures comprise this modified HEDIS® measure: (1) The percentage of members who received follow-up care within 7 days of discharge; and (2) The percentage of members who received follow-up care within 30 days of discharge. This measure is also an HHSC Performance Indicator for the Texas Medicaid and CHIP programs.

<i>Follow-up After Hospitalization for Mental Illness</i>					
7-Day Follow-Up			30-Day Follow-Up		
	CY 2011 results	Dashboard standard		CY 2011 results	Dashboard standard
STAR	43 percent	43 percent	STAR	71 percent	66 percent
CHIP	44 percent	43 percent	CHIP	71 percent	71 percent
STAR+PLUS	48 percent	43 percent	STAR+PLUS	74 percent	64 percent
STAR Health	69 percent	55 percent	STAR Health	91 percent	63 percent
NorthSTAR*	24 percent	---	NorthSTAR*	51 percent	---

*This measure is not an HHSC Performance Indicator for NorthSTAR.

Results among programs for *7-Day Follow-Up* ranged from 24 percent in NorthSTAR to 69 percent in STAR Health. Results among programs for *30-Day Follow-Up* ranged from 51 percent in NorthSTAR to 91 percent in STAR Health.

STAR results were similar to the national HEDIS[®] means for the sub-measures. For follow-up care within seven days, the STAR rate was two percentage points below the HEDIS[®] mean of 45 percent. For follow-up care within 30 days, the STAR rate was seven percentage points above the HEDIS[®] mean of 64 percent.

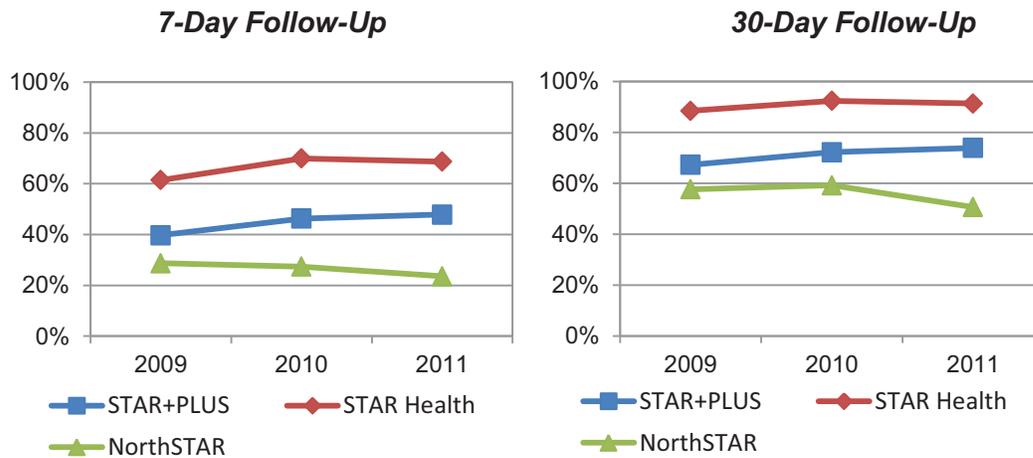
All programs performed well in comparison to their respective HHSC Dashboard standards. STAR Health performed exceptionally well in comparison to its respective Dashboard standards.

In general, trends in performance on this measure changed little between 2009 to 2011 for STAR and CHIP. Specifically, for *7-Day Follow-Up*, STAR had a net increase of 2.8 percent and CHIP had a net increase of 0.6 percent. For *30-Day Follow-Up*, STAR had a net increase of 1.7 percent and CHIP had a net decrease of 0.6 percent. **Figure 47** shows trends in *Follow-up After Hospitalization for Mental Illness* in STAR+PLUS, STAR Health, and NorthSTAR from 2009 to 2011.

STAR+PLUS: Rates for STAR+PLUS increased consistently over the three-year period. For *7-Day Follow-Up*, the net increase from 2009 to 2011 was 8.1 percent. For *30-Day Follow-Up*, the net increase was 6.7 percent.

Among STAR+PLUS MCOs, Evercare had the greatest increase in rates across the three-year period, with a net increase of 19.3 percentage points for *7-Day Follow-Up* and 16.3 percentage points for *30-Day Follow-Up*. Evercare also had the highest rates among STAR+PLUS MCOs for 2011 across both sub-measures. Conversely, rates for Molina decreased across the three-year period, with a net decrease of 23.7 percentage points for *7-Day Follow-Up* and 12.5 percentage points for *30-Day Follow-Up*.

Figure 47. Follow-up After Hospitalization for Mental Illness – Results for STAR+PLUS, STAR Health, and NorthSTAR, 2009-2011



Among the STAR+PLUS service areas, Harris had the greatest increase across the three-year period, with a net increase of 14.5 percentage points for *7-Day Follow-Up*, and a net increase of 12.0 percentage points for *30-Day Follow-Up*. The Travis service area had the highest rates across the three-year period; however, performance in Harris has increased such that both service areas had similar rates in 2011.

STAR Health: Rates for STAR Health also increased from 2009 to 2011. For *7-Day Follow-Up*, the net increase over the three-year period was 7.3 percent, with a peak of 70 percent in 2010. For *30-Day Follow-Up*, rates followed a similar trend, with a net increase of 2.9 percent, and a peak of 92 percent in 2010.

NorthSTAR: Rates for NorthSTAR generally decreased from 2009 to 2011. For *7-Day Follow-Up*, rates decreased from 29 percent in 2009 to 24 percent in 2011, with a net decrease of 5.2 percentage points. For *30-Day Follow-Up*, rates decreased from 58 percent to 51 percent in 2011, with a net decrease of 7.0 percentage points.

Overall, performance on this measure has improved in STAR+PLUS and STAR Health, but has steadily declined for NorthSTAR across the three-year period.

Follow-up Care for Children Prescribed ADHD Medication

Over five million children in the United States have Attention Deficit Hyperactivity Disorder (ADHD), which is a problem with inattentiveness or impulsivity that can affect a child's functioning.^{163,164} Children with this disorder often have trouble socializing with other children, experience difficulties with school work, and are more prone to injuries due to impulsive behavior.^{165,166} Medication is an effective primary treatment for ADHD. However, children prescribed medication should be monitored to ensure that they are receiving the care they need. Specifically, the AAP recommends follow-up visits at regular intervals to assess the

effectiveness of pharmacological treatment and to adjust the treatment plan accordingly.¹⁶⁷ Children who attend follow-up visits and adhere to medication treatment show improvement in symptoms and are less likely to experience adverse events such as emergency department visits.^{168,169}

The *Follow-up for Children Prescribed ADHD Medication* measure provides the percentage of children who were newly prescribed ADHD medication and who had at least three follow-up care visits within a 10-month period. Two sub-measures comprise this modified HEDIS[®] measure:

- *Initiation Phase*: The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner within the first 30 days.
- *Continuation and Maintenance (C&M) Phase*: The percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days, and who, in addition to the visit in the *Initiation Phase*, had at least two follow-up visits with a practitioner within 270 days (9 months) after the *Initiation Phase* ended.

At HHSC’s request, the EQRO lifted provider constraints for this measure, which may result in inflation of rates. The name “HEDIS[®]” was removed from discussion of this measure, as it does not conform precisely to NCQA specifications. The EQRO calculates this measure annually for STAR, CHIP, STAR Health, and NorthSTAR.¹⁷⁰ This measure is also an HHSC Performance Indicator for these programs, with the exception of NorthSTAR.

Results among programs for the *Initiation Phase* ranged from 29 percent in NorthSTAR to 86 percent in STAR Health. Results among programs for the *Continuation and Maintenance Phase* ranged from 42 percent in NorthSTAR to 90 percent in STAR Health.

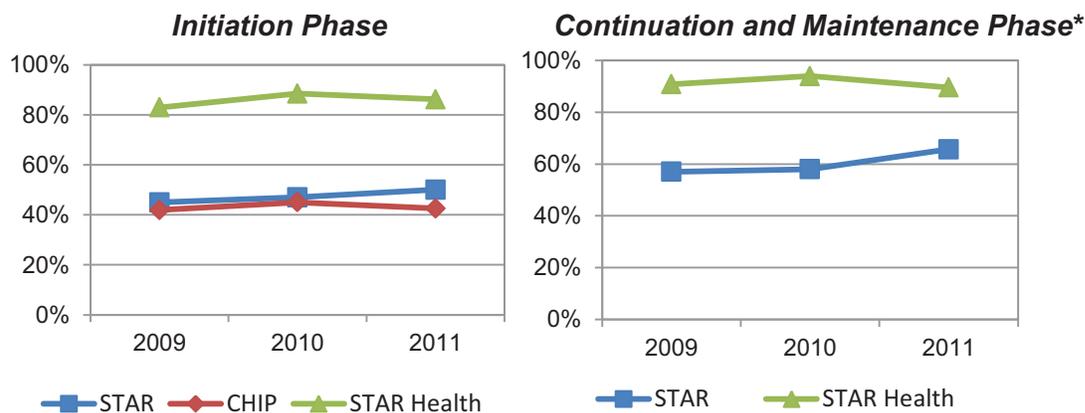
<i>Follow-up Care for Children Prescribed ADHD Medication</i>					
<i>Initiation Phase</i>			<i>Continuation and Maintenance Phase</i>		
	CY 2011 results	Dashboard standard		CY 2011 results	Dashboard standard
STAR	50 percent	41 percent	STAR	66 percent	50 percent
CHIP	43 percent	40 percent	CHIP	58 percent	46 percent
STAR Health	86 percent	35 percent	STAR Health	90 percent	42 percent
*NorthSTAR	29 percent	---	*NorthSTAR	42 percent	---

*This measure is not an HHSC Performance Indicator for NorthSTAR.

STAR results were higher than national HEDIS® means for both sub-measures. For the *Initiation Phase*, the STAR rate was 12 percentage points above the HEDIS® mean of 38 percent. For the *Continuation and Maintenance Phase*, the STAR rate was 22 percentage points above the HEDIS® mean of 44 percent. All programs performed well in comparison to their respective HHSC Dashboard standards. STAR Health performed exceptionally well in comparison to its respective HHSC Dashboard standards.

Figure 48 shows trends in *Follow-up for Children Prescribed ADHD Medication* in STAR, CHIP and STAR Health from 2009 to 2011. NorthSTAR results were only reported for CY 2011; therefore, results for this program are not included in this figure. CHIP results for the *Continuation and Maintenance Phase* are not included due to denominators less than 30 (low denominators) for 2009 and 2010.

Figure 48. Follow-up for Children Prescribed ADHD Medication – Results for STAR and STAR Health 2009-2011



*Results for CHIP are not included in this graph due to denominators less than 30 (low denominators).

In general, trends in performance on this measure changed little between 2009 to 2011 for CHIP and STAR Health. For the *Initiation Phase*, CHIP had a net increase of 0.7 percentage points and STAR Health had a net increase of 3.2 percentage points. For the *Continuation and Maintenance Phase*, STAR Health had a net decrease of 1.3 percentage points.

Rates for STAR across the three-year period increased. Specifically, for the *Initiation Phase*, STAR had a net increase of 5.1 percentage points, and for the *Continuation and Maintenance Phase*, STAR had a net increase of 8.7 percentage points.

Among STAR MCOs, Amerigroup and Parkland had a large increase in rates for both sub-measures. From 2009 to 2011, Amerigroup had a net increase of 9.3 percentage points for the *Initiation Phase*, and a net increase of 21.0 percentage points for the *Continuation and Maintenance Phase*. Parkland had a net increase of 15.9 percentage points for the *Initiation Phase*, and a net increase of 30.5 percentage points for the *Continuation and Maintenance Phase*.

Among STAR service areas, Dallas had the largest increase in rates for both sub-measures. From 2009 to 2011, the rate for the *Initiation Phase* increased by 19.1 percentage points, and the rate for the *Continuation and Maintenance Phase* increased by 37.7 percentage points.

Antidepressant Medication Management

Approximately 15 million adults in the United States suffer from depression.¹⁷¹ Depression impairs an individual's quality of life and is a leading cause of disability. In addition, people who have depression are at an increased risk of suicide if they do not undergo treatment.¹⁷² Medication is recognized as an effective treatment for depression.¹⁷³ Medication is administered during the acute and continuation phases of treatment, which are meant to cause remission of the disease and prevent relapse. It is often necessary to stay on medication to maintain its therapeutic effect. Because half of patients stop medication prematurely, it is necessary to assess the percentage of patients who stay on antidepressant medication for the duration of the treatment period.¹⁷⁴

The HEDIS® *Antidepressant Medication Management* measure assesses the percentage of members 18 years or older who were diagnosed with a new episode of major depression and were treated with antidepressant medication.

This measure is comprised of two sub-measures that address both the acute and continuation phases of treatment:

- The *Effective Acute-Phase Treatment* sub-measure shows the percentage of adults newly diagnosed with major depression who were treated with an antidepressant medication and remained on the medication for at least 84 days (12 weeks).
- The *Effective Continuation-Phase Treatment* sub-measure shows the percentage of adults newly diagnosed with major depression who were treated with an antidepressant medication and remained on the medication for at least 180 days (6 months).

The EQRO calculated this measure for 2010 and 2011 for STAR, STAR+PLUS, and NorthSTAR.¹⁷⁵ This measure is also an HHSC Performance Indicator for these programs, with the exception of NorthSTAR. The CY 2011 STAR results are not presented due to denominators less than 30 (low denominators).

HEDIS® <i>Antidepressant Medication Management</i>					
<i>Effective Acute-Phase Treatment</i>			<i>Effective Continuation-Phase Treatment</i>		
	CY 2011 results	Dashboard standard		CY 2011 results	Dashboard standard
STAR+PLUS	53 percent	43 percent	STAR+PLUS	36 percent	24 percent
*NorthSTAR	58 percent	---	*NorthSTAR	42 percent	---

*This measure is not an HHSC Performance Indicator for NorthSTAR.

In STAR+PLUS, the rate for *Effective Acute -Phase Treatment* was 10 percentage points higher than the HHSC Dashboard standard of 43 percent, and the rate for *Effective Continuation-Phase Treatment* was 12 percentage points higher than the HHSC Dashboard standard of 24 percent.

In NorthSTAR, the rate for *Effective Acute-Phase Treatment* was 58 percent, and the rate for *Effective Continuation-Phase Treatment* was 42 percent.

From 2010 to 2011, performance on this measure in STAR+PLUS changed little. The rate for the acute phase increased by 3.2 percentage points and the rate for the continuation phase decreased by 0.2 percentage points. However, rates for NorthSTAR increased considerably across the two-year period – by 12.5 percentage points for the acute phase and 11.7 percentage points for the continuation phase.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Approximately 21 million people in the United States have a substance use disorder, which includes dependence on or abuse of alcohol, illicit drugs, and prescription drugs (used for non-medical purposes).¹⁷⁶ Individuals who have substance use disorders have an increased risk of experiencing negative health consequences, legal problems, homelessness, and interpersonal violence.¹⁷⁷ Despite the negative impact of substance use disorders, only 10 percent of Americans who need treatment receive it each year.¹⁷⁸ Among individuals receiving treatment, research suggests that as many as one-half may leave treatment prematurely.¹⁷⁹ Treatment engagement, defined as the period between an individual’s initiation and completion of substance abuse treatment, is an important indicator of access to alcohol or other drug (AOD) treatment.

The HEDIS® *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure assesses the percentage of adolescent and adult members newly diagnosed with AOD dependence who received the following:

- 1) *Initiation of AOD Dependence Treatment* – the percentage of members who received inpatient or outpatient treatment within 14 days. Specifically, inpatient or outpatient treatment includes an AOD dependence admission, outpatient visit, intensive outpatient encounter, or partial hospitalization.
- 2) *Engagement of AOD Dependence Treatment* – the percentage of members who initiated treatment and received two or more additional services within 30 days of the initiation visit.

<u>HEDIS® <i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</i></u>		
CY 2011 results		
	Initiation	Engagement
STAR	39 percent	11 percent
STAR+PLUS	35 percent	6 percent
NorthSTAR	25 percent	5 percent

The EQRO calculated this measure for CY 2011 for the STAR, STAR+PLUS, and NorthSTAR programs.¹⁸⁰ Results for treatment initiation ranged from 25 percent in NorthSTAR to 39 percent in STAR, and results for treatment engagement ranged from 5 percent in NorthSTAR to 11 percent in STAR.

STAR results were similar to the national HEDIS[®] means for this measure. Specifically, the rate for treatment initiation was four percentage points lower than the HEDIS[®] mean of 43 percent, and the rate for treatment engagement was three percentage points lower than the HEDIS[®] mean of 14 percent.

5.4 – Preventive Care

Approximately 17 percent of the pediatric population and 36 percent of the adult population in the United States are classified as obese.^{181,182} Obesity substantially increases the risk of morbidity from several conditions, including coronary artery disease, type 2 diabetes, cancer, and stroke.^{183, 184} In addition, obese individuals are at an increased risk of developing conditions such as asthma, sleep apnea, and arthritis.¹⁸⁵ A person’s body mass index (BMI) is calculated from measurements of height and weight, and can be used in conjunction with other diagnostic criteria to identify risk factors for adverse health consequences.^{186,187} Screening for BMI provides the opportunity to implement treatment plans for individuals who are overweight or obese. In the pediatric population, screening for BMI also provides the opportunity to counsel at-risk children and their parents about nutrition and physical activity. Counseling for nutrition and physical activity is important for early intervention in this population, lessening the negative impact of obesity and its complications in adulthood.^{188,189}

Adult BMI Assessment

The HEDIS[®] *Adult BMI Assessment* measure represents the percentage of members age 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or one year prior. The EQRO calculated this measure for CY 2010 and CY 2011 for STAR+PLUS. This is a hybrid measure, with results based on medical record review. Results for hybrid studies are not available at the service area level.

<u>HEDIS[®] Adult BMI Assessment in STAR+PLUS</u>	
2010	46 percent
2011	57 percent

In CY 2011, 57 percent of STAR+PLUS members had their BMI documented. From 2010 to 2011, the rate of BMI assessment increased by 11 percentage points.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The HEDIS[®] *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure represents the percentage of members 3 to 17 years of age who had an outpatient visit with a primary care provider (PCP) or obstetrics/gynecology provider (OB/GYN) and who had the following during the measurement year: (1) *BMI Percentile Documentation*; (2) *Counseling for Nutrition*; and (3) *Counseling for Physical Activity*. Each sub-measure is reported separately, for all age groups combined. This is a hybrid measure that was conducted in CY 2011 for STAR and CHIP, with results based on medical record review. Results for hybrid studies are not available at the service area level.

Approximately one-third of STAR and CHIP members had their BMI percentile documented (36 and 33 percent, respectively). For both programs, the rate of counseling for nutrition was higher than the rate of counseling for physical activity. Specifically, in STAR, 56 percent of members received counseling for nutrition, while 42 percent of members received counseling for physical activity. In CHIP, 46 percent of members received counseling for nutrition, while 36 percent of members received counseling for physical activity.

HEDIS® *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents in CY 2011*

	<i>BMI Percentile Documentation</i>	<i>Counseling for Nutrition</i>	<i>Counseling for Physical Activity</i>
STAR	36 percent	56 percent	42 percent
CHIP	33 percent	46 percent	36 percent

STAR performance was similar to the HEDIS® mean for the *BMI Percentile Documentation* sub-measure and above the HEDIS® mean for both counseling sub-measures. Specifically:

- The STAR rate for *BMI Percentile Documentation* was 1 percentage point below the HEDIS® mean of 37 percent.
- The STAR rate for *Counseling for Nutrition* was 10 percentage points above the HEDIS® mean of 46 percent.
- The STAR rate for *Counseling for Physical Activity* was 5 percentage points above the HEDIS® mean of 37 percent.

A hybrid study for this measure was also conducted in 2010 for STAR. In comparison to 2010, STAR performance improved across all three sub-measures. Specifically, STAR had a net increase of 9.2 percentage points for *BMI Percentile Documentation*, 3.4 percentage points for *Counseling for Nutrition*, and 3.7 percentage points for *Counseling for Physical Activity*.

Among the STAR MCOs, FirstCare had the greatest improvement from 2010 to 2011, with a net increase of 16.8 percentage points for *BMI Percentile Documentation*, 27.5 percentage points for *Counseling for Nutrition*, and 26.3 percentage points for *Counseling for Physical Activity*. Although FirstCare did not have the highest rates among MCOs for this measure in 2011, its level of improvement across the two-year period is notable.

6 – Focus Studies and Special Projects

6.1 – STAR+PLUS Long-Term Care Focus Study

With the passage of the Patient Protection and Affordable Care Act, there has been increased national policy attention focused on dual-eligible beneficiaries – low-income seniors and adults with disabilities – enrolled in both the Medicare and Medicaid programs. Nationwide, there are approximately 9 million dual-eligible beneficiaries, who are among the most chronically ill and costly individuals in these programs.¹⁹⁰ To address the complexity of care for this high-cost, high-need population, the Affordable Care Act established the Federal Coordinated Health Care Office within the CMS (Duals Office) to improve care coordination for dual-eligible beneficiaries.¹⁹¹ The Duals Office and the CMS Innovations Center are currently providing funding to states to design person-centered service delivery models that fully integrate primary, acute, mental health, and long-term services for dual-eligible beneficiaries.

Texas is one of the states that submitted a proposal to implement a Dual-Eligibles Care Demonstration Project.¹⁹² As Texas moves toward an integrated care model for dual-eligible beneficiaries, a greater understanding of health needs in this population will provide the foundation for improved integration and care management to improve members' health and quality of life, and reduce costs associated with preventable inpatient and nursing home admissions.

In FY 2011, the EQRO began a longitudinal focus study of STAR+PLUS dual-eligible members using the Medicare Health Outcomes Survey (M-HOS), which provides a comprehensive description of the health characteristics and needs of dual-eligible populations.¹⁹³ Survey participants were selected from a stratified random sample of dual-eligible members enrolled in STAR+PLUS for 12 months or longer between November 2010 and October 2011. The EQRO set a target sample of 4,800 completed telephone interviews with members, representing 1,200 respondents for each MCO participating in STAR+PLUS in FY 2011 -- Amerigroup, Molina, Superior, and UnitedHealthcare-Texas.

The Survey Research Center (SRC) at the University of Florida conducted the survey using computer-assisted telephone interviewing (CATI) between November 2011 and June 2012. The targeted number of surveys was met for all four quotas. Twenty-eight percent of surveys were completed by a proxy respondent (e.g., family members, caregivers) because the member was physically or mentally unable to participate in the telephone survey. The response rate for the survey was 53 percent (calculated out of all verified, eligible households that could be contacted) and the cooperation rate was 67 percent (calculated out of only those members who either participated or refused).

A summary of results from the baseline survey is provided below:

- **Body mass index.** Forty-one percent of dual-eligible members were classified as obese.
- **Smoking.** Eighteen percent of members reported smoking cigarettes or using tobacco.

- **Self-reported health and functional status.** Using the Veterans RAND-12 items, two-thirds of members reported their health as “fair” or “poor” (66 percent). The majority of members had problems with their work or activities as a result of their physical health (79 percent to 82 percent) or emotional problems (53 percent to 60 percent). One-third of members said their health problems interfered with their social life most or all of the time (35 percent).
- **General and comparative health.** Nearly two-thirds of members said their health was “fair” or “poor” compared to people their own age (64 percent). Compared to one year ago, 42 percent reported their physical health was worse, and 29 percent reported their emotional health was worse.
- **Chronic medical conditions.** The five most prevalent chronic medical conditions observed in the dual-eligible population were hypertension (72 percent), arthritis of the hip or knee (51 percent), arthritis of the hand or wrist (41 percent), diabetes (39 percent), and osteoporosis (31 percent). There was also a high prevalence of comorbidities, with nearly two-thirds of members having three or more medical conditions (64 percent).
- **Activities of daily living.** The most common daily activity impairments reported by members were related to walking (52 percent) and bathing (48 percent).
- **Healthy days measures.** Members reported that their physical health was “not good” an average of 14 days in the past month, and that their emotional health was “not good” an average of 11 days in the past month. Members reported that poor health prevented them from doing their usual activities an average of 13 days in the past month.
- **Depression.** Three-quarters of members had a positive screen for depression and were considered at-risk for a depressive disorder (74 percent).
- **Arthritis and back pain.** Approximately half of members reported experiencing moderate or severe arthritis pain in the past month (53 percent). Thirty-nine percent of members reported that back pain interfered with their daily activities most or all of the time.
- **HEDIS® Physical Activity in Older Adults.** Fifty-five percent of members discussed their level of exercise or physical activity with their doctor, and 58 percent were advised by their doctor to start, increase, or maintain their level of exercise or physical activity.
- **HEDIS® Fall Risk Management.** Fifty-seven percent of members reported problems with balance and walking, and 37 percent had fallen to the ground in the past year. Among these members, 50 percent discussed these issues with their doctor, and 72 percent reported their doctor provided an intervention (e.g., cane or walker, exercise program) to prevent future falls.
- **HEDIS® Urinary Incontinence in Older Adults.** Almost half of members had a urine leakage problem (48 percent), of whom 69 percent discussed the problem with their doctor, and 37 percent received treatment.

- **HEDIS® Osteoporosis Testing.** Fifty-six percent of women had a bone density test to check for osteoporosis, compared to 72 percent nationally.

The STAR+PLUS Dual-Eligible Long-Term Care baseline results are based on cross-sectional data and provide a snapshot of the physical and mental health status and functioning of dual-eligible members at a single point in time. This data can be used by STAR+PLUS MCOs to identify opportunities for quality improvement, specifically in regard to health promotion programs, screening and treatment for depression, effective treatment and management of pain, and improving functional status.

The EQRO will conduct a follow-up survey in 2013 to determine how health and functional status has changed among these members over the two-year period.

6.2 – Risk-Adjustment and Case-Mix Studies

The EQRO conducted a variety of case-mix analyses and risk-adjustment simulations in FY 2011 and 2012. Using the latest Chronic Illness Disability Payment System (CDPS), the EQRO calculated case-mix ratios and spending ratios for MCOs in the STAR and STAR+PLUS programs at the service area (SA) level and by eligibility group. Based on risk-adjustment workgroup meetings held with HHSC and the MCOs, several variables were added to represent diagnostic categories for low birth weight infants, improving the appropriateness of the risk-adjustment models for this important population. For STAR, the EQRO calculated Texas-specific risk-adjustment models to obtain regression weights based on actual Texas experience, which were then applied to member encounter data to estimate the case-mix and spending ratios for each MCO by SA and eligibility group.

In addition to CDPS updates, the EQRO also simulated numerous scenarios for the Texas At-Risk Recoupment and Quality Challenge (QC) programs. These simulations used different point assignments, recoupment strategies, and risk-adjustment approaches to estimate the likely impact of different design options for both the At-Risk and QC programs. Because no single risk-adjustment approach is necessarily correct for all quality measures, the EQRO conducted several meetings with MCOs to obtain their input on appropriate risk adjustors for the various measures comprising these QC programs. Results of different simulations were reported to HHSC continuously throughout the year, and revisions were made to the simulations based on their input.

The EQRO addressed a number of analytic concerns inherent in the quality measures used in these programs, including the imputation of missing values for HEDIS® measures with low denominators and the use of strict or relaxed provider constraints used for determining HEDIS® compliance. Numerous risk-adjustment simulations used the AHRQ PQIs and PDIs, as well as 3M measures of Potentially Preventable Events (PPEs), including Potentially Preventable Admissions (PPAs), Readmissions (PPRs), Emergency Department Visits (PPVs), and Complications (PPCs). This work involved close collaboration with 3M to ensure the correct calculation, application, and interpretation of these measures. The EQRO also applied varying definitions to estimate the excess expenditures associated with PPEs.

In addition to these activities, a number of economic analyses were performed at HHSC's request. The EQRO has undertaken literature reviews of various approaches to: (1) risk-adjustment of long-term care payments under Medicaid; and (2) pay-for-quality initiatives nationwide. Current projects include an analysis of FFS/PCCM and STAR expenditures to determine the relative contributions of health status, costs per member per month, and utilization to the observed cost differences between these programs for members transitioning into STAR. The EQRO is also in the process of calculating the NCQA Relative Resource Use (RRU) measures using Texas-specific risk-adjustment calculations, allowing for comparison of quality measures with resource use to determine the relative value provided by different MCOs.

6.3 – Texas Health Learning Collaborative (THLC)

In FY 2011, programming staff in the ICHP Information Services Group began developing several web-based applications for researchers and stakeholders to distribute, exchange, and discuss health care data. As part of this initiative, the EQRO developed the Texas Health Learning Collaborative (THLC) – a secure web portal that allows Texas HHSC and Medicaid provider organizations to access and share important and timely information on key quality of care metrics.

The THLC portal provides up-to-date, provider-level reporting on measures of potentially preventable events, access, and effectiveness using millions of Medicaid performance records. The interface includes interactive maps, charts, and figures, which allow users to customize views and reports by time period, service type, line of business, geographic area, and other factors. The portal also includes features that allow users to distribute videos and other multi-media resources, deliver webinars, participate in discussion forums, and exchange files. Web development by ICHP is fully HIPAA compliant, and utilizes a variety of application-appropriate platforms.

6.4 – STAR+PLUS Outcomes Study

Implementing home and community-based service (HCBS) alternatives to institutional care has been a priority for many state Medicaid programs over the last three decades. An increasing number of these programs provide care to older and disabled Medicaid members through managed care delivery systems and provider choice limits (1915(b) waivers) combined with provision of long-term care services in the home and community rather than institutional settings (1915(c) waivers). However, little is known about the quality of care associated with these programs. The current literature on outcomes associated with HCBS waiver programs is limited and primarily focuses on health care expenditures for adults 60 years and older and/or the dual-eligible population.^{194,195,196} There is limited information about the quality of care provided within 1915(b) and (c) HCBS waiver programs, particularly for the disabled Medicaid population.¹⁹⁷

As of 2009, there were 33 1915(c) waiver programs administered by 25 states. These programs provide care for approximately 1.4 million Medicaid members with annual expenditures of \$8.9 billion.¹⁹⁸ In June 2012, the Department of Health and Human Services, Office of the Inspector

General (DHHS OIG) released a report noting that “the beneficiaries served by these programs (1915(c) HCBS waivers) are among Medicaid’s most vulnerable, and the nature of these programs puts beneficiaries at risk for receiving inadequate care.”¹⁹⁹ Moreover, the DHHS OIG found that quality of care in these programs was not consistently monitored.

The Texas STAR+PLUS program provides acute and long-term services and supports to beneficiaries meeting an institutional level of care (LOC) in the home or community through a 1915(c) waiver. The EQRO is in the process of conducting a comprehensive, longitudinal examination of the quality of care for Medicaid members with disabilities in STAR+PLUS. Enrollment in STAR+PLUS is mandatory for disabled Medicaid members 21 years and older who reside in counties where the program is offered and who qualify for Supplemental Security Income (SSI) benefits, for Medicaid because of low income, or for STAR+PLUS HCBS waiver services.

The STAR+PLUS program was phased into different service areas throughout Texas over more than a decade, beginning with Harris County in 1998. This phased approach provides a unique opportunity to longitudinally examine the effects of the STAR+PLUS program on the quality and outcomes of care for disabled Medicaid members.

In 2013, the EQRO will examine outcomes for Medicaid members over 21 years of age with disabilities in the Texas STAR+PLUS program.²⁰⁰ The comparison group consists of disabled Medicaid members in either Medicaid fee-for-service (FFS) or primary care case management (PCCM) who met the criteria for enrollment in STAR+PLUS but lived in service areas where STAR+PLUS was not offered at the time. To accommodate the lag in receiving claims and encounter data, these analyses focus on the time period from 2006 through 2010.

Mixed models will be used to examine the effects of the STAR+PLUS program on quality of primary and chronic care, within racial and ethnic subgroups, and within areas of varying levels of socioeconomic disadvantage both before and after the STAR+PLUS program implementation.^{201,202} In addition to race/ethnicity and socioeconomic status, the gender, age and health status of members are included as covariates, with age measured in years and health status measured using the Clinical Risk Groups (CRGs).

The outcome measures will consist of ten HEDIS[®] indicators: (1) HEDIS[®] *Adults' Access to Preventive/Ambulatory Health Services*; (2) HEDIS[®] *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*; (3) HEDIS[®] *Use of Appropriate Medication for People with Asthma*; (4) HEDIS[®] *Medication Management for People with Asthma*; (5) HEDIS[®] *Cholesterol Management for People with Cardiovascular Conditions* (testing only); (6) HEDIS[®] *Comprehensive Diabetes Care* (administrative data only); (7) HEDIS[®] *Antidepressant Medication Management*; (8) HEDIS[®] *Follow-Up After Hospitalization for Mental Illness*; (9) HEDIS[®] *Persistence of Beta-Blocker Treatment After a Heart Attack*; and (10) HEDIS[®] *Pharmacotherapy Management of COPD Exacerbation*.

6.5 – MCO Report Cards Study

With the implementation of the Patient Protection and Affordable Care Act in 2014, Medicaid beneficiaries will face an increasing number of choices – in particular, the choice of which health plan to join. New members in Texas Medicaid and CHIP could have up to five health plans to choose from, depending on their service area. In FY 2013, to assist new members in their selection of a health plan, HHSC developed MCO report cards showing how the health plans in each service area compare on areas of health care quality that are important to members. Report cards that compare physicians, physician groups, hospitals, and health plans are becoming increasingly more common as state agencies and health care institutions seek to increase the involvement of patients in more of their health care decisions.^{203,204}

To support this initiative and ensure that development of MCO report cards follows a patient-centered approach, in FY 2012 the EQRO conducted a preliminary, qualitative study with adult Medicaid members and parents of child members. This study was comprised of two phases: (1) development of MCO report card mock-ups, including the selection of appropriate quality of care measures to be included on the cards, devising a scientifically valid method for scoring the health plans on selected measures, and designing the mock-ups using professional techniques and tools for layout and graphical content; and (2) focus groups to test the MCO report card mock-ups with members, collecting members' input regarding the content and design of the report cards.

Three versions of the MCO report cards were developed, focusing on quality of care for children in STAR and CHIP, adults in STAR, and adults in STAR+PLUS. The EQRO used three criteria in selecting appropriate quality of care measures for the report cards. Specifically, the measures must: (1) be appropriate to the population of Medicaid or CHIP members to which they pertain; (2) be high-impact, having relevance to the majority, if not all, members in the program; and (3) represent an adequate number of members and show a wide distribution of scores at the MCO level. **Table 7** shows the quality of care measures selected for each of the three MCO report card versions.

On each card, the measures were grouped into three domains – Preventive Care, Effectiveness of Care, and Patient Satisfaction. Ratings in the report card mock-ups were prepared using FY 2010 data for health plans in the Bexar service area, which has three health plans in STAR, CHIP, and STAR+PLUS. The health plans were scored on each measure using a five-star rating system, which reflected the health plan's performance on the measure in relation to the state average and allowed differences in performance across health plans to be more readily apparent. Stars were assigned to health plans following the statewide quintiles of distribution on each measure. For example, plan code performance in the 20th percentile or lower would assign one star to the health plan, while plan code performance in the 81st percentile or higher would assign five stars to the health plan.

Table 7. Quality of Care Measures Selected for MCO Report Cards ^a

Quality of Care Measure	Report Card Version		
	STAR/CHIP Child	STAR Adult	STAR+PLUS Adult
Preventive care measures (HEDIS[®])			
<i>Well-child Visits in the First 15 Months of Life</i>	✓		
<i>Well-child Visits in the 3rd, 4th, 5th, and 6th Years</i>	✓		
<i>Adolescent Well-care Visits</i>	✓		
<i>Prenatal Care</i>		✓	
<i>Postpartum Care</i>		✓	
<i>Adults' Access to Preventive/Ambulatory Services</i>			✓
<i>Breast Cancer Screening</i>			✓
Effectiveness measures (HEDIS[®])			
<i>Follow-up for Children Prescribed ADHD Medication</i>	✓		
<i>Comprehensive Diabetes Care – HbA1c Testing</i>			✓
<i>Antidepressant Medication Management</i>			✓
Effectiveness measures (AHRQ PDI/PQI)			
<i>Asthma PDI</i>	✓		
<i>Asthma PQI</i>		✓	✓
<i>Diabetes PQI</i>		✓	
<i>Hypertension PQI</i>			✓
Satisfaction with Care (CAHPS[®])			
<i>Getting Care Quickly composite</i>	✓	✓	✓
<i>How Well Doctors Communicate composite</i>	✓	✓	✓
<i>Health Plan Rating</i>	✓	✓	✓

^a This list represents measures that were tested in the focus groups; not all of these measures were chosen for the final report cards.

To ensure that this study included full representation of the diversity of members in Texas Medicaid and CHIP, the EQRO developed a quota sampling approach for the focus groups. Twenty-four focus groups were planned, stratified according to:

- Four program/eligibility categories: STAR/CHIP parent, STAR adult, STAR+PLUS Medicaid-only, and STAR+PLUS dual-eligible
- Three racial/ethnic groups: White, non-Hispanic; Black, non-Hispanic; and Hispanic
- Two geographic categories – urban and rural

One focus group was conducted for each unique set of characteristics. All urban focus groups took place in Houston. Rural focus groups were conducted in Lubbock, Longview, and McAllen. The focus groups were conducted with women in the selected programs by two experienced moderators during October 2012 and January 2013. The moderator's guide addressed the following topics: (a) participants' process of choosing a health plan, (b) definitions of good and bad quality health care, (c) impressions of the health care report cards, (d) understanding of the report cards, (e) usefulness of report cards, (f) helpfulness of the instruction sheet, (g) feelings on culturally tailored messaging, (h) preferred grading system for health plans, and (i) preferred way to receive the report card. The appropriate report card mock-ups and culturally tailored instruction sheets were distributed to focus group participants during the session.

Overall, women faulted the report card on two major themes: (1) they believed the report card should primarily serve as a conduit to a better doctor (or specialist) and disliked that the card contained no doctor ratings or contacts; and (2) they thought many of the items on the report card reflected the actions of patients rather than the quality of plans. Based on findings from the focus groups, the EQRO made the following recommendations for revising the MCO report cards:

- **Only include relevant information from relevant sources.** Women in the groups responded quickly to report card items that spoke directly to conditions they personally experienced. If participants saw a number of items that were not personally relevant, they had a tendency to dismiss the entire report card. The measures related to patient satisfaction were of greatest relevance to most participants, in large part because they addressed the timeliness of care, which was of great interest to most women in the groups.
- **Define the measures clearly and meaningfully.** Participants said many of the items were less about the health plans than about doctors or people covered by the plans. For example, the AHRQ *Asthma PQI* and *PDI* measures were listed as reflecting how many people avoided hospitalization for treatment. While this is accurate from the perspective of measure specifications, it was an inadequate description according to some participants because it had little to do with the health plan and more to do with people's dedication to their treatment.
- **Duplication.** In communities with a large number of people with reading difficulties, the duplication of information in visual and verbal forms is ideal. For example, participants were almost unanimous in their favorable evaluation of visuals that accompanied each item on the report card (e.g., a picture of a blood pressure cuff to indicate blood pressure, a picture of an inhaler to indicate asthma). When group members had weaker or no reading skills, they preferred health plan ratings depicted using visual scales with stars or faces. Thus, it would benefit these hard-to-reach audiences to offer both verbal and non-verbal scales whenever possible.

These strategies for improving the MCO report cards were used in their re-design in FY 2013, in preparation for final versions to be published and made publicly available to new members.

Appendix A. CY 2011 Recommendations

Domain: Effectiveness of outpatient/ambulatory care for chronic conditions		
Program/s	Recommendation	Rationale
STAR+PLUS	<p>In order to improve the effectiveness of outpatient and ambulatory care for chronic conditions, health plans should implement or improve upon efforts to:</p> <ul style="list-style-type: none"> • Utilize disease management programs that: <ul style="list-style-type: none"> ○ Incorporate components of the Chronic Care Management Model, including: (1) patient education and behavioral support; (2) advanced access to care and use of a health care team; (3) guideline-based therapy; and (4) a clinical registry system.²⁰⁵ ○ Incorporate culturally competent self-management training and practices,²⁰⁶ as well as the use of web-based applications to monitor symptoms.²⁰⁷ 	<p>Potentially avoidable inpatient admissions for chronic conditions such as diabetes, COPD, asthma, and hypertension may reflect reduced effectiveness in outpatient/ambulatory care for these conditions.^{208,209}</p> <p>In STAR+PLUS, the rates of inpatient admissions for diabetes short-term and long-term complications improved between 2009 and 2011, yet remained high. Furthermore, measures of effectiveness of diabetes care found deficiencies in numerous areas, including rates of eye exams, and adequate control of HbA1c and LDL-C levels.</p> <p>The rate of inpatient admissions for COPD or adult asthma in STAR+PLUS was also very high, and has doubled since the prior reporting period.</p>
STAR Health	<ul style="list-style-type: none"> • Increase patient participation in shared decision-making and education to promote self-management, such as implementing group consultations and assistance with preparation for doctor visits.^{210,211} 	<p>STAR Health also had high rates of admission for diabetes short-term complications.</p>
STAR STAR+PLUS	<ul style="list-style-type: none"> • Emphasize the patient-centered medical home, which will improve the transmission of crucial patient information between patients with chronic conditions and their providers, and lead to fewer instances of preventable inpatient admissions.²¹² 	<p>Several MCOs in STAR and STAR+PLUS had PPA rates that were significantly higher than expected given the case-mix of their members experiencing hospitalizations. Furthermore, in both programs, the average excess expenditures associated with PPAs were considerable.</p>

<p>STAR STAR+PLUS</p>	<ul style="list-style-type: none"> • Use information from the Texas Health Learning Collaborative web portal (as it becomes available), to develop profiles of members at greatest risk of having a PPE that can be used in utilization management efforts, as well as in more focused interventions and performance improvement projects. 	<p>Health status and age are important individual factors predicting PPE expenditures and number of events. For all PPEs, members with chronic conditions had greater risk. The association with health status was greatest for PPRs.</p>
<p>STAR+PLUS</p>	<ul style="list-style-type: none"> • Incorporate use of telehealth care (often as part of a more complex intervention). Telehealth care enables patients with chronic conditions to communicate with providers from home when symptoms arise.²¹³ • Incorporate use of walking interventions and other interventions involving pulmonary rehabilitation for patients with COPD.²¹⁴ 	<p>COPD is a prevalent condition among adults in STAR+PLUS, and was the most common condition leading to PPAs in STAR+PLUS – representing 14 percent of all PPAs.</p>
<p>NorthSTAR</p>	<ul style="list-style-type: none"> • Consider innovative strategies to connect members with follow-up care, such as medication management coordinators,²¹⁵ trained patient navigators,²¹⁶ and home care visits for at-risk patients.²¹⁷ 	<p>Rates of follow-up after hospitalization for mental illness in NorthSTAR were below the HEDIS® national rates.</p> <p>Hospitalization for mental illness affects a large number of NorthSTAR members. Inadequate follow-up increases the risk of subsequent, potentially avoidable readmissions.</p>

Domain: Acute respiratory care for children		
Program/s	Recommendations	Rationale
STAR CHIP STAR Health	<p>To reduce inappropriate prescription of antibiotics for children with upper respiratory infections, health plans should implement or improve upon:</p> <ul style="list-style-type: none"> Interventions that direct educational efforts to parents and guardians through printed materials such as posters, brochures, and newsletters that take into account lower health literacy in this population.^{218,219,220} Physician-directed behavior change strategies, including guideline dissemination, small-group education, frequent updates, educational materials, and feedback about antibiotic prescribing by practice and provider.^{221,222} 	<p>Almost all STAR MCOs and service areas failed to meet the national HEDIS[®] means for appropriate testing for pharyngitis and appropriate treatment for URI.</p> <p>In STAR Health and CHIP, the rates of appropriate testing/treatment for pharyngitis and URI were also lower than national HEDIS[®] means.</p> <p>These results suggest that STAR, STAR Health, and CHIP providers are inappropriately prescribing antibiotics, which can lead to the emergence of antibiotic-resistant strains, such as <i>Streptococcus pneumoniae</i>.^{223,224}</p>

Domain: Obesity screening and management		
Program/s	Recommendations	Rationale
STAR CHIP STAR+PLUS STAR Health	<p>Texas Medicaid MCOs/BHOs and CHIP should implement or improve upon efforts to measure and manage members' obesity. Potential strategies include:</p> <ul style="list-style-type: none"> Implementing/modifying an electronic health record (EHR) system with prompts that include: (1) Automatic BMI calculation based on height and weight recorded on patient intake forms; (2) Alerts of unhealthy BMI percentile; and (3) Interactive growth chart plotting for children.^{225,226,227} Health plans should work with providers to consider the EHR Incentive Program for those without EHRs. Initiating unobtrusive interventions such as keeping food and exercise diaries to increase awareness and accountability.²²⁸ Use of standardized programs of health risk monitoring for youths and adults with psychiatric conditions, such as those implemented by the New York State Office of Mental health, to monitor the weight of patients in outpatient settings.^{229,230} 	<p>Half of STAR+PLUS members were obese, a percentage much higher than that of the Texas or national adult population.</p> <p>The STAR and CHIP programs fell short of the HEDIS[®] mean for <i>BMI Percentile Documentation</i>.</p> <p>EHR systems and similar methods have been shown to increase documentation of BMI, which is positively associated with obesity diagnosis and getting dieting counseling and treatment.^{231,232,233}</p> <p>Nearly half of child, adolescent, and adult members in the STAR BH surveys were overweight or obese. Research has shown that adults with mental disorders die, on average, 25 years earlier than adults in the general population, and obesity is a likely contributor.²³⁴</p>

Domain: Service coordination in STAR+PLUS		
Program	Recommendations	Rationale
STAR+PLUS	<p>To improve service coordination in STAR+PLUS, health plans should adopt more stringent standards regarding the frequency and means of contact between service coordinators and members. New standards may include:</p> <ul style="list-style-type: none"> • In-home visits by service coordinators • Proactive telephone contact with members by service coordinators on a regular schedule (quarterly or monthly) • Use of telehealth technology to ensure that service coordination is patient-centered and tailored to members' needs^{235,236} • Protocols for improving communication that involve all stakeholders – service coordinators, nurses, providers, members, and their families <p>To improve shared decision-making in service coordination, HHSC should encourage MCOs to ensure that members are involved more fully in the development of their service plans. Research has found that models which emphasize patients' agreement with their service plans are associated with lower rates of functional decline and higher satisfaction with services.²³⁷</p>	<p>Findings from the STAR+PLUS HCBS Waiver Study qualitative interviews show that STAR+PLUS members often do not know who to call to get help. Many do not have contact information for their service coordinators, and many cannot name someone at their health plan who coordinates their care.</p> <p>For STAR+PLUS members who do not have a nurse who visits them regularly (often those with less severe conditions), low levels of contact with service coordinators translate to unmet needs for care.</p> <p>In addition, only two-thirds of members in STAR+PLUS survey said that their service coordinator involved them in making decisions about their services (64 percent).</p>

Appendix B. Positive Findings and Improvement Areas

Table B1. Positive Findings for Quality of Care in Texas Medicaid/CHIP

Pediatric preventive care	
Quality Indicator	Findings
<i>Children and Adolescents' Access to Primary Care Practitioners</i>	Across programs, child and adolescent members had good access to primary care practitioners, with over 90 percent of members visiting a PCP during the measurement period.
<i>Well-Child Visits and Adolescent Well-Care</i>	Rates of well-child and well-care visits increased slightly over the three-year period for all programs. Rates of increase were especially pronounced in STAR Health. All programs met HHSC Dashboard standards for well-child/well-care visits in all age groups across the three-year period.
<i>HEDIS® Annual Dental Visit</i>	Overall, the rate of annual dental visits in CHIP Dental increased from 59 percent in 2008 to 66 percent in 2010, exceeding the 2011 HEDIS® national average of 48 percent.
Pediatric Quality Indicators	
<i>Asthma PDI</i>	Over the three-year period, pediatric inpatient admissions for asthma decreased in STAR, CHIP, and STAR Health. In 2011, <i>Asthma PDI</i> rates in STAR (100 per 100,000) were below both the HHSC Dashboard standard of 181 per 100,000 and the AHRQ national average of 147 per 100,000.
<i>Gastroenteritis PDI</i>	Pediatric inpatient admissions for gastroenteritis decreased for all programs during the three-year period, particularly in STAR+PLUS.
Prevention Quality Indicators	
<i>Diabetes Short-Term Complications PQI</i>	Adult inpatient admissions for diabetes short-term complications dropped considerably from 2009 to 2011 in STAR+PLUS. The STAR rate for <i>Diabetes Short-Term cComplications PQI</i> was 61 per 100,000 in 2011, which was roughly equivalent to both the AHRQ national average of 62 per 100,000 and the HHSC Dashboard standard of 56 per 100,000.

Table B1 – Positive Findings (continued)

Prevention Quality Indicators	
Quality Indicator	Findings
<i>Diabetes Long-Term Complications PQI</i>	Adult inpatient admissions for diabetes long-term complications dropped considerably from 2009 to 2011 in STAR+PLUS. In 2011, rates in STAR were noticeably better than the HHSC Dashboard standard of 64 per 100,000, and all MCOs had rates lower than the AHRQ national average of 122 per 100,000.
<i>Bacterial Pneumonia PQI</i>	<i>Bacterial Pneumonia PQI</i> rates in STAR+PLUS fell from 765 per 100,000 in 2009 to 622 per 100,000 in 2011, while STAR rates decreased from 58 to 46 per 100,000 during that span. The STAR rates were also substantially lower than the HHSC Dashboard standard for this measure (174 per 100,000).
<i>Urinary Tract Infection PQI</i>	Adult inpatient admissions for urinary tract infection showed a steady decline in STAR+PLUS from 2009 to 2011. In 2011, the STAR <i>UTI PQI</i> rate of 67 per 100,000 was far below the HHSC Dashboard standard of 177 per 100,000 for the STAR program.
Health plan information	
Encounter data validation	Match rates for date of service and procedure were over the desired 95 percent target in all programs, while match rates for diagnosis were over 90 percent in all programs.
Disease management (DM) programs	
DM participation rates	In 2011, the rate of member participation in asthma and diabetes DM programs in STAR+PLUS was 90 percent and 86 percent, respectively.
Satisfaction with timeliness of care, primary, and specialist care	
<i>Good Access to Urgent Care</i>	The rate for STAR Health (96 percent) was higher than the HHSC Dashboard standard of 88 percent for <i>Good Access to Urgent Care</i> .
<i>Good Access to Routine Care</i>	The rate for STAR Health (84 percent) was higher than the HHSC Dashboard standard of 76 percent for <i>Good Access to Routine Care</i> .
<i>Good Access to Specialist Referral</i>	The rate for STAR Health (84 percent) was notably higher than the HHSC Dashboard standard of 75 percent for <i>Good Access to Specialist Referral</i> . The rate among dual-eligible STAR+PLUS members (78 percent) was also higher than the HHSC Dashboard standard of 73 percent.

Table B1 – Positive Findings (continued)

Satisfaction with the patient-centered medical home	
Quality Indicator	Findings
Percent of members with a personal doctor	Greater than 80 percent of Texas Medicaid and CHIP members reported having a personal doctor, with the exception of adult members in STAR (68 percent). Member ratings of their personal doctor generally exceeded the national averages.
CAHPS [®] <i>How Well Doctors Communicate</i>	Scores for <i>How Well Doctors Communicate</i> were high among parents of child members, ranging from 88 percent in STAR to 94 percent in STAR Health. Scores among adult members were also high, ranging from 82 percent for STAR+PLUS Medicaid-only members to 90 percent for STAR+PLUS dual-eligible members.
Care for chronic conditions	
HEDIS [®] <i>Use of Appropriate Medications for People with Asthma</i>	For members 5 to 11 years old, rates of appropriate asthma medication use in STAR exceeded the HEDIS [®] national mean of 92 percent. In addition, rates in all programs exceeded the HHSC Dashboard standard of 92 percent for this age group. For members 12 to 50 years old, the rate in STAR (93 percent) also exceeded the national HEDIS [®] mean of 86 percent.
HEDIS [®] <i>Annual Monitoring for Patients on Persistent Medications</i>	The vast majority of eligible STAR+PLUS members received annual medication monitoring, with a rate of 88 percent for all medications combined.
Behavioral health care	
<i>Follow-up After Hospitalization for Mental Illness</i>	STAR results were similar to the national HEDIS [®] means for 7-day and 30-day follow-up after hospitalization for mental illness. It should be noted that, at HHSC's request, the EQRO lifted provider constraints for this measure. Lifting provider constraints may result in inflation of rates. All programs performed well in comparison to their respective HHSC Dashboard standards, STAR Health in particular. Rates for STAR+PLUS and STAR Health increased consistently from 2009 to 2011.

Table B1 – Positive Findings (continued)

Behavioral health care	
Quality Indicator	Findings
<i>Follow-up for Children Prescribed ADHD Medication</i>	For the <i>Initiation Phase</i> , the STAR rate (50 percent) was higher than the HEDIS [®] mean of 38 percent. For the <i>Continuation and Maintenance Phase</i> , the STAR rate (66 percent) was higher than the HEDIS [®] mean of 44 percent. It should be noted that, at HHSC's request, the EQRO lifted provider constraints for this measure. Lifting provider constraints may result in inflation of rates.
HEDIS [®] <i>Antidepressant Medication Management</i>	In STAR+PLUS, the rate for <i>Effective Acute-Phase Treatment</i> was 53 percent, which is higher than the HHSC Dashboard standard of 43 percent. The rate for <i>Effective Continuation-Phase Treatment</i> was 36 percent, also higher than the HHSC Dashboard standard of 24 percent.

Table B2. Improvement Areas for Quality of Care in Texas Medicaid/CHIP

Health Status	
Quality Indicator	Findings
Childhood obesity	The PCCM program had a high reported obesity rate, with nearly one-third of members classified as obese (31 percent). This finding is relevant for STAR and STAR+PLUS MCOs that have moved into former PCCM counties.
Obesity in STAR+PLUS	For the STAR+PLUS Medicaid-only and dual-eligible populations, nearly one-half of all members were considered obese, and one-fourth of all members were considered overweight.
Adult preventive care	
<i>Timeliness of Prenatal Care</i>	Rates of timely prenatal care increased in STAR+PLUS between 2009 and 2011. Despite the increase in STAR+PLUS, the 2011 rate (68 percent) remained below the HHSC Dashboard standard of 81 percent.
<i>Postpartum Care</i>	The percentage of deliveries receiving a postpartum visit in STAR+PLUS increased slightly across the three-year period; however, the rate in 2011 (38 percent) was still considerably below the HHSC Dashboard standard of 59 percent.
HEDIS [®] <i>Cervical Cancer Screening</i>	The results for cervical cancer screening in STAR (59 percent) and STAR+PLUS (40 percent) fell short of both the HEDIS [®] mean of 67 percent and the HHSC Dashboard standard of 65 percent.

Table B2 – Improvement Areas (continued)

Adult preventive care	
Quality Indicator	Findings
<p>HEDIS[®] <i>Chlamydia Screening in Women</i></p>	<p>In 2011, the percentage of eligible women in the STAR program who received Chlamydia screening during the measurement period (51 percent) was lower than the national HEDIS[®] mean of 58 percent. In addition, the rate among eligible STAR Health members 21 to 24 years of age was 53 percent, which fell short of the HEDIS[®] mean of 62 percent for this age group.²³⁸ In CHIP, less than one in three eligible women received Chlamydia screening (31 percent).</p>
Disease management (DM) programs	
<p>DM participation rates</p>	<p>In 2011, STAR rates for member participation in asthma and diabetes DM programs were the lowest among the programs, with rates of 59 percent and 43 percent, respectively.</p>
Satisfaction with timeliness of care	
<p>CAHPS[®] <i>Getting Care Quickly</i></p>	<p>The adult rate in STAR (71 percent) fell below the national Medicaid average of 81 percent for <i>Getting Care Quickly</i>.</p>
<p><i>Good Access to Urgent Care</i></p>	<p>The adult rate in STAR (74 percent) fell below the HHSC Dashboard standard of 81 percent for <i>Good Access to Urgent Care</i>.</p>
<p><i>Good Access to Routine Care</i></p>	<p>Scores on <i>Good Access to Routine Care</i> for members in CHIP (78 percent), child and adult members in STAR (79 percent and 67 percent, respectively), and Medicaid-only adults in STAR+PLUS (73 percent) were below their respective HHSC Dashboard standards.</p>
<p><i>No Delays for Health Plan Approval</i></p>	<p>Performance on <i>No Delays for Health Plan Approval</i> was below the HHSC Dashboard standards for all members, with the exception of STAR Health, which had a rate equal to its HHSC Dashboard standard. Scores ranged from 63 percent to 69 percent among children and from 38 percent to 50 percent among adults.</p>
<p><i>No Wait to be Taken to the Exam Room Greater than 15 Minutes</i></p>	<p>Performance was considerably below the HHSC Dashboard standards for <i>No Wait to be Taken to the Exam Room Greater than 15 Minutes</i> for all members, ranging from 24 percent to 30 percent among children and from 21 percent to 33 percent among adults.</p>

Table B2 – Improvement Areas (continued)

Satisfaction with primary and specialist care	
Quality Indicator	Findings
CAHPS® <i>Getting Needed Care</i>	Scores for <i>Getting Needed Care</i> among child members ranged from 72 percent in STAR and CHIP to 80 percent in STAR Health, and were lower than those reported for children in Medicaid and SCHIP nationally. Scores for this measure among adult members ranged from 60 percent for STAR+PLUS Medicaid-only members to 74 percent for STAR+PLUS dual-eligible members, also below the national averages.
<i>Good Access to Specialist Referral</i>	Program-level rates for <i>Good Access to Specialist Referral</i> for children in STAR (69 percent) and CHIP (73 percent) were below their respective HHSC Dashboard standards. Rates for adults in STAR and Medicaid-only STAR+PLUS members were also lower than their respective standards.
<i>Good Access to Special Therapies</i>	In STAR+PLUS, the rate for <i>Good Access to Special Therapies</i> was considerably below the HHSC Dashboard standard of 66 percent for both Medicaid-only members (52 percent) and dual-eligible members (53 percent).
Satisfaction with customer service	
CAHPS® <i>Health Plan Information and Customer Service</i>	Among caregivers of children in STAR Health, 75 percent usually or always had positive experiences with health plan customer service. This score is lower than that reported for children in the other programs, and represents a considerable decline from 85 percent in 2010.
Acute respiratory care	
HEDIS® <i>Appropriate Treatment for Children with URI</i>	The percentage of children in STAR who received appropriate treatment for URI was 83 percent, which is lower than the national HEDIS® mean of 87 percent. Rates for this measure are generally low and have changed little over the three-year period
HEDIS® <i>Appropriate Testing for Children with Pharyngitis</i>	Rates of appropriate testing for pediatric pharyngitis were low in all programs from 2009 to 2011. Furthermore, rates in STAR were lower than the HEDIS® mean across all three years. In 2011, the rate for STAR was 58 percent, compared to 65 percent of children in Medicaid nationally.

Table B2 – Improvement Areas (continued)

Care for chronic conditions	
Quality Indicator	Findings
HEDIS® <i>Use of Appropriate Medications for People with Asthma</i>	In STAR+PLUS, the rate of use of appropriate medications for members 12 to 50 years old with asthma (80 percent) fell below the HHSC Dashboard standard of 86 percent. In addition, the rate among adults in STAR+PLUS declined from 91 percent in 2009 to 80 percent in 2011.
HEDIS® <i>Comprehensive Diabetes Care</i>	For adults with diabetes in STAR, CY 2011 results for all sub-measures were below their respective HEDIS® national means and HHSC Dashboard standards – suggesting a general need for improvement in diabetes care for this population. The rates for <i>Eye Exam</i> (36 percent), <i>LDL-C Control</i> (18 percent), and <i>HbA1c Control</i> (29 percent) were particularly low in STAR in comparison to the national means. For adults in STAR+PLUS, rates on all sub-measures were generally higher, but also indicated need for improvement – particularly for the <i>Eye Exam</i> (37 percent) and <i>HbA1c Control</i> sub-measures (26 percent).
HEDIS® <i>Controlling High Blood Pressure</i>	Rates of adequate blood pressure control for the STAR program (44 percent) and STAR+PLUS program (40 percent) were lower than the HHSC Dashboard standard of 54 percent for both programs. The rate for STAR was also lower than the national HEDIS® mean of 56 percent.

Endnotes

¹ Squires, D.A. 2012. *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*. Available at: <http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/May/High-Health-Care-Spending.aspx>.

² KFF (Kaiser Family Foundation). 2012a. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. Available at: <http://www.kff.org/medicaid/8384.cfm>.

³ HHSC (Texas Health and Human Services Commission). 2013a. *Texas Medicaid and CHIP in Perspective, Ninth Edition*. Available at: <http://www.hhsc.state.tx.us/medicaid/reports/PB9/PinkBook.pdf>.

⁴ KFF. 2012b. *Medicaid and Managed Care: Key Data, Trends and Issues – February 2012*. Available at: <http://www.kff.org/medicaid/upload/8046-02.pdf>.

⁵ KFF. 2012c. *Medicaid Today; Preparing for Tomorrow. A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*. Available at: <http://www.kff.org/medicaid/upload/8380.pdf>.

⁶ HHSC. 2013a.

⁷ KFF. 2011a. *Texas & United States. State Medicaid Fact Sheets*. Available at: <http://www.statehealthfacts.org>.

⁸ Ortolon, K. 2011. “Managing Medicaid.” *Texas Medicine* 107(10): 53-56.

⁹ Inglehart, J.K. 2011. “Desperately Seeking Savings: States Shift More Medicaid Enrollees to Managed Care.” *Health Affairs* 30(9): 1627-1629.

¹⁰ HHSC. 2013b. “Medicaid Managed Care Initiatives”. Available at: <http://www.hhsc.state.tx.us/medicaid/MMC.shtml>.

¹¹ IOM (Institute of Medicine). 2001. *Crossing the Quality Chasm: A New Health System for the 20th Century*. Washington, D.C.: National Academy Press.

¹² The U.S. Department of Health and Human Services first proposed regulations to specify these standards in a Notice of Proposed Rulemaking published in the Federal Register on September 29, 1998, and in a final regulation issued in the Federal Register on January 19, 2001. The final regulations published in the Federal Register on June 14, 2002 amended the Medicaid Managed Care regulations published on January 19, 2001.

¹³ CMS (Centers for Medicare & Medicaid Services). 2003. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* Final Protocol Version 1.0. February 11, 2003. Available at: <http://www.cms.hhs.gov/>.

¹⁴ For certain deliverables, such as EQRO satisfaction surveys and special studies, results of activities conducted during FY/CY 2012 are also presented.

¹⁵ The set of HEDIS[®] measures run for STAR Health was more limited than the set run for STAR and CHIP. At HHSC’s request, the following quality of care measures, which may be applied to children, were not run for STAR Health on CY 2011 data: *Childhood Immunization Status, Identification of Alcohol and*

Other Drug Services, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.

¹⁶ ICHP (The Institute for Child Health Policy). 2012. *Texas Medicaid and Managed Care and the Children's Health Insurance Program – Quality of Care Reports – Contract Year 2012*. Gainesville, Florida: The University of Florida.

¹⁷ HHSC. 2013c. *HHSC Reports, Publications & Recommendations*. Available at: http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp.

¹⁸ Donabedian, A. 1980. *Explorations in Quality Assessment and Monitoring, Volume I. The Definition of Quality and Approaches to its Assessment*. Ann Arbor, MI: Health Administration Press.

¹⁹ Donabedian, A. 1988. "The quality of care. How can it be assessed?" *JAMA* 260:1743–1748.

²⁰ IOM. 2001.

²¹ McPherson, M., P. Arango, H. Fox, C. Lauver, M. McManus, P.W. Newacheck, J.M. Perri, J.P. Shonkoff, and B. Strickland. 1998. "A new definition of children with special health care needs." *Pediatrics*. 102:137-140.

²² Neff J., V. Sharp, J. Muldoon, J. Graham, J. Popalisky, and J.C. Gay. 2002. "Identifying and Classifying Children with Chronic Conditions Using Administrative Data with the Clinical Risk Group Classification System." *Ambulatory Pediatrics* 2(1): 1-79.

²³ Hughes J.S., R.F. Averill, J. Eisenhandler, N.I. Goldfield, J. Muldoon, J.M. Neff, and J.C. Gay. 2004. "Clinical Risk Groups (CRGs): A Classification System for Risk-Adjusted Capitation-Based Payment and Health Care Management." *Medical Care* 42(1): 81-90.

²⁴ CAHMI (Child and Adolescent Health Measurement Initiative). 2008. "Children with Special Health Care Needs (CSHCN) Screener." Available at <http://cahmi.org>.

²⁵ National Survey of Children with Special Health Care Needs (NS-CSHCN). 2009/20010. Available at: <http://cshcndata.org>.

²⁶ Most EQRO member surveys are conducted every other year. The STAR Health Survey was conducted in 2012, but not in 2011.

²⁷ CDC (Centers for Disease Control and Prevention). 2009a. "Growth Charts – Clinical Growth Charts." Available at http://www.cdc.gov/growthcharts/clinical_charts.htm.

²⁸ CDC. 2013. *Healthy Weight: Assessing Your Weight*. Available at: <http://www.cdc.gov/healthyweight/assessing/index.html>.

²⁹ IOM. 1993. *Access to Health Care in America*. Washington, D.C.: National Academy Press.

³⁰ WHO (World Health Organization). 2012a. "Chronic Diseases and Their Common Risk Factors." Available at: http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf.

³¹ Mokdad, A.H., J.S. Marks, D.F. Stroup, J.L. Gerberding. 2004. "Actual causes of death in the United States." *Journal of the American Medical Association* 291(10): 1238-1245.

-
- ³² Mokdad, A.H., J.S. Marks, D.F. Stroup, J.L. Gerberding. 2005. "Correction: actual causes of death in the United States." *Journal of the American Medical Association* 293(3): 293-294.
- ³³ AHRQ and U.S. Preventive Services Task Force (USPSTF). 2012. *The Guide to Clinical Preventive Services*. 2012. Available at: <http://www.ahrq.gov/clinic/pocketgd2012/pocketgd2012.pdf>.
- ³⁴ Maciosek, M.V., A.B. Coffield, N.M. Edwards, T.J. Flottemesch, M.J. Goodman, and L.I. Solberg. 2006. "Priorities among effective clinical preventive services: Results of a systematic review and analysis." *American Journal of Preventive Medicine* 31: 52-61.
- ³⁵ AAP (American Academy of Pediatrics): Committee on Child Health Financing. 2006. "Scope of health benefits for children from birth through age 21." *Pediatrics* 117(3): 979-982.
- ³⁶ AAP: Committee on Adolescence. 2008. "Achieving quality health services for adolescents." *Pediatrics* 121(6): 1263-1270.
- ³⁷ Shipman, S.A., J. Lan, C. Chang, and D.C. Goodman. 2010. "Geographic maldistribution of primary care for children." *Pediatrics* 127(1): 19-27.
- ³⁸ Regalado, M. and N. Halfon. 2001. "Primary care services: Promoting optimal child development from birth to three years." *Archives of Pediatric and Adolescent Medicine* 155(12): 1311-1322.
- ³⁹ AAP: Committee on Children with Disabilities. 2001. "Developmental surveillance and screening of infants and young children." *Pediatrics* 108(1): 192-196.
- ⁴⁰ AAP. 2008. "Bright Futures: Health Care Professionals Tools and Resources." Available at: http://brightfutures.aap.org/clinical_practice.html.
- ⁴¹ CDC. 2007. *Adolescent Health in the United States, 2007*. Available at: <http://www.cdc.gov/nchs/data/misc/adolescent2007.pdf>.
- ⁴² AMA (American Medical Association). 1997. *Guidelines for Adolescent Preventive Services*. Available at: <http://www.ama-assn.org>.
- ⁴³ CDC. 2011a. *Ten Great Public Health Achievements – United States, 2001-2010*. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm?s_cid=mm6019a5_w.
- ⁴⁴ CDC. 2012a. *2012 Recommended Vaccinations for Children from Birth Through 3 Years Old*. Available at: <http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf>.
- ⁴⁵ AAP. 2009. *Managing Infectious Diseases in Child Care and Schools, 2nd Edition*. Available at: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Documents/MIDCCSoutbreaks.pdf>
- ⁴⁶ Kroger A.T., W.L. Atkinson, E.K. Marcuse, L.K. Pickering, and the Advisory Committee on Immunization Practices (ACIP) Centers for Disease. 2006. "General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP)". *Morbidity and Mortality Weekly Report* 1:55(RR-15): 1-48.
- ⁴⁷ National Committee for Quality Assurance (NCQA). 2010. *Childhood Immunization Status*. Available at: <http://www.ncqa.org/portals/0/Childhood%20Immunization%20Status.pdf>

-
- ⁴⁸ Dye, B.A., S. Tan, V. Smith, B.G. Lewis, L.K. Barker, G. Thornton-Evans, P.I. Eke, E.D. Beltran-Aguilar, A.M. Horowitz, and L. Chien-Hsun. 2007. *Trends in oral health status: United States, 1988-1994 and 1999-2004*. Hyattsville, MD: National Center for Health Statistics.
- ⁴⁹ HHS (Department of Health and Human Services). 2000. *Oral health in America: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services.
- ⁵⁰ KFF. 2012d. *Oral Health in the US: Key Facts*. Available at: <http://www.kff.org/uninsured/upload/8324.pdf>.
- ⁵¹ Edelstein, B.L. and C.H. Chinn. 2009. "Update on disparities in oral health and access to dental care for America's children." *Academic Pediatrics* 9(6): 415-419.
- ⁵² Dye, B.A., et al. 2007.
- ⁵³ Dye, B.A., et al. 2007.
- ⁵⁴ Lewis, C., W. Mouradian, R. Slayton, and A. Williams. 2007. "Dental insurance and its impact on preventative dental care visits for U.S. children." *Journal of the American Dental Association* 138(3):369-380.
- ⁵⁵ Manski, R. J., and E. Brown. 2007. *Dental use, expenses, private dental coverage, and changes, 1996 and 2004*. Rockville, MD: Agency for Healthcare Research and Quality.
- ⁵⁶ Collins, J.L., J. Lehnher, S.F. Posner, and K.E. Toomey. 2009. "Ties that bind: Maternal and child health and chronic disease prevention at the Centers for Disease Control and Prevention." *Public Health Research, Practice, and Policy* 6(1): 1-6.
- ⁵⁷ AHRQ: The Healthcare Cost and Utilization Project (HCUP). 2011. "Complicating Conditions of Pregnancy and Childbirth, 2008." Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf>.
- ⁵⁸ AAP and ACOG (American College of Obstetricians and Gynecologists). 2007. *Guidelines for Perinatal Care, Sixth Edition*. Elk Grove Village, IL: American Academy of Pediatrics.
- ⁵⁹ Breastcancer.org. 2012. "U.S. breast cancer statistics." Available at: http://www.breastcancer.org/symptoms/understand_bc/statistics.
- ⁶⁰ Independent U.K. Panel on Breast Cancer Screening. 2012. "The benefits and harms of breast cancer screening: an independent review." *The Lancet* 380(9855): 1778-1786.
- ⁶¹ AAFP (The American Academy of Family Physicians). 2009. "Breast cancer." Available at: <http://www.aafp.org/online/en/home/clinical/exam/breastcancer.html>.
- ⁶² CDC. 2012b. "Gynecologic cancers: Cervical cancer." Available at: <http://www.cdc.gov/cancer/cervical/>.
- ⁶³ American Cancer Society. 2012. "Cancer Prevention and Early Detection: Facts and Figures." Available at: <http://www.cancer.org/Research/CancerFactsFigures/CancerPreventionEarlyDetectionFactsFigures/>.
- ⁶⁴ CDC. 2012c. "Chlamydia-CDC Fact Sheet." Available at: <http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm>.

-
- ⁶⁵ ACOG. 2007. "Spotlight on Chlamydia: Annual Screenings a Must for Young Women." Available at: http://www.acog.org/About_ACOG/News_Room/News_Releases/2007/.
- ⁶⁶ CDC. 2012c.
- ⁶⁷ CDC. 2012c.
- ⁶⁸ AHRQ. 2004. *Prevention Quality Indicators Overview*. Available at http://www.qualityindicators.ahrq.gov/pqi_overview.htm.
- ⁶⁹ Three-year trends are not available due to changes to the specifications for *COPD* and *Adult Asthma PQIs* that occurred in 2012. See: http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V44/PQI_Changes_4.4.pdf
- ⁷⁰ 3M HIS (3M Health Information Systems). 2011. *Potentially Preventable Events*. Murray, UT: 3M HIS.
- ⁷¹ Vest, J. R., L.D. Gamm, B.A. Oxford, B.I. Gonzalez, and K.M. Slawson. 2010. "Determinants of Preventable Readmissions in the United States: A Systematic Review." *Implementation Science*, 5(88), 1-28.
- ⁷² Vest, J.R. et al. 2010.
- ⁷³ Lindquist, L.A. and D.W. Baker. 2011. "Understanding Preventable Hospital Readmissions: Masqueraders, Markers, and True Causal Factors." *Journal of Hospital Medicine* 6(2): 51-53.
- ⁷⁴ Friedman, B. and J. Basu. 2004. "The Rate and Cost of Hospital Readmissions for Preventable Conditions." *Medical Care Research and Review* 61(2): 225-240.
- ⁷⁵ National Alliance on Mental Illness. 2007. "Mental Illness: Facts and Numbers." Available at: http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/NAMI_MI_FactsandNumbers2009.pdf.
- ⁷⁶ Berren, M.R., J.M. Santiago, M.R. Zent, and C.P. Carbone. 1999. "Health care utilization by persons with severe and persistent mental illness." *Psychiatric Services* 50(4): 559-561.
- ⁷⁷ Fogarty, C.T., S. Sharma, V.K. Chetty, and L. Culpepper. 2008. "Mental health conditions are associated with increased health care utilization among urban family medicine patients." *Journal of the American Board of Family Medicine* 21(5): 398-407.
- ⁷⁸ Rates reported for this measure in NorthSTAR include STAR and FFS claims in the Dallas service area.
- ⁷⁹ National Survey on Drug Use and Health. 2011. "Summary of national findings." Available at: http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/NAMI_MI_FactsandNumbers2009.pdf.
- ⁸⁰ SAMHSA (Substance Abuse and Mental Health Services Administration). 2012. *Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits*. Available at: <http://www.samhsa.gov/data/2k12/DAWN096/SR096EDHighlights2010.htm>.
- ⁸¹ Rates reported for this measure in NorthSTAR include STAR and FFS claims in the Dallas service area.

⁸² IOM. 2001.

⁸³ Habib, J.L. 2010. "EHRs, Meaningful Use, and a Model EMR." *Drug Benefit Trends* 22(4).

⁸⁴ CDC. 2012d. *Meaningful Use*. Available at <http://www.cdc.gov/ehrmeaningfuluse/introduction.html>.

⁸⁵ Beginning in 2012, the EQRO shifted to conducting EDV studies every two years.

⁸⁶ CMS. 2002. *Validating Encounter Data: A Protocol for Use in Conducting External Quality Review of Medicaid Managed Care Organizations and Prepaid Health Plans*. Baltimore, MD.

⁸⁷ Blumenthal, D. and M. Tavenner. 2010. "The 'Meaningful Use' Regulation for Electronic Health Records." *The New England Journal of Medicine*, 363(6)

⁸⁸ CDC. 2012d.

⁸⁹ Data on incentives for providers to implement EHR during FY 2011 was not available for Delta Dental or ValueOptions.

⁹⁰ Texas Government Code § 533.0131. Available at: <http://www.legis.state.tx.us/tlodocs/77R/billtext/html/HB01591F.htm>.

⁹¹ CMS. 2002.

⁹² AMA. 2011. *CPT – Current Procedural Terminology*. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page?>

⁹³ CDC. 2009b. *International Classification of Diseases, Ninth Revision (ICD-9)*. Available at: <http://www.cdc.gov/nchs/icd/icd9.htm>.

⁹⁴ KFF. 2010. *A Primer: Key Information on our Nation's Health Coverage Program for Low-Income People*. June 2010. Available at <http://www.kff.org/medicaid/upload/7334-04.pdf>

⁹⁵ HHSC. 2008. *HHSC Uniform Managed Care Manual: Disease Management*. Available at http://www.hhsc.state.tx.us/medicaid/UMCM/Chp9/9_1.pdf.

⁹⁶ The 2011 AI tool for Superior did not specifically collect DM participation rates for STAR Health. Moving forward, the EQRO will modify the AI tool to permit a separate assessment of STAR Health.

⁹⁷ HHSC. 2008.

⁹⁸ FirstCare, Parkland, Superior, and UnitedHealthcare contracted with DMOs.

⁹⁹ Only Driscoll, FirstCare, and Parkland did not report assigning DM participants to risk groups.

¹⁰⁰ This information is drawn from the Administrative Interview Conference Calls with the health plans. ICHP does not have this information available for the DM programs in Delta Dental, Parkland, or ValueOptions.

¹⁰¹ Community First members can ‘opt-in’ to the DM programs if an assessment is completed. Otherwise, the DM programs are ‘opt-out’.

¹⁰² CMS. 2012a. *Preview of Nursing Home Quality Assurance & Performance Improvement (QAPI) Guide – QAPI at a Glance*. Available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-05.pdf>

¹⁰³ Health Resources and Services Administration (HRSA), 2011. *Developing and Implementing a QI Plan*. Available at <http://www.hrsa.gov/quality/toolbox/508pdfs/developingqiplan.pdf>

¹⁰⁴ CMS. 2012a.

¹⁰⁵ Delta Dental: Chi-square = 30.89, p < 0.001; Seton: Chi-square = 7.98, p = 0.005.

¹⁰⁶ CMS. 2012a.

¹⁰⁷ Wickizer, T.M., G. Franklin, D. Fulton-Kehoe, J.A. Turner, R. Mootz, and T. Smith-Weller. 2004. “Patient satisfaction, treatment experience, and disability outcomes in a population-based cohort of injured workers in Washington State: Implications for quality improvement.” *Health Services Research* 39(4 pt 1): 727-748.

¹⁰⁸ Pascoe, G.C. 1983. “Patient Satisfaction in Primary Health Care: A Literature Review and Analysis.” *Evaluation and Program Planning* 6: 185-210.

¹⁰⁹ Halfon, N., M. Inkelas, R. Mistry, and L.M. Olson. 2004. “Satisfaction With Health Care for Young Children.” *Pediatrics* 113: 1965-1972.

¹¹⁰ Donabedian, A. 1980.

¹¹¹ Ware, J.E., A. Davies-Avery, and A.L. Stewart. 1978. “The measurement and meaning of patient satisfaction.” *Health and Medical Care Services Review* 1: 1-15.

¹¹² Mangione-Smith, R., and E.A. McGlynn. 1998. “Assessing the Quality of Healthcare Provided to Children.” *Health Services Research* 33(suppl.): 1059-1090.

¹¹³ Darby, C. 2002. “Patient/Parent Assessment of the Quality of Care.” *Ambulatory Pediatrics* 2(suppl.): 345-348.

¹¹⁴ PCORI (Patient-Centered Outcomes Research Institute). 2012. *National Priorities for Research and Research Agenda*. Available at: <http://www.pcori.org/assets/PCORI-National-Priorities-and-Research-Agenda-2012-05-21-FINAL.pdf>.

¹¹⁵ Rathert, C., M.D. Wyrwich, and S.A. Boren. 2012. “Patient-Centered Care and Outcomes: A Systematic Review of the Literature.” *Medical Care Research and Review*, Nov. 20, 2012.

¹¹⁶ Ahmed, S., R.A. Berzon, D.A. Revicki, W.R. Lenderking, C.M. Moinpour, E. Basch, B.B. Reeve, A.W. Wu, and the International Society for Quality of Life Research. 2012. “The use of patient-reported outcomes (PRO) within comparative effectiveness research: implications for clinical practice and health care policy.” *Medical Care* 50(12): 1060-1070.

¹¹⁷ IOM. 2001.

¹¹⁸ At the time of this report, the most recent AHRQ national results available for CAHPS® composites in Medicaid and CHIP were from 2011.

¹¹⁹ Significance tests are run on unweighted data. Chi-square = 34.108, $p < 0.001$.

¹²⁰ The result for this indicator increased in Community First, from 22 percent in 2009 to 29 percent in 2011.

¹²¹ Significance tests are run on unweighted data. Chi-square = 30.209, $p < 0.001$.

¹²² Driscoll and UnitedHealthcare-Texas saw no change in this indicator between 2010 and 2011; the El Paso First rate dropped by one percentage point.

¹²³ At the time of this report, the most recent AHRQ national results available for CAHPS® composites in Medicaid and CHIP were from 2011.

¹²⁴ The NCQA-scaled score for *Getting Needed Care* in Molina decreased from 2.19 to 1.95: $F = 10.828$, $p < 0.001$.

¹²⁵ The NCQA-scaled score for *Getting Needed Care* in Superior decreased from 2.26 to 2.04: $F = 9.782$, $p = 0.002$.

¹²⁶ The NCQA-scaled scores for *Getting Specialized Services* in the 2011 STAR Child Survey were significantly different among the STAR MCOs: $F = 3.113$, $p < 0.001$.

¹²⁷ The NCQA-scaled scores for *Getting Specialized Services* in the 2011 CHIP Survey were significantly different among the CHIP MCOs: $F = 1.708$, $p = 0.046$.

¹²⁸ Chi-square = 12.779, $p < 0.001$.

¹²⁹ Molina: Chi-square = 7.785, $p = 0.005$.

¹³⁰ Superior: Chi-square = 3.716, $p = 0.054$.

¹³¹ AAFP. 2012. *Patient-Centered Medical Home*. Available at: <http://www.aafp.org/online/en/home/policy/policies/p/patientcenteredmedhome.html>.

¹³² ACP (American College of Physicians). 2007. *Joint Principles of the Patient-Centered Medical Home*. Available at: http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf.

¹³³ Reid, R.J., P.A. Fishman, O. Yu, T.R. Ross, J.T. Tufano, M.P. Soman, and E.B. Larson. 2009. "Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care* 15(9):e71-87.

¹³⁴ Fong Ha, J. and N. Longnecker. 2010. "Doctor-Patient Communication: A Review." *The Ochsner Journal* 10(1): 38-43.

¹³⁵ Joosten, E.A., L. DeFuentes-Merillas, G.H. de Weert, T. Sensky, C.P van der Staak, and C.A. de Jong. 2009. "Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status." *Psychotherapy and Psychosomatics* 77(4): 219-226.

¹³⁶ The result for this indicator for dual-eligible members in 2011 is not available because the denominator was too low to report (< 30).

¹³⁷ The Legislative Budget Board Staff (LBBS). 2009. *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. Available at: <http://www.lbb.state.tx.us/>.

¹³⁸ A fifth ECHO composite, *Getting Treatment and Information from the Plan or MBHO*, is not reported due to low denominators (< 30).

¹³⁹ IOM. 2001.

¹⁴⁰ Hart, A.M. 2007. "An evidence-based approach to the diagnosis and management of acute respiratory infections." *The Journal for Nurse Practitioners* 3(9): 607-611.

¹⁴¹ Hart, A.M. 2007.

¹⁴² Murray, R.C., and S.K. Chennupati. 2012. "Chronic streptococcal and non-streptococcal pharyngitis." *Infectious Disorders Drug Targets* 12(4): 281-285.

¹⁴³ Shaikh, N., E. Leonard, and J.M. Martin. 2010. "Prevalence of Streptococcal Pharyngitis and Streptococcal Carriage in Children: A Meta-Analysis." *Pediatrics* 126(3): e557-e564.

¹⁴⁴ CDC. 2012e. "Get Smart: Know When Antibiotics Work." Available at: <http://www.cdc.gov/getsmart/antibiotic-use/fast-facts.html#ref2>.

¹⁴⁵ Ayanruoh, S., M. Waseem, F. Quee, A. Humphrey, and T. Reynolds. 2009. "Impact of rapid streptococcal test on antibiotic use in a pediatric emergency department." *Pediatric Emergency Care* 25(11): 748-750.

¹⁴⁶ Knutson, D. and C. Braun. 2002. "Diagnosis and Management of Acute Bronchitis". *American Family Physician* 65(10): 2039-2045.

¹⁴⁷ Gonzales, R., T. Anderer, C.E. McCulloch, J.H. Maseli, F.J. Bloom, T.R. Graf, M. Stahl, M. Yefko, J. Molecavage, and J.P. Metlay. 2013. "A Cluster Randomized Trial of Decision Support Strategies for Reducing Antibiotic Use in Acute Bronchitis." *JAMA Internal Medicine* 14:1-7.

¹⁴⁸ CDC and AAP. 2009. "Careful Antibiotic Use: Stemming the Tide of Antibiotic Resistance: Recommendations by CDC/AAP to Promote Appropriate Antibiotic Use in Children." Available at: <http://www.cdc.gov/getsmart/campaign-materials/info-sheets/child-approp-treatmt.html>.

¹⁴⁹ Ressel, G. 2001. "Principles of Appropriate Antibiotic Use: Part V. Acute Bronchitis." *American Family Physician* 64(6): 1098-1099.

¹⁵⁰ Akinbami, L.J., J.E. Moorman, and X. Liu. 2011. "Asthma prevalence, health care use, and mortality: United States, 2005-2009." *National Health Statistics Reports* 32: 1-15.

¹⁵¹ NAEPP (National Asthma Education and Prevention Program). 2007. *Expert panel report 3: guidelines for the diagnosis and management of asthma*. Bethesda, MD: National Heart, Lung, and Blood Institute.

¹⁵² Because most members in CHIP and STAR Health are no longer eligible after age 18, the 12- to 50-year age group for HEDIS[®] *Use of Appropriate Medications for People with Asthma* more accurately

represents members 12 to 18 years old in these programs. Therefore, comparisons with the HEDIS[®] 2011 national mean for the 12- to 50-year age group should be made with caution.

¹⁵³ The 2011 HHSC Dashboard standard of 92 percent for HEDIS[®] *Use of Appropriate Medications for People with Asthma* in the 5- to 11-year age group applies to STAR, CHIP, and STAR Health. There is no HHSC Dashboard standard for this age group in STAR+PLUS.

¹⁵⁴ Although the STAR+PLUS program expanded in 2011, the decline in HEDIS[®] *Use of Appropriate Medications for People with Asthma* is not explained by the addition of the new Jefferson service area, which had low denominators for this measure.

¹⁵⁵ ADA (American Diabetes Association). 2012. "Living with diabetes: Complications." Available at: <http://www.diabetes.org/living-with-diabetes/complications/>.

¹⁵⁶ ADA. 2013. "Executive summary: Standards of medical care in diabetes - 2013." *Diabetes Care* 36(S1): S4-S10.

¹⁵⁷ Asche, C., J. LaFleur, and C. Conner. 2011. "A review of diabetes treatment adherence and the association with clinical and economic outcomes." *Clinical Therapeutics* 33(1): 74-109.

¹⁵⁸ The Mayo Clinic. 2012 "High blood pressure dangers: Hypertension's effects on your body." Available at: <http://www.mayoclinic.com/health/high-blood-pressure/HI00062>.

¹⁵⁹ Classen, D. 2003. "Medication safety: Moving from illusion to reality." *JAMA* 289(9): 1154-1156.

¹⁶⁰ DHHS. 2008. *Results from the 2007 National Survey on Drug Use and Health: National Findings*. Available at: <http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm>.

¹⁶¹ Cougnard, A., M. Parrot, S. Grolleau, E. Kalmi, A. Desage, D. Misdrahi, H. Brun-Rousseau, and H. Verdoux. 2005. "Pattern of health service utilization and predictors of readmission after a first admission for psychosis: a 2-year follow-up study." *Acta Psychiatrica Scandinavica* 113: 340-349.

¹⁶² Thompson, E.E., H.W. Neighbors, C. Munday, and S. Trierweiler. 2003. "Length of stay, referral to aftercare, and rehospitalization among psychiatric inpatients." *Psychiatric Services* 54(9): 1271-1276.

¹⁶³ CDC. 2010. "Increasing prevalence of parent-reported attention-deficit/hyperactivity disorder among children - United States, 2003 and 2007." *Morbidity and Mortality Weekly Report* 59(44): 1439-1443.

¹⁶⁴ AAP: Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. 2011. "ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of Attention-Deficit/Hyperactivity Disorder in children and adolescents." *Pediatrics* 128(5): 1007-1022.

¹⁶⁵ AAP: Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. 2011.

¹⁶⁶ CDC. 2011b. "Attention-Deficit/Hyperactivity Disorder (AHDH): Other concerns and conditions." Available at: <http://www.cdc.gov/ncbddd/adhd/conditions.html>.

¹⁶⁷ AAP: Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. 2011.

¹⁶⁸ Brown, R.T., R.W. Amler, W.S. Freeman, J.M. Perrin, M.T. Stein, H.M. Feldman, K. Pierce, and M.L. Wolraich. 2005. "Treatment of attention-deficit/hyperactivity disorder: Overview of the evidence." *Pediatrics* 115(6): e749-e757.

¹⁶⁹ Leibson, C.L., W.J. Barbaresi, J. Ransom, R.C. Colligan, J. Kemner, A.L. Weaver, and S.K. Katusic. 2006. "Emergency Department Use and Costs for Youth With Attention-Deficit/Hyperactivity Disorder: Associations With Stimulant Treatment." *Ambulatory Pediatrics* 6(1): 45-53.

¹⁷⁰ Rates reported for this measure in NorthSTAR include STAR and FFS claims in the Dallas service area.

¹⁷¹ NAMI (National Alliance on Mental Illness). 2009. "Major Depression Fact Sheet." Available at: http://www.nami.org/Content/NavigationMenu/Mental_Illnesses/Depression/NAMI_Depression_FactSheet_2009.pdf.

¹⁷² VA/DoD. (Department of Veteran Affairs and Department of Defense). 2009. *VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder*. Available at: http://www.healthquality.va.gov/Major_Depressive_Disorder_MDD_Clinical_Practice_Guideline.asp.

¹⁷³ NAMI. 2009.

¹⁷⁴ Melartin, T.K., H.J. Rytsala, U.S. Leskela, P.S. Lestela-Mielonen, T.P. Sokero, and E.T. Isometsa. 2005. "Continuity is the main challenge in treating major depressive disorder in psychiatric care." *Journal of Clinical Psychiatry* 66(2): 220-227.

¹⁷⁵ Rates reported for this measure in NorthSTAR include STAR and FFS claims in the Dallas service area.

¹⁷⁶ DHHS. 2012. *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*. Available at: <http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm>.

¹⁷⁷ Han, B., A.M. Clinton-Sherrod, J. Gfroerer, M.R. Pemberton, and S.L. Calvin. 2011. "State and sociodemographic variations in substance use treatment need and receipt in the United States." Available at: http://www.samhsa.gov/data/2k11/DataReview/DR004_State_VariationsDataReview.pdf.

¹⁷⁸ Han, B., et al. 2011.

¹⁷⁹ NIDA (National Institute on Drug Abuse), NIH, and DHHS. 2009. *Principles of Drug Addiction Treatment: A Research-Based Guide*. Available at: http://www.drugabuse.gov/sites/default/files/podat_0.pdf.

¹⁸⁰ Rates reported for this measure in NorthSTAR include STAR and FFS claims in the Dallas service area.

¹⁸¹ CDC. 2012f. "Obesity and Overweight for Professionals: Childhood: Data." Available at: <http://www.cdc.gov/obesity/data/childhood.html>.

¹⁸² CDC. 2012g. "Obesity and Overweight." Available at: <http://www.cdc.gov/nchs/fastats/overwt.htm>.

¹⁸³ NIH (National Institutes of Health), NHLBI (National Heart, Lung, and Blood Institute), NAASO (North American Association for the Study of Obesity). 2000. *The Practical Guide to the Identification,*

Evaluation, and Treatment of Overweight and Obesity in Adults. Available at:
http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf.

¹⁸⁵ HHS (U.S. Department of Health and Human Services): Office of the Surgeon General. 2013 “Overweight and obesity: Health consequences.” Available at:
http://www.surgeongeneral.gov/library/calls/obesity/fact_consequences.html.

¹⁸⁶ WHO. 2012b. “BMI classification.” Available at:
http://apps.who.int/bmi/index.jsp?introPage=intro_3.html.

¹⁸⁷ NIH, et al. 2000.

¹⁸⁸ Guardamagna, O., F. Abello, P. Cagliero, and L. Lughetti. 2012. “Impact of nutrition since early life on cardiovascular prevention.” *Italian Journal of Pediatrics* 38(1):73.

¹⁸⁹ Ebbeling, C.B., D.B. Pawlak, and D.S. Ludwig. 2000. “Childhood obesity: public-health crisis, common sense cure.” *The Lancet* 360(9331): 473-482.

¹⁹⁰ KFF. 2011b. *Dual eligible: Medicaid’s Role for Low-income Medicare Beneficiaries*. Available at
<http://www.kff.org/medicaid/4091.cfm>.

¹⁹¹ CMS. Federally Coordinated Health Care Office. 2012b. Information available at:
<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/>.

¹⁹² HHSC. 2012. *Texas Dual Eligibles Integrated Care Demonstration Project Application*. Available at
<http://www.hhsc.state.tx.us/medicaid/dep/index.shtml>.

¹⁹³ NCQA. 2011. *HEDIS® Specifications for the Medicare Health Outcomes Survey, Volume 6*. Washington, D.C.

¹⁹⁴ Wysocki A, M. Butler, R.L. Kane, R.A. Kane, T. Shippee, and F. Sainfort. 2012. “Long-term care for older adults: A review of home and community-based services versus institutional care.” *Comparative Effectiveness Review*. Number 81. AHRQ Publication No. 12(13)-EHC134-EF. November 2012.

¹⁹⁵ Bubolz, T., C. Emerson, and J. Skinner. 2012. “State spending on dual eligibles under age 65 shows variations, evidence of cost shifting from Medicaid to Medicare.” *Health Affairs* 31(5):939-947.

¹⁹⁶ Sands, L.P., H. Xu, M. Weiner, M.B. Rosenman, B.A. Craig, and J. Thomas. 2008. “Comparison of resource utilization for Medicaid dementia patients using nursing homes versus home and community-based waivers for long term care.” *Medical Care*. 46(4):449-453.

¹⁹⁷ Walsh, E.G., J.M. Wiener, S. Haber, A. Bragg, M. Freiman, and J.G. Ouslander. 2012. “Potentially avoidable hospitalizations of dually eligible Medicare and Medicaid beneficiaries from nursing facility and home and community-based services waiver programs.” *Journal of the American Geriatric Society*. 60:821-829.

¹⁹⁸ KFF. 2012e. *Medicaid Home and Community-Based Services Programs: 2009 Data Update*. December 2012; Washington DC: The Kaiser Family Foundation.

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- ¹⁹⁹ DHHS. Office of Inspector General. 2012. *Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs*. June 2012; OEI-02-08-00170. Rockville, Maryland. Available at: <https://oig.hhs.gov/oei/reports/oei-02-08-00170.pdf>.
- ²⁰⁰ Disabled Medicaid members are defined as those receiving Supplemental Security Income (SSI) related to their disability status.
- ²⁰¹ Cheng, J., L.J. Edwards, M.M. Maldonado-Molina, K.A. Komro, and K.E. Muller. 2008. "Real longitudinal data analysis for real people: Building a good enough mixed model." *Statistics in Medicine* 29: 504-520.
- ²⁰² Gurka, M.J., and L.J. Edwards. 2008. "Mixed Models." In *Handbook of Statistics, Volume 27: Epidemiology and Medical Statistics*. Amsterdam: Elsevier, North-Holland.
- ²⁰³ NCQA. 2012. *Health Care Quality Report Cards*. Available at: <http://reportcard.ncqa.org>.
- ²⁰⁴ Sinaiko, A.D., D. Eastman, and M.B. Rosenthal. 2012. "How report cards on physicians, physician groups and hospitals can have greater impact on consumer choices." *Health Affairs* 31(3): 602-611.
- ²⁰⁵ Adams, S.G., P.K. Smith, P.F. Allan, and J.E. Cornell. 2007. "Systematic review of the chronic care model in Chronic Obstructive Pulmonary Disease prevention and management." *Archives of Internal Medicine* 167: 551-561.
- ²⁰⁶ Chobanian, A.V., G.L. Bakris, H.R. Black, W.C.ushman, L.A. Green, J.L. Izzo, D.W. Jones, B.J. Materson, S. Oparil, J.T. Wright, E.J. Roccella, and the National High Blood Pressure Education Program Coordinating Committee. 2003. "Seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure." *Hypertension* 42: 1206-1252.
- ²⁰⁷ Meigs, J.B., E. Cagliero, A. Dubey, P. Murphy-Sheehy, C. Gildesgame, H. Chueh, M.J. Barry, D.E. Singer, and D.M. Nathan. 2003. "A controlled trial of web-based diabetes disease management: The MGH diabetes primary care improvement project." *Diabetes Care* 26(3): 750-757.
- ²⁰⁸ DeLia, D. 2003. "Distributional issues in the analysis of preventable hospitalizations." *Health Services Research* 38(6): 1761-1780.
- ²⁰⁹ Bindman, A.B., K. Grumbach, D. Osmond, M. Komaromy, K. Vranizan, N. Lurie, J. Billings, and A. Stewart. 1995. "Preventable hospitalizations and access to health care." *The Journal of the American Medical Association* 274(4): 305-311.
- ²¹⁰ Renders, C.M., G.D. Valk, S.J. Griffin, E.H. Wagner, J.T. Eijk Van, and W.J.J. Assendelft. 2001. "Interventions to improve the management of diabetes in primary care, outpatient, and community settings." *Diabetes Care*, 24(10): 1821-1833.
- ²¹¹ van Dam, H.A., F. van der Horst, B. van den Borne, R. Ryckman, and H. Crebolder. 2003. "Provider-patient interaction in diabetes care: Effects of patient self-care and outcomes: A systematic review." *Patient Education and Counseling*, 51(1): 17-28.
- ²¹² Fuller, R.L., S. Clinton, N.I. Goldfield, and W.P. Kelly. 2010. "Building the Affordable Medical Home." *Journal of Ambulatory Care Management* 33 (1), 71-80.
- ²¹³ McLean, S., U. Nurmatov, J.L. Liu, C. Paqliari, J. Car, and A. Sheikh. 2011. "Telehealthcare for chronic obstructive pulmonary disease." *Cochrane Database of Systematic Reviews* 7: CD00718.

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- ²¹⁴ Clark, N.M., J.A. Dodge, M.R. Partridge, and F.J. Martinez. 2009. "Focusing on outcomes: Making the most of COPD interventions." *International Journal of COPD* 4: 61-77.
- ²¹⁵ Maples, N.J., L.A. Copeland, J.E. Zeber, X. Li, T.A. Moore, A. Dassori, D.I. Velligan, and A.L. Miller. "Can medication management coordinators help improve continuity of care after psychiatric hospitalization?" *Psychiatric Services* 63(6): 554-560.
- ²¹⁶ CMS. 2012c. *Health Care Innovation Award Project Profiles*. Available at: <http://innovations.cms.gov/Files/x/HCIA-Project-Profiles.pdf>.
- ²¹⁷ Colburn, J. 2010. "Preventing Hospital Readmissions for Members with Behavioral Health Disorders." Presented at *Medicaid Health Plans of America Annual Meeting*, Nov. 4, 2010. Available at: <http://www.mhpa.org/>.
- ²¹⁸ Perz, J.F., A.S. Craig, C.S. Coffey, D.M. Jorgensen, E. Mitchel, S. Hall, W. Schaffner, and M.R. Griffin. 2002. "Changes in antibiotic prescribing for children after a community-wide campaign." *JAMA* 287(23): 3103-3109.
- ²¹⁹ AHRQ. 2010. "Medicaid Managed Care Plan Provides Reports, Guidelines, and Education Materials to Physicians, Reducing Inappropriate Prescribing of Antibiotics to Children and Adolescents." Available at: <http://www.innovations.ahrq.gov/content.aspx?id=2788>.
- ²²⁰ Matthews, T.L., and J.C. Sewell. 2002. *State Official's Guide to Health Literacy*. Available at: <http://www.csg.org/knowledgecenter/docs/SOG02HealthLiteracy.PDF>.
- ²²¹ Finkelstein, J.A., S.S. Huang, K. Kleinman, S.L. Rifas-Shiman, C.J. Stille, J. Daniel, N. Schiff, R. Steingard, S.B. Soumerai, D. Ross-Degnan, D. Goldmann, and R. Platt. 2008. "Impact of a 16-community trial to promote judicious antibiotic use in Massachusetts." *Pediatrics* 121(1): e15-e23.
- ²²² AHRQ, 2010.
- ²²³ CDC. 2012e.
- ²²⁴ Ayanruoh, S., M. Waseem, F. Quee, A. Humphrey, and T. Reynolds. 2009. "Impact of rapid streptococcal test on antibiotic use in a pediatric emergency department." *Pediatric Emergency Care* 25(11): 748-750.
- ²²⁵ Schriefer, S.P., S.E. Landis, D.J. Turbow, and S.C. Patch. 2009. "Effects of a computerized body mass index prompt on diagnosis and treatment of adult obesity." *Family Medicine* 41(7): 502-507.
- ²²⁶ Rattay, K.T., M. Ramakrishnan, A. Atkinson, M. Gilson, and V. Drayton. 2009. "Use of an electronic medical record system to support primary care recommendations to prevent, identify, and manage childhood obesity." *Pediatrics* 123(S2): S100-S107.
- ²²⁷ Bode, D.V., T.A. Roberts., and C. Johnson. 2013. "Increased adolescent overweight and obesity documentation through a simple electronic medical record intervention." *Military Medicine* 178(1): 115-118.
- ²²⁸ Gillis, D., M. Bauner, and E. Granot. 2007. "A community-based behavior modification intervention for childhood obesity." *Journal of Pediatric Endocrinology and Metabolism* 20; 197-203.

²²⁹ Mangurian, C., G.A. Miller, C.T. Jackson, H. Li, S.M. Essock, and L.I. Sederer. 2011. "State Mental Health Policy: Physical health screening in state mental health clinics: The New York health indicators initiative." *Psychiatric Services* 61(4): 1331-1337.

²³⁰ Gabel, S., M. Radigan, R. Wang, and L.I. Sederer. 2011. "Health monitoring and promotion among youths with psychiatric disorders: program development and initial findings." *Psychiatric Services* 62(11): 1331-1337.

²³¹ Laiteerapong, N., C.E. Keh, K.B. Naylor, V.L. Yang, L.M. Vinci, J.L. Oyler, and V.M. Arora. 2011. "A Resident-led quality improvement initiative to improve obesity screening." *American Journal of Medical Quality* 26: 315.

²³² Bode, D.V., et al. 2013.

²³³ Schriefer, S.P., et al., 2009.

²³⁴ Parks J.D., P. Svendsen, P. Singer, M.E. Foti, and B. Mauer. 2006. *Morbidity and Mortality in People With Serious Mental Illness. 13th Technical Report*. Alexandria, VA: National Association of State Mental Health Program Directors, 2006. Available at: <http://theempowermentcenter.net/>.

²³⁵ Forducey, P.G., R.L. Glueckauf, T.F. Bergquist, M.M. Maheu, and M. Yutsis. 2012. "Telehealth for persons with severe functional disabilities and their caregivers: facilitating self-care management in the home setting." *Psychological Services* 9(2): 144-162.

²³⁶ Jia, A., H. Feng, X. Wang, S.S. Wu, and N. Chumbler. 2011. "A longitudinal study of health service utilization for diabetes patients in a care coordination home telehealth programme." *Journal of Telemedicine and Telecare* 17(3): 123-126.

²³⁷ Hebert, R., M. Raiche, M.F. Dubois, N.R. Gueye, N. Dubuc, M. Tousignant, and The PRISMA Group. 2010. "Impact of PRISMA, a coordination-type integrated service delivery system for frail older people in Quebec (Canada): A quasi-experimental study." *Journal of Gerontology*, 65: 107-118.

²³⁸ Although the maximum age for STAR Health members is 23 years old, the upper age band for the HEDIS[®] *Chlamydia Screening in Women* measure is 21 to 24 years old.

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1	Iowa High Quality Healthcare Initiative Implementation Project Plan	Mon 2/16/15	Thu 4/21/16	
2	Initiation Phase	Mon 2/16/15	Mon 9/21/15	
3	RFP release date	Mon 2/16/15	Mon 2/16/15	State of Iowa
4	RFP Team Review / Advanced Party Workgroups	Mon 2/16/15	Mon 5/18/15	Business Development
5	Proposals due	Mon 5/18/15	Mon 5/18/15	Business Development
6	Notice of Intent to Award	Fri 7/31/15	Fri 7/31/15	State of Iowa
7	Contract award	Fri 7/31/15	Mon 9/21/15	State of Iowa
8	Award Communications	Fri 7/31/15	Tue 9/15/15	
9	Issue award announcement internal communication	Fri 7/31/15	Fri 7/31/15	Corporate Communications
10	Issue award announcement press release	Tue 9/15/15	Tue 9/15/15	Corporate Communications
11	Legal	Mon 8/3/15	Fri 9/4/15	
12	Sign contract with the State of Iowa	Mon 8/31/15	Mon 8/31/15	Legal
13	Conduct Project Kickoff Meeting	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
14	Conduct RFP Review Meeting	Mon 8/3/15	Fri 8/7/15	Regulatory
15	Conduct Contract Review Meeting	Tue 9/1/15	Fri 9/4/15	Regulatory
16	Implementation Management Office Project Setup Tasks	Mon 8/3/15	Thu 9/3/15	
17	Setup checklist	Mon 8/3/15	Tue 9/1/15	Implementation Management Office
18	Transition Team Engagement Meeting	Thu 9/3/15	Thu 9/3/15	Implementation Management Office
19	Identify Steering Committee	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
20	Schedule Steering Committee Meetings	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
21	Identify Project Team Members	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
22	Schedule Project Team Meetings	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
23	Establish IMO SharePoint Site for IA High Quality Healthcare Initiative	Mon 8/3/15	Fri 8/7/15	Implementation Management Office
24	Hold Project Kick Off Meeting	Mon 8/3/15	Mon 8/3/15	Implementation Management Office
25	Confirm technology resources	Mon 8/3/15	Fri 8/7/15	Implementation Management Office
26	Identify Risks/Risk Log	Mon 8/3/15	Fri 8/7/15	Implementation Management Office
27	Identify Questions/Question Log	Mon 8/3/15	Fri 8/7/15	Implementation Management Office
28	Build Implementation Budget	Tue 9/1/15	Mon 9/21/15	
29	FTE Budget	Tue 9/1/15	Fri 9/18/15	
30	Obtain Membership Projection Document	Tue 9/1/15	Tue 9/1/15	Implementation Management Office
31	Obtain Impact Assessment Document	Tue 9/1/15	Tue 9/1/15	Implementation Management Office
32	Send membership projections and impact assessment document to Finance	Wed 9/9/15	Wed 9/9/15	Implementation Management Office
33	Validate full FTE budget	Thu 9/17/15	Thu 9/17/15	Implementation Management Office
34	Post FTE budgets to project SharePoint site	Fri 9/18/15	Fri 9/18/15	Implementation Management Office

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
35	SG&A and Capital Budget	Thu 9/17/15	Mon 9/21/15	
36	Meet with Finance to review full implementation SG&A and capital budgets	Thu 9/17/15	Thu 9/17/15	Implementation Management Office
37	Final review of budget	Fri 9/18/15	Fri 9/18/15	Implementation Management Office
38	Post budgets to project SharePoint Site	Mon 9/21/15	Mon 9/21/15	Implementation Management Office
39	Planning Phase	Mon 3/23/15	Thu 10/1/15	
40	Requirements	Mon 6/1/15	Thu 10/1/15	
41	Identify Commitment Requirements	Mon 6/1/15	Thu 6/18/15	
42	Document requirements from RFP	Mon 6/1/15	Fri 6/12/15	Project Team
43	Conduct Requirements Matrix Review Meeting	Wed 6/17/15	Thu 6/18/15	Implementation Management Office
44	Identify Contractual Requirements	Thu 9/10/15	Tue 9/29/15	
45	Document requirements from contract (DELTA)	Tue 9/22/15	Tue 9/29/15	Project Team
46	Conduct Requirements Matrix Review Meeting	Thu 9/10/15	Fri 9/11/15	Implementation Management Office
47	Finalize Requirements Matrix Document	Wed 9/30/15	Thu 10/1/15	Implementation Management Office
48	MS Schedule Implementation Plan	Mon 3/23/15	Fri 9/18/15	
49	Create Baseline MS Project Schedule	Mon 3/23/15	Fri 4/3/15	Implementation Management Office
50	Refine MS Project Schedule with functional leads	Tue 8/4/15	Mon 8/17/15	Implementation Management Office
51	Finalize, Obtain Implementation Management Office Management Review/Approval & Post Baseline MS Project Schedule	Mon 9/14/15	Fri 9/18/15	Implementation Management Office
52	Monitor and Control	Tue 9/1/15	Fri 1/8/16	
53	State Readiness Review	Tue 9/1/15	Fri 10/23/15	
54	Determine scope of review with State	Tue 9/1/15	Mon 9/7/15	Implementation Management Office
55	Coordinate logistics (e.g., space, travel)	Tue 9/8/15	Mon 9/21/15	Implementation Management Office
56	Schedule mock interview/preparation sessions	Tue 9/8/15	Tue 9/8/15	Implementation Management Office
57	Conduct mock interview/preparation sessions	Tue 9/8/15	Mon 9/21/15	Implementation Management Office
58	Validate system access for demos	Tue 9/8/15	Mon 9/14/15	Implementation Management Office
59	Test facilities & equipment	Tue 9/8/15	Mon 9/14/15	Implementation Management Office
60	Order welcome signs from Corporate Communications	Tue 9/8/15	Mon 9/21/15	Implementation Management Office
61	Participate in State Readiness Review	Mon 9/21/15	Fri 9/25/15	Implementation Management Office
62	Amerigroup Response to Findings	Mon 9/28/15	Fri 10/23/15	
63	Receive/Address deficiencies	Mon 9/28/15	Fri 10/23/15	Project Team
64	Submit updated responses/additional requests	Fri 10/23/15	Fri 10/23/15	Regulatory
65	Internal Readiness Review	Thu 10/15/15	Fri 1/1/16	
66	Schedule Internal Readiness Review Meeting	Thu 10/15/15	Fri 10/16/15	Implementation Management Office
67	Receive Feedback from Business Owners	Fri 10/16/15	Tue 10/27/15	Implementation Management Office

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
68	Conduct Internal Readiness Review	Tue 10/27/15	Tue 10/27/15	Implementation Management Office
69	Resolve Identified Items	Wed 10/28/15	Fri 1/1/16	Project Team
70	Member Effective Go-Live	Mon 12/28/15	Fri 1/8/16	
71	Schedule Daily Pre and Post Member Effective Date Meetings	Mon 12/28/15	Fri 1/8/16	Implementation Management Office
72	Member Effective Date	Fri 1/1/16	Fri 1/1/16	
73	Execution Phase	Fri 7/31/15	Thu 12/31/15	
74	Human Capital	Fri 7/31/15	Thu 12/31/15	
75	Recruitment/Hiring	Fri 7/31/15	Thu 12/31/15	
76	Develop staffing plan	Fri 7/31/15	Wed 8/26/15	Business Development
77	Submit Staffing Plan to State for Approval	Mon 8/31/15	Fri 9/11/15	
78	Hire Key Positions	Fri 7/31/15	Thu 12/31/15	
79	Contract Administrator / CEO	Fri 7/31/15	Wed 8/19/15	Human Resources
80	COO	Fri 7/31/15	Wed 8/19/15	
81	Clerical and Support Staff	Mon 8/10/15	Thu 11/5/15	Human Resources
82	Medical Director	Fri 7/31/15	Wed 8/19/15	Human Resources
83	Chief Financial Officer	Fri 7/31/15	Wed 8/19/15	Human Resources
84	Compliance Officer	Fri 7/31/15	Wed 8/19/15	
85	Pharmacy Director / Coordinator	Fri 7/31/15	Wed 8/19/15	
86	Grievance and Appeals Manager	Fri 7/31/15	Thu 8/27/15	Human Resources
87	Quality Management Manager	Fri 7/31/15	Wed 8/19/15	
88	Utilization Management Manager	Mon 8/10/15	Thu 8/27/15	Human Resources
89	UM Staff	Fri 7/31/15	Wed 10/28/15	
90	Behavioral Health Manager	Fri 7/31/15	Thu 8/27/15	Human Resources
91	BH Staff	Fri 7/31/15	Wed 10/28/15	
92	Member Services Manager	Fri 7/31/15	Wed 8/19/15	
93	Member Services Staff	Fri 7/31/15	Wed 10/28/15	Human Resources
94	Provider Services Manager	Mon 8/10/15	Thu 8/27/15	Human Resources
95	Provider Services Staff	Mon 8/10/15	Thu 11/5/15	Human Resources
96	Information Systems Manager	Fri 7/31/15	Wed 8/19/15	
97	Claims Administrator	Fri 7/31/15	Wed 8/19/15	
98	Care Management Manager	Fri 7/31/15	Wed 8/19/15	
99	Program Integrity Manager	Fri 7/31/15	Wed 8/19/15	
100	Long Term Care Manager	Mon 8/10/15	Thu 8/27/15	Human Resources
101	Marketing and Community Relations Staff	Mon 8/10/15	Thu 11/5/15	Human Resources

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
102	Human Resources Manager	Fri 7/31/15	Thu 8/27/15	Human Resources
103	Hire Additional Positions	Wed 9/2/15	Thu 12/31/15	Human Resources
104	Org Chart	Fri 7/31/15	Thu 8/13/15	
105	Develop Health Plan organization chart	Fri 7/31/15	Thu 8/13/15	Human Resources
106	Job Descriptions	Tue 8/4/15	Mon 8/17/15	
107	Define job descriptions outlining the roles, responsibilities, and educational requirements	Tue 8/4/15	Mon 8/17/15	Human Resources
108	Onboarding	Fri 7/31/15	Fri 7/31/15	
109	Determine which systems/applications staff will need access	Fri 7/31/15	Fri 7/31/15	
110	Submit SAR for access for new associates	Fri 7/31/15	Fri 7/31/15	
111	Training	Mon 11/2/15	Thu 12/31/15	
112	Leadership Training	Mon 9/21/15	Thu 12/31/15	
113	Analyze training and orientation needs for management	Mon 9/21/15	Thu 10/8/15	Performance Solutions
114	Conduct training	Fri 10/9/15	Mon 12/21/15	Performance Solutions
115	Corporate Training	Mon 9/21/15	Thu 12/31/15	
116	Analyze training needs	Mon 9/21/15	Thu 10/8/15	Performance Solutions
117	Conduct training	Fri 10/9/15	Mon 12/21/15	Performance Solutions
118	Market Specific Training	Mon 11/2/15	Wed 12/30/15	
119	Analyze training needs	Mon 9/21/15	Fri 9/25/15	Performance Solutions
120	Design training	Mon 9/28/15	Fri 10/9/15	Performance Solutions
121	Business approve training design	Mon 10/12/15	Tue 10/13/15	Health Plan
122	Develop training materials	Mon 9/28/15	Fri 10/16/15	Performance Solutions
123	Business approve training materials	Mon 10/19/15	Fri 10/23/15	Health Plan
124	Milestone: Market-Specific Training Development Completed	Mon 11/2/15	Mon 11/2/15	Performance Solutions
125	Conduct training	Mon 11/2/15	Tue 12/15/15	Performance Solutions
126	Clinical Training (UM, Care Coordination, BH)	Mon 9/7/15	Thu 12/31/15	
127	Analyze training needs	Mon 9/7/15	Fri 9/11/15	HCMS
128	Design training	Mon 9/14/15	Fri 9/25/15	HCMS
129	Business approve training design	Mon 9/28/15	Tue 9/29/15	HCMS
130	Develop training materials	Wed 9/30/15	Tue 10/13/15	HCMS
131	Business approve training materials	Wed 10/14/15	Tue 10/20/15	HCMS
132	Milestone: Clinical Training Development Completed	Tue 10/20/15	Tue 10/20/15	HCMS
133	Conduct training	Wed 10/21/15	Fri 1/1/16	Performance Solutions
134	LTSS Training	Mon 11/2/15	Tue 12/15/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
135	Hire Training Manager	Mon 11/2/15	Fri 11/13/15	Health Plan, Talent Acquisition
136	Secure training locations	Mon 11/2/15	Fri 11/13/15	Health Plan, PSO
137	Hire Trainers	Mon 11/2/15	Tue 12/15/15	Health Plan, PSO
138	Modify Training Material	Mon 11/2/15	Fri 11/13/15	PSO
139	Training Schedule	Mon 11/2/15	Fri 11/13/15	Health Plan, PSO
140	Conduct training	Mon 11/2/15	Tue 12/15/15	Performance Solutions
141	Space Planning (CRE)	Tue 8/4/15	Tue 11/3/15	
142	Leases Signed	Tue 8/4/15	Tue 8/4/15	Corporate Real Estate
143	Design	Wed 8/5/15	Tue 8/18/15	Corporate Real Estate
144	Construction Documents	Wed 8/19/15	Tue 9/1/15	Corporate Real Estate
145	Planning and Permits	Wed 9/2/15	Tue 9/15/15	Corporate Real Estate
146	Construction	Wed 9/16/15	Tue 10/27/15	Corporate Real Estate
147	Inspection/Move-In	Wed 10/28/15	Tue 11/3/15	Corporate Real Estate
148	Space planning/development completed	Tue 11/3/15	Tue 11/3/15	Corporate Real Estate
149	Medical Network	Fri 7/31/15	Thu 12/31/15	
150	Development Team	Fri 7/31/15	Thu 8/6/15	
151	Determine Development Team	Fri 7/31/15	Fri 7/31/15	Provider Relations
152	Establish development Decision Log	Fri 7/31/15	Fri 7/31/15	Provider Relations
153	Complete Development Market Profile	Fri 7/31/15	Thu 8/6/15	Provider Relations
154	Cover Letter	Fri 7/31/15	Thu 11/19/15	
155	New Agreement Cover Letter	Fri 7/31/15	Thu 11/19/15	
156	Review Revisions/legal	Fri 8/7/15	Thu 8/20/15	Provider Relations, Legal
157	File with state	Fri 7/31/15	Thu 11/19/15	Provider Relations
158	Letter of Intent	Fri 7/31/15	Thu 11/19/15	
159	Review Revisions/Legal	Fri 8/7/15	Thu 8/20/15	Provider Relations, Legal
160	FAQ - External	Fri 8/7/15	Thu 8/20/15	Provider Relations
161	FAQ Call Script - Internal	Fri 8/7/15	Thu 8/20/15	Provider Relations
162	File with state	Fri 7/31/15	Thu 11/19/15	Provider Relations
163	Develop Internal Reference Documents	Fri 8/7/15	Thu 8/20/15	
164	Update General Quick Reference	Fri 8/7/15	Thu 8/20/15	Provider Relations, Provider Comms
165	Create State Specific Quick Reference	Fri 8/7/15	Thu 8/20/15	Provider Relations, Provider Comms
166	Set up Development Reporting Package	Fri 8/7/15	Mon 11/30/15	
167	Determine reporting Needs for Project	Fri 8/7/15	Mon 11/30/15	Provider Relations, Regulatory
168	Define Reporting Needs Specifications	Fri 8/7/15	Mon 11/30/15	Provider Relations, Regulatory

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
169	Develop Reporting Package	Fri 8/7/15	Mon 11/30/15	Provider Relations, Regulatory
170	Pull Final RFP Bid Reporting Package	Fri 8/7/15	Mon 11/30/15	Provider Relations, Regulatory
171	Adjust Reporting Needs Based on Project Specific Needs	Fri 8/7/15	Mon 11/30/15	Provider Relations, Regulatory
172	Training post-Award	Fri 8/7/15	Mon 11/30/15	Provider Relations
173	Update FAQ/Quick Reference Guides	Fri 8/7/15	Mon 11/30/15	Provider Relations, Provider Comms
174	AmeriGroup Network	Fri 7/31/15	Thu 11/19/15	
175	Staffing	Fri 7/31/15	Thu 11/19/15	Provider Relations
176	Determine Local Network Management Staffing Model	Fri 7/31/15	Thu 11/19/15	Provider Relations
177	Determine Rapid Deployment Team to assist with project	Fri 7/31/15	Thu 11/19/15	Provider Relations
178	Determine Local Network Management Staffing Model	Fri 7/31/15	Thu 11/19/15	Provider Relations
179	Prioritize positions (target start dates)	Fri 7/31/15	Thu 11/19/15	Provider Relations
180	Develop strategy to launch recruitment, candidate pipeline, interviews	Fri 7/31/15	Thu 11/19/15	Provider Relations
181	Implement contingent offer process	Fri 7/31/15	Thu 11/19/15	Provider Relations
182	Launch post-award recruitment strategy	Fri 7/31/15	Thu 11/19/15	Provider Relations
183	Network Management	Fri 7/31/15	Thu 11/19/15	
184	Reporting Package	Fri 7/31/15	Thu 11/19/15	
185	Determine State Reporting Requirements	Fri 7/31/15	Thu 11/19/15	Provider Relations, Regulatory
186	Define Reporting Needs Specifications	Fri 7/31/15	Thu 11/19/15	Provider Relations, Regulatory
187	Develop Reporting Package	Fri 7/31/15	Thu 11/19/15	Provider Relations, Regulatory
188	Contracting Strategy	Fri 7/31/15	Thu 11/19/15	
189	Analyze Data	Fri 7/31/15	Thu 11/19/15	Provider Relations
190	Pull Mailing Data	Fri 7/31/15	Thu 11/19/15	Provider Relations
191	Finalize Data Scrub	Fri 7/31/15	Thu 11/19/15	Provider Relations
192	Define Minimal Network	Fri 7/31/15	Thu 11/19/15	Provider Relations
193	Define Optimal Network	Fri 7/31/15	Thu 11/19/15	Provider Relations
194	Network Gap Analysis	Fri 7/31/15	Thu 11/19/15	
195	Initial gap analysis based on targeted network	Fri 7/31/15	Thu 11/19/15	Provider Relations
196	Gap analysis post initial recruiting wave	Fri 7/31/15	Thu 11/19/15	Provider Relations
197	Produce overall Amerigroup network strategy	Fri 7/31/15	Thu 11/19/15	Provider Relations
198	Identify tasks associated with compliance with NPI	Fri 7/31/15	Thu 11/19/15	Provider Relations
199	Identify network development of specific contracting needs	Fri 7/31/15	Thu 11/19/15	Provider Relations
200	Indentification of ancillary contracting	Fri 7/31/15	Thu 11/19/15	Provider Relations
201	Contracts Development	Fri 7/31/15	Thu 11/19/15	
202	Contract Development	Fri 7/31/15	Thu 11/19/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
203	Develop Contract	Fri 7/31/15	Thu 11/19/15	Provider Relations
204	Create standard base contract templates	Fri 7/31/15	Thu 11/19/15	Provider Relations
205	Create regulatory appendix	Fri 7/31/15	Thu 11/19/15	Provider Relations
206	Create Payment appendix (FQHC Physician/ANC/Health Homes/Hospital)	Fri 7/31/15	Thu 11/19/15	Provider Relations
207	File with state	Fri 7/31/15	Thu 11/19/15	Provider Relations
208	Review revisions/Legal	Fri 7/31/15	Thu 11/19/15	Provider Relations
209	Finalize approved contract and documents	Fri 7/31/15	Thu 11/19/15	Provider Relations
210	Build templates to make available for contracting	Fri 7/31/15	Thu 11/19/15	Provider Relations
211	Contract Pricing	Fri 7/31/15	Thu 11/19/15	
212	Development of pricing strategy	Fri 7/31/15	Thu 11/19/15	Provider Relations
213	Implement contracting Checkbook from Finance	Fri 7/31/15	Thu 11/19/15	Provider Relations
214	Load and test fee schedules	Fri 7/31/15	Thu 11/19/15	Provider Relations
215	Out of Network case rate negotiation	Fri 7/31/15	Thu 11/19/15	Provider Relations
216	Network Development	Fri 7/31/15	Thu 12/31/15	
217	Physicians	Fri 7/31/15	Thu 11/19/15	
218	Training of Recruiters	Fri 7/31/15	Thu 11/19/15	Provider Relations
219	Identification of targeted providers for contracting	Fri 7/31/15	Thu 11/19/15	Provider Relations
220	Produce contract mailing	Fri 7/31/15	Thu 11/19/15	Provider Relations
221	File Prep	Fri 7/31/15	Thu 11/19/15	Provider Relations
222	Create local mass mailing file	Fri 7/31/15	Thu 11/19/15	Provider Relations
223	Develop Mailing Package	Fri 7/31/15	Thu 11/19/15	Provider Relations
224	Prepare and send mass mailing to targeted providers	Fri 7/31/15	Thu 11/19/15	Provider Relations
225	Conduct follow-up phone calls to targeted providers in 2 week intervals	Fri 7/31/15	Thu 11/19/15	Provider Relations
226	Identification of key physician groups	Fri 7/31/15	Thu 11/19/15	Provider Relations
227	Create database for tracking	Fri 7/31/15	Thu 11/19/15	Provider Relations
228	Prioritize Provider follow-up	Fri 7/31/15	Thu 11/19/15	Provider Relations
229	Determine if follow up mail vs phone and owners	Fri 7/31/15	Thu 11/19/15	Provider Relations
230	Secure resources for follow up	Fri 7/31/15	Thu 11/19/15	Provider Relations
231	Execute on follow up lan	Fri 7/31/15	Thu 11/19/15	Provider Relations
232	Submit contracts for credentialing	Fri 7/31/15	Thu 11/19/15	Provider Relations
233	Submit contracts for loading	Fri 7/31/15	Thu 11/19/15	Provider Relations
234	Follow up as applicable on mission information	Fri 7/31/15	Thu 11/19/15	Provider Relations
235	Confirm launch network	Fri 7/31/15	Thu 11/19/15	Provider Relations

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
236	Status of credentialing verified	Fri 7/31/15	Thu 11/19/15	Provider Relations
237	Welcome packet sent	Fri 7/31/15	Thu 11/19/15	Provider Relations
238	Submit geo-access reports as required	Fri 7/31/15	Thu 11/19/15	Provider Relations
239	Facilities, Ancillaries, Health Homes	Fri 7/31/15	Thu 11/19/15	
240	Training of AGP recruiters	Fri 7/31/15	Thu 11/19/15	Provider Relations
241	Identifiacation of targeted providers contracting	Fri 7/31/15	Thu 11/19/15	Provider Relations
242	Produce Mailing	Fri 7/31/15	Thu 11/19/15	Provider Relations
243	Create local mass mailing file	Fri 7/31/15	Thu 11/19/15	Provider Relations
244	Develop Mailing Package	Fri 7/31/15	Thu 11/19/15	Provider Relations
245	Prepare and send mass mailing to targeted providers	Fri 7/31/15	Thu 11/19/15	Provider Relations
246	Establish AGP infrastructure	Fri 7/31/15	Thu 11/19/15	Provider Relations
247	Establish local AGP Infrastructure to receive contracts, initiate follow-up phone calls	Fri 7/31/15	Thu 11/19/15	Provider Relations
248	Conduct follow-up phone calls to targeted providers in 2 week intervals	Fri 7/31/15	Thu 11/19/15	Provider Relations
249	Identificaion of key physician groups	Fri 7/31/15	Thu 11/19/15	Provider Relations
250	Determine if follow up mail vs phone and owners	Fri 7/31/15	Thu 11/19/15	Provider Relations
251	Secure resources for follow up	Fri 7/31/15	Thu 11/19/15	Provider Relations
252	Execute on follow up plan	Fri 7/31/15	Thu 11/19/15	Provider Relations
253	LTSS Providers	Fri 7/31/15	Thu 11/19/15	
254	Training of AGP recruiters	Fri 7/31/15	Thu 11/19/15	Provider Relations
255	Identifiacation of targeted providers contracting	Fri 7/31/15	Thu 11/19/15	Provider Relations
256	Produce Mailing	Fri 7/31/15	Thu 11/19/15	Provider Relations
257	Create local mass mailing file	Fri 7/31/15	Thu 11/19/15	Provider Relations
258	Develop Mailing Package	Fri 7/31/15	Thu 11/19/15	Provider Relations
259	Prepare and send mass mailing to targeted providers	Fri 7/31/15	Thu 11/19/15	Provider Relations
260	Establish AGP infrastructure	Fri 7/31/15	Thu 11/19/15	Provider Relations
261	Establish local AGP Infrastructure to receive contracts, initiate follow-up phone calls	Fri 7/31/15	Thu 11/19/15	Provider Relations
262	Conduct follow-up phone calls to targeted providers in 2 week intervals	Fri 7/31/15	Thu 11/19/15	Provider Relations
263	Identificaion of key physician groups	Fri 7/31/15	Thu 11/19/15	Provider Relations
264	Determine if follow up mail vs phone and owners	Fri 7/31/15	Thu 11/19/15	Provider Relations
265	Secure resources for follow up	Fri 7/31/15	Thu 11/19/15	Provider Relations
266	Execute on follow up plan	Fri 7/31/15	Thu 11/19/15	Provider Relations
267	AmeriGroup Network Operations	Fri 7/31/15	Thu 11/19/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
268	Credentialing	Fri 7/31/15	Thu 11/19/15	
269	Credentialing requirements researched in RFP	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
270	RFP/State Medicaid credentialing requirements identified	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
271	State-specific credentialing requirements grid reviewed, updated and approved by compliance	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
272	Determine type of credentialing agreement	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
273	Credentialing agreement between provider and AGP written	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
274	Determine state filing requirements	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
275	Provider File report sent from AGP Network Management to NCC	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
276	Credentialing Status Report submitted	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
277	New Market Form completed -- Market Number assigned	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
278	Obtain Market number assignment	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
279	Put providers into credentialing cycle	Fri 7/31/15	Thu 11/19/15	Provider Relations, Credentialing
280	Configuration, Loading and Testing	Fri 7/31/15	Thu 11/19/15	
281	Develop workflow for negotiated contracts for physicians and facilities	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
282	Develop workflow for negotiated contracts for ancillaries	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
283	Demo load	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
284	Load all contracts as they are received	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
285	Configure and load all contracts	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
286	Testing	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
287	Revision period	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
288	Review and approve testing audit	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
289	Review with facilities	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
290	Build Physician Fee Schedules	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
291	Build Facility and Ancillary fee schedules	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
292	Tie Providers to fee schedules	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
293	Provider Quality Check on Contract and Fee Schedule load	Fri 7/31/15	Thu 11/19/15	Provider Relations, PDM
294	Provider Recruitment	Fri 7/31/15	Thu 12/31/15	
295	Provider Applications	Fri 7/31/15	Thu 11/19/15	Provider Communications
296	Recruitment Strategy and Materials	Fri 7/31/15	Thu 11/19/15	IA Health Plan
297	Sign Letters of Agreement (LOAs)	Fri 7/31/15	Thu 11/19/15	Legal
298	Submit network to State for approval	Fri 11/20/15	Fri 11/20/15	Regulatory
299	Provider Training	Thu 8/13/15	Thu 12/31/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
300	Analyze training needs	Thu 8/13/15	Thu 8/27/15	Provider Relations
301	Design training	Thu 8/27/15	Thu 9/10/15	PSO
302	Business approve training design	Thu 9/10/15	Mon 9/14/15	Provider Relations
303	Develop training materials	Mon 9/14/15	Mon 9/28/15	PSO
304	Business approve training materials	Mon 9/28/15	Mon 10/5/15	Provider Relations
305	Milestone: Provider Training Development Completed	Mon 10/5/15	Tue 10/6/15	PSO
306	Conduct provider orientation and training	Tue 10/6/15	Thu 12/31/15	PSO
307	Provider Configuration	Fri 7/31/15	Thu 11/19/15	
308	Provider Data Conversion	Fri 7/31/15	Thu 11/19/15	PDM
309	Update/Configure Rates	Fri 7/31/15	Thu 11/19/15	
310	Configure Updated Rates	Fri 7/31/15	Thu 11/19/15	PDM
311	Configure Provider Incentive/Pay	Fri 7/31/15	Thu 11/19/15	PDM
312	Agreement Assignment	Fri 7/31/15	Thu 11/19/15	PDM
313	Quality Management	Fri 7/31/15	Fri 11/6/15	
314	QM Operations	Fri 7/31/15	Thu 10/8/15	
315	Develop QM Program and Descriptions	Fri 7/31/15	Thu 8/13/15	Health Plan, QM
316	Develop QM P&Ps	Fri 8/14/15	Thu 9/10/15	Health Plan, QM
317	Set up/Implement QOC/S Tracking Process	Fri 9/11/15	Thu 9/24/15	Health Plan, QM
318	Set up/Implement Credentialing Process	Fri 9/25/15	Thu 10/8/15	
319	QM Committees	Fri 9/11/15	Thu 10/1/15	
320	Identify BOD members	Fri 9/11/15	Thu 9/17/15	Health Plan, QM
321	Identify Internal Committee Members	Fri 9/11/15	Thu 9/17/15	Health Plan, QM
322	Schedule QMC and other appropriate committees	Fri 9/18/15	Thu 9/24/15	Health Plan, QM
323	Identify PAS committee members	Fri 9/25/15	Thu 10/1/15	Health Plan, QM
324	QM Outreach and Performance Improvement	Fri 9/11/15	Fri 11/6/15	
325	Develop Prevention and Wellness/Maternal program documents and workplan	Fri 9/11/15	Thu 9/24/15	Health Plan, QM
326	Prepare policies and SOPs for submission to appropriate committees	Fri 9/11/15	Thu 9/17/15	Health Plan, QM
327	Assess/complete any contract amendments needed for automated member calls/mailings	Fri 9/11/15	Thu 9/24/15	Health Plan, QM
328	Develop member outreach postcard mailers	Fri 9/25/15	Thu 10/8/15	Health Plan, QM
329	Develop member outreach scripts	Fri 9/11/15	Thu 9/24/15	Health Plan, QM
330	Obtain state approval on scripts, postcards and web based materials	Fri 10/9/15	Thu 11/5/15	Health Plan, QM
331	Complete requiremetns document for inclusion of all applicable HEDIS measure logic	Fri 9/25/15	Thu 10/8/15	Health Plan, QM

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
332	Outreach database completion	Fri 9/11/15	Thu 9/24/15	Health Plan, QM
333	Implement Member Outreach	Fri 11/6/15	Fri 11/6/15	Health Plan, QM
334	Member and Provider Services Operations	Fri 7/31/15	Tue 12/8/15	
335	Member Stakeholder Engagement	Fri 7/31/15	Wed 12/2/15	
336	Stakeholder Advisory Board	Fri 7/31/15	Wed 12/2/15	
337	Develop Stakeholder Advisory Board Plan	Fri 7/31/15	Thu 8/27/15	Health Plan, QM
338	Identify Stakeholder Advisory Board Composition	Fri 7/31/15	Thu 8/27/15	Health Plan, QM
339	Publicize Stakeholder Advisory Board	Thu 10/1/15	Wed 10/21/15	Health Plan, QM
340	Develop Stakeholder Advisory Board Documentation requirements	Fri 7/31/15	Thu 8/27/15	Health Plan, QM
341	Convene and facilitate first Stakeholder Advisory Board Meeting	Wed 12/2/15	Wed 12/2/15	Health Plan, QM
342	Stakeholder Education	Fri 7/31/15	Tue 11/3/15	
343	Identify Stakeholders	Fri 7/31/15	Thu 8/27/15	Health Plan, QM
344	Publicize to stakeholders forum for raising questions	Thu 10/1/15	Wed 10/7/15	Health Plan, QM
345	Develop Stakeholder Education Plan	Fri 7/31/15	Thu 8/27/15	Health Plan, QM
346	Submit Stakeholder Education Plan to State for Review	Thu 10/1/15	Wed 10/28/15	Health Plan, QM
347	State Approval of Stakeholder Education Plan	Mon 11/2/15	Mon 11/2/15	Health Plan, QM
348	Implement Stakeholder Education Plan	Tue 11/3/15	Tue 11/3/15	Health Plan, QM
349	Provider Services	Mon 9/21/15	Tue 12/8/15	
350	Obtain Local 800 number for PR Team	Mon 9/21/15	Fri 9/25/15	PSO
351	Develop IVR flow	Mon 9/21/15	Fri 9/25/15	PSO
352	Identify staffing requirements	Mon 9/21/15	Fri 9/25/15	PSO
353	Develop staffing model	Mon 9/21/15	Fri 9/25/15	Health Plan, PSO
354	Determine Location	Mon 9/21/15	Fri 9/25/15	PSO
355	Create job descriptions	Mon 9/21/15	Fri 10/2/15	Health Plan, PSO, Talent Acquisition
356	Develop Recruitment Model	Mon 9/21/15	Fri 9/25/15	Health Plan, Talent Acquisition
357	Post New Requisitions	Mon 10/5/15	Fri 10/9/15	Talent Acquisition
358	Review and Update Call Flows	Mon 9/21/15	Fri 9/25/15	Health Plan, PSO
359	Review and Update P&Ps	Mon 9/21/15	Fri 10/2/15	Health Plan, PSO
360	Conduct Hiring	Mon 10/12/15	Fri 11/6/15	Talent Acquisition
361	Conduct Training	Mon 11/9/15	Tue 12/8/15	PSO
362	Membership and Enrollment	Fri 7/31/15	Thu 8/27/15	
363	Identify Staffing requirements	Fri 7/31/15	Thu 8/6/15	Health Plan
364	Hire Staff	Fri 7/31/15	Thu 8/27/15	Health Plan, Talent Acquisition
365	Procure Space for new staffing	Fri 7/31/15	Thu 8/6/15	Health Plan, CRE

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
366	Procure Applications and software for new staff	Fri 7/31/15	Thu 8/6/15	Health Plan, IT
367	Conduct Training	Fri 7/31/15	Thu 8/27/15	PSO
368	Modify any processes per RFP	Fri 7/31/15	Thu 8/13/15	Health Plan
369	Review and revise enrollment process	Fri 7/31/15	Thu 8/13/15	Health Plan, Enrollment
370	Contingency Plan/Staff for PCP and return mail processing	Fri 7/31/15	Thu 8/13/15	Health Plan, Document Services
371	Member Services	Fri 7/31/15	Thu 10/15/15	
372	Identify Staffing requirements	Fri 7/31/15	Thu 8/6/15	Health Plan
373	Develop Staffing model	Fri 7/31/15	Thu 8/6/15	Health Plan
374	Determine Location	Fri 7/31/15	Thu 8/6/15	Health Plan, CRE
375	Create Job descriptions	Fri 7/31/15	Thu 8/13/15	Health Plan, Talent Acquisition
376	Develop Recruitment Model	Fri 7/31/15	Thu 8/6/15	Health Plan, Talent Acquisition
377	Post new Requisitions	Fri 8/14/15	Thu 8/20/15	Talent Acquisition
378	Review and update Call Flows	Fri 7/31/15	Thu 8/6/15	Health Plan
379	Review and Updated P&Ps	Fri 7/31/15	Thu 8/13/15	Health Plan
380	Conduct Hiring	Fri 8/21/15	Thu 9/17/15	Talent Acquisition
381	Conduct Training	Fri 9/18/15	Thu 10/15/15	PSO
382	Member Communications	Tue 9/1/15	Mon 11/23/15	
383	Communications Plan	Tue 9/1/15	Mon 9/28/15	
384	Develop Communications Plan	Tue 9/1/15	Mon 9/28/15	Health Plan
385	Member Handbook	Tue 9/1/15	Thu 12/24/15	
386	Content Update	Tue 9/1/15	Mon 11/2/15	
387	Cover/Marketing Pages Updates	Tue 9/1/15	Mon 11/2/15	
388	Copy	Tue 9/1/15	Mon 9/14/15	Brand and Marketing
389	Internal Review	Tue 9/15/15	Mon 9/21/15	CMAP/CVP
390	External Review	Tue 9/22/15	Mon 10/19/15	State of Iowa
391	Print Layouts	Tue 11/3/15	Wed 12/16/15	
392	Round 1	Tue 11/3/15	Wed 12/2/15	Member Communications
393	Round 2	Thu 12/3/15	Wed 12/16/15	Member Communications
394	Production	Thu 12/17/15	Thu 12/24/15	
395	Send to eBusiness for posting	Thu 12/17/15	Thu 12/17/15	Provider Communications
396	Post to Web portal	Fri 12/18/15	Thu 12/24/15	eBusiness
397	Send to Call Center	Thu 12/17/15	Thu 12/17/15	Provider Communications
398	Send to Print	Thu 12/17/15	Thu 12/17/15	Provider Communications
399	Ship to Plan for use	Thu 12/17/15	Thu 12/17/15	Document Services

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
400	Stock at Ricoh for distribution	Thu 12/17/15	Thu 12/17/15	Document Services
401	Provider Directory (Print and Online)	Tue 9/1/15	Fri 12/18/15	
402	Content Update	Tue 9/1/15	Mon 11/9/15	
403	Cover/Marketing Pages Updates	Tue 9/1/15	Mon 11/9/15	
404	Copy	Tue 9/1/15	Mon 9/14/15	Brand and Marketing
405	Internal Review	Tue 9/15/15	Mon 10/12/15	CMAP/CVP
406	External Review	Tue 10/13/15	Mon 11/9/15	State of Iowa
407	Provider Listings	Tue 9/1/15	Thu 10/22/15	
408	Directory Requirements	Tue 9/1/15	Thu 9/24/15	
409	Gather/Confirm requirements for provider data configuration	Tue 9/1/15	Mon 9/7/15	PLM/Tech Services
410	Health Plan review/provide feedback	Tue 9/8/15	Wed 9/9/15	Health Plan
411	Create BRD (If new codes are needed)	Thu 9/10/15	Fri 9/18/15	PLM/Tech Services
412	Update Print Directory logic	Mon 9/21/15	Tue 9/22/15	PLM/Tech Services
413	Update Online Directory logic	Wed 9/23/15	Thu 9/24/15	PLM/Tech Services
414	Directory Extract for first directory	Fri 9/25/15	Tue 10/20/15	
415	Development	Fri 9/25/15	Mon 10/5/15	Data Exchange
416	Unit Testing	Tue 10/6/15	Tue 10/6/15	Data Exchange
417	IT BA Testing	Wed 10/7/15	Mon 10/12/15	Data Exchange
418	UAT Testing	Tue 10/13/15	Wed 10/14/15	PDQ
419	Remediation/QA Fixes	Thu 10/15/15	Fri 10/16/15	Data Exchange
420	Production Verification	Mon 10/19/15	Tue 10/20/15	Health Plan
421	Directory Extract for ongoing directory	Fri 9/25/15	Thu 10/22/15	
422	Development	Fri 9/25/15	Mon 10/5/15	Data Exchange
423	Unit Testing	Tue 10/6/15	Tue 10/6/15	Data Exchange
424	IT BA Testing	Wed 10/7/15	Mon 10/12/15	Data Exchange
425	UAT Testing	Tue 10/13/15	Wed 10/14/15	PDQ
426	Remediation/QA Fixes	Thu 10/15/15	Fri 10/16/15	Data Exchange
427	Send to production	Mon 10/19/15	Tue 10/20/15	PDQ
428	Production Verification	Wed 10/21/15	Thu 10/22/15	Health Plan
429	Print Layouts	Tue 11/10/15	Wed 12/2/15	
430	Round 1	Tue 11/10/15	Wed 12/2/15	Member Communications
431	Round 2	Tue 11/10/15	Mon 11/23/15	Member Communications
432	Production	Thu 12/3/15	Fri 12/18/15	
433	Send to eBusiness for posting	Thu 12/3/15	Thu 12/3/15	Provider Communications

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
434	Post to Web portal	Fri 12/4/15	Thu 12/17/15	eBusiness
435	Send to Call Center	Thu 12/3/15	Thu 12/3/15	Provider Communications
436	Send to Print	Thu 12/3/15	Thu 12/3/15	Provider Communications
437	Ship to Plan for use	Fri 12/18/15	Fri 12/18/15	Document Services
438	Stock at Ricoh for distribution	Fri 12/4/15	Fri 12/4/15	Document Services
439	ID Card	Tue 9/1/15	Tue 11/24/15	
440	Define ID Card Requirements	Tue 9/1/15	Wed 9/9/15	
441	Develop scope document	Tue 9/1/15	Thu 9/3/15	Enrollment
442	Document Requirements	Fri 9/4/15	Tue 9/8/15	Enrollment
443	Approve ID Card requirements	Wed 9/9/15	Wed 9/9/15	Enrollment
444	ID Card Program Development	Thu 9/10/15	Fri 9/25/15	
445	Design ID Card	Mon 9/28/15	Tue 11/24/15	
446	Design	Mon 9/28/15	Tue 10/13/15	
447	Review ID card requirements	Mon 9/28/15	Mon 9/28/15	Enrollment
448	Design ID card	Tue 9/29/15	Thu 10/1/15	Brand and Marketing
449	Submit job request for internal review	Fri 10/2/15	Tue 10/6/15	Enrollment
450	Review/edit	Wed 10/7/15	Tue 10/13/15	Brand and Marketing
451	Internal Review	Wed 10/14/15	Wed 10/28/15	
452	Conduct CMAP Review	Wed 10/14/15	Thu 10/22/15	CMAP/CVP
453	Conduct Legal/CVP Review	Fri 10/23/15	Wed 10/28/15	Legal/CVP
454	External Review	Thu 10/29/15	Tue 11/24/15	
455	Submit ID card to the State for review/approval	Thu 10/29/15	Thu 10/29/15	Regulatory
456	State reviews/approves ID card	Fri 10/30/15	Tue 11/17/15	State of Iowa
457	ID card design approved	Wed 11/18/15	Tue 11/24/15	Enrollment
458	Member Letters/Forms	Tue 9/1/15	Mon 11/9/15	
459	Member Welcome Packet	Tue 9/1/15	Mon 11/9/15	
460	Create communication and submit job request	Tue 9/1/15	Mon 9/28/15	Member Communications
461	Internal Review	Tue 9/29/15	Mon 10/12/15	CMAP/CVP
462	External Review - State Approval	Tue 10/13/15	Mon 11/9/15	State of Iowa
463	Ready to mail to member	Mon 11/9/15	Mon 11/9/15	Member Communications
464	Privacy Letters	Tue 9/1/15	Mon 11/9/15	
465	Create communication and submit job request	Tue 9/1/15	Mon 9/28/15	Member Communications
466	Internal Review	Tue 9/29/15	Mon 10/12/15	CMAP/CVP
467	External Review - State Approval	Tue 10/13/15	Mon 11/9/15	State of Iowa

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
468	Ready to mail to member	Mon 11/9/15	Mon 11/9/15	Member Communications
469	Privacy Forms	Tue 9/1/15	Mon 11/9/15	
470	Create communication and submit job request	Tue 9/1/15	Mon 9/28/15	Member Communications
471	Internal Review	Tue 9/29/15	Mon 10/12/15	CMAP/CVP
472	External Review - State Approval	Tue 10/13/15	Mon 11/9/15	State of Iowa
473	Ready to mail to member	Mon 11/9/15	Mon 11/9/15	Member Communications
474	Program Brochures	Tue 9/1/15	Tue 11/3/15	
475	Submit Job Request	Tue 9/1/15	Mon 9/7/15	Member Communications
476	Draft	Tue 9/8/15	Mon 9/21/15	Member Communications
477	Internal Review	Tue 9/22/15	Mon 10/5/15	CMAP/CVP
478	External Review	Tue 10/6/15	Mon 11/2/15	State of Iowa
479	Ready for Use	Tue 11/3/15	Tue 11/3/15	
480	Program Forms & Other Pieces	Tue 9/1/15	Tue 11/3/15	
481	Submit Job Request	Tue 9/1/15	Mon 9/7/15	Member Communications
482	Draft	Tue 9/8/15	Mon 9/21/15	Member Communications
483	Internal Review	Tue 9/22/15	Mon 10/5/15	CMAP/CVP
484	State review and approval	Tue 10/6/15	Mon 11/2/15	State of Iowa
485	Ready for Use	Tue 11/3/15	Tue 11/3/15	
486	Outreach Campaigns	Tue 9/1/15	Tue 10/20/15	
487	Continue to develop Outreach Campaigns	Tue 9/1/15	Mon 9/21/15	Member Communications
488	Provide Plan to State	Tue 9/22/15	Tue 9/22/15	Regulatory
489	Receive State Approval	Wed 9/23/15	Tue 10/20/15	State of Iowa
490	Call Center Taking Points	Tue 9/1/15	Mon 10/19/15	
491	Pre Go-live	Tue 9/1/15	Mon 10/19/15	
492	Develop talking points	Tue 9/1/15	Mon 9/28/15	Member Communications
493	Receive internal approval	Tue 9/29/15	Mon 10/12/15	CMAP/CVP
494	Post to Knowledge Database	Tue 10/13/15	Mon 10/19/15	Member Communications
495	Post Go-live 1/1	Tue 9/1/15	Mon 10/19/15	
496	Update talking points for the 1/1 population	Tue 9/1/15	Mon 9/28/15	Member Communications
497	Receive internal CMAP approval	Tue 9/29/15	Mon 10/12/15	CMAP/CVP
498	Post to Knowledge Database	Tue 10/13/15	Mon 10/19/15	Member Communications
499	Provider Communications	Fri 7/31/15	Mon 11/9/15	
500	Provider Manual	Fri 7/31/15	Mon 11/9/15	
501	Content Update	Fri 7/31/15	Thu 9/24/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
502	Cover/Marketing Pages Updates	Fri 7/31/15	Thu 9/24/15	
503	Copy	Fri 7/31/15	Thu 8/13/15	Provider Communications
504	Internal Review	Fri 8/14/15	Thu 8/27/15	CMAP/CVP
505	External Review	Fri 8/28/15	Thu 9/24/15	State of Iowa
506	Print Layouts	Fri 9/25/15	Thu 10/22/15	
507	Round 1	Fri 9/25/15	Thu 10/8/15	Provider Communications
508	Round 2	Fri 10/9/15	Thu 10/22/15	Provider Communications
509	Production	Fri 10/23/15	Mon 11/9/15	
510	Send to eBusiness for posting	Fri 10/23/15	Fri 10/23/15	Provider Communications
511	Post to Web portal	Mon 10/26/15	Fri 11/6/15	eBusiness
512	Send to Print	Fri 10/23/15	Fri 10/23/15	Provider Communications
513	Ship to Plan for use	Mon 11/9/15	Mon 11/9/15	Document Services
514	Stock at Ricoh for distribution	Mon 10/26/15	Mon 10/26/15	Document Services
515	Quick Reference Guide	Fri 7/31/15	Thu 10/8/15	
516	Create communication and submit job request	Fri 7/31/15	Thu 8/27/15	Provider Communications
517	Internal Review	Fri 8/28/15	Thu 9/10/15	CMAP/CVP
518	External Review - State Approval	Fri 9/11/15	Thu 10/8/15	State of Iowa
519	Ready to mail	Thu 10/8/15	Thu 10/8/15	Provider Communications
520	Health Care Management (HCM)	Fri 7/31/15	Tue 11/17/15	
521	HCM System build	Fri 7/31/15	Fri 10/2/15	
522	Configure	Fri 7/31/15	Thu 10/1/15	Health Care Management
523	Implement	Fri 10/2/15	Fri 10/2/15	
524	Program Descriptions	Fri 7/31/15	Tue 9/15/15	
525	Utilization Management (UM) Program Description	Fri 7/31/15	Tue 9/15/15	
526	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, UM
527	Modify Utilization Management Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, UM
528	Submit Utilization Management Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
529	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
530	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
531	Case Management (CM) Program Description	Fri 7/31/15	Tue 9/15/15	
532	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, CM
533	Modify Case Management Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, CM

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
534	Submit Case Management Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
535	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
536	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
537	Disease Management (DMCUU) Program Description	Fri 7/31/15	Tue 9/15/15	
538	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, DMCUU
539	Modify Disease Management Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, DMCUU
540	Submit Disease Management Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
541	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
542	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
543	Behavioral Health (BH) Program Description	Fri 7/31/15	Tue 9/15/15	
544	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, BH
545	Modify Behavioral Health Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, BH
546	Submit Behavioral Health Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
547	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
548	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
549	Maternal Child Services (MCS) Program Description	Fri 7/31/15	Tue 9/15/15	
550	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, MCS
551	Modify Maternal Child Services Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, MCS
552	Submit Maternal Child Services Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
553	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
554	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
555	Clinical Systems and Reporting (CSR) Program Description	Fri 7/31/15	Tue 9/15/15	
556	Review current program descriptions	Fri 7/31/15	Fri 7/31/15	HCM, CSR
557	Modify Clinical Systems and Reporting Program Description for State approval	Mon 8/3/15	Fri 8/14/15	HCM, CSR
558	Submit Clinical Systems and reporting Program Description to State for approval	Mon 8/17/15	Fri 9/11/15	Regulatory
559	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
560	Communicate State Approval	Tue 9/15/15	Tue 9/15/15	Regulatory
561	Policy & Procedures	Mon 8/3/15	Thu 10/29/15	
562	Utilization Management	Wed 9/16/15	Thu 10/29/15	
563	Review and Develop P&Ps	Wed 9/16/15	Tue 10/13/15	HCM

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
564	Submit required P&Ps to state for approval	Wed 10/14/15	Tue 10/27/15	CMAP/CVP
565	Receive approval from the State	Wed 10/28/15	Wed 10/28/15	State of Iowa
566	Communicate approval of P&Ps from State	Thu 10/29/15	Thu 10/29/15	Regulatory
567	Case Management	Mon 8/3/15	Tue 9/15/15	
568	Develop P&Ps	Mon 8/3/15	Fri 8/28/15	HCM
569	Submit required P&Ps to state for approval	Mon 8/31/15	Fri 9/11/15	CMAP/CVP
570	Receive approval from the State	Mon 9/14/15	Mon 9/14/15	State of Iowa
571	Communicate approval of P&Ps from State	Tue 9/15/15	Tue 9/15/15	Regulatory
572	Disease Management	Wed 9/16/15	Thu 10/29/15	
573	Develop P&Ps	Wed 9/16/15	Tue 10/13/15	HCM
574	Submit required P&Ps to state for approval	Wed 10/14/15	Tue 10/27/15	CMAP/CVP
575	Receive approval from the State	Wed 10/28/15	Wed 10/28/15	State of Iowa
576	Communicate approval of P&Ps from State	Thu 10/29/15	Thu 10/29/15	Regulatory
577	Behavioral Health	Wed 9/16/15	Thu 10/29/15	
578	Review and Develop P&Ps	Wed 9/16/15	Tue 10/13/15	HCM
579	Submit required P&Ps to state for approval	Wed 10/14/15	Tue 10/27/15	CMAP/CVP
580	Receive approval from the State	Wed 10/28/15	Wed 10/28/15	State of Iowa
581	Communicate approval of P&Ps from State	Thu 10/29/15	Thu 10/29/15	Regulatory
582	Maternal Child Services	Wed 9/16/15	Thu 10/29/15	
583	Review and Develop P&Ps	Wed 9/16/15	Tue 10/13/15	HCM
584	Submit required P&Ps to state for approval	Wed 10/14/15	Tue 10/27/15	CMAP/CVP
585	Receive approval from the State	Wed 10/28/15	Wed 10/28/15	State of Iowa
586	Communicate approval of P&Ps from State	Thu 10/29/15	Thu 10/29/15	Regulatory
587	Clinical Systems and Reporting	Wed 9/16/15	Thu 10/29/15	
588	Review and Develop P&Ps	Wed 9/16/15	Tue 10/13/15	HCM
589	Submit required P&Ps to state for approval	Wed 10/14/15	Tue 10/27/15	CMAP/CVP
590	Receive approval from the State	Wed 10/28/15	Wed 10/28/15	State of Iowa
591	Communicate approval of P&Ps from State	Thu 10/29/15	Thu 10/29/15	Regulatory
592	Establish Advisory Committees	Fri 7/31/15	Fri 7/31/15	
593	Behaviorial Health Advisory Committee	Fri 7/31/15	Fri 7/31/15	
594	Advisory Committee on Immunization Practices (ACIP)	Fri 7/31/15	Fri 7/31/15	
595	HCM Letters	Mon 8/3/15	Tue 11/17/15	
596	HCM Letter Creation	Mon 8/3/15	Tue 11/3/15	
597	Utilization Management Letters	Wed 9/16/15	Tue 11/3/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
598	Draft Utilization Management letters	Wed 9/16/15	Thu 9/17/15	Health Care Management
599	Submit to CMAP for approval	Fri 9/18/15	Fri 9/18/15	Member Communications
600	Letters sent to CMAP reviewers for approval	Mon 9/21/15	Fri 10/2/15	CMAP/CVP
601	Submit Utilization Management letters to State for approval	Mon 10/5/15	Fri 10/30/15	Regulatory
602	Receive approval from the State	Mon 11/2/15	Mon 11/2/15	State of Iowa
603	Communicate State approval of all Utilization Management letters	Mon 11/2/15	Mon 11/2/15	Member Communications
604	Copywriting process completed - Letters into MACCESS	Tue 11/3/15	Tue 11/3/15	Member Communications
605	Case Management Letters	Mon 8/3/15	Fri 9/18/15	
606	Draft Case Management letters	Mon 8/3/15	Tue 8/4/15	Health Care Management
607	Submit to CMAP for approval	Wed 8/5/15	Wed 8/5/15	Member Communications
608	Letters sent to CMAP reviewers for approval	Thu 8/6/15	Wed 8/19/15	CMAP/CVP
609	Submit Case Management letters to State for approval	Thu 8/20/15	Wed 9/16/15	Regulatory
610	Receive approval from the State	Thu 9/17/15	Thu 9/17/15	State of Iowa
611	Communicate State approval of all Case Management letters	Thu 9/17/15	Thu 9/17/15	Member Communications
612	Copywriting process completed - letters into MACCESS	Fri 9/18/15	Fri 9/18/15	Member Communications
613	Disease Management Letters	Wed 9/16/15	Tue 11/3/15	
614	Draft Disease Management letters	Wed 9/16/15	Thu 9/17/15	Health Care Management Services
615	Submit to CMAP for approval	Fri 9/18/15	Fri 9/18/15	Member Communications
616	Letters sent to CMAP reviewers for approval	Mon 9/21/15	Fri 10/2/15	CMAP/CVP
617	Submit Disease Management letters to State for approval	Mon 10/5/15	Fri 10/30/15	Regulatory
618	Receive approval from the State	Mon 11/2/15	Mon 11/2/15	State of Iowa
619	Communicate State approval of all Disease Management letters	Mon 11/2/15	Mon 11/2/15	Member Communications
620	Copywriting process completed - letters into MACCESS	Tue 11/3/15	Tue 11/3/15	Member Communications
621	Behavioral Health Letters	Wed 9/16/15	Tue 11/3/15	
622	Draft Behavioral Health letters	Wed 9/16/15	Thu 9/17/15	Health Care Management Services
623	Submit to CMAP for approval	Fri 9/18/15	Fri 9/18/15	Member Communications
624	Letters sent to CMAP reviewers for approval	Mon 9/21/15	Fri 10/2/15	CMAP/CVP
625	Submit Behavioral Health letters to State for approval	Mon 10/5/15	Fri 10/30/15	Regulatory
626	Receive approval from the State	Mon 11/2/15	Mon 11/2/15	State of Iowa
627	Communicate State approval of all Behavioral Health letters	Mon 11/2/15	Mon 11/2/15	Member Communications
628	Copywriting process completed - letters into MACCESS	Tue 11/3/15	Tue 11/3/15	Member Communications
629	Maternal Child Services Letters	Wed 9/16/15	Tue 11/3/15	
630	Draft Maternal Child Services letters	Wed 9/16/15	Thu 9/17/15	Health Care Management Services
631	Submit to CMAP for approval	Fri 9/18/15	Fri 9/18/15	Member Communications

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
632	Letters sent to CMAP reviewers for approval	Mon 9/21/15	Fri 10/2/15	CMAP/CVP
633	Submit Maternal Child Services letters to State for approval	Mon 10/5/15	Fri 10/30/15	Regulatory
634	Receive approval from the State	Mon 11/2/15	Mon 11/2/15	State of Iowa
635	Communicate State approval of all Maternal Child Services letters	Mon 11/2/15	Mon 11/2/15	Member Communications
636	Copywriting process completed - letters into MACCESS	Tue 11/3/15	Tue 11/3/15	Member Communications
637	Clinical Systems and Reporting Letters	Wed 9/16/15	Tue 11/3/15	
638	Draft Clinical Systems and Reporting letters	Wed 9/16/15	Thu 9/17/15	Health Care Management Services
639	Submit to CMAP for approval	Fri 9/18/15	Fri 9/18/15	Member Communications
640	Letters sent to CMAP reviewers for approval	Mon 9/21/15	Fri 10/2/15	CMAP/CVP
641	Submit Clinical Systems and Reporting letters to State for approval	Mon 10/5/15	Fri 10/30/15	Regulatory
642	Receive approval from the State	Mon 11/2/15	Mon 11/2/15	State of Iowa
643	Communicate State approval of all Clinical Systems and Reporting letters	Mon 11/2/15	Mon 11/2/15	Member Communications
644	Copywriting process completed - letters into MACCESS	Tue 11/3/15	Tue 11/3/15	Member Communications
645	Configure all letters in MACCESS	Wed 11/4/15	Tue 11/17/15	MACCESS Team
646	Workflows	Mon 10/12/15	Fri 11/13/15	
647	Utilization Management	Mon 10/12/15	Fri 11/13/15	
648	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, UM
649	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, UM
650	Case Management	Mon 10/12/15	Fri 11/13/15	
651	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, CM
652	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, CM
653	Disease Management	Mon 10/12/15	Fri 11/13/15	
654	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, DMCUU
655	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, DMCUU
656	Behavioral Health	Mon 10/12/15	Fri 11/13/15	
657	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, BH
658	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, BH
659	Maternal Child Services	Mon 10/12/15	Fri 11/13/15	
660	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, MCS

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
661	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, MCS
662	Clinical Systems and Reporting	Mon 10/12/15	Fri 11/13/15	
663	Review current workflows and determine changes/additional workflows	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, CSR
664	Create workflows/update workflows	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, CSR
665	Transition Plan	Fri 7/31/15	Fri 11/13/15	
666	Auth Waiver	Fri 7/31/15	Wed 10/14/15	
667	Determine transition rules and procedures	Fri 7/31/15	Tue 9/1/15	Health Plan
668	Submit Auth Waiver Change Request to Pre-Cert Committee	Wed 9/2/15	Mon 9/7/15	Health Plan
669	Pre-cert committee approves changes	Tue 9/8/15	Wed 9/9/15	Pre-cert Committee
670	Create and Submit request for Auth Override Tool	Wed 9/9/15	Wed 9/9/15	Pre-cert Committee
671	Test Auth Override Tool	Thu 9/10/15	Wed 9/30/15	HCM
672	Validate Auth Waiver in Production	Thu 10/1/15	Wed 10/14/15	HCM
673	Continuity of Care	Fri 7/31/15	Fri 11/13/15	
674	Determine continuity of care plan requirements	Fri 7/31/15	Thu 8/6/15	HCM
675	Create continuity of care plan	Fri 8/7/15	Thu 9/3/15	HCM
676	Submit continuity of care plan to Regulatory to submit to State for approval as part of Desk readiness	Fri 9/4/15	Thu 9/17/15	Regulatory
677	Define process for open authorizations at time of acquisition (Transition of Care)	Fri 9/18/15	Thu 10/15/15	Health Plan, HCM
678	Review electronic file and determine order of priority	Fri 10/16/15	Thu 11/12/15	Health Plan, HCM, IT
679	Define members with open authorizations at time of transition	Mon 10/12/15	Fri 11/6/15	
680	Inpatient, including transplants	Mon 10/12/15	Fri 11/6/15	Health Plan, HCM
681	Prior Auth Inpatient	Mon 10/12/15	Fri 11/6/15	Health Plan, HCM
682	Outpatients -- Home Health PT, OT, ST and arrange for assessments to determine the need for ongoing treatment	Mon 10/12/15	Fri 11/6/15	Health Plan, HCM
683	Initiate contact with members	Mon 10/12/15	Fri 11/6/15	Health Plan, HCM
684	Inpatient Concurrent Review	Mon 10/5/15	Fri 11/13/15	
685	Research non PAR hospital payment	Mon 10/5/15	Fri 10/16/15	Health Plan, HCM
686	Notify telephonic review hospitals of concurrent review process	Mon 10/19/15	Fri 10/30/15	Health Plan, HCM
687	Run test reports	Mon 11/2/15	Fri 11/13/15	Health Plan, HCM
688	Implement Internal daily flash process	Mon 11/2/15	Fri 11/13/15	Health Plan, HCM
689	Implement bi-weekly flash report to Corporate	Mon 11/2/15	Fri 11/13/15	Health Plan, HCM
690	Implement fill monthly flash for month closing	Mon 11/2/15	Fri 11/13/15	Health Plan, HCM
691	Emergency Room - Define Diversion Program	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
692	HCM Reports	Fri 7/31/15	Fri 11/6/15	
693	Utilization Management Operational Reports	Fri 7/31/15	Fri 11/6/15	
694	Identify required reports	Fri 7/31/15	Thu 8/13/15	
695	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	UM, HCM
696	Test reports	Fri 9/11/15	Thu 10/8/15	UM, HCM, IT
697	Implement	Fri 10/9/15	Thu 11/5/15	UM, HCM, IT
698	Validate in production	Fri 11/6/15	Fri 11/6/15	UM, HCM, IT
699	Case Management Operational Reports	Fri 7/31/15	Fri 11/6/15	
700	Identify required reports	Fri 7/31/15	Thu 8/13/15	
701	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	CM, HCM
702	Test reports	Fri 9/11/15	Thu 10/8/15	CM, HCM, IT
703	Implement	Fri 10/9/15	Thu 11/5/15	CM, HCM, IT
704	Validate in production	Fri 11/6/15	Fri 11/6/15	CM, HCM, IT
705	Disease Management Operational Reports	Fri 7/31/15	Fri 11/6/15	
706	Identify required reports	Fri 7/31/15	Thu 8/13/15	
707	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	DMCUU, HCM
708	Test reports	Fri 9/11/15	Thu 10/8/15	DMCUU, HCM, IT
709	Implement	Fri 10/9/15	Thu 11/5/15	DMCUU, HCM, IT
710	Validate in production	Fri 11/6/15	Fri 11/6/15	DMCUU, HCM, IT
711	Behavioral Health Operational Reports	Fri 7/31/15	Fri 11/6/15	
712	Identify required reports	Fri 7/31/15	Thu 8/13/15	
713	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	BH, HCM
714	Test reports	Fri 9/11/15	Thu 10/8/15	BH, HCM, IT
715	Implement	Fri 10/9/15	Thu 11/5/15	BH, HCM, IT
716	Validate in production	Fri 11/6/15	Fri 11/6/15	BH, HCM, IT
717	Maternal Child Services Operational Reports	Fri 7/31/15	Fri 11/6/15	
718	Identify required reports	Fri 7/31/15	Thu 8/13/15	MCS, HCM
719	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	MCS, HCM, IT
720	Test reports	Fri 9/11/15	Thu 10/8/15	MCS, HCM, IT
721	Implement	Fri 10/9/15	Thu 11/5/15	MCS, HCM, IT
722	Validate in production	Fri 11/6/15	Fri 11/6/15	MCS, HCM, IT
723	Clinical Systems and Reporting Operational Reports	Fri 7/31/15	Fri 11/6/15	
724	Identify required reports	Fri 7/31/15	Thu 8/13/15	
725	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	CSR, HCM

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
726	Test reports	Fri 9/11/15	Thu 10/8/15	CSR, HCM, IT
727	Implement	Fri 10/9/15	Thu 11/5/15	CSR, HCM, IT
728	Validate in production	Fri 11/6/15	Fri 11/6/15	CSR, HCM, IT
729	Regulatory Reports	Fri 7/31/15	Fri 11/6/15	
730	Identify all reports	Fri 7/31/15	Thu 8/13/15	
731	Scope requirements for reports	Fri 7/31/15	Thu 9/10/15	HCM, Regulatory
732	Test reports	Fri 9/11/15	Thu 10/8/15	HCM, Regulatory, IT
733	Implement	Fri 10/9/15	Thu 11/5/15	HCM, Regulatory, IT
734	Validate in production	Fri 11/6/15	Fri 11/6/15	HCM, Regulatory, IT
735	Configure Clinical System and Reporting Systems	Fri 7/31/15	Thu 10/29/15	
736	Configure CareCompass	Fri 7/31/15	Thu 10/1/15	Clinical Systems and Reporting
737	Test CareCompass	Fri 10/2/15	Thu 10/29/15	Clinical Systems and Reporting
738	Configure Member 360	Fri 7/31/15	Thu 10/29/15	
739	Configure Member 360	Fri 7/31/15	Thu 10/1/15	Clinical Systems and Reporting
740	Test Member 360	Fri 10/2/15	Thu 10/29/15	Clinical Systems and Reporting
741	Configure Patient 360	Fri 7/31/15	Thu 10/29/15	
742	Configure Patient 360	Fri 7/31/15	Thu 10/1/15	Clinical Systems and Reporting
743	Test Patient 360	Fri 10/2/15	Thu 10/29/15	Clinical Systems and Reporting
744	Health Homes	Fri 7/31/15	Fri 11/13/15	
745	Utilization Management	Fri 7/31/15	Fri 11/13/15	
746	Program Descriptions	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, UM
747	Revise Policy and Procedures	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, UM
748	Training for Associates	Fri 7/31/15	Fri 7/31/15	
749	Recruiting and Contracting	Fri 7/31/15	Fri 7/31/15	
750	Case Management	Fri 7/31/15	Fri 11/13/15	
751	Program Descriptions	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, CM
752	Revise Policy and Procedures	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, CM
753	Training for Associates	Fri 7/31/15	Fri 7/31/15	
754	Recruiting and Contracting	Fri 7/31/15	Fri 7/31/15	
755	Disease Management	Fri 7/31/15	Fri 11/13/15	
756	Program Descriptions	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, DMCCU
757	Revise Policy and Procedures	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, DMCCU
758	Training for Associates	Fri 7/31/15	Fri 7/31/15	
759	Recruiting and Contracting	Fri 7/31/15	Fri 7/31/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
760	Behavioral Health	Fri 7/31/15	Fri 11/13/15	
761	Program Descriptions	Mon 10/12/15	Fri 10/16/15	Health Plan, HCM, BH
762	Revise Policy and Procedures	Mon 10/19/15	Fri 11/13/15	Health Plan, HCM, BH
763	Training for Associates	Fri 7/31/15	Fri 7/31/15	
764	Recruiting and Contracting	Fri 7/31/15	Fri 7/31/15	
765	Long Term Services and Supports (LTSS)	Fri 7/31/15	Thu 1/14/16	
766	Health Plan LTSS	Fri 7/31/15	Fri 11/13/15	
767	Training of staff	Mon 10/5/15	Fri 11/13/15	
768	Hire Training Manager	Mon 10/5/15	Fri 10/16/15	Health Plan, Talent Acquisition
769	Secure training locations	Mon 10/26/15	Fri 11/6/15	Health Plan, PSO
770	Hire Trainers	Mon 10/5/15	Fri 11/13/15	Health Plan, PSO, Talent Acquisition
771	Modify Training Material	Mon 10/19/15	Fri 10/30/15	PSO
772	Training Schedule	Mon 10/19/15	Fri 10/30/15	Health Plan, PSO
773	Hire Associates	Fri 7/31/15	Thu 10/22/15	Talent Acquisition
774	iPad application to enable forms not in Care Compass to be completed	Fri 7/31/15	Tue 12/8/15	
775	Submit solution to CSR steering committee to establish priority	Fri 7/31/15	Thu 8/13/15	Health Plan, HCM
776	Identify Requirements	Fri 8/14/15	Thu 8/27/15	Health Plan, HCM
777	Build Solution	Fri 8/28/15	Thu 9/24/15	IT
778	BA Testing	Fri 9/25/15	Thu 10/8/15	IT
779	UAT	Fri 11/20/15	Mon 12/7/15	IT
780	Production	Tue 12/8/15	Tue 12/8/15	IT
781	Integration of needed LTSS forms into Care Compass	Mon 10/12/15	Fri 11/20/15	
782	LTSS Develop Service Plan	Mon 9/21/15	Wed 12/23/15	
783	Examine requirements to understand needs/demands	Mon 9/21/15	Fri 10/2/15	
784	Develop BRD	Mon 10/12/15	Fri 10/23/15	Health Plan, HCM
785	System Design	Mon 10/26/15	Fri 11/20/15	HCM, IT
786	BA Testing	Mon 11/23/15	Tue 12/8/15	IT
787	UAT Testing	Wed 12/9/15	Tue 12/22/15	IT
788	Production	Wed 12/23/15	Wed 12/23/15	IT
789	Care Compass reporting support	Mon 9/28/15	Tue 12/8/15	
790	Examine requirements to understand needs/demands	Mon 9/28/15	Fri 10/9/15	Health Plan
791	Develop SLAs	Mon 10/12/15	Fri 10/23/15	Health Plan, LTSS
792	Develop staffing requirements	Mon 10/26/15	Fri 11/6/15	Health Plan, LTSS
793	Hire required staff	Mon 11/9/15	Tue 12/8/15	Health Plan, Talent Acquisition

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
794	HCBS Waivers	Fri 7/31/15	Fri 9/25/15	
795	Document HCBS requirements and waivers	Mon 9/14/15	Fri 9/25/15	Health Plan, LTSS
796	Implement InterRAI and Supports Intensity Scales (SIS)	Fri 7/31/15	Thu 8/6/15	Health Plan, LTSS
797	Review State's Waiver Program Application	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
798	Universal Assessment Tool	Mon 9/21/15	Wed 12/9/15	
799	Review requirements document	Mon 9/21/15	Fri 9/25/15	Health Plan, IT, LTSS
800	Develop BRD	Mon 9/28/15	Fri 10/9/15	Health Plan, IT, LTSS
801	Development	Mon 10/12/15	Fri 11/6/15	IT
802	BA Testing	Mon 11/9/15	Fri 11/20/15	IT
803	UAT Testing	Mon 11/23/15	Tue 12/8/15	IT
804	Production	Wed 12/9/15	Wed 12/9/15	IT
805	Ensure risk agreement meets State requirements	Fri 7/31/15	Thu 8/13/15	
806	Review risk agreement against state requirements	Fri 7/31/15	Thu 8/13/15	Health Plan, Regulatory
807	Autopopulate forms through Ipad	Mon 9/28/15	Wed 12/9/15	
808	Develop BRD	Mon 9/28/15	Fri 10/9/15	Health Plan, IT
809	System Development	Mon 10/12/15	Fri 11/6/15	IT
810	BA Testing	Mon 11/9/15	Fri 11/20/15	IT
811	UAT Testing	Mon 11/23/15	Tue 12/8/15	IT
812	Production	Wed 12/9/15	Wed 12/9/15	IT
813	Establishment of LTSS Stakeholder/ Advisory group	Mon 9/28/15	Fri 10/16/15	
814	Identify Member Advocate	Mon 9/28/15	Fri 10/2/15	Health Plan
815	Identify participants	Mon 10/5/15	Fri 10/16/15	Health Plan
816	Consumer Choices Option	Mon 9/21/15	Thu 1/14/16	
817	Identify Requirements	Mon 9/21/15	Fri 10/2/15	Health Plan, LTSS
818	Develop Training Materials	Mon 10/5/15	Mon 10/5/15	Health Plan, LTSS
819	Develop ISB Provider Enrollment process	Mon 11/16/15	Tue 12/1/15	Health Plan, LTSS
820	Develop Member Communications	Wed 12/2/15	Wed 12/2/15	Health Plan, LTSS
821	Enroll independent support brokers	Mon 10/5/15	Fri 11/13/15	Health Plan, LTSS
822	Work with and train independent support brokers	Thu 12/3/15	Thu 1/14/16	Health Plan, LTSS
823	Implement FMS	Fri 7/31/15	Fri 7/31/15	
824	Identify requirements	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
825	Finalize contract with the vendor	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
826	Develop and Document Process Flows	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
827	Coordinate Training (Internal and External)	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
828	Test file sharing	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
829	Readiness Review	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
830	Website Updates	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
831	Production	Fri 7/31/15	Fri 7/31/15	Health Plan, LTSS
832	Retention plan for LTSS members	Mon 9/21/15	Mon 11/9/15	
833	Identify Requirements	Mon 9/21/15	Fri 10/2/15	Health Plan
834	Identify Vendor	Mon 10/5/15	Fri 10/9/15	Health Plan, Vendor Management
835	Develop Contract and SOW	Mon 10/12/15	Fri 11/6/15	Vendor Management, Legal
836	Vendor to perform member outreach/retention	Mon 11/9/15	Mon 11/9/15	Vendor Management
837	Managing Community-Based Case Manager/Care Coordinator productivity and thoroughness	Mon 9/21/15	Tue 11/17/15	
838	Requirements	Mon 9/21/15	Fri 10/2/15	
839	Design	Mon 10/5/15	Fri 10/30/15	
840	System Integration Testing	Mon 11/2/15	Mon 11/2/15	
841	User Acceptance Testing	Tue 11/3/15	Mon 11/16/15	
842	Production	Tue 11/17/15	Tue 11/17/15	
843	Community-Based Case Manager/Care Coordinator audits and feedback	Mon 10/12/15	Fri 11/20/15	
844	Identify audit requirements	Mon 10/12/15	Fri 10/23/15	Health Plan
845	Identify frequency of audits	Mon 10/26/15	Fri 10/30/15	Health Plan
846	Develop audit schedule	Mon 11/2/15	Fri 11/6/15	Health Plan
847	Develop feedback tool	Mon 11/9/15	Fri 11/20/15	Health Plan
848	Update Audit Tool	Mon 9/21/15	Mon 11/16/15	
849	Develop BRD	Mon 9/21/15	Fri 10/2/15	Health Plan, IT
850	BA Testing	Mon 10/5/15	Fri 10/30/15	IT
851	User Acceptance Testing	Mon 11/2/15	Fri 11/13/15	IT
852	Production	Mon 11/16/15	Mon 11/16/15	IT
853	Community-Based Case Manager/Care Coordinator report card LTSS	Mon 10/5/15	Wed 12/9/15	
854	Requirements	Mon 10/5/15	Fri 10/16/15	Health Plan
855	Design	Mon 10/19/15	Fri 11/13/15	IT
856	System Integration Testing	Mon 11/16/15	Fri 11/20/15	IT
857	User Acceptance Testing	Mon 11/23/15	Tue 12/8/15	IT
858	Production	Wed 12/9/15	Wed 12/9/15	IT
859	Stakeholder partnerships	Fri 7/31/15	Fri 7/31/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
860	Establish partnerships	Fri 7/31/15	Fri 7/31/15	
861	Community-Based Case Manager/Care Coordinator Specialization	Mon 10/5/15	Tue 12/8/15	
862	Hiring Staff	Mon 10/5/15	Fri 10/30/15	Health Plan, Human Resources
863	Training Staff	Mon 11/2/15	Tue 12/1/15	Health Plan, PSO
864	Reviewing Work Load	Mon 11/2/15	Fri 11/6/15	Health Plan
865	Assigning Workload to new FTEs	Wed 12/2/15	Tue 12/8/15	Health Plan
866	Medically fragile or complex members	Mon 10/5/15	Wed 11/25/15	
867	Respiratory Program	Mon 10/5/15	Wed 11/25/15	
868	Vendor meeting	Mon 10/5/15	Mon 10/5/15	Health Plan
869	Provider Relations/Leadership analyzing data/Finance	Tue 10/6/15	Mon 10/12/15	Health Plan
870	Meet with vendor for final approval of program	Tue 10/13/15	Tue 10/13/15	Health Plan
871	Develop procedure/policies	Wed 10/14/15	Tue 10/27/15	Health Plan
872	Staff training	Wed 10/28/15	Tue 11/24/15	Health Plan
873	Implement	Wed 11/25/15	Wed 11/25/15	Health Plan
874	Transition Plan	Fri 7/31/15	Wed 12/9/15	
875	Auth Waiver	Fri 7/31/15	Wed 12/9/15	
876	Determine transition rules and procedures	Fri 7/31/15	Thu 8/6/15	
877	Submit Auth Waiver Change Request to Pre-Cert Committee	Mon 9/14/15	Mon 9/14/15	Health Plan
878	Pre-cert committee approves changes	Tue 9/15/15	Mon 9/28/15	Health Plan
879	Create and Submit ACCR for Auth Override Tool	Tue 9/29/15	Mon 10/26/15	Health Plan
880	Test Auth Override Tool (link to dependency on PLM creating AOT)	Tue 10/27/15	Mon 11/23/15	Health Plan
881	Validate Auth Waiver in Production	Tue 11/24/15	Wed 12/9/15	Health Plan
882	Continuity of Care	Fri 7/31/15	Fri 11/13/15	
883	Determine continuity of care plan requirements	Fri 7/31/15	Thu 8/27/15	Health Plan
884	Create continuity of care plan	Mon 10/5/15	Fri 10/30/15	Health Plan
885	Submit Continuity of Care plan to Regulatory for possible State for approval	Mon 11/2/15	Fri 11/13/15	Health Plan
886	Pharmacy Implementation	Tue 9/1/15	Tue 12/15/15	
887	Execution	Tue 9/1/15	Tue 12/15/15	
888	Vendor Contracts	Tue 9/1/15	Tue 11/3/15	
889	Negotiate and Finalize Pharmacy Contract	Tue 9/1/15	Mon 9/28/15	Pharmacy, Vendor Management
890	Submit Draft Contract to the State	Tue 9/29/15	Tue 9/29/15	Pharmacy, Vendor Management
891	Receive Legal-Approval of Contract	Wed 9/30/15	Tue 10/27/15	State of Iowa
892	Execute Contract	Wed 10/28/15	Fri 10/30/15	Pharmacy, Vendor Management

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
893	Send Final Executed Contract to Legal for State Filing	Mon 11/2/15	Mon 11/2/15	Pharmacy, Vendor Management
894	Receive State-Approved Pharmacy Contract	Tue 11/3/15	Tue 11/3/15	State of Iowa
895	MTM Vendor	Tue 9/1/15	Mon 10/12/15	
896	Execute Contract	Tue 9/1/15	Mon 9/28/15	Vendor Management
897	Execute NDA	Mon 10/5/15	Mon 10/5/15	Vendor Management
898	Execute CA	Mon 10/12/15	Mon 10/12/15	Vendor Management
899	Pharmacy Network	Tue 9/1/15	Wed 12/2/15	
900	Solicit Pharmacies for Network	Tue 9/1/15	Wed 12/2/15	Pharmacy, Vendor Management
901	Pharmacy Provider Education	Mon 10/5/15	Mon 11/30/15	
902	Determine Provider Training Strategy	Mon 10/5/15	Fri 10/9/15	Pharmacy
903	Education Tools	Mon 10/12/15	Mon 11/30/15	
904	Develop Pharmacy Provider Education Presentation	Mon 10/12/15	Fri 10/16/15	Pharmacy
905	Review Pharmacy Provider Education Presentation	Fri 10/16/15	Tue 10/20/15	Pharmacy
906	Update Pharmacy Provider Education Presentation Based on Feedback	Wed 10/21/15	Thu 10/22/15	Pharmacy
907	Submit Pharmacy Provider Education Presentation for CMAP & State Review/Approval	Fri 10/23/15	Fri 10/23/15	Member Communications
908	Receive CMAP & State Approved Pharmacy Provider Education Presentation	Fri 10/23/15	Thu 11/19/15	State of Iowa
909	Confirm eBusiness Posted Pharmacy Provider Educational Presentation to the Pharmacy Provider Web Portal	Mon 11/30/15	Mon 11/30/15	Pharmacy
910	Pharmacy P&Ps	Mon 10/5/15	Fri 11/6/15	
911	Update/Develop Administrative P&Ps	Mon 10/5/15	Thu 10/8/15	Pharmacy
912	Submit Administrative P&Ps for State Review/Approval	Fri 10/9/15	Fri 10/9/15	Regulatory
913	Receive State Approval of Administrative P&Ps	Mon 10/12/15	Fri 11/6/15	State of Iowa
914	Communications	Thu 10/4/12	Tue 12/15/15	
915	Member ID Cards	Mon 10/5/15	Mon 10/5/15	
916	Obtain Bin/PCN/Group Information for Member ID Cards and Provide to Member Communications	Mon 10/5/15	Mon 10/5/15	Pharmacy
917	Pharmacy Notification	Mon 10/5/15	Wed 12/2/15	
918	Determine Strategy for Distribution of Pharmacy Notice	Mon 10/5/15	Fri 10/9/15	Pharmacy
919	Request a Draft Pharmacy Notice from vendor	Mon 10/12/15	Mon 10/12/15	Pharmacy
920	Communication Distribution Schedule for Pharmacy Notice	Tue 10/13/15	Thu 10/15/15	Pharmacy
921	Develop Draft Pharmacy Notice and Provide to AGP	Tue 10/13/15	Mon 10/19/15	Pharmacy
922	Forward Draft Pharmacy Notice to Team for Review and Updates	Tue 10/20/15	Thu 10/22/15	Pharmacy
923	Update Pharmacy Notice	Fri 10/23/15	Thu 10/29/15	Pharmacy

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
924	Submit Pharmacy Notice for CMAP Review and Approval	Thu 10/29/15	Fri 10/30/15	Member Communications
925	Receive CMAP Approval of Pharmacy Notice	Fri 10/30/15	Tue 12/1/15	Regulatory
926	Send Approved Pharmacy Notice to Vendor	Tue 12/1/15	Wed 12/2/15	State of Iowa
927	Fax Pharmacy Notice to Pharmacy Network	Tue 12/1/15	Wed 12/2/15	Regulatory
928	Provider Communications	Mon 11/2/15	Mon 11/16/15	
929	Provider Directory	Mon 11/2/15	Mon 11/16/15	
930	Submit pharmacy network file to Technology Services/Regulatory	Mon 11/2/15	Mon 11/2/15	Pharmacy
931	Pharmacy Search Locator Tool	Tue 11/3/15	Mon 11/16/15	Pharmacy, eBusiness
932	Provider Portal	Tue 11/3/15	Mon 11/9/15	Pharmacy, eBusiness
933	Member Communications	Thu 10/4/12	Tue 12/15/15	
934	Member Handbook	Mon 11/2/15	Tue 12/15/15	
935	Review Member Handbook for Pharmacy Updates via CMAP Review Process	Mon 11/2/15	Tue 12/15/15	Pharmacy, Member Communications
936	Member Portal	Thu 10/4/12	Wed 12/9/15	
937	Develop Business Requirements	Mon 10/5/15	Fri 10/16/15	Pharmacy
938	Review Business Requirements and Approve	Thu 10/4/12	Fri 10/23/15	Pharmacy, eBusiness
939	Submit Business Requirements to eBusiness	Thu 10/4/12	Mon 10/26/15	Pharmacy, eBusiness
940	Create Mock-Up	Thu 10/4/12	Mon 11/9/15	eBusiness
941	Review Mock-Up and Approve	Thu 10/4/12	Mon 11/16/15	Pharmacy
942	Submit Mock-Up for CMAP and State Review/Approval	Tue 11/17/15	Tue 11/17/15	Member Communications
943	Receive CMAP and State Approval	Wed 11/18/15	Thu 12/3/15	Regulatory
944	Configure Portal Updates	Fri 12/4/15	Tue 12/8/15	eBusiness
945	Confirm eBusiness Deployed Pharmacy Updates to Production	Wed 12/9/15	Wed 12/9/15	Pharmacy
946	Vision Implementation	Fri 7/31/15	Mon 12/14/15	
947	Execution	Fri 7/31/15	Mon 12/14/15	
948	Vendor Contracts	Fri 7/31/15	Fri 10/2/15	
949	Negotiate and Finalize Vision Contract	Fri 7/31/15	Thu 8/27/15	Vendor Management
950	Submit Draft Contract to the State	Fri 8/28/15	Fri 8/28/15	Vendor Management
951	Receive Legal-Approval of Contract	Mon 8/31/15	Fri 9/25/15	State of Iowa
952	Execute Contract	Mon 9/28/15	Wed 9/30/15	Vendor Management
953	Send Final Executed Contract to Legal for State Filing	Thu 10/1/15	Thu 10/1/15	Vendor Management
954	Receive State-Approved Vision Contract	Fri 10/2/15	Fri 10/2/15	State of Iowa
955	Vision Network	Fri 7/31/15	Thu 10/29/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
956	Solicit Providers for Network	Fri 7/31/15	Thu 10/29/15	Vendor Management
957	Vision Provider Education	Fri 7/31/15	Mon 12/14/15	
958	Determine Provider Training Strategy	Fri 7/31/15	Thu 8/13/15	Vendor Management
959	Education Tools	Mon 10/5/15	Mon 12/14/15	
960	Develop Vision Provider Education Presentation	Mon 10/5/15	Fri 10/9/15	Vendor Management
961	Review Vision Provider Education Presentation	Mon 10/12/15	Wed 10/14/15	Vendor Management
962	Update Vision Provider Education Presentation Based on Feedback	Mon 10/19/15	Tue 10/20/15	Vendor Management
963	Submit Vision Provider Education Presentation for CMAP & State Review/Approval	Fri 10/23/15	Fri 10/23/15	Member Communications
964	Receive CMAP & State Approved Vision Provider Education Presentation	Fri 10/23/15	Thu 11/19/15	State of Iowa
965	Confirm eBusiness Posted Vision Provider Educational Presentation to the Vision Provider Web Portal	Mon 12/14/15	Mon 12/14/15	Vendor Management
966	Vision P&Ps	Fri 7/31/15	Fri 10/23/15	
967	Update/Develop Administrative P&Ps	Fri 7/31/15	Wed 8/5/15	Vendor Management
968	Submit Administrative P&Ps for State Review/Approval	Mon 9/14/15	Mon 9/14/15	Regulatory
969	Receive State Approval of Administrative P&Ps	Mon 9/14/15	Fri 10/23/15	State of Iowa
970	Communications	Tue 9/1/15	Thu 12/10/15	
971	Member ID Cards	Mon 11/2/15	Mon 11/2/15	
972	Obtain Bin/PCN/Group Information for Member ID Cards and Provide to Member Communications	Mon 11/2/15	Mon 11/2/15	Vendor Management
973	Vision Notification	Mon 11/2/15	Mon 12/7/15	
974	Determine Strategy for Distribution of Vision Notice	Mon 11/2/15	Fri 11/6/15	Vendor Management
975	Request a Draft Vision Notice from vendor	Fri 11/6/15	Fri 11/6/15	Vendor Management
976	Communication Distribution Schedule for Vision Notice	Mon 11/9/15	Mon 11/9/15	Vendor Management
977	Develop Draft Vision Notice and Provide to AGP	Tue 11/10/15	Tue 11/10/15	Vendor Management
978	Forward Draft Vision Notice to Team for Review and Updates	Tue 11/10/15	Mon 11/16/15	Vendor Management
979	Update Vision Notice	Mon 11/16/15	Mon 11/23/15	Vendor Management
980	Submit Vision Notice for CMAP Review and Approval	Mon 11/2/15	Mon 11/2/15	Member Communications
981	Receive CMAP Approval of Vision Notice	Mon 11/2/15	Tue 12/1/15	Regulatory
982	Send Approved Vision Notice to Vendor	Mon 12/7/15	Mon 12/7/15	State of Iowa
983	Fax Vision Notice to Vision Network	Mon 12/7/15	Mon 12/7/15	Regulatory
984	Provider Communications	Mon 11/2/15	Mon 12/7/15	
985	Provider Directory	Mon 11/2/15	Mon 12/7/15	
986	Submit vision network file to Technology Services/Regulatory	Mon 11/2/15	Mon 11/2/15	Vendor Management

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
987	Vision Search Locator Tool	Mon 11/2/15	Tue 12/1/15	Vendor Management, eBusiness
988	Provider Portal	Tue 12/1/15	Mon 12/7/15	Vendor Management, eBusiness
989	Member Communications	Tue 9/1/15	Thu 12/10/15	
990	Member Handbook	Mon 10/5/15	Fri 10/9/15	
991	Review Member Handbook for Vision Updates via CMAP Review Process	Mon 10/5/15	Fri 10/9/15	Vendor Management, Member Communications
992	Member Portal	Tue 9/1/15	Thu 12/10/15	
993	Develop Business Requirements	Tue 9/1/15	Mon 9/28/15	Vendor Management
994	Review Business Requirements and Approve	Mon 9/28/15	Fri 10/2/15	Vendor Management, eBusiness
995	Submit Business Requirements to eBusiness	Mon 10/5/15	Mon 10/5/15	Vendor Management, eBusiness
996	Create Mock-Up	Mon 10/5/15	Fri 10/16/15	eBusiness
997	Review Mock-Up and Approve	Mon 10/19/15	Fri 10/23/15	Vendor Management
998	Submit Mock-Up for CMAP and State Review/Approval	Fri 10/23/15	Thu 11/5/15	Member Communications
999	Receive CMAP and State Approval	Thu 11/5/15	Fri 12/4/15	Regulatory
1000	Configure Portal Updates	Fri 12/4/15	Tue 12/8/15	eBusiness
1001	Confirm eBusiness Deployed Vision Updates to Production	Thu 12/10/15	Thu 12/10/15	Vendor Management
1002	Reporting	Fri 7/31/15	Thu 11/12/15	
1003	Identify Report Needs	Fri 7/31/15	Thu 9/10/15	Project Team
1004	Identify Frequency of Reports	Fri 7/31/15	Thu 9/10/15	Project Team
1005	Identify Type of State Reports	Fri 7/31/15	Thu 9/10/15	Regulatory
1006	Identify Type of Department Reports	Fri 7/31/15	Thu 9/10/15	Project Team
1007	Implementation of Reports	Fri 9/11/15	Thu 11/12/15	
1008	Daily (As Needed) Reports	Fri 9/11/15	Thu 11/12/15	Project Team
1009	Weekly (First 60 days)	Fri 9/11/15	Thu 11/12/15	Project Team
1010	Monthly	Fri 9/11/15	Thu 11/12/15	Project Team
1011	Quarterly	Fri 9/11/15	Thu 11/12/15	Project Team
1012	Annual	Fri 9/11/15	Thu 11/12/15	Project Team
1013	Websites	Fri 7/31/15	Tue 11/10/15	
1014	Member Website	Fri 7/31/15	Tue 11/10/15	
1015	Design	Fri 7/31/15	Thu 8/27/15	Member Communications
1016	Submit job request for any changes	Fri 8/28/15	Fri 8/28/15	eBusiness
1017	Receive CMAP/CVP approval	Mon 8/31/15	Fri 9/11/15	Brand and Marketing
1018	Submit to State for review/approval	Mon 9/14/15	Fri 10/9/15	eBusiness
1019	Submit core request to eBusiness	Mon 10/12/15	Fri 10/23/15	Brand and Marketing
1020	Changes in QA Environment	Mon 10/26/15	Mon 10/26/15	eBusiness

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1021	QA Changes	Tue 10/27/15	Mon 11/9/15	Brand and Marketing
1022	Publish content to Production	Tue 11/10/15	Tue 11/10/15	eBusiness
1023	Provider Website	Fri 7/31/15	Tue 11/10/15	
1024	Design	Fri 7/31/15	Thu 8/27/15	Provider Communications
1025	Submit job request for any changes	Fri 8/28/15	Fri 8/28/15	eBusiness
1026	Receive CMAP/CVP approval	Mon 8/31/15	Fri 9/11/15	Brand and Marketing
1027	Submit to State for review/approval	Mon 9/14/15	Fri 10/9/15	eBusiness
1028	Submit core request to eBusiness	Mon 10/12/15	Fri 10/23/15	Brand and Marketing
1029	Changes in QA Environment	Mon 10/26/15	Mon 10/26/15	eBusiness
1030	QA Changes	Tue 10/27/15	Mon 11/9/15	Brand and Marketing
1031	Publish content to Production	Tue 11/10/15	Tue 11/10/15	eBusiness
1032	National Customer Care Center (NCC)	Fri 7/31/15	Thu 10/22/15	
1033	Update ATLAS Knowledge Information System	Fri 7/31/15	Thu 10/22/15	Call Center
1034	Update Workflow	Fri 7/31/15	Thu 10/22/15	Call Center
1035	Update Compass Knowledge Management System Rules	Fri 7/31/15	Thu 10/22/15	Call Center
1036	Update Document Repository Tool (DRT)	Fri 7/31/15	Thu 10/22/15	Call Center
1037	Update IVR	Fri 7/31/15	Thu 10/22/15	Call Center
1038	Claims	Fri 7/31/15	Mon 11/9/15	
1039	Establish Claims Operational Planning and Governance	Fri 7/31/15	Thu 8/6/15	
1040	Workforce Management	Fri 7/31/15	Thu 11/5/15	
1041	Complete Capacity Model	Fri 7/31/15	Thu 8/13/15	Claims
1042	Hire Claims Staff	Fri 8/14/15	Thu 9/24/15	Claims
1043	Train New Claims Staff	Fri 9/25/15	Thu 11/5/15	Claims
1044	Document Management/Process Flow changes (MACCESS)	Fri 7/31/15	Mon 10/26/15	
1045	Update/Create Policies and Procedures	Fri 7/31/15	Thu 8/27/15	Claims
1046	Update/Create Processing Instructions	Tue 9/29/15	Mon 10/26/15	Claims
1047	Promote use of EDI to non-users	Fri 7/31/15	Thu 9/10/15	Claims
1048	Claims Rules Set up	Fri 7/31/15	Mon 11/9/15	
1049	Health Plan Service	Fri 7/31/15	Thu 9/10/15	
1050	Update Configuration Requirements Documents	Fri 7/31/15	Thu 9/10/15	
1051	Update Configuration Design Documents	Fri 7/31/15	Thu 9/10/15	
1052	Update Configuration	Fri 7/31/15	Mon 10/26/15	
1053	Configure Group/Class/Plan	Fri 7/31/15	Thu 9/10/15	
1054	Configure Premium/Billing	Fri 9/11/15	Thu 9/24/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1055	Configure Provider Agreements	Tue 10/13/15	Mon 10/26/15	
1056	Test Configuration	Mon 11/2/15	Fri 11/6/15	
1057	Validate Group/Class/Plan	Mon 11/2/15	Fri 11/6/15	
1058	Validate Premium/Billing	Mon 11/2/15	Fri 11/6/15	
1059	Validate Provider Agreements	Mon 11/2/15	Fri 11/6/15	
1060	Implement in Production	Mon 11/9/15	Mon 11/9/15	
1061	Implement Group/Class/Plan	Mon 11/9/15	Mon 11/9/15	
1062	Implement Premium/Billing	Mon 11/9/15	Mon 11/9/15	
1063	Implement Provider Agreements	Mon 11/9/15	Mon 11/9/15	
1064	Develop Reports	Fri 7/31/15	Thu 11/5/15	
1065	Operational	Fri 7/31/15	Thu 11/5/15	Claims
1066	Regulatory	Fri 7/31/15	Thu 11/5/15	Claims
1067	Benefits Configurations	Fri 7/31/15	Mon 12/14/15	
1068	Benefits Requirements	Fri 7/31/15	Thu 8/27/15	Provider Services Organization
1069	Benefits Configuration	Fri 8/28/15	Thu 10/1/15	Provider Services Organization
1070	Benefits Summary Configuration	Fri 10/2/15	Thu 10/15/15	Provider Services Organization
1071	Testing	Fri 10/16/15	Thu 11/12/15	
1072	Production	Fri 11/13/15	Mon 12/14/15	
1073	Group Class Plan	Fri 7/31/15	Thu 11/19/15	
1074	Code Editing	Fri 7/31/15	Thu 11/19/15	Provider Services Organization
1075	Non Pricing Configuration	Fri 7/31/15	Thu 11/19/15	Provider Services Organization
1076	National Accounts	Fri 7/31/15	Thu 11/19/15	Provider Services Organization
1077	Enrollment	Fri 7/31/15	Tue 12/15/15	
1078	Security	Fri 7/31/15	Mon 8/3/15	
1079	Verify Access to State Eligibility Verification Web site	Fri 7/31/15	Mon 8/3/15	Enrollment
1080	Enrollment Internal Documentation	Fri 7/31/15	Thu 8/20/15	
1081	Update impacted P&P's	Fri 7/31/15	Thu 8/20/15	Enrollment
1082	Submit service desk ticket to create State specific Urgent In-Box in Outlook	Fri 7/31/15	Thu 8/20/15	Enrollment
1083	Facets Configuration	Fri 7/31/15	Mon 9/14/15	
1084	Identify additional user defined codes needed in Facets	Fri 7/31/15	Mon 9/14/15	
1085	Identify new codes	Fri 7/31/15	Thu 8/27/15	Enrollment
1086	Submit request to HPS for new Facets codes as needed	Fri 8/28/15	Thu 9/10/15	Enrollment
1087	Verify new codes are in Production	Fri 9/11/15	Fri 9/11/15	Enrollment

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1088	Submit request to HPS to set up default State Medicaid code for MMS	Mon 9/14/15	Mon 9/14/15	Enrollment
1089	Enrollment Load Imports	Fri 7/31/15	Tue 12/15/15	
1090	Enrollment Roster File and MEET	Fri 7/31/15	Tue 12/15/15	
1091	Develop scope document & deliver to Technology Services (companion guide trigger)	Fri 7/31/15	Thu 8/27/15	Enrollment
1092	Develop requirements document & send to Enrollment for review/signoff	Fri 7/31/15	Thu 8/27/15	Tech Services
1093	Review requirements document & provide signoff	Fri 8/28/15	Mon 8/31/15	Enrollment
1094	Development, Unit Test	Thu 10/1/15	Wed 10/28/15	Tech Services
1095	Receive member test file	Mon 11/2/15	Mon 11/2/15	Tech Services
1096	BA Test including Test Case Development	Tue 11/3/15	Wed 11/18/15	Tech Services
1097	UAT	Thu 11/19/15	Thu 12/10/15	Enrollment
1098	Implementation	Fri 12/11/15	Fri 12/11/15	Tech Services
1099	First monthly file loaded successfully to Enroll SQL	Mon 12/14/15	Mon 12/14/15	Enrollment
1100	First daily file loaded successfully to Enroll SQL	Tue 12/15/15	Tue 12/15/15	Enrollment
1101	Encounters	Fri 7/31/15	Mon 8/17/15	
1102	Receive Companion Guides, System Guides, Contract and all Encounters related documentation	Fri 7/31/15	Fri 7/31/15	Encounters
1103	Identify and review Companion Guides, System Guides, Contract and all Encounters related documentation	Mon 8/3/15	Mon 8/3/15	Encounters
1104	Develop Operational Requirements	Tue 8/4/15	Mon 8/17/15	
1105	Identify submission frequency criteria/penalties	Tue 8/4/15	Mon 8/17/15	Encounters
1106	Identify rejection remediation requirements	Tue 8/4/15	Mon 8/17/15	Encounters
1107	Identify requirements for additional internal control reporting	Tue 8/4/15	Mon 8/17/15	Encounters
1108	FACETS	Tue 9/1/15	Thu 12/3/15	
1109	Develop System Requirements	Tue 9/1/15	Mon 10/5/15	
1110	Requirements Import from Facets	Tue 9/1/15	Mon 9/14/15	
1111	Identify additional data requirements from Facets	Tue 9/1/15	Mon 9/14/15	Encounters
1112	Requirements Outbound (Encounters Extracts)	Tue 9/15/15	Mon 10/5/15	
1113	Mapping of Source Data	Tue 9/15/15	Mon 9/21/15	Technology Services
1114	Business Rules	Tue 9/22/15	Mon 9/28/15	Encounters
1115	Identify existing scrubs to be used and new scrub criteria	Tue 9/29/15	Mon 10/5/15	Encounters
1116	Requirements Inbound	Tue 9/15/15	Mon 9/21/15	
1117	Mapping of Remit Data	Tue 9/15/15	Mon 9/21/15	Technology Services
1118	Develop Software	Mon 10/12/15	Mon 11/2/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1119	Development	Mon 10/12/15	Fri 10/23/15	Encounters
1120	Unit Test	Mon 10/26/15	Wed 10/28/15	Encounters
1121	Remediation (mapping)	Thu 10/29/15	Thu 10/29/15	Technology Services
1122	UAT	Fri 10/30/15	Fri 10/30/15	Encounters
1123	Deployment to production	Mon 11/2/15	Mon 11/2/15	Technology Services
1124	Development - Reports	Tue 10/6/15	Wed 11/4/15	
1125	Reports	Tue 10/6/15	Mon 10/19/15	Technology Services
1126	Unit Test	Tue 10/20/15	Mon 10/26/15	Technology Services
1127	QA Deployment of Software	Tue 10/27/15	Wed 10/28/15	Technology Services
1128	Tidal Jobs	Thu 10/29/15	Wed 11/4/15	Technology Services
1129	QA Testing	Tue 11/3/15	Mon 11/16/15	
1130	Develop QA test plan and scripts	Tue 11/3/15	Mon 11/9/15	Encounters
1131	Execute QA test plan and scripts	Tue 11/10/15	Mon 11/16/15	Encounters
1132	Integrated Testing with the State	Tue 11/17/15	Tue 12/1/15	
1133	Receive state testing criteria	Tue 11/17/15	Tue 11/17/15	Encounters
1134	Review state testing criteria	Wed 11/18/15	Wed 11/18/15	Encounters
1135	Develop state test plan	Thu 11/19/15	Thu 11/19/15	Encounters
1136	State ready to begin testing	Fri 11/20/15	Fri 11/20/15	Encounters
1137	Execute state test plan	Mon 11/23/15	Tue 12/1/15	Encounters
1138	State Testing	Wed 12/2/15	Wed 12/2/15	
1139	State testing completed and certified - FACETS	Wed 12/2/15	Wed 12/2/15	Encounters
1140	State testing completed and certified - Vision	Wed 12/2/15	Wed 12/2/15	Encounters
1141	State testing completed and certified - Pharmacy	Wed 12/2/15	Wed 12/2/15	Encounters
1142	State testing completed and certified - Remits	Wed 12/2/15	Wed 12/2/15	Encounters
1143	Production Deployment	Thu 12/3/15	Thu 12/3/15	
1144	Production deployment of software	Thu 12/3/15	Thu 12/3/15	Encounters
1145	Finance	Fri 7/31/15	Tue 12/22/15	
1146	Financial Plan Accounting	Mon 10/5/15	Mon 10/5/15	
1147	Set up monthly monitoring of administrative expenses not to exceed cap	Mon 10/5/15	Mon 10/5/15	Finance
1148	Premium Reconciliation	Fri 7/31/15	Tue 12/22/15	
1149	Billing Process	Fri 7/31/15	Tue 9/22/15	
1150	Gather G/C/P stakeholder requirements	Fri 7/31/15	Thu 8/13/15	Finance
1151	Receive G/C/P Stakeholder Approval	Mon 9/21/15	Tue 9/22/15	Finance
1152	820 Payment File	Wed 9/23/15	Thu 10/22/15	

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1153	Review mapping information from State 820/834 CG	Wed 9/23/15	Tue 10/6/15	Finance
1154	Setup EC Gateway and Faciledi using CG	Wed 10/7/15	Tue 10/13/15	Finance
1155	Load payment test file into SQL database	Wed 10/14/15	Thu 10/15/15	Finance
1156	Analyze payment test 820 file	Fri 10/16/15	Tue 10/20/15	Finance
1157	Develop payment file mapping /configuration document	Wed 10/21/15	Thu 10/22/15	Finance
1158	ePAS Testing	Fri 10/23/15	Fri 12/11/15	
1159	Develop and submit business requirements to Technology Services	Fri 10/23/15	Thu 10/29/15	Finance
1160	Develop ePAS member category, rate and product configuration documents	Fri 10/30/15	Wed 11/4/15	Finance
1161	Analysis / design	Thu 11/5/15	Tue 11/10/15	Finance
1162	Development (import payment & billing into ePAS dev system)	Wed 11/11/15	Tue 11/24/15	Finance
1163	BA testing	Wed 11/25/15	Mon 12/7/15	Finance
1164	UAT	Tue 12/8/15	Thu 12/10/15	Finance
1165	Implementation to production	Fri 12/11/15	Fri 12/11/15	Finance
1166	ePAS Production	Mon 12/14/15	Tue 12/22/15	
1167	Receive production 820 payment file from the State	Mon 12/14/15	Mon 12/14/15	Finance
1168	Load 820 payment file to SQL server	Tue 12/15/15	Wed 12/16/15	Finance
1169	Run production billing batch process	Thu 12/17/15	Thu 12/17/15	Finance
1170	Import billing file into ePAS	Fri 12/18/15	Fri 12/18/15	Finance
1171	Import payment file into ePAS	Mon 12/21/15	Mon 12/21/15	Finance
1172	Run analysis process and review results	Tue 12/22/15	Tue 12/22/15	Finance
1173	Closeout Phase	Mon 2/16/15	Thu 4/21/16	
1174	Provide Post Go-Live Support	Fri 1/1/16	Fri 3/25/16	
1175	Conduct daily post-go live calls	Fri 1/1/16	Thu 1/14/16	Implementation Management Office
1176	Monitor project and address emerging issues	Fri 1/1/16	Fri 3/25/16	Implementation Management Office
1177	Lessons Learned	Mon 2/16/15	Wed 4/13/16	
1178	Conduct Lessons Learned survey and interviews	Fri 1/1/16	Fri 2/12/16	Implementation Management Office
1179	Receive & collate Lessons Learned survey results	Mon 2/16/15	Fri 2/20/15	Implementation Management Office
1180	Conduct Lessons Learned meeting(s)	Thu 3/17/16	Thu 3/17/16	Implementation Management Office
1181	Create Lessons Learned action plan	Thu 3/17/16	Thu 3/17/16	Implementation Management Office
1182	Execute Lessons Learned action plan	Thu 3/17/16	Wed 4/13/16	Implementation Management Office
1183	Project Transition to Operational Owners	Mon 3/28/16	Fri 4/8/16	
1184	Complete Implementation Management Office Project Transition Document	Mon 3/28/16	Fri 4/8/16	Implementation Management Office
1185	Conduct Transition Meeting	Mon 3/28/16	Mon 3/28/16	Implementation Management Office
1186	Project transition to operational owners complete	Mon 3/28/16	Mon 3/28/16	Implementation Management Office

Iowa High Quality Healthcare Initiative Implementation Project Plan				
ID	Task Name	Start	Finish	Resources
1187	Formal Project Closure & Document Archival	Fri 4/15/16	Thu 4/21/16	
1188	Conduct project closure meeting with executive sponsor and account manager	Fri 4/15/16	Fri 4/15/16	Implementation Management Office
1189	Present Project Lessons Learned Report to project sponsor	Fri 4/15/16	Fri 4/15/16	Implementation Management Office
1190	Obtain formal written close project authorization from project sponsor	Fri 4/15/16	Fri 4/15/16	Implementation Management Office
1191	Archive all project artifacts and SharePoint site	Fri 4/15/16	Thu 4/21/16	Implementation Management Office

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Annual Dental Visits

	HEDIS 2012	HEDIS 2013	HEDIS 2014
GA	69.68	69.92	69.67
NY	53.07	58.33	60.25
NCQA 75th	58.34	61.23	61.13
NCQA 90th	69.07	69.92	66.8

Well-child Visit 3-6 Year

	HEDIS 2012	HEDIS 2013	HEDIS 2014
GA	73.55	68.21	72.98
FL	83.11	74.31	79.88
TX	79.23	79.32	79.09
IN	68.88	73.33	70.43
NY	82.27	84.58	86.23
MD	86.4	83.56	83.89
NCQA 75th	79.32	78.51	77.26
NCQA 90th	83.04	82.08	82.69

Well-child Visit 12-21 Year

	HEDIS 2012	HEDIS 2013	HEDIS 2014
GA	43.94	46.58	52.55
TX	60.47	61.46	62.77
FL	55.4	56.48	58.45
IN	57.91	55.09	60.93
NY	61.83	61.42	69.7
MD	61.95	68.06	67.93
NCQA 75th	57.61	57.4	59.21
NCQA 90th	64.72	65.45	65.56

Follow-up After Mental Illness Discharge - 7 Days

	HEDIS 2012	HEDIS 2013	HEDIS 2014
TN	55.18	58	58.19
GA	48.41	45.8	50.85
NY	53.47	65.67	67.75
IN	75.84	74.24	65.42
NCQA 75th	57.68	54.8	54.45
NCQA 90th	69.57	68.79	63.21

ADHD Initiation Phase

	HEDIS 2012	HEDIS 2013	HEDIS 2014
TN	61.33	60.54	60.59
GA	44.27	42.32	43.12
NY	57.74	61.21	56.24
IN	52.48	49.55	46.32
NCQA 75th	44.46	45.65	46.99
NCQA 90th	52.48	51.86	53.03

Comprehensive Diabetes - HbA1c test

	HEDIS 2012	HEDIS 2013	HEDIS 2014
NY	90.19	86.97	90.68
MD	78.48	80.93	83.41
TN	81.99	79.35	81.2
FL	79	82.39	79.72
TX	81.03	82.81	84.77
NCQA 75th	87.01	87.32	87.59
NCQA 90th	91.13	90.97	91.73

Comprehensive Diabetes - Nephropathy

	HEDIS 2012	HEDIS 2013	HEDIS 2014
NY	83.93	83.1	85.36
MD	75.78	75.78	75.7
TN	77.73	73.25	78.12
FL	83.11	78.78	79.95
TX	81.26	81.47	84.33
NCQA 75th	83.03	82.74	83.11
NCQA 90th	86.93	85.85	86.86

**AMERIGROUP IOWA, INC.
PROVIDER AGREEMENT**

WITH

(NAME OF PROVIDER)

**AMERIGROUP IOWA, INC.
PROVIDER AGREEMENT**

This Provider Agreement (hereinafter "Agreement") is made and entered into by and between Amerigroup Iowa, Inc. (hereinafter "Amerigroup") and _____ (hereinafter "Provider"), effective as of the date set forth immediately below Amerigroup's signature (the "Effective Date").

**ARTICLE I
DEFINITIONS**

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Amerigroup, or any entity which is under common control with Amerigroup, and (ii) that is designated as an Affiliate on Amerigroup's commonly available web site. Unless otherwise set forth in the Participation Attachment(s) for Government Program(s), Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Audit" means a review of the Claim(s) and supporting clinical information submitted by Provider to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the Plan Compensation Schedule ("PCS")) guidelines and instructions, Amerigroup medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives.

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Plan submitted by a provider for payment by a Plan for Health Services rendered to a Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Amerigroup Rate" means the lesser of Provider's Charges for Covered Services, or the total reimbursement amount that Provider and Amerigroup have agreed upon as set forth in the PCS. The Amerigroup Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Plan and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage. Covered Services do not include the preventable adverse events as set forth in the provider manual(s).

"Government Contract" means the contract between Amerigroup and an applicable party, such as an Agency, which governs the delivery of Health Services by Amerigroup to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under Title XVIII, Title XIX or Title XXI of the Social Security Act, and any other federal or state funded program or product as designated by Amerigroup.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Other Payors" means persons or entities, pursuant to an agreement with Amerigroup or an Affiliate, that access the rates, terms or conditions of this Agreement with respect to certain Network(s), excluding Government Programs unless otherwise set forth in any Participation Attachment(s) for Government Programs. Other Payors include, without limitation, other Blue Cross and/or Blue Shield Plans that are not Affiliates, and employers or insurers providing Health Benefit Plans pursuant to partially or wholly insured, self-administered or self-insured programs.

"Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is party to an agreement to provide Covered Services to Members that has met all applicable Plan credentialing requirements or standards of participation for the services the Participating Provider provides, and that is designated by Plan to participate in one or more Network(s).

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plans, and/or Plan programs such as quality and/or incentive programs.

"Plan" means Amerigroup, an Affiliate, and/or an Other Payor. For purposes of this Agreement, when the term "Plan" applies to an entity other than Amerigroup, "Plan" shall be construed to only mean such entity.

"Plan Compensation Schedule" ("PCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Amerigroup Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Amerigroup compensation related terms and requirements.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

ARTICLE II SERVICES/OBLIGATIONS

- 2.1 Member Identification. Amerigroup shall ensure that Plan provides a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Plan to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.
- 2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or

Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

- 2.3 Publication and Use of Provider Information. Provider agrees that Amerigroup, Plans or their designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, and performance data.
- 2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.
- 2.5 Submission and Adjudication of Claims. Provider shall submit, and Plan shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements.
- 2.6 Payment in Full and Hold Harmless.
- 2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable Amerigroup Rate whether such payment is in the form of a Cost Share, a payment by Plan, or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Plan be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the Amerigroup Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the Amerigroup Rate as payment in full if the Member has not yet satisfied his/her deductible.
- 2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by applicable Plan, insolvency of applicable Plan, breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. This section does not prohibit Provider from collecting reimbursement for the following from the Member:
- 2.6.2.1 Cost Shares, if applicable;
- 2.6.2.2 Health Services that are not Covered Services (other than preventable adverse events). However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:
- a) The waiver notifies the Member that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;
 - b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;
 - c) The waiver notifies the Member of the approximate cost of the Health Service;
 - d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.
- 2.6.2.3 Any reduction in or denial of payment as a result of the Member's failure to comply with his/her utilization management program pursuant to his/her Health Benefit Plan, except when Provider has been designated by Amerigroup to comply with utilization management for the Health Services provided by Provider to the Member.

- 2.7 Recoupment/Offset/Adjustment for Overpayments. Amerigroup shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Amerigroup to Provider against any payments due and payable by Amerigroup to Provider under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Amerigroup that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund to the Amerigroup within thirty (30) days of when Amerigroup notifies Provider. If such reimbursement is not received by Amerigroup within the thirty (30) days following the date of such notice, Amerigroup shall be entitled to offset such overpayment against other amounts due and payable by Amerigroup to Provider in accordance with Regulatory Requirements. Amerigroup reserves the right to employ a third party collection agency in the event of non-payment.
- 2.8 Use of Subcontractors. Provider and Plan may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Amerigroup with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Plan for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein. Amerigroup shall not be liable for any reimbursement in addition to the applicable Amerigroup Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from Amerigroup, Plan or Members. Notwithstanding the foregoing, if Amerigroup has a direct contract with the subcontractor ("direct contract"), the direct contract shall prevail over this Agreement and the subcontractor shall bill Amerigroup under the direct contract for any subcontracted services, unless otherwise agreed to by the parties.
- 2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to abide by, and comply with, Amerigroup's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Plan. Amerigroup or its designees may modify the provider manual(s) and Policies by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of material modifications thereto.
- 2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Amerigroup.
- 2.11 Programs and Provider Panels. Provider acknowledges that as of the Effective Date, he/she/it participates only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider acknowledges that Plan may have, develop, or contract to develop, various networks or programs that have a variety of provider panels, program components and other requirements, and that Plan may discontinue, or modify such networks or programs. In addition to and separate from Networks that support some or all of Plan's product(s) and/or program(s) (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by way of example only, laboratory services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Plan. Provider agrees to refer Members to Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any Out of Network Compensation provision of this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Amerigroup, Plan or the Member, unless Provider was authorized to provide such Health Service by Plan. In addition to those Networks designated on the Provider Networks Attachment, Amerigroup may also identify Provider as a Participating Provider in additional Networks and/or products designated in writing from time to time by Amerigroup. The terms and conditions of Provider's participation as a Participating Provider in such Networks and/or products shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and Amerigroup.

- 2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Amerigroup of:
- 2.12.1 Any change in Provider's business address;
- 2.12.2 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Plan, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or
- 2.12.3 Any change in accreditation, provider affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.
- 2.13 Provider Credentialing. Provider warrants that he/she/it meets all applicable Plan credentialing requirements or any other applicable standards of participation for Networks in which Provider participates. A description of the credentialing program or applicable standards of participation, including any applicable accreditation requirements, is set forth in the provider manual(s). Provider acknowledges that until such time as Provider has been determined to have fully met Plan's credentialing requirements or applicable standards of participation, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the Amerigroup Rates set forth in the PCS attached hereto.
- 2.14 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan in accordance with the provider manual(s).
- 2.15 Supervision of Services. ProviderAncillary Provider agrees that all Health Services provided to MembersCoveredIndividual under this Agreement shall be provided by ProviderAncillary Provider or by a qualified person under Provider's direct supervision direction. ProviderAncillary Provider warrantsmaintain that any nurses or other health professionals employed by or providing services for ProviderAncillary Provider shall be duly licensed or certified under applicable law.
- 2.16 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Plan regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Plan promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.
- 2.17 Preventable Adverse Events. Notwithstanding any provision in this Agreement to the contrary, when any preventable adverse event as set forth in the provider manual(s) occurs with respect to a Member, the Provider shall neither bill, nor seek to collect from, nor accept any payment from Plan or Member for such event. If Provider receives any payment from Plan or Member for such event, it shall refund such payment within ten (10) days of becoming aware of such receipt. Further, Provider shall comply with any applicable Regulatory Requirements with respect to reporting preventable adverse events, and shall cooperate with Amerigroup, to the extent reasonable, in any Amerigroup initiative designed to help analyze or reduce such preventable adverse events.
- 2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner.

ARTICLE III CONFIDENTIALITY/RECORDS

- 3.1 Proprietary Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. This Agreement, including but not limited to the Amerigroup Rates, is Amerigroup's proprietary information. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Plan or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and Amerigroup shall each have a system in place that meets all applicable Regulatory Requirements to protect all

records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of confidential information by Provider or Amerigroup will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Amerigroup if Provider is required to disclose any proprietary information at the request of an Agency or pursuant to any federal or state freedom of information act request.

- 3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from Amerigroup to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact Amerigroup to report receipt of misrouted Member Information.
- 3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Plan or any other party. Nothing in this Agreement shall prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose Amerigroup Rates or specific terms of the compensation arrangement under this Agreement.
- 3.4 Plan Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Plan or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity, concurrent review, appropriateness of care, accuracy of payment, compliance with this Agreement, and for research. In lieu of on-site access, at Plan's request, Provider or its designees shall submit records to Plan, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Any examination or Audit of Provider records shall be performed using generally accepted, statistically valid or industry standard methodology. Provider acknowledges that failure to submit records to Plan in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.
- 3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Amerigroup, Plan, the Member, or other treating health care providers.

ARTICLE IV INSURANCE

- 4.1 Amerigroup Insurance. Amerigroup shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure Amerigroup and its employees, acting within the scope of their duties.

- 4.2 Provider Insurance. Provider shall self-insure or maintain insurance in types and amounts acceptable to Amerigroup as set forth in the provider manual(s), or as required under applicable Regulatory Requirements.

**ARTICLE V
RELATIONSHIP OF THE PARTIES**

- 5.1 Relationship of the Parties. For purposes of this Agreement, Amerigroup and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Amerigroup or Plan be construed to be providers of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Covered Services.
- 5.2 Contracting Party. If Provider is a partnership, corporation, or any other entity other than an individual, all references herein to "Provider" shall also mean and refer to each individual within such entity who Provider certifies is owned or employed by Provider, and who has applied for and been accepted by Plan as a Participating Provider.

**ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY**

- 6.1 Indemnification. Amerigroup and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries, from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's or his/her/its failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its agent's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement. Notwithstanding the foregoing, if a claim is brought by a governmental entity against Plan, and Plan seeks indemnification from Provider pursuant to this section, then Provider shall not engage in any direct communication with such governmental entity regarding such claim without Plan's prior consent.
- 6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Plan be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity. Notwithstanding the foregoing, if a claim is brought by an Agency against Plan, the foregoing limitations of liability shall not apply.
- 6.3 Period of Limitations. Unless otherwise provided for in this Agreement, a Health Benefit Plan, the provider manual(s), Policies, Participation Attachment(s), and excluding fraud, waste, or abuse, neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim. The deadline for initiating an action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent a dispute is timely commenced, it will be administered in accordance with Article VII of this Agreement.

**ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION**

- 7.1 Dispute Resolution. All disputes between Amerigroup and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.
- 7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Amerigroup provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two hundred thousand dollars (\$200,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two hundred thousand dollars (\$200,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.
- 7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. If the dispute resolution efforts described in section 7.1 cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.
- 7.2.1 Location of Arbitration. The arbitration hearing shall be held in the city and state in which the Anthem office identified in the address block on the signature page of this Agreement is located, except that if there is no address block on the signature page, then the arbitration hearing shall be held in the city and state in which the Anthem entity that is a party to this Agreement has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.
- 7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars (\$4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars (\$4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.
- 7.2.3 Appeal. If the total amount of the arbitration award is five million dollars (\$5,000,000) or more,

inclusive of interest, costs, and attorneys' fees, or if the arbitrator(s) issues an injunction against a party, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. A decision that has been appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

- 7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.3, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.
- 7.2.5 Limitations on Injunctive Relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree that any injunctive relief sought against the other party shall be limited to the conduct relevant to the parties to the arbitration and shall not be sought for the benefit of individuals or entities who are not parties to the arbitration. The arbitrator(s) are not authorized to issue injunctive relief for the benefit of an individual or entity who is not a party to the arbitration. The arbitrator shall be limited to issuing injunctive relief related to the specific issues in the arbitration.
- 7.3 Attorney's Fees and Costs. The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

ARTICLE VIII TERM AND TERMINATION

- 8.1 Term of Agreement. This Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year, and shall continue in effect thereafter unless otherwise terminated as provided herein.
- 8.2 Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party.
- 8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.
- 8.4 Immediate Termination.
- 8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by Amerigroup if:
- 8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

- 8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to Amerigroup or to a third party; or
 - 8.4.1.3 Provider files for bankruptcy, or makes an assignment for the benefit of its creditors without Amerigroup's written consent, or if a receiver is appointed; or
 - 8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or
 - 8.4.1.5 Provider fails to maintain compliance with Plan's credentialing standards or other applicable standards of participation; or
 - 8.4.1.6 Amerigroup reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or
 - 8.4.1.7 Provider has been abusive to a Member, a Amerigroup employee or representative; or
 - 8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are identified as ineligible persons who are terminated, barred, suspended, ineligible, or otherwise excluded from participation on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS/OIG List of Excluded Individuals/Entities, and/or on an applicable state list of excluded providers, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any program under Titles VXIII, XIX or XX of the Social Security Act as the result of a settlement agreement; or
 - 8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation.
- 8.4.2 This Agreement may be terminated immediately by Provider if:
- 8.4.2.1 Amerigroup commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or
 - 8.4.2.2 Amerigroup commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or
 - 8.4.2.3 Amerigroup files for bankruptcy, or if a receiver is appointed.
- 8.5 Termination of Individual Providers. If applicable, Amerigroup reserves the right to terminate individual providers under the terms of this Article VIII while continuing the Agreement for one or more providers in a group.
- 8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.
- 8.7 Continuation of Care Upon Termination. Unless otherwise set forth in the Health Benefit Plan, or required by Regulatory Requirements, Provider shall, upon termination of this Agreement for reasons other than the grounds set forth in the Immediate Termination section, continue to provide and be compensated for Covered Services rendered to Members under the terms and conditions of this Agreement until the earlier of ninety (90) days or such time that: (1) the Member has completed the course of treatment and if applicable, was discharged; or (2) reasonable and medically appropriate arrangements have been made for a Participating Provider to render Health Services to the Member. Notwithstanding the foregoing, for Members who: (i) have entered the second or third trimester of pregnancy at the time of such termination, or (ii) are defined as terminally ill under § 1861 (dd) (3) (A) of the Social Security Act at the time of such termination, this continuance of care section and all other provisions of this Agreement shall remain in effect for such pregnant Members through the provision of postpartum care directly related to their delivery, and for such terminally ill Members for the remainder of their life for care directly related to the treatment of the terminal illness.

- 8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement:
- 8.8.1 Publication and Use of Provider Information;
 - 8.8.2 Payment in Full and Hold Harmless;
 - 8.8.3 Recoupment/Offset/Adjustment for Overpayments;
 - 8.8.4 Confidentiality/Records;
 - 8.8.5 Indemnification and Limitation of Liability;
 - 8.8.6 Dispute Resolution and Arbitration;
 - 8.8.7 Continuation of Care Upon Termination; and
 - 8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

**ARTICLE IX
GENERAL PROVISIONS**

- 9.1 Amendment. Except as otherwise provided for in this Agreement, Amerigroup retains the right to amend this Agreement, the Amerigroup Rate, any attachments or addenda by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment. Except to the extent that Amerigroup determines an amendment is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by Amerigroup or one hundred eighty (180) days from the date Provider has provided notice of his/her/its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to Amerigroup within the time frames described herein will constitute acceptance of the amendment by Provider.
- 9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of Amerigroup. Any assignment by Provider without such prior consent shall be voidable at the sole discretion of Amerigroup. Amerigroup may assign this Agreement in whole or in part. In the event of a partial assignment of this Agreement by Amerigroup, the obligations of the Provider shall be performed for Amerigroup with respect to the part retained and shall be performed for Amerigroup's assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Amerigroup with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.
- 9.3 Scope/Change in Status.
- 9.3.1 Amerigroup and Provider agree that this Agreement applies to Health Services rendered at the Provider's location(s) on file with Amerigroup. Amerigroup may, if in Amerigroup's judgment the circumstances require such, limit this Agreement to Provider's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:
 - 9.3.1.1 Provider sells all or substantially all of his/her/its assets; or
 - 9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or
 - 9.3.1.3 Provider acquires or controls any other medical practice or entity or is in any manner otherwise acquired or controlled by any other party, whether by purchase, merger, consolidation, alliance, joint venture, partnership, association or expansion; or

- 9.3.1.4 Provider otherwise changes his/her/its locations, business or operations, or business or corporate form or status; or
- 9.3.1.5 Provider creates or otherwise operates a licensed health maintenance organization or commercial health plan (whether such creation or operation is direct or through a Provider affiliate).
- 9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of Amerigroup's rights as set forth elsewhere in this Agreement, Amerigroup shall have the right to terminate this Agreement upon thirty (30) days written notice to Provider if Amerigroup determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations of Provider hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Amerigroup elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.
- 9.3.3 Provider shall provide Amerigroup with thirty (30) days prior written notice of:
- 9.3.3.1 A change in providers who are part of the group, if applicable. Any new providers must meet Plan's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or
- 9.3.3.2 Any new physical location, tax identification number, mailing address or similar demographic information; or
- 9.3.3.3 A change in operations, business or corporate form as set forth in subsections 9.3.1.1 through 9.3.1.5 above.
- 9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.
- 9.5 Entire Agreement. This Agreement, exhibits, attachments and amendments hereto, together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there are any conflicts between any of the provisions of this Agreement and the provider manual(s), this Agreement will take precedence.
- 9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder for any reason beyond his/her/its reasonable control, including without limitation, acts of God, natural or man-made disasters, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.
- 9.7 Compliance with Regulatory Requirements. Amerigroup and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Amerigroup upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.
- 9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at <http://www.epls.gov/> or its successor), on the HHS/OIG List of Excluded Individuals/Entities (available through the internet at <http://www.oig.hhs.gov/fraud/exclusions.asp> or its successor), on an applicable state list of excluded providers, or as otherwise designated by federal or state authorities. Provider shall remain

continuously responsible for ensuring that its employees, contractors, subcontractors or agents are not ineligible persons. If Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Provider shall have an obligation to (1) immediately notify Amerigroup of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

- 9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state where Amerigroup has its primary place of business, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.
- 9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).
- 9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or Plan from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Plan does not warrant or guarantee that Provider will be utilized by any particular number of Members.
- 9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail, or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) upon receipt by registered or certified mail, postage prepaid, (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, five (5) days from the date set forth on the correspondence. Unless specified otherwise in writing by a party, Amerigroup shall send Provider notice to an address that Amerigroup has on file for Provider, and Provider shall be send Amerigroup notice to Amerigroup's address as set forth on the signature page. Notwithstanding the foregoing, Amerigroup may post updates to its provider manual(s) and Policies on its web site.
- 9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.
- 9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.
- 9.14 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.
- 9.15 Counterparts and Electronic Signatures.
- 9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.
- 9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION
WHICH MAY BE ENFORCED BY THE PARTIES**

PROVIDER LEGAL NAME _____

By: _____
Signature, Authorized Representative of Provider(s) Date

Printed: _____
Name Title

Address: _____
Street City State Zip

Tax Identification Number (TIN): _____

(Note: if any of the following is not applicable, please leave blank)

License Number: _____

NPI Number: _____

Medicare Number: _____

Medicaid Number: _____

Facsimile Number: _____

Email Address: _____

Web Site: _____

AMERIGROUP INTERNAL USE ONLY

Amerigroup

By: _____
Signature, Authorized Representative of Amerigroup Date

Printed: _____
Name Title

Address: _____
Street City State Zip

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

(Note: if any of the following is not applicable, please leave blank)

Facsimile Number: _____

Email Address: _____

Web Site: _____

PROVIDER NETWORKS ATTACHMENT

As of the Effective Date of this Agreement, Provider will be designated as Participating Provider in the following:

Government Programs:

Health Benefit Plans issued pursuant to an agreement between Plan and Agency in which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers regardless of product licensure status. Provider participates in the following Networks which support such Health Benefit Plans:

Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (hawk-i)

**MEDICAID
PARTICIPATION ATTACHMENT TO THE
AMERIGROUP IOWA, INC.
PROVIDER AGREEMENT**

This is a Medicaid Participation Attachment ("Attachment") to the Amerigroup Provider ("Agreement"), entered into by and between Amerigroup and Provider and is incorporated into the Agreement.

**ARTICLE I
DEFINITIONS**

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

"Functionally Necessary" and "Functional Necessity" mean reasonable and necessary services to enable independent living such as assistance with activities of daily living and instrumental activities of daily living.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Amerigroup.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Plan's Medicaid Program(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Plan's Medicaid Program(s).

"Medically Necessary/Medical Necessity" means those Covered Services that are, under the terms and conditions of the Government Contract, determined through Plan utilization management to be:

- (1) Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member;
- (2) Provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment;
- (3) Within standards of professional practice and given at the appropriate time and in the appropriate setting;
- (4) Not primarily for the convenience of the Medicaid Member, the Medicaid Member's physician or other Participating Provider; and
- (5) The most appropriate level of Medicaid Covered Services, which can safely be provided. This definition is also expanded to include Functionally Necessary and Functional Necessity services and products that will keep a Medicaid Member as independent and living in their own environment. Historically, such services have been considered social services, community based services or local access resources. In an effort to maintain individuals in the community and not in licensed facilities, the term Medically Necessary will now include non-medical services, products and resources.

"State Agency" means the Iowa Department of Public Health (IDPH), the Iowa Department of Human Services (DHS) or other duly authorized state agency.

**ARTICLE II
SERVICES/OBLIGATIONS**

- 2.1 Participation-Medicaid Network. As a participant in Amerigroup's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members enrolled in Amerigroup's Medicaid Network in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Amerigroup for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's

participation in Amerigroup's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

- 2.2 Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members. To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to 24 hour-per-day, 7 day-per-week urgent and Emergency Services, as defined in the PCS. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Amerigroup with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.
- 2.3 Provider Responsibility. Amerigroup shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Amerigroup may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Amerigroup pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.
- 2.4 Reporting Fraud and Abuse. Provider shall cooperate with Amerigroup's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Amerigroup or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Amerigroup.
- 2.5 Plan Marketing/Information Requirements. Provider agrees to abide by Plan's marketing/information requirements. Provider shall forward to Plan for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Plan or the applicable State Agency.
- 2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Amerigroup shall make available upon Provider's request schedules of Medicaid Covered Services for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications to such schedules.
- 2.7 Revocation of Delegated Activities. Amerigroup may revoke delegation of any activities and reporting responsibilities or impose other sanctions if Provider's performance is inadequate. Such revocation shall be consistent with the termination provisions of this Attachment.
- 2.8 Reporting Requirements. Provider agrees to comply with the reporting requirements listed in 42 CFR § 447.26(d) as a condition of payment from Amerigroup.
- 2.9 Third Party Liability. Provider agrees to identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise required, seek such third party liability payment before submitting claims to Amerigroup.
- 2.7 Medicaid Member Verification. Provider shall establish a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Medical Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall establish a Medicaid Member's eligibility as soon as reasonably practical. Plan shall provide a system for Providers to contact Plan to verify a Medicaid Member's eligibility 24 hours a day, 7 days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

- 2.10 Hospital Affiliation and Privileges. To the extent required under Plan's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one or more of Amerigroup's participating hospitals. In addition, in accordance with the Change in Provider Information Provider Section of the Agreement, Provider shall immediately notify Amerigroup in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.
- 2.11 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, Provider acknowledges and agrees that Amerigroup is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.
- 2.12 Coordinated and Managed Care. Provider shall participate in utilization management and care management programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s).
- 2.13 Representations and Warranties. Provider represents and warrants that all information provided to Amerigroup is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Amerigroup to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Amerigroup with written notice of any material changes to such information.

ARTICLE III COMPENSATION AND AUDIT

- 3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or required by Regulatory Requirements, Provider shall submit Claims to Plan, using appropriate and current Coded Service Identifier(s), within ninety (90) days from the date the Health Services are rendered or Plan may refuse payment. If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.
- 3.1.1 Provider agrees to provide to Amerigroup, unless otherwise instructed, at no cost to Amerigroup, Plan or the Medicaid Member, all information necessary for Plan to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. Once Amerigroup determines Plan has any payment liability, all Clean Claims will be paid in accordance with the terms and conditions of the Medicaid Member's Health Benefit Plan, the PCS, and the provider manual(s).
- 3.1.2 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Plan either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").
- 3.1.3 If Amerigroup or Plan asks for additional information so that Plan may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the ninety (90) day period referenced in section 3.1 above, whichever is longer.

- 3.1.4 Amerigroup shall adjudicate a Clean Claim, in accordance with, and within the time frames under, the Regulatory Requirements applicable to Plan's Medicaid Program(s).
- 3.2 Medicaid Affiliate Services. Provider acknowledges that Amerigroup is affiliated with health plans that offer similar benefits under similar programs as the programs covered hereunder ("Medicaid Affiliates"). The parties acknowledge that Provider is not a Participating Provider in Medicaid Affiliate's Network for purposes of rendering services to Medicaid Members. However, in the event Provider treats a Medicaid Member of a Medicaid Affiliate, subject to Regulatory Requirements, Provider shall accept as payment in full the rates established by the Medicaid Affiliate's state program governing care to Medicaid Members. Such services must be Medicaid Covered Services under the Medicaid Affiliate's state program, and shall require prior authorization, except for Emergency Services and services for which a Medicaid Member is entitled to self-refer. Upon request, Amerigroup shall coordinate and provide information as necessary between Provider and Medicaid Affiliate for services rendered to Medicaid Member.
- 3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Plan has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.
- 3.3.1 Provider agrees to cooperate with Amerigroup audits and monitoring of Provider's data, data submission and performance as well as any additional oversight mechanisms which monitor performance and compliance with Government Contract requirements on an ongoing basis. Provider further agrees to cooperate with formal reviews which shall be conducted at least quarterly.
- 3.3.2 Provider agrees to cooperate with DHS audits of Provider's data. Whenever deficiencies or areas of improvement are identified, Amerigroup and Provider shall take corrective action. Amerigroup shall provide to DHS the findings of all Provider performance monitoring and reviews upon request and shall notify the DHS any time Provider is placed on corrective action.
- 3.4 Physician-Hospital Organizations. If Provider is a physician-hospital organization or another entity that accepts financial risk for services that Amerigroup does not directly provide, Provider must monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of premium/revenue. Provider must provide Amerigroup at least quarterly with requested information which shall be used to monitor Provider's performance including but not limited to the following: (i) a statement of revenues and expenses; (ii) a balance sheet; (iii) cash flows and changes in equity/fund balance; and (iv) incurred but not received (IBNR) estimates.
- 3.5 Quality Improvement. Provider shall implement quality improvement goals and performance improvement activities specific to the types of services provided by Provider.
- 3.6 Encounter Data. If Provider is paid on a capitated basis, Provider shall submit encounter data within ninety (90) days of the date of service.
- 3.7 Critical Incident Reporting. Provider agrees to: (i) report critical incidents; (ii) respond to critical incidents; (iii) document critical incidents; and (iv) to cooperate with any investigation conducted by the Amerigroup or an outside agency.
- 3.8 Enforcement of §6032 of the 2005 Deficit Reduction Act (DRA). If Provider receives one million (\$1,000,000) dollars or more in Medicaid payments in a federal fiscal year, Provider shall have written policies for all employees, including management, and for all employees of any contractor or agent, that provide all detailed information required by the DRA.

ARTICLE IV COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

- 4.1 Federal Funds. Provider acknowledges that payments Provider receives from Plan to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by

45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

- 4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.
- 4.3 National Provider Identifier (NPI) Number. Provider shall maintain an NPI number which shall be consistent with 45 CFR 162.410.
- 4.4 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

ARTICLE V COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

- 5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.
- 5.2 Medicaid Hold Harmless. Provider agrees that Plan's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Program(s). This provision shall remain in effect even in the event Plan becomes insolvent.
- 5.3 State Agency Contract. Provider shall comply with the terms applicable to providers set forth in the Iowa Department of Human Services Request for Proposal Iowa High Quality Healthcare Initiative RFP# MED-16-009RFP (RFP), the Government Contract, including incorporated documents, between Plan and the Agency, which applicable terms are incorporated herein by reference. Plan agrees to provide Provider with a description of the applicable terms upon request.
- 5.4 Mental Health Information. Provider agrees to maintain the confidentiality of mental health information by cooperating with and implementing policies which allow release of mental health information only as allowed by Iowa Code §228.
- 5.5 Substance Abuse Information. Provider shall protect and maintain the confidentiality of substance abuse information, allowing the release of substance abuse information only in compliance with policies set forth in 42 CFR Part 2 and other applicable Regulatory Requirements.
- 5.6 I-SMART Data. If Provider provides substance abuse services, Provider shall report I-SMART data on all Medicaid Members receiving substance abuse services regardless of source of payment .
- 5.7 Dual Eligibles. Provider agrees to provide Medically Necessary Covered Services to Members who are also eligible for Medicare if the service is not covered by Medicare. Provider agrees that Covered Services provided under this Agreement are delivered without charge to Members who are dually eligible for Medicare and Medicaid.
- 5.8 Nursing Facility Providers.

If Provider is a nursing facility, Provider shall:

- 5.8.1 Promptly notify Amerigroup of a Medicaid Member's admission or request for admission to the nursing facility as soon as Provider has knowledge of such admission or request for admission;
- 5.8.2 Notify Amerigroup immediately if Provider is considering discharging a Member and agrees to consult with the Medicaid Member's care coordinator;
- 5.8.3 Notify the Medicaid Member and/or the Medicaid Member's representative (if applicable) in writing prior to discharge in accordance with Regulatory Requirements;
- 5.8.4 Collect all applicable patient liability amounts from Medicaid Members;
- 5.8.5 Notify Amerigroup of any change in a Medicaid Member's medical or functional condition that could impact the Medicaid Member's level of care eligibility for the currently authorized level of nursing facility services;
- 5.8.6 Comply with federal Preadmission Screening and Resident Review (PASRR) requirements to provide or arrange to provide specialized services and all applicable Iowa Law governing admission, transfer and discharge policies; and
- 5.8.7 Provider agrees that if Provider is involuntarily decertified by the State of Iowa or CMS, the Agreement and this Attachment will automatically be terminated in accordance with federal requirements.
- 5.9 Home and Community Based Services (HCBS) Providers:
- If Provider is an HCBS Provider, Provider agrees:
- 5.9.1 To provide at least thirty (30) days advance notice to Amerigroup when Provider is no longer willing or able to provide services to a Medicaid Member and to cooperate with the Medicaid Member's care coordinator to facilitate a seamless transition to alternate providers;
- 5.9.2 In the event that a HCBS provider change is initiated for a Medicaid Member, regardless of any other provision in the Agreement, Provider shall continue to provide Medicaid Covered Services to the Medicaid Member in accordance with the Medicaid Member's plan of care until the Medicaid Member has been transitioned to a new provider, as determined by Amerigroup, or as otherwise directed by Amerigroup, which may exceed thirty (30) days from the date of notice to Amerigroup;
- 5.9.3 To immediately report any deviations from a Medicaid Member's service schedule to the Medicaid Member's care coordinator; and
- 5.9.4 To comply with all child and dependent adult abuse reporting requirements.
- 5.10 Medical Records. In addition to the Plan Access to and Requests for Provider Records Section of the Agreement, Provider shall comply with Amerigroup's policies and procedures for maintaining medical records content and documentation in compliance with the provisions of Iowa Admin. Code 441 Chapter 79.3 and all other applicable Regulatory Requirements. Provider shall assure that its records document all medical services that the Medicaid Member receives in accordance with Regulatory Requirements. Provider shall maintain Medicaid Members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by Regulatory Requirements. Provider agrees to provide a copy of a Medicaid Member's medical record upon reasonable request by the Medicaid Member at no charge.
- 5.11 Provider Availability. Provider shall be available to Medicaid Members twenty-four (24) hours-a-day, seven (7) days-a-week, and shall comply with corrective actions implemented by Amerigroup if Provider is identified through an audit as failing to meet this standard.
- 5.12 Cultural Competency. Provider shall ensure that Medicaid Covered Services rendered to Medicaid Members, both clinical and non-clinical, are accessible to all Medicaid Members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and Medicaid Members with physical and mental disabilities. Provider must provide information regarding

treatment options in a culturally-competent manner, including the option of no treatment. Provider must ensure that Medicaid Members with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

- 5.13 Background Checks. Providers shall comply with state requirements for employee background checks and shall disclose any staff providing services who have ever had a founded child or dependent adult abuse report, or been convicted of a felony. Staff providing services shall include anyone having contact with Medicaid Members or Medicaid Member data. Provider shall disclose any such report in a timely manner in a written statement to Amerigroup within ten (10) days from the date of conviction, regardless of appeal rights.

ARTICLE VI TERMINATION

- 6.1 Termination of Medicaid Participation Attachment. Either party may terminate this Attachment without cause by giving at least one hundred and eighty (180) days prior written notice of termination to the other party.
- 6.2 Termination of Government Contract. If a Government Contract between Agency and Amerigroup terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program, this Attachment shall have no further or effect with respect to the applicable Medicaid Program.
- 6.3 Effect of Termination. Following termination of this Attachment, the remainder of the Agreement shall continue in full force and effect, if applicable.

ARTICLE VII GENERAL PROVISIONS

- 7.1 Regulatory Amendment. Notwithstanding the Amendment Section in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Program(s) without the necessity of executing written amendments.
- 7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions in the Agreement, the terms and conditions of this Attachment shall govern. Except as otherwise set forth herein, all other terms and conditions of the Agreement remain in full force and effect.
- 7.3 Subcontractor Requirements. In addition to the Provider Subcontractors Section in the Agreement, Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the State. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations (42 CFR 438.610). Provider agrees to comply with requirements set forth in 42 CFR 455.100 through 455.106 regarding disclosure by providers of ownership and control information and disclosure of information on a provider's owners' and other persons' conviction of criminal offenses against Medicare, Medicaid, or Title XX services program ("Disclosures") and will agree to provide required disclosures at the time of initial contract, upon contract renewal, and/or upon request by the Amerigroup. Provider further agrees to notify Amerigroup within fourteen (14) days of any changes to the Disclosures.
- 7.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

PLAN COMPENSATION SCHEDULE ("PCS")

**ARTICLE I
DEFINITIONS**

"Capitation" means the amount of pre-payment made by Amerigroup to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services. Individual services billed shall not be reimbursed separately.

"Case Rate" means the all-inclusive Amerigroup Rate for an entire admission or one outpatient encounter for Covered Services. Individual services billed shall not be reimbursed separately.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 claim form or its successor. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT[®]-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM"), and National Drug Code ("NDC") or their successors.

"DRG" means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the Amerigroup Rate for Covered Services. Individual services billed shall not be reimbursed separately.

"DRG Weight" means the CMS weight for each DRG as published in the Federal Register or other weights used by Amerigroup, including but not limited to, weights for the specific DRG grouper methodology that is utilized.

"Eligible Charges" means charges billed by Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, Amerigroup administrative, clinical and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the Amerigroup Rate after application of Cost Shares and coordination of benefits. Amerigroup shall not reimburse Provider for services or items Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are needed to evaluate or treat an Emergency Condition.

"Encounter Data" means Claims information submitted by Provider under capitated or risk-sharing arrangements, for rendered to Members for Covered Services.

"Fee Schedule(s)" means the complete listing of Amerigroup Rate(s) for specific services that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Global Case Rate" means the all-inclusive Amerigroup Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services. Individual services billed shall not be reimbursed separately.

"Percentage Rate" means the Amerigroup Rate that is a percentage of Eligible Charges billed by Provider for

Covered Services.

"Per Diem Rate" means the Amerigroup Rate that is the all-inclusive fixed payment for Covered Services rendered on a single date of service. Individual services billed shall not be reimbursed separately.

"Per Hour Rate" means the Amerigroup Rate that is payment based on an increment of time for Covered Services.

"Per Unit Rate" means the Amerigroup Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the Amerigroup Rate that is the all-inclusive fixed payment for one encounter for Covered Services. Individual services billed shall not be reimbursed separately.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Amerigroup as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services.

ARTICLE II GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 claim form or its successor. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions. Plan audits that result in identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action as may set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Amerigroup shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. If an update is delayed beyond the sixty (60) days, Amerigroup shall notify Provider. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected and Provider shall resubmit Claim with correct code. Claims processed prior to the implementation of the revised codes shall not be reprocessed. In addition, Claims with codes which have been deleted will be rejected.

Coding Software. Updates to Amerigroup's Claims processing filters, code editing software, any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider.

Modifiers. All appropriate modifiers must be used in accordance with standard billing guidelines, if applicable.

New/Expanded Service or New/Expanded Technology. In accordance with the Change in Scope and Status provision of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to Amerigroup at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/ Expanded Service or New/ Expanded Technology; (3) such other reasonable data and information required by Amerigroup to evaluate the New/Expanded Service or New/Expanded Technology. In addition, Amerigroup may also need to obtain approval from applicable Agency prior to Amerigroup making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If Amerigroup agrees that the New/Expanded Service or New/ Expanded Technology may be reimbursable under this

Agreement, then Amerigroup shall notify Provider, and both parties agree to negotiate in good faith, a new Amerigroup Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of Amerigroup's notice to Provider. If the parties are unable to reach an agreement on a new Amerigroup Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by Amerigroup, and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a) "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of Effective Date of this Agreement and; (b) for which there is not a specific Amerigroup Rate as set forth in this PCS.

b) "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/ Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-priced Codes for Covered Services. Amerigroup reserves the right to price non-priced codes for Covered Services, including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, and Individual Consideration Codes ("IC"). If a code for a Covered Service (i) does not have a published dollar amount on the then current applicable Plan, State or CMS Fee Schedule, (ii) has a zero dollar amount listed, or (iii) requires manual pricing, then such code shall be reimbursed at a rate established by Amerigroup for such Covered Service. Amerigroup may require the submission of medical records, invoices, or other documentation prior to the adjudication of such Claim(s). Notwithstanding the foregoing, any Covered Services not specified in this PCS or in the Fee Schedule(s) are not reimbursable.

Updates to Amerigroup Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, Amerigroup shall use commercially reasonable efforts to update the Amerigroup Rate(s) based on any Agency, vendor, or other entity ("External Sources") no later than sixty (60) days after Amerigroup's receipt of the final rate change(s) from such External Sources, or on the effective date of such final rate change(s), whichever is later. Examples include, but are not limited to, Medicare fee schedules and rates, state Medicaid fee schedules and rates. Notwithstanding the foregoing, Amerigroup shall use commercially reasonable efforts to load such payment system changes as quickly as practicable following the release date of such changes. Claims processed prior to the implementation of the new Amerigroup Rate(s) in Amerigroup's payment system shall not be reprocessed. In the event that reprocessing of Claims is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, Plan may reconcile the Claim adjustments to determine the remaining amount Provider owes Plan, or that Plan owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes Plan) shall occur automatically without advance notification to Provider.

Tax Assessment and Penalties. The Amerigroup Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirement. Neither Provider nor Plan shall add any amount to or deduct any amount from the Amerigroup Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

ARTICLE III PROVIDER TYPE

[TO BE COMPLETED BASED ON PROVIDER TYPE(S) – USE DEFINITIONS AS REQUIRED BY STATE/FEDERAL LAW OR AS FOUND IN THE PROVIDER TYPE MENU DOCUMENT]

**ARTICLE IV
SPECIFIC REIMBURSEMENT TERMS**

MEDICAID