State of Georgia

Department of Community Health (DCH)

External Quality Review of Compliance With Standards

for

Amerigroup Community Care for Georgia Families 360°

November 2015

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016-4545

Phone 602.801.6600 ◆ Fax 602.801.6051

CONTENTS

1. Overview

Background

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

As part of the redesign of the Georgia Medicaid program, DCH developed a new managed care program called Georgia Families (GF) 360°, which was launched on March 3, 2014. DCH transitioned children in State custody, children receiving adoption assistance (AA), and certain children in the juvenile justice system from the FFS delivery system into the GF 360° managed care program. The DCH contracted with Amerigroup Community Care (Amerigroup) to provide services on a state-wide basis, to improve care coordination and continuity of care, and to provide better health outcomes for these members. Within this report, the three populations served by this program are collectively referred to as the GF 360° program.

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

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

Description of the External Quality Review of Compliance With Standards

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2014–June 30, 2015. For the review period of July 1, 2013–June 30, 2014, DCH requested that HSAG provide feedback on Amerigroup's processes and procedures for the GF 360° program.

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

For the CY 2014 review period, the GF 360° program had been operational for less than four months; therefore, HSAG's observations and recommendations about the program were included in the Amerigroup Georgia Families compliance report for that time period. Although this is the second year of a three-year cycle of external quality reviews for the three Georgia Families CMOs, this is the first year that HSAG evaluated and completed a separate external quality review report for Amerigroup's contract for the GF 360° program. HSAG performed a desk review of Amerigroup's documents and an on-site review that included reviewing additional documents, conducting interviews with key Amerigroup staff members, and conducting file reviews. HSAG evaluated the degree to which Amerigroup complied with federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories. The six review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR 438.214–438.230. The standards HSAG evaluated included requirements that addressed the following areas:

- Provider Selection, Credentialing, and Recredentialing
- Subcontractual Relationships and Delegation
- Member Rights and Protections
- Member Information
- Grievance System
- Disenrollment Requirements and Limitations

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

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

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG determined findings for the compliance review from its:

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

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

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

Table 2-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Provider Selection, Credentialing, and Recredentialing	**18**	**18**	**16**	**2**	**0**	**88.9%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**7**	**0**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**6**	**0**	**0**	**100.0%**
IV	Member Information	**27**	**27**	**25**	**2**	**0**	**92.6%**
V	Grievance System	**47**	**47**	**43**	**4**	**0**	**91.5%**
VI	Disenrollment Requirements and Limitations	**14**	**14**	**9**	**5**	**0**	**64.3%**
	Total Compliance Score	**119**	**119**	**106**	**13**	**0**	**89.1%**

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

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

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

The remainder of this section provides a high-level summary of Amerigroup's performance noted in each of the areas reviewed. In addition, the summary describes any areas that were not fully compliant with the requirements for Amerigroup.

Standard I—Provider Selection, Credentialing, and Recredentialing

Performance Strengths

Amerigroup maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities were performed according to industry and State requirements. The CMO completed all recredentialing activities within the required time frames and consistently used primary verification sources to validate providers' licensure, credentials, insurance, and certificates. Amerigroup monitored providers to ensure the provision of quality care and, when quality issues were identified, implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status.

The initial focus of provider training and education was the development of stakeholders' understanding of operational topics to ensure these entities were able to navigate the GF 360° system. Amerigroup continued to expand and develop the training component for the GF 360° program by building relationships with national and State experts to provide training on quality of care as well as systems of care. The CMO provided multiple opportunities for training and information sharing via online training and face-to-face meetings/trainings.

HSAG reviewed 10 credentialing case files and found that six of the 10 files reviewed were 100 percent compliant with all case review elements.

HSAG also reviewed 10 recredentialing case files and noted that all files were compliant with all case review elements. Recredentialing decisions were completed within 36 months of the initial or most recent credentialing/recredentialing decision, and the CMO used primary sources, the Office of Inspector General (OIG) website, and State licensure boards to verify licensure and credentials, and to check for any exclusion from participation as a Medicaid provider.

Areas Requiring Corrective Action

HSAG noted that while Amerigroup's policy demonstrated compliance with the 120-day credentialing decision standard, the reported practice conflicted with this policy. Additionally, according to the National Committee for Quality Assurance (NCQA), completion time frames for credentialing decisions are counted back from the credentialing decision date to the date the provider signed the attestation. Credentialing staff stated that the CMO had 120 days from the time the provider's file was identified as "clean" to make the credentialing decision. HSAG identified four provider files for which credentialing decisions were made greater than 120 days from the attestation date.

As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, Amerigroup will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.

Amerigroup developed a GF 360° training plan for law enforcement officials, judges, district and county attorneys, and other key stakeholders. Although all entities were provided access to the training, Amerigroup must develop tracking tools to identify which training modules are being completed, who is completing the training, and when it is being completed.

Standard II—Subcontractual Relationships and Delegation

Performance Strengths

Amerigroup maintained its policies and procedures to ensure compliance with industry and State standards. Amerigroup identified a delegation designee who worked with the corporate delegation designee to review "national delegates" providing services for the CMO. The CMO's designee was responsible for providing findings and recommendations to the appropriate staff and committees, as well as monitoring the delegates' performance on an ongoing basis. The CMO monitored delegate performance through ongoing assessment of the individual delegate functions and took corrective action when deficiencies were identified.

HSAG reviewed delegation files for three of Amerigroup's delegates. All of the delegation files contained a written agreement that specified delegated activities and reporting responsibilities, performance expectations, and options for addressing deficiencies identified during annual reviews. HSAG noted that Amerigroup had reviewed all delegates, and all files were compliant with the case review elements.

Areas Requiring Corrective Action

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

Standard III—Member Rights and Protection

Performance Strengths

Amerigroup submitted policies, procedures, and the member handbook as evidence that the CMO and its providers took into consideration member rights while providing care. All of the member rights included in both the federal standard and the State contract were included in these documents. Amerigroup provided Health Insurance Portability and Accountability Act of 1996 (HIPAA) and discrimination policies as evidence that it had mechanisms to comply with confidentiality requirements.

Areas Requiring Corrective Action

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

Standard IV—Member Information

Performance Strengths

Member materials were available in alternative languages when needed and at a reading level appropriate for the member. When requested, member materials were provided in Braille, large print, and via audio CD. Oral interpretation services were provided free of charge. The online provider directory was easy to use and contained the mandated information.

Areas Requiring Corrective Action

Amerigroup staff indicated that DCH approved Amerigroup's request to discontinue the annual mailing of the member handbook. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on Amerigroup's website or that a hard copy will be mailed upon request. The policies submitted for review did not reflect how Amerigroup complied with this requirement.

The new member packet for AA members did not include the dentist change form and information on Kenny A. healthcare requirements.

As a result of these findings:

- Amerigroup must update its applicable policies to include a description of how the CMO notifies members (not newly enrolled members) that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy must also reflect how often existing members receive the notice.
- Amerigroup must include the dentist change form and information on Kenny A. healthcare requirements in the AA new member packet.

Standard V—Grievance System

Performance Strengths

Amerigroup provided detailed grievance, administrative review, and administrative law hearings policies and procedures. The CMO had designated staff who demonstrated a comprehensive understanding of the grievance system process. Amerigroup informed members and providers of the grievance and appeal processes via the member and provider handbooks. During the on-site visit

HSAG reviewed 10 grievance files and 10 appeal files. All cases were compliant with the applicable timeliness requirements.

Areas Requiring Corrective Action

Amerigroup acknowledged each grievance and request for administrative review (appeal) in writing within 10 working days of receipt; however, Amerigroup did not ensure through policy or procedure that these notices were in the member's primary language. In addition, Amerigroup's policies and procedures indicated that the member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent was given a reasonable opportunity to present evidence in support of the administrative review (appeal); however, Amerigroup did not inform the member of the limited time available to present the evidence in expedited circumstances.

During the file review for grievances and appeals, HSAG noted that the appeal resolution letters for upheld denials were not written in a manner that could be easily understood. In some instances the letters contained medical terminology and a direct copy of the clinical reviewer's notes.

As a result of these findings:

- Amerigroup must modify its processes, procedures, and policies so that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language.
- Amerigroup must develop and implement a mechanism to provide information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review (appeal).
- Amerigroup must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review (appeal) resolution letters.

Standard VI—Disenrollment Requirements and Limitations

Performance Strengths

Amerigroup ensured that members were not discriminated against on the basis of religion, gender, race, color, national origin, health, health status, pre-existing conditions, or the need for healthcare services. The possible reasons for disenrollment with cause were appropriately documented, and Amerigroup staff assisted the member with disenrollment paperwork if needed.

Areas Requiring Corrective Action

The Amerigroup Disenrollment procedure did not include all of the required contractual information pertaining to a member's disenrollment for cause and without cause. For example, the policy did not indicate that an AA member may disenroll *without* cause during the FFS selection

period and that the member should be returned to the Medicaid FFS delivery system, nor did it indicate that a member may request disenrollment *for cause* at any time.

The Membership Load—Facets policy and procedure indicated that Amerigroup members were enrolled using the CMO's "internal standard," which was a processing time of two business days. Amerigroup staff indicated that the member would be enrolled upon receipt of the eligibility file, making the policy and practice inconsistent. This policy also did not include information pertaining to a GF 360° member's enrollment status changing from an eligible to ineligible category.

As a result of these findings:

- Amerigroup must update its Disenrollment policy to address voluntary disenrollment of AA members without cause during the FFS selection period and return the member to the Medicaid FFS delivery system.
- Amerigroup must update its Disenrollment policy to include a provision that a member may request disenrollment for cause and at any time.
- Amerigroup must update its Membership Load—Facets policy to indicate that GF 360° program members are enrolled upon receipt of the eligibility file from DCH. In addition the policy must include information pertaining to a member's enrollment status changing from an eligible to ineligible category.

3. Corrective Action Plan Process

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

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

Appendix A. **Review of the Standards**

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

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for **Amerigroup Community Care for Georgia Families 360°**

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

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
1. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1)* and *42CFR438.214(c)*	Amerigroup does not discriminate against any provider for participation, reimbursement or indemnification who acts within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Amerigroup does not discriminate against providers who serve high-risk populations or specialist in conditions that require costly treatment. Evidence: Std.I.1 - GA Phys and AHP Agmt (pg. 15, paragraph 6.12) Std.I.1 – Scion Credentialing Manual (pg. 34; PDF pg. 35) Std.I.1 – Avesis GA Medicaid Contract Addendum – Amerigroup (pg.2, #10)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup's Credentialing and Ongoing Assessment of Organizational Providers (Facilities and Ancillary Providers) policy outlined the CMO's procedures for the credentialing process. To ensure decisions were made in a nondiscriminatory manner, Amerigroup's credentialing department conducted an annual retrospective sample audit of denied and approved file decisions. During the on-site interviews staff reported that the credentialing and recredentialing process was completed by the corporate credentialing office.		
Required Actions: None.		
2. The Contractor does not employ or contract with providers excluded from participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (requires a policy and must be in provider subcontracts). The Contractor is responsible for routinely checking the exclusions list and shall immediately terminate any provider found to be excluded and notify the member per the requirements outlined in this contract. *42CFR438.214(d)* *Contract: 4.8.1.4*	Amerigroup does not employ or contract with providers excluded from participation in federal healthcare programs under Section 1128 or Section 1128A of the Social Security Act. This information is included in our provider subcontracts as well as our internal policy. We routinely check the exclusion list and immediately terminate any provider found to be excluded. Members are notified per the requirements outlined in our contract. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
	Std.I.2 - Cred Recred LIP (pg.17) Std.I.2 - Cred and Reassess for Orgs (pg. 7) Std.I.2 - Gov. Sanct Notification (pgs. 2-7) Std.I.2 – GA Phys and AHP Agmt. (pg. 13, Section 5.5 – 5.6) Std.I.2 - OIG Sanctions Notifications April 2015 Std.I.2 – Scion Credentialing Manual (pgs. 2, 34, 38) Std.I.2 - Avesis Provider Agreement (pg.7,11) Std.I.2 –Avesis Credentialing PnP (pg. 1) Std.I-2 - Avesis Recredentialing PnP (pgs. 1-2) Std.I.2 - Avesis On-Going Credentialing PnP (pg.1) Std.I.2 – Avesis Credentialing Program Overview (pg.4)	
Findings: Amerigroup provided the CMO's policy for monthly exclusion monitoring which indicated that the CMO completed monthly monitoring of employees, and providers. During the on-site interview staff reported that any provider identified as an excluded provider was automatically removed from Amerigroup's provider system.		
Required Actions: None.		
3. If the Contractor declines to include individuals or groups of providers in its network, the Contractor gives the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: 4.8.1.7*	In the event that Amerigroup declines to include individuals or groups of providers in our network, we notify the affected providers in writing of the reason for our decision. Evidence: Std.I.3 - Cred and Recred for LIP PnP(pgs. 22-23) Std.1.3 - Cred Committee Denial Letter - Example 1 Std.I.3 - Recred Denial Letter - Example 2 Std.I.3 - Recred Denial Letter - Example 3 Std.I.3 - Cred Committee - Denial Letter for Network Participation Std.I.3 – Scion Credentialing Manual (pg. 14, pdf. pg 13) Std.I.3 – Avesis Credentialing Program Overview (pg.5) Std.I.3 – Avesis Provider Appeal Rights Non-Approval to Network (pg.1)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
	Std.I-3 Avesis Credentialing Committee PnP (pg.1) Std.I.3 Avesis Credentialing PnP pg. 5	
Findings: Amerigroup provided its credentialing and recredentialing policy, which indicated that if a provider was not accepted into the network, the corporate credentialing department sent the provider a letter notifying the provider of the decision and information on how to appeal the decision.		
Required Actions: None.		
4. The Contractor shall maintain written policies and procedures for the credentialing and recredentialing of network providers using standards established by the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) or URAC. *Contract: 4.8.15.1*	Amerigroup maintains written policies and procedures for credentialing and recredentialing network providers using standards established by National Committee for Quality Assurance (NCQA), CMS and the State of Georgia. Evidence: Std.I.4 - Cred Recred LIP (Entire Policy) Std.I.4 - Cred and Reassess for Orgs (pg.3-14 & 25) Std.I.4 – Avesis Credentialing Program Overview (pg.3) Std.I.4 –Avesis Credentialing PnP (pg. 1) Std.I.4 – Scion Credentialing Manual (pgs. 3, 11-12, 14, 16-18, 20, 35, 37)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided policies and procedures that outlined the credentialing and recredentialing process for providers in its network. During the interview staff reported that the corporate office completed all credentialing and recredentialing activities. As part of the verification process the corporate credentialing department reviewed the application/documentation for completeness.		
Required Actions: None.		
5. The Contractor has written policies and procedures for the credentialing and recredentialing of network providers that include:		
(a) The verification of the existence and maintenance of: ◆ Credentials. ◆ Licenses. ◆ Certificates. ◆ Insurance coverage. *Contract: 4.8.15.2*	Amerigroup's written policies and procedures for the credentialing and recredentialing of network providers include the verification of existence and maintenance of credentials, licenses, certificates and insurance coverage. Evidence: Std.I.5(a) - Cred Recred LIP (pgs. 9-21)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
	Std.I.5(a) - Cred and Reassess for Orgs (pgs. 6-7, Nos. 4 &8) Std.I.5(a) – Avesis Credentialing PnP (pg. 2-5) Std.I.5(a) - Avesis Recredentialing PnP (pgs. 2-3) Std.I.5(a) – Scion Credentialing Manual (pgs.3,15-17, 19-20, 36-38) Std.I.5(a) - Avesis On-Going Credentialing PnP (pg.1) Std.I.5(a) – Avesis Credentialing Program Overview (pg.1 &3)	
Findings: Amerigroup's credentialing and recredentialing policy and procedure indicated that verification of information provided in the application packet must be completed before submitting the file to the Credentialing Committee for determination. HSAG noted that primary sources were used to verify credentials, licensure, certification, and insurance coverage.		
Required Actions: None.		
(b) Verification using primary sources. *Contract: 4.8.15.2*	Amerigroup's written policies and procedures for the credentialing and recredentialing of network providers include verification using primary sources. Evidence: Std.I.5(b) - Cred Recred LIP (pg. 8) Std.I.5(b) – Avesis Credentialing PnP (pgs.2-5) Std.I.5(b) – Avesis Credentialing Program Overview (pg.2-3 &6) Std.I.5(b) – Scion Credentialing Manual (pgs.9,11,14,17, 20 &39)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup staff reported that primary sources were used during credentialing and recredentialing of providers. The policy reviewed for this element also denoted the use of primary sources to verify information and documentation provided for the credentialing or recredentialing process. During the credentialing and recredentialing file review, HSAG noted that all of the files reviewed contained provider information gathered from primary sources (i.e., OIG and State licensure boards).		
Required Actions: None.		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
(c) The methodology and process for recredentialing providers. *Contract: 4.8.15.2*	Amerigroup's written policies and procedures for the credentialing and recredentialing network providers include the methodology and process for recredentialing providers. Evidence: Std.I.5(c) - Cred Recred LIP(Entire Policy) Std.I.5(c) - Cred and Reassess for Orgs(Entire Policy) Std.I.5(c) - Practitioner Office Site Quality (Entire Policy) Std.I.5(c) - Avesis Recredentialing PnP (Entire Policy) Std.I.5(c) – Avesis Credentialing Program Overview (pg.6) Std.I.5(c) – Scion Credentialing Manual (pg.12, 17-18 &39)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided the CMO's policy that outlined the recredentialing process. During the on-site interviews staff reported that the recredentialing process was initiated eight months prior to the provider's 36-month due date. A notice was sent to providers, and they were given 30 days to respond and provide the requested documentation. Staff reported that, in some instances, up to five or six requests were made, both written and telephonic, before the information was provided. If a provider did not respond within three months of the initial contact, the provider was sent a termination letter that outlined the reason for termination and the date of termination (90 days prior to the end of the contract term). If the provider submitted all of the requested documentation, Amerigroup worked to recredential the provider prior to the end of the 36-month time period.		
Required Actions: None.		
(d) A description of the initial quality assessment of private practitioner offices and other patient care settings. *Contract: 4.8.15.2*	Amerigroup's written policies and procedures for the credentialing and recredentialing of network providers include a description of the initial quality assessment of private practitioner offices and other patient care settings. Evidence: Std.I.5(d) -Practitioner Office Site Quality Std.I.5(d) - Service Model Site Form Std.I.5(d) – Scion Credentialing Manual (pg.21-22)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided its policy for Practitioner Office Site Quality that stated, "At credentialing, the Amerigroup Health Plan Provider Relations		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
Representative or a designee qualified to perform site visits conducts physician/practitioner site visits for each office location." During the on-site interviews staff reported that the provider relations staff completed "some" initial site visits for ancillary providers; however, NCQA changed its standards and initial site visits were no longer required. Provider relations staff members were in the providers' offices up to six times per month, and they completed a site visit when a complaint was received.		
Required Actions: None.		
(e) Procedures for disciplinary action, such as reducing, suspending, or terminating provider privileges. *Contract: 4.8.15.2*	Amerigroup policies and procedures for the credentialing and recredentialing of network providers that include procedures for disciplinary action, such as reducing, suspending, or terminating provider privileges. Evidence: Std.I.5(e) -Cred Recred for LIP PnP (pgs. 27, 30 – entire policy) Std.I.5(e) - Quality of Care - Core Procedure (Entire Policy) Std.I.5(e) – Scion Credentialing Manual (pg.30-32) Std.I.5(e) – Avesis On-Going Credentialing PnP (pg. 1-2)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup's Quality of Care—Core Procedure policy outlined the actions taken when concerns were identified, the type of concerns that were to be reported, and the disciplinary actions that could be used to bring the provider into compliance or to remove the provider from the network.		
Required Actions: None.		
6. The Contractor makes credentialing decisions on all completed application packets within 120 calendar days of receipt. *Contract: 4.8.15.1*	Amerigroup makes credentialing decisions on all completed application packets within 120 calendar days of receipt. Evidence: Std.I.6 - Cred Recred LIP (pg. 30) Std.I.6 - GA Quarterly Cred Compliance Q01 2015 Std.I.6 - GA Quarterly Cred Compliance Q03 2014 Std.I.6 - GA Quarterly Cred Compliance Q04 2014 Std.I.6 – Avesis Credentialing PnP (pg.2) Std.I.6 – Scion Credentialing Manual	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
Findings: Amerigroup's Credentialing and Recredentialing policy for licensed, independent providers stated, **"**unless otherwise mandated by state regulation the requirement for timeliness of credentialing a physician or practitioner is 180 calendar days from the date the provider signs the attestation to the date of the credentialing committee's final decision." Staff reported that the decision time frame for the credentialing process started when the providers file was considered clean and the 120-day time frame for credentialing decisions did not begin until the providers file was considered clean by the corporate credentialing office. Completion time frames for credentialing decisions, according to NCQA, are counted back from the credentialing decision date to the date the provider signed the attestation. During the file review HSAG noted two provider files for which credentialing decisions had been made greater than 120 days from the attestation date. One was credentialed 187 days after receipt of the application, and another was credentialed 132 days after receipt of the application.		
Required Actions: As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, Amerigroup will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.		
7. For Georgia Families 360° (GF 360°), the Contractor shall include providers recommended by the Division of Family and Children Services (DFCS), Department of Behavioral Health and Developmental Disabilities (DBHDD), Department of Juvenile Justice (DJJ), Department of Education (DOE), Department of Early Care and Learning (DECAL), or Department of Public Health (DPH) in the provider network if the provider/agency meets the enrollment criteria for Georgia Fee-for-Service (FFS) Medicaid and meets the contractor credentialing requirements. *Addendum #1: 4.8.15.7*	Amerigroup includes providers recommended by the Division of Family and Children Services (DFCS), Department of Behavioral Health and Developmental Disabilities (DBHDD), Department of Juvenile Justice (DJJ), Department of Education (DOE), Department of Early Care and Learning (DECAL), or Department of Public Health (DPH) in our provider network for GF 360° if the provider/agency meets the enrollment criteria for Georgia Fee-for-Service (FFS) Medicaid and meets the our credentialing requirements. Evidence: Std.I.7 - GA Medicaid Provider Manual (page 116) GF 360° Credentialing and Quality section Std.I.7 - GF 360° _ 7 Community Service Board Directory Std.I.7 - GF 360° 7 FQHC Contact List Std.I.7 - I CORE IFI Provider 041015 (network list)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup staff reported that providers recommended by DFCS, DBHDD, DJJ, DOE, DECAL, and DPH were credentialed by the CMO employing the same credentialing procedures used with network providers. Staff reported that if the recommended provider did not meet the minimum criteria for the credentialing process, the provider could be identified as a non-PAR provider.		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
Required Actions: None.		
8. The Contractor shall develop and provide to DCH within 120 calendar days of the operations start date a GF 360° provider handbook specific to the needs of the GF 360° population. *Addendum #1: 4.9.2.4*	Amerigroup developed and provided DCH with a provider handbook specific to the needs of the GF 360° population 120 calendar days before our operations start date. Evidence: Std.I.8 -GA Medicaid Provider Manual (pg. 18-20, 25, 34,126-130 (PDF pgs.21-23, 28, 37, 129-133) Std.I.8 - STD I GF360 _10 Provider Education plan	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided DCH with the provider handbook for review and feedback prior to the operations start date.		
Required Actions: None.		
9. The GF 360° provider handbook must include: ◆ How GF 360° members, caregivers, foster and adoptive parents, DFCS staff, and DJJ staff may access care management, the requirements for behavioral health providers and PCPs to share a GF 360° member's physical and behavioral health clinic information, and requirements included in the Kenny A. Consent Decree. ◆ Details regarding provider requirements and legal obligations for providing medical information as required by DFCS and DJJ, and/or necessary for court hearings. *Addendum #1: 4.9.2.5*	Amerigroup's GF 360° Provider Handbook includes the information outlined in this provision. Evidence: Std.I.9 - GA Medicaid Provider Manual: GF 360° Care Coordination and Case Management – pgs. 126-130, PDF pgs.129-133) Std.I.9 - GA GA Caid Behavioral Health Addendum (page 2)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° provider handbook included all of the required information identified in this element.		
Required Actions: None.		
10. The Contractor shall submit to DCH a GF 360° provider education and training approach within 150 calendar days of the operations start date. *Addendum #1: 4.9.3.4*	Amerigroup submitted our GF 360° Provider Education and training approach to DCH 150 calendar days prior to the operation start date. Evidence: Std.I.10 - Provider Education Plan	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided the initial and most recent provider education plan. Staff reported during the on-site audit that the initial training plan was reviewed and approved by DCH prior to the start of the training process.		

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
Required Actions: None.		
11. The GF 360° provider education and outreach approach must include, at a minimum: ◆ Recommendations from experts in the field including DFCS, DBHDD, DOE, DPH, DECAL, and DJJ to identify relevant training modules. ◆ Initial and ongoing training of GF 360° staff and the provider network (as applicable to each) that addresses, but is not limited to: ▪ Covered services and the provider's responsibility for providing and/or coordinating such services. Special emphasis on areas that vary from commercial coverage rules. ▪ Coordinating care using a system of care approach between foster parents and caregivers; DFCS case managers, juvenile probation/parole specialist (JPPS), or other involved case managers; attorneys ad litem; judges; law enforcement officials; adoptive parents; and other involved parties from State agencies. *Addendum #1: 4.9.3.4*	Amerigroup's provider education and outreach approach includes the information outlined in this provision. Evidence: Std.I.11 - GF 360° _ 11 AGP Provider Town Hall Q4 14 Std.I.11 - Provider_TownHall_Q3Aug14_APPROVED Std.I.11 - GF 360° _11 GAPEC-0780-14 GF 360° Dec Town Hall Webinars_FINAL Std.I.11 - GF 360° _ 11 GF 360° Town Hall- Provider v2 Std.I.11 - GA Medicaid Provider Manual – BH Overview (pg. 35-36, 38 PDF pg. 38-39) Std.I.11 - GA Caid Behavioral Health Addendum (page 2) Std.I.11 - GF 360° _11 Creating a TIC SOC	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup staff members reported that they were continually working on training development to ensure the information provided was robust and up to date. Staff reported that training was broken out into three buckets: operational training, quality, and system improvement. Operational training was offered weekly to all providers during outreach contacts. Operational training was ongoing during the last year, and the majority of providers had been trained. The CMO training staff members had a cadence call with owners of this process, and they obtained information and suggestions from the owners. Amerigroup used Georgetown University for systems of care training and is working with national and State experts to develop training. The CMO was considering developing a system of care training curriculum and was working on building a relationship with Children's Healthcare of Atlanta.		
Required Actions: None.		
(a) Requirements for providing Health Care Services to GF 360° members, including: ◆ Medical consent requirements. ◆ Required timelines for services and assessments. ◆ Specific medical information required for court requests and judicial review of medical care.	Amerigroup provides the Health Care Service requirements outlined in this provision to GF 360° Members. Evidence: Std.I.11(a) – Trauma Assessment Template and Instructions FINAL	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
◆ Appropriate utilization of psychotropic medications. ◆ Evidence-based behavioral health treatment interventions. ◆ Specific behavioral and physical health needs of these children and young adults. ◆ Training for trauma-informed care. ◆ The effect of abuse and neglect on the developing brain. ◆ The effect of intrauterine assault, fetal alcohol syndrome, and shaken baby syndrome. ◆ How to screen for and identify behavioral health disorders. ◆ The contractor referral process for behavioral health services. ◆ The availability of a care coordination team for members and how to access the care coordinator. *Addendum #1: 4.9.3.4*	Std.I.11(a) -ALL_SBIRTFlier Std.I.11(a) -ALL_BHCaseMgmt Std.I.11(a) -ALL_WorkingTogetherPCP Std.I.11(a) -Psych Testing Training Providers Std.I.11(a) - GF360 Town Hall- Provider v2 Std.I.11(a) - GAGA_TraumaAssessment Std.I.11(a) - GAGA_CAID_BHCodingSupport Std.I.11(a) Creating a Trauma-Informed SOC_Dec 2013 Std.I.11(a) - Reports_Trauma Informed and SOC 2014 CHOA Std.I.11(a) - Provider_TownHall_Q3Aug14_APPROVED	
Findings: Amerigroup's initial trainings focused on operational topics that ensured providers and other community stakeholders were able to navigate the Amerigroup GF 360° program. Staff reported that after the initial trainings, the focus was to provide more clinically focused trainings that would enhance the provider's ability to work with the GF 360° population.		
Required Actions: None.		
12. The Contractor shall provide training for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ, and attorneys ad litem about the requirements of the contract and needs of GF 360° members. These training sessions should also be open to DCH, DFCS, DJJ, and other sister agencies. *Addendum #1: 4.9.3.5*	Amerigroup provides training for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ, and attorneys ad litem about the requirements of the contract and needs of GF 360° members. These training sessions are also open to DCH, DFCS, DJJ, and other sister agencies. Evidence: Std.I.12. - DeKalb CAC Attorney Judge Outreach Std.I.12. - Special Training for Law Enforcement Std.I.12. - Statewide Juvenile Court Spring Conference 2015 Std.I.12. - Fulton County Judge Attorney Training Sept14 Std.I.12. - Juvenile Court Council Leadership Training Std.I.12. - Carrol County Juvenile Court Training	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
	Std.I.12. – Fulton County Court Training Oct 14 Std.I.12. - General Orientation v2 Std.I.12. - Paulding County Court Training	
Findings: Amerigroup GF 360° staff members reported working with attorneys and judges to provide information and training during court staff meetings. The CMO provided an opportunity for law enforcement officials to complete training components via online training. There were no actual requirements for completing this training, and the CMO was unable to track who completed the training. Training staff reached out to police academies in Georgia to provide training for incoming cadets and set up information booths at conferences for judges and law enforcement. Amerigroup staff reported that the main obstacle was obtaining buy-in from law enforcement to complete this training. Amerigroup continued to build its GF 360° training plan and provided all identified entities with access to training. However, the CMO was unable to determine if this training was being completed or utilized.		
Required Actions: Amerigroup must continue to work with law enforcement officials to provide face-to-face training opportunities and to develop tracking tools to identify which training modules are being completed, who is completing the training, and when it is being completed.		
13. The Contractor shall submit a training plan that includes proposed locations, dates of trainings, and training materials to DCH 60 calendar days prior to the operations start date. These training materials shall be updated annually, at a minimum, and more often if a change in law or policy alters the content of the training materials (GF 360° training). *Addendum #1: 4.9.3.5*	Amerigroup submitted a training plan that included proposed locations, dates of trainings, and training materials to DCH 60 calendar days prior to the operations start date. These training materials are updated annually, at a minimum, and more often if a change in law or policy alters the content of the training materials (GF 360° training). Evidence: Std.I.13- GF 360 Training Plan 2015 – 2016 Std.I.13- External Agency Training Grid 2014 – 2015 Std.I.13- External Agency Training Plan 2014 – 2015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided the initial education plan, in addition to the most recent education plan. Staff reported that the initial training plan was reviewed and approved by DCH prior to the start of the training process.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for Amerigroup Community Care for Georgia Families 360°

Standard I—Provider Selection, Credentialing, and Recredentialing					
Met	=	16	X 1.00	=	16
Not Met	=	2	X .00	=	0
Not Applicable	=		*NA*		*NA*
Total Applicable	=	18	**Total Score**	=	16
Total Score ÷ Total Applicable				=	88.9%

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: 16.1.3*	Amerigroup oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. Evidence: Std.II.1 - Delegate Account Management Responsibilities (pg.1, 3,4) Std.II.1 - Vendor Selection and Oversight Program PnP (pgs. 1, 3-5) Std.II.1 - Health Plan Oversight for Delegate Activities PnP (pgs. 3-4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup's Health Plan Oversight for Delegate Activities policy outlined the monitoring process used to oversee delegates. Monitoring was completed quarterly, at a minimum, and the CMO completed additional reviews when a delegate was on a CAP. The review was completed by a subject matter expert who identified and reported any deficiencies to the CMO's account manager. Review information was provided and noted in the Quarterly Joint Operations meetings and provided to the Vendor Selection Oversight Committee (VSOC) for review and recommendations.		
Required Actions: None.		
2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: 16.1.3*	Before any delegation, Amerigroup evaluates a prospective subcontractor's ability to perform the activities to be delegated. Evidence: Std.II.2 - Delegate Account Management Responsibilities (pgs. 3-4) Std.II.2 - Health Plan Oversight for Delegate Activities PnP (pgs. 3-4) Std.II.2 - Vendor Selection and Oversight Program PnP (pgs. 1, 3-5) Std II.2 - 2005_Avesis__Claims Pre-Delegation Audit Std II.2 - 2005_Avesis_Pre-Del CAP Response Std II.2 - 2008_ Avesis_Cred_Pre-Delegation Report Std II.2 - 2011 Scion Pre-Delegate Audit Summary Tool Std II.2 - Scion GA Pre-Delegation Audit	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: Amerigroup's delegation policy outlined the procedure for delegation. During the on-site interview staff reported that the delegation work group was responsible for predelegation evaluations and ensuring delegates were approved prior to contract execution. The CMO's account manager was responsible for all contracting efforts between the delegate and the CMO to include verification of the completion of all predelegation audits.		
Required Actions: None.		
3. There is a written delegation agreement with each delegate that: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. *42CFR438.230(b)(2)* *Contract: 16.1.2*	Amerigroup has a written delegation agreement with each delegate that specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Evidence: Std.II.3 – AIM GA MOU 10-31-14 (Entire MOU) Std.II.3 - Vendor Selection and Oversight Program PnP (pg. 7) Std.II.3 - GA_Avesis_Base Agreement Std.II.3 - GA_Avesis_Management Services Agreement Std.II.3 - GA_LogistiCare_Base Agreement-4.1.2011 Std.II.3 - GA_Scion_ Base Agreement-2.1.2011 Std.II.3 - GA_Scion_MSA	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: During the on-site audit HSAG auditors reviewed three delegate files. All three of the files had written delegation agreements with the language identified in this element.		
Required Actions: None.		
4. The Contractor implements written procedures for monitoring the delegate's performance on an ongoing basis. The Contractor subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or state CMO laws and regulations. *42CFR438.230(b)(3)* *Contract: 16.1.3*	Amerigroup has written procedures for monitoring the delegate's performance on an ongoing basis. Amerigroup subjects subcontractors to a formal review according to a periodic schedule established by the State, consistent with industry standards or state CMO laws and regulations. Evidence: Std.II.4 - Health Plan Oversight for Delegate Activities PnP (pgs. 1, 3-4)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.II.4 - Joint Operations Meeting with Delegates PnP (pgs. 2-3) Std.II.4 - Vendor Selection and Oversight Program PnP (pgs. 1, 3-5) <u>Supplemental Documentation:</u> Std.II.4 - 2014 Avesis TPA Summary Tool Std.II.4 - 2014 LogistiCare Summary Tool Std.II.4 - 2014 Scion Dental Summary Tool Std.II.4 - Minutes-Avesis-Joint Ops Mtg-3Q2014(Approved) Std.II.4 - Minutes-Avesis-Joint Ops Mtg-4Q2014(Approved) Std.II.4 - Minutes-Avesis-Joint Ops Mtg-1Q2015(Not approved) Std.II.4 - Minutes-LogistiCare-Joint Ops Mtg-3Q2014 (Approved) Std.II.4 - Minutes-LogistiCare-Joint Ops Mtg-4Q2014 (Approved) Std.II.4 - Minutes-LogistiCare-Joint Ops Mtg-1Q2015 (Not Approved) Std.II.4 - Minutes-Scion-Joint Ops Mtg-3Q2014 (Approved) Std.II.4 - Minutes-Scion-Joint Ops Mtg-4Q2014 (Approved) Std.II.4 - Minutes-Scion-Joint Ops Mtg-1Q2015 (Not Approved)	

Findings: Amerigroup provided policies and procedures that met all aspects of this element. During the on-site audit, CMO staff reported the subject matter

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
experts (SMEs) from the corporate office completed quarterly reviews of delegate performance. The SMEs completed the review and provided the findings to the Georgia Amerigroup staff members for follow-up. Staff reported that no State plan representative was participating in the delegate review at the local level.		
Required Actions: None.		
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: 16.1.3*	If Amerigroup identifies deficiencies or areas for improvement in the subcontractor's performance, Amerigroup and the subcontractor take corrective action. Evidence: Std.II.5 - Health Plan Oversight for Delegate Activities PnP (pgs.3-4) Std.II.5 - Vendor Selection and Oversight Program PnP (pgs. 3) Std.II.5 - Joint Operations Meeting with Delegates PnP (pgs. 2-3) Std.II.5 – Standard Notification of Reported Deficiencies PnP (pgs.1-4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup's corporate office designated a SME at the corporate level to complete the delegate review. When a deficiency was identified, the CMO's account manager was notified of the deficiency and was responsible for resolving the deficiency using the approved CAP or performance improvement plan (PIP). If the delegate was placed on a CAP, the delegate and Amerigroup developed the CAP. The CAP was then reviewed by the compliance department for accuracy, and the timeline was developed based on completion within 60 to 90 days. This information was provided to the VSOC for review and approval. None of the subcontractors reviewed on-site were on a CAP or PIP.		
Required Actions: None.		
6. The Contractor must provide a listing, including detailed contract information, for all of its subcontractors involved in the execution of the contract, including description of the subcontractor's organization and the responsibilities that are delegated. *Contract:16.1.7*	Amerigroup provides a listing, including detailed contract information, for all of its subcontractors involved in the execution of the contract, including description of the subcontractor's organization and the responsibilities that are delegated. Evidence: Std.V.6 - Subcontractor Agreement Report Q0414 Std.V.6 - Subcontractor Information Report Q314	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided a listing of delegates that provided detailed contact information, a description of the subcontractors' organizations, and delegated		

Standard II—Subcontractual Relationships and Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
responsibilities.		
Required Actions: None.		
7. The Contractor must not contract or permit the performance of any work or services by subcontractors without prior written consent of DCH. *Contract: 16.1.1*	Amerigroup does not contract or permit the performance of any work or services by subcontractors without prior written consent of DCH. Evidence: Std.II.7 - DCH Approval of AIM Vendor Oct. 2014 Std.II.7 - Medicaid Compliance Vendor Management Due Diligence (pg. 5-7) Std.II.7 - Medicaid Compliance Vendor Management Offshore Due Diligence (pg. 4-5) Std.II.7 - Vendor Selection and Oversight Program PnP (pgs. 7)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: CMO staff reported during the on-site audit interview that information about subcontracts being considered for delegation with Amerigroup was identified at the corporate level. The information was provided to the CMO's delegate staff who then worked with DCH to gain written approval of the delegate.		
Required Actions: None.		

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

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has written policies regarding member rights. *42CFR438.100(a)(1)* *Contract: 4.3.4.1*	Amerigroup has written policies in place regarding member rights. Evidence: Std.III.1 - Member Rights and Responsibilities – GA (Entire Policy) Std.III.1- GAGA Rights and Responsibilities ENG Webpage – Amerigroup Link: (https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup provided its Member Rights and Responsibilities, Right of Access to Inspect/Copy Protected Health Information, and Member Privacy Rights policies as evidence of compliance. Member rights were also included in the GF 360° member handbooks for all of the GF 360° populations.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members. *42CFR438.100(a)(2)*	Amerigroup ensures that our staff and affiliated providers take member rights into account when furnishing services. Evidence: Std.III.2 - GA Medicaid Provider Manual (pg. 45-48) Std.III.2 - Member Rights and Responsibilities – GA (Entire Policy) Std.III.2 - Avesis Members' Rights PnP (pg.1) Std.III.2 - Scion Rights of Members PnP	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The provider manual included member rights information to ensure providers were aware of and considered member rights when furnishing services. The Member Rights and Responsibilities procedure indicated that human resources provided educational information regarding member rights and responsibilities for newly hired Amerigroup staff during new hire orientation.		
Required Actions: None.		
3. The Contractor ensures that these rights are included in the Member Handbook and at a minimum specifies the member's right to: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy.	Amerigroup ensures that the rights outlined in this requirement are included in the member handbook. Evidence: Std.III.3. Member Rights and Responsibilities - GA Std.III.3. GAGA Rights and Responsibilities ENG Webpage – Amerigroup Link:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ Have all records and medical and personal information remain confidential. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records pursuant to 45CFR160 and 164, subparts A and E, and request that they be amended or corrected as specified in 45CFR164.524 and 164.526. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). ◆ Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated. ◆ Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the covered services provided to the member for which DCH does not pay the Contractor; not be held liable for covered services provided to the member for which DCH or the CMO plan does not pay the health care provider that furnishes the services; and not be held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the Contractor provided the services directly. ◆ Only be responsible for cost sharing in accordance with 42CFR447.50 through 447.60 and Attachment K of the contract. *42CFR438.100(b)(2) & (3)* *Contract: 4.3.4.1*	(https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf) P4HBMEMBER HANDBOOK(pages 41-43, PDF pgs. 47-49) MCD/PCFK/AA MEMBER HANDBOOK(pgs. 46-48, PDF pgs. 53-55)	

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Member Rights and Responsibilities procedure and the GF 360° member handbooks included all of the rights in this element.		
Required Actions: None.		
4. The Contractor shall ensure that members are aware of their rights and responsibilities, the role of primary care physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation, how to request a grievance, appeal, or Administrative Law Hearings, and how to report suspected fraud and abuse. The Contractor shall convey this information via written materials and via telephone, internet, and face-to-face communications that allow the members to submit questions and receive responses from the Contractor. *Contract: 4.3.1*	Amerigroup ensures that members are made aware of their rights and responsibilities, the role of primary care physicians (PCPs), how to obtain care, what to do in an emergency or urgent medical situation, how to request a grievance, appeal, or Administrative Law Hearings, and how to report suspected fraud and abuse. This information is conveyed to members via written materials, telephone, internet and face-to-face communications to allow members to submit questions and receive responses from Amerigroup. Evidence: Std.III.4. Member Rights and Responsibilities - GA Std.III.4. GAGA Rights and Responsibilities ENG Webpage – Amerigroup Link: (https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf) MCD/PCFK/AA Member Handbook: Role of PCP/Obtain Care - pgs. 4-7 (PDF pgs. 11-14) ER/Urgent Situation - pgs. 14-16 (PDF pgs. 21-23) Grievance, appeal, law hearing - pgs. 36-42 (PDF pgs. 43-49) R & R - pgs. 46-48 (PDF 53-55) Fraud & Abuse - pg. 49 (PDF pg.56) P4HB Member Handbook: Role of PCP/Obtain Care - pgs. 18-20 (PDF pgs. 24-26) ER/Urgent Situation - pgs. 9,13, 16-17 (PDF pgs. 15,19, 22-23) Grievance, appeal, law hearing - pgs.32-37 (PDF pgs. 38-	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	43) R & R - pgs. 41-43 (PDF pgs. 47-49) Fraud & Abuse - pg. 43-44 (PDF pg.49-50)	
Findings: The information contained in this element was included in the GF 360° member handbooks. Amerigroup staff indicated that members were given the appropriate member handbook upon enrollment, and they were also available on the Amerigroup website.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. *42CFR438.100(d)* *Contract: General Program Requirements*	Amerigroup complies with federal and State laws pertaining to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91, the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. Evidence: Std III.5. Member Rights and Responsibilities - GA Std.III.5. GAGA Rights and Responsibilities ENG Webpage – Amerigroup Link: (https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf) Std.III.5 - Avesis Members' Rights PnP (pg.1) Std.III.5 - Scion Rights of Members PnP	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The GF 360° member handbooks included notices that Amerigroup complied with State and federal laws pertaining to civil rights and other privacy and confidentiality provisions.		
Required Actions: None.		
6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.224*	Amerigroup uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA) as evidenced by the policies and procedures listed below. Each policy or procedure addresses a specific use or	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	disclosure rule under HIPAA in its entirety. Std.III.6 - Averting Serious Threat to Safety Disclosure Policy Std.III.6 - Coroners, Medical Examiners and Funeral Director Disclosure Policy Std.III.6 - De-Identification Policy Std.III.6 - De-Identification Procedure Std.III.6 - De-Identification of PHI and the Creation of a Limited Data Set MBU Procedure Std.III.6 - Deceased Member Disclosure Policy Std.III.6 - Disaster relief Efforts Disclosure Procedure Std.III.6 - Disclosure of Protected Health Information Outside of Anthem Policy Std.III.6 - Disclosure When the Individual Is or Is Not Available Policy Std.III.6 - Disclosure With Authorization Policy Std.III.6 - Disclosures to Agents, Brokers and Producers Policy Std.III.6 - Disclosures to State Medicaid Agencies Policy Std.III.6 - Disclosures to Veterans Health Administration Policy Std.III.6 - External Email Transmission Procedure Std.III.6 - Health Oversight Release Disclosure Procedure Std.III.6 - Judicial and Administrative Disclosure Procedure Std.III.6 - Law Enforcement Release Disclosure Procedure Std.III.6 - Limited Data Set Disclosures Policy Std.III.6 - Media Disclosure Policy Std.III.6 - Minimum Necessary Requirements Policy Std.III.6 - Minimum Necessary Requirements Procedure MBU Std.III.6 - Member Privacy Rights Procedure MBU –	

Standard III—Member Rights and Protections		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Access to PHI Std.III.6 - Psychotherapy Notes Policy Std.III.6 - Public Health Activates Disclosure Procedure Std.III.6 - Quality Control Disclosure for Protected Health Information Policy Std.III.6 - Required by Law Disclosure Procedure Std.III.6 - Research Disclosure Procedure Std.III.6 - Sensitive Services Policy Std.III.6 - Social Security Number Limitation Policy Std.III.6 - Specialized Non – Routine Disclosures Policy Std.III.6 - Summary Health Information Disclosure Policy Std.III.6 - Treatment, Payment and Health Care Operations Disclosure Policy Std.III.6 - Use of Protected Health Information Within Anthem Policy Std.III.6 - Victims of Abuse, Neglect or Domestic Violence Disclosure Procedure Std.III.6 - Workers Compensation Disclosure Procedure Std.III.6 - Right of Access to Inspect / Copy PHI Std.III.6 – Scion HIPPA Manual Std.III.6 –Avesis HIPAA Privacy and Security Std.III.6 - Avesis HIPAA Access to PHI	
Findings: Amerigroup provided several protected health information (PHI)-related policy and procedure documents which demonstrated that the CMO was in compliance with this element.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for Amerigroup Community Care for Georgia Families 360°

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

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor provides all newly enrolled members the Member Handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member. *42CFR438.10(f)(3)* *Contract: 4.3.3.1*	Amerigroup provides all newly enrolled members with the Member Handbook within 10 calendar days after receiving notice of enrollment from DCH or its agent. Effective July 2014, DCH approved the discontinuance of the annual mailing of the member handbook. Evidence: Std. IV.1 PnP Member ID Cards (pg. 2) Std. IV.1. PnP Membership Load (pg. 2) Std. IV.1 - Provider Directory Update 7.24.14 (pg. 2)	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: For the AA population, Amerigroup staff confirmed that the member handbook was included in the new member packet. When the ID card production file was received by the vendor, a new member packet mailing label file was created, and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. For the FC/DJJP population, the member handbook was supplied in hard copy in the case worker's office. Amerigroup staff indicated that DCH approved its request to discontinue the annual mailing of the member handbook. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request. The policies submitted for review did not reflect how Amerigroup notified members that the handbook was available for review on its website or that the handbook could be mailed upon request.		
Required Actions: Amerigroup must update its applicable policies to include a description of how the CMO notifies existing members (not newly enrolled members) that the member handbook was available on the CMO's website or how to obtain a hard copy. The policy and procedure must also reflect how often existing members receive the notice.		
2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent. *42CFR438.10(f)(3)* *Contract: 4.3.5.1*	Effective July 2014, DCH approved the discontinuance of mailing the provider directory in new member packets. The provider directory is available online and members are notified in the new member packet that a hard copy is available upon request. Evidence: Std.IV.2 - GA Provider Directory Std.IV.2 - Members Portal Screen Print Std. IV.2 - Provider Directory Update 7.24.14 (pg. 2)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.IV.2 - MCD/PCFK/AA MEMBER HANDBOOK- (Cover Letter page -unmarked page 2; PDF pg. 3) Std.IV.2 - P4HB Member Handbook- Cover Letter page (unmarked page 2; PDF pg. 3)	
Findings: The DCH granted Amerigroup a waiver from providing a hard copy provider directory to newly enrolled members. The Amerigroup GF 360° member handbooks directed members to the CMO website which contained the provider directory, or to contact member services to request a provider directory and/or for assistance with provider selection.		
Required Actions: None.		
3. The Contractor makes all written information available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The Contractor notifies all members and potential members that information is available in alternative formats and how to access those formats. *42CFR438.10(d)(1) & (2)* *Contract: 4.3.2.1*	Amerigroup makes all written information available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. We notify all members and potential members that information is available in alternative formats and how to access those formats. Evidence: Std.IV.3. -PnP Member Rights and Responsibilities – GA (p. 2, # 2(d)) Std.IV.3.- Rights and Responsibilities Members – Amerigroup – (https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf) Std. IV.3.- PnP Request for Translation and Alternate Format of Member Communication (pgs. 2-3, 4-6) Std.IV.3. - PnP Written Materials and Guidelines (pg. 2) Std.IV.3 - MCD/PCFK/AA MEMBER HANDBOOK- (Unmarked first and second page and marked pg. 2; PDF pgs. 2,3, 9) Std.IV.3 - P4HB Member Handbook-	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Cover page, unmarked second page and marked p. 2 (PDF pgs. a, c, 2)	
Findings: The Requests for Translations and Alternate Formats of Member Communications policy and procedure indicated that Amerigroup would provide materials in Braille, large print, and via audio CD. The Written Materials Guidelines policy and procedure indicated that member materials were written at the fifth-grade reading level and were available in English and Spanish. The member handbooks instructed the member to call member services to obtain assistance in receiving materials in alternate formats and languages.		
Required Actions: None.		
4. The Contractor makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH. All written materials include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important information and directs the member to call the Contractor to request the document in an alternative language, or to have it orally translated. *42CFR438.10(c)(3)* *Contract: 4.3.2.2 and 4.3.2.3*	Amerigroup makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH. All Amerigroup written materials include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important information and directs the member to call Amerigroup to request the document in an alternative language, or to have it orally translated. Evidence: Std. IV.4.- PnP Member Rights and Responsibilities – GA (p. 2 # 2(d)) Std. IV.4. - Rights and Responsibilities Members – Amerigroup – (https://www.myamerigroup.com/Documents/GAGA_Rights_Responsibility_ENG.pdf) Std. IV.4 - PnP Written Materials and Guidelines (pg. 2) Std. IV.4. -PnP Request for Translation and Alternate Format of Member Communication (pgs. 2-3, 4-6) Std.IV.4.- MCD/PCFK/AA Member Handbook: Unmarked second page and marked pg. 2 (PDF pgs. 2, 9)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.IV.4.- P4HB Member Handbook: Unmarked second page & marked pg. 2 (PDF pg. b, 2 & 8)	
Findings: The Amerigroup GF 360° member handbooks included language blocks in 13 different languages that instructed the member to call member services to obtain assistance in receiving materials in alternate formats and languages, including English and Spanish.		
Required Actions: None.		
5. All written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level. The Contractor must use one of the following reference materials to determine the reading level: ◆ Fry Readability Index. ◆ PROSE The Readability Analyst (software developed by Education Activities, Inc.). ◆ Gunning FOG Index. ◆ McLaughlin SMOG Index. ◆ The Flesch-Kincaid Index. ◆ Other word processing software approved by DCH. *42CFR438.10(b)(1)* *Contract: 4.3.2.4*	All Amerigroup written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level. Evidence: Std.IV.5 - PnP Written Materials and Guidelines - (pg. 2 #3 (a))	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Written Materials Guidelines policy and procedure indicated that the CMO used the Flesch-Kincaid Index to verify that member materials were written at the fifth-grade reading level.		
Required Actions: None.		
6. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: 4.3.10.1*	Amerigroup makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. Evidence: Std.IV.6.- PnP Written Materials and Guidelines (p. 2) Std.IV.6.- MCD/PCFK/AA MEMBER HANDBOOK Unmarked second page & marked p. 2 (PDF pg. 2 & 9) Std.IV.6.- P4HB Member Handbook	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Unmarked second page & marked p. 2 (PDF pg. 2 & 8)	
Findings: The Amerigroup GF 360° member handbooks indicated that the member should call member services for oral/verbal translation. The handbooks also indicated that the service was available free of charge.		
Required Actions: None.		
7. The Contractor has in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan. *42CFR438.10(b)(3)*	Amerigroup has mechanism in place to help enrollees and potential enrollees understand the requirements and benefits of the plan. Evidence: Std.IV.7- Georgia 2014 State Marketing Plan Std.IV.7 -Georgia 2015 State Marketing Plan Final	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Georgia 2014 Marketing Plan indicated that the objective of the marketing plan was to develop a culturally diverse and competent outreach program to ensure members felt comfortable and understood the options available to them. The Amerigroup GF 360° member handbooks explained the benefits and indicated that members should call member services if they needed help to understand the benefits.		
Required Actions: None.		
8. The provider directory shall include names, locations, office hours, telephone numbers of, and non-English languages spoken by, current contracted providers. This includes, at a minimum, information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals. The provider directory also identifies providers that are not accepting new patients. *42CFR438.10(f)(6)* *Contract: 4.3.5.2*	Amerigroup's Provider Directory include names, locations, office hours, telephone numbers of, and non-English languages spoken by, current contracted providers. This includes information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals. The online provider directory also identifies providers that are not accepting new patients. Evidence: Std.IV.8 - GA Provider Directory	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The provider directory available on the Amerigroup website included all of the requirements of this element.		
Required Actions: None.		
9. The Member Handbook includes a table of contents. *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes a table of contents. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.IV.9 - MCD/PCFK/AA Member Handbook: Table of Contents – unmarked pgs. 4-6 (PDF pgs. 5-7) Std.IV.9 - P4HB Member Handbook: Table of Contents -- unmarked pgs. 3-5 (PDF pgs. d-f)	
Findings: The Amerigroup GF 360° member handbooks contained a table of contents.		
Required Actions: None.		
10. The Member Handbook includes information about the roles and responsibilities of the member (this information to be supplied by DCH), and what to do when family size changes. *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes information about the roles and responsibilities of the member (this information to be supplied by DCH), and what to do when family size changes. Evidence: Std.IV.10 - MCD/PCFK/AA Member Handbook: R&R pgs. 46-48 (PDF pgs. 53-55) Family Size changes: unmarked six (6) page , marked pgs.1, 42 (PDF pgs. 7, 8, 49) Std.IV.10 - P4HB Member Handbook: R&R – pgs. 41-43 (PDF pgs. 47-49) Family Size changes: Unmarked fifth (5) page, marked pg. 38 (PDF pg. 6, 44)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks included information on the roles and responsibilities of the member. The AA member handbook included instructions on what to do if family size changed.		
Required Actions: None.		
11. The Member Handbook includes information about the role of the PCP and information about choosing a PCP. *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes information about the role of the PCP and information about choosing a PCP. Evidence: Std.IV.11 - MCD/PCFK/AA Member Handbook: Role of PCP/Obtain Care – pgs. 4-7 (PDF 11-14)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.IV.11 - P4HB Member Handbook: Role of PCP/Obtain Care – pgs. 6-9 (PDF pgs. 12-15)	
Findings: The Amerigroup GF 360° member handbooks included information on the role of the PCP and information about choosing a PCP.		
Required Actions: None.		
12. The Member Handbook includes: ◆ Information on benefits and services, including a description of all available Georgia Families (GF) benefits and services. ◆ Information on how to access services, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)services, non-emergency transportation services (NET), maternity, and family planning services. ◆ An explanation of any service limitations or exclusions from coverage. ◆ A notice stating that the Contractor shall be liable only for those services authorized by the Contractor. ◆ Information on how and where members may access benefits not available from or not covered by the Contractor. ◆ Cost sharing. ◆ The policies and procedures for disenrollment. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes the provisions outlined in this requirement. Evidence: Std.IV.12 - MCD/PCFK/AA Member Handbook: Benefits & Services/Access/Limitations/Exclusion – pgs. 11-14 (PDF pgs. 18-21) Health Check (EPSDT) – pgs.16 – 22 (PDF 23-29) NET – pgs. 8-10 (PDF pgs. 15-17) Liability – pgs. 11, 14, 42-44, 47 (PDF pgs. 21, 49-51,54) Cost Sharing/Copayments – pgs. 5,12-13 (PDF pgs. 19-20, 67) Disenrollment – pgs. 5,43 (PDF pgs. 50, 67) Std.IV.12 - P4HB Member Handbook: Benefits & Services/Access/Limitations/Exclusion – pgs. 11-12, 14-17, 21, 23-26, 30 NET – pgs. 10-11, 12 and 26-27 (PDF pgs. 16-17 and 32-33) Liability – pgs. 38-40,42 (PDF pgs. 44-46,48) Cost Sharing/Copayments – pg. 42 Disenrollment – pgs. 38-39 (PDF pgs. 44-45)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks included information about benefits and services, and how to access services including EPSDT, nonemergency transportation, maternity, and family planning services. It also included an explanation of exclusions, how and where members could access benefits not covered by Amerigroup, information on copays, and policies and procedures for disenrollment.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
13. The Member Handbook includes: ◆ The medical necessity definition used in determining whether services will be covered. ◆ A description of all pre-certification, prior authorization, or other requirements for treatments and services. ◆ A description of utilization review policies and procedures used by the Contractor. ◆ The policy on referrals for specialty care and for other covered services not furnished by the member's PCP. ◆ Information on how to obtain services when the member is out of the service region. ◆ Geographic boundaries of the service region. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes the provisions outlined in this requirement. Evidence: Std.IV.13 - MCD/PCFK/AA Member Handbook: Medically Necessary - pg. 10 (PDF pg. 17) Pre-Certification/Prior Authorization – pgs. 11-12, 15, 30-31 (PDF pgs. 18-19, 22, 37-38) Utilization – pg. 11 (PDF pgs. 18) Referral/Specialty Care – pgs. 6, 13 (PDF pgs. 13, 20) Service out of region - pg. 16 (pg. 23) Boundaries --pgs. 3-4 (PDF pgs. 10-11) Std.IV.13 - P4HB Member Handbook: Medically Necessary - pg. 16 (PDF pg. 22) Pre-Certification/Prior Authorization – pg. 29 (PDF pg. 35) Utilization – pg. 29 (PDF pg. 35) Referral/Specialty Care – pg. 14, 22 (PDF pg. 20, 28) Service out of region – pg. 13, 24 (PDF pg. 19, 30) Boundaries - pgs. 3-5 (PDF pgs. 9-11)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks contained all of the information described in this element.		
Required Actions: None.		
14. The Member Handbook includes: ◆ A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available on request. ◆ A notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including the Contractor's toll-free telephone line and Web site. *42CFR438.10(f)(2) and 42CFR438.10(f)(6)*	Amerigroup's Member Handbook includes the provisions outlined in this requirement. Evidence: Std.IV.14 - MCD/PCFK/AA Member Handbook: Toll-Free Line/Web Site - Cover letter page, pgs. 1-2 (PDF pgs.3, 8-10) Provider Incentives- pg. 45 (PDF pg. 52)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.3.3.2	Std.IV.14 - P4HB Member Handbook: Pgs. 1-2 (PDF pgs. 7-8) Pgs. 40-41 (PDF pgs. 46-47)	
Findings: The Amerigroup GF 360° member handbooks included a statement that information about Amerigroup's physician incentive plans was available upon request. Appropriate mailing addresses and telephone numbers, including the CMO's toll-free telephone number and website information, were also included in the member handbooks.		
Required Actions: None.		
15. The Member Handbook includes a description of member rights and responsibilities as described in Section 4.3.4 of the Contract and 42CFR438.100. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Amerigroup's Member Handbook includes a description of member rights and responsibilities as described in Section 4.3.4 of our Contract. Evidence: Std.IV.15 - MCD/PCFK/AA Member Handbook: R&R - pgs. 46-48 (PDF pgs. 53-55) Std.IV.15 - P4HB Member Handbook: R&R - pgs. 41-43 (PDF pgs. 47-49)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks included a description of member rights and responsibilities.		
Required Actions: None.		
16. The Member Handbook information on advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment. ◆ The contractor's policies on respecting the implementation of those rights, including a statement of any limitation regarding the implementation of the Advance Directives as a matter of conscience. ◆ Information must inform members that complaints may be filed with	Amerigroup's Member Handbook includes information on advance directives for adult members as outlined in this requirement. Evidence: Std.IV.16 - MCD/PCFK/AA Member Handbook: Advance Directives - pg. 35-36 (PDF pg. 42-43) Std.IV.16 - P4HB Member Handbook: Advance Directives - pg. 31 (PDF pg.37)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
the State's Survey and Certificate Agency. *42CFR438.10(g)* *Contract: 4.3.3.2, 4.6.12.1.1, 4.6.12.1.2, and 4.6.12.3*		
Findings: The Amerigroup GF 360° member handbooks included the required advance directive information described in this element.		
Required Actions: None.		
17. The Member Handbook includes: ◆ The extent to which and how after hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and post-stabilization services with reference to the definitions in 42CFR438.114(a). ▪ The fact that prior-authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)* *Contract: 4.3.3.3*	Amerigroup's Member Handbook includes the information on emergency coverage as outlined in this provision. Evidence: Std.IV.17 - Emergency Services Core Process PnP (Entire Policy) Std.IV.17 -MCD/PCFK/AA Member Handbook: What constitutes an emergency - Pg. 15 (PDF pg. 22) Emergency and post stabilization no referral/prior authorization - Pgs. 11, 13, 15-16, 46, 48 (PDF pgs. 18, 20, 22-23, 53,55) Std.IV.17-P4HB Member Handbook: What constitutes an emergency – Pgs. 17,22-24, 29, 41-42 (PDF pgs. 15, 23, 28-30, 35,47-48) Emergency and post stabilization no referral/prior authorization - Pg. 14 (PDF pg. 20)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbook included information regarding after-hours and emergency coverage including what constitutes an emergency and the definition for poststabilization services. It also included when prior authorization was needed, procedures for emergency services, and informed members they could use any hospital in case of an emergency.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
18. The Member Handbook information on the Grievance System includes: ◆ The right to file a grievance or an appeal with the Contractor. ◆ The requirements and timeframes for filing grievances and appeals. ◆ The availability of assistance in filing a grievance or an appeal with the Contractor. ◆ The toll free numbers the member may use to file a grievance or an appeal by phone. ◆ The right to a State Administrative Law hearing, the method to obtain a hearing, and the rules that govern representation at the hearing. *42CFR438.10(g)* *Contract: 4.3.3.4*	Amerigroup's Member Handbook includes information in the Grievance System as outlined in this provision. Evidence: Std.IV.18 - MCD/PCFK/AA Member Handbook: Grievance, appeal, law hearing - Pgs. 36-42 (PDF pgs. 43-49) Std.IV.18 - P4HB Member Handbook: Grievances, appeal, law hearing - Pgs. 32-38 (PDF pgs. 38-44)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks included information on the grievance system including the right to file, the requirements and time frames, availability of assistance when filing, toll-free numbers to file, and the right to a State administrative law hearing.		
Required Actions: None.		
19. The Member Handbook information on the Grievance System includes: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for the State Administrative Law hearing is filed within the timeframes specified for filing. ◆ Notice that if the member files an appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. *42CFR438.10(g)* *Contract: 4.3.3.4*	Amerigroup's Member Handbook includes information in the Grievance System as outlined in this provision. Evidence: Std.IV.19 - MCD/PCFK/AA Member Handbook: Grievance, appeal, law hearing – Pgs. 41-42 (PDF pgs. 48-49) Std.IV.19 -P4HB Member Handbook: Grievances, appeal, law hearing - Pgs. 36-37 (PDF pgs. 42-43)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup GF 360° member handbooks indicated that when requested by a member, benefits may continue if the appeal or State administrative law hearing was filed within appropriate time frames and that the member may be required to pay the cost of services furnished during the appeal or administrative law hearing process if the final decision was adverse to the member.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
20. The Contractor gives written notice to DCH of any significant change in information to members at least 30 calendar days before the effective date of the change. *42CFR438.10(f)(4)* *Contract: 4.3.2.5*	Amerigroup gives written notice to DCH of any significant change in information to members at least 30 calendar days before the effective date of the change. Evidence: Std.IV.20 - PnP Written Materials and Guidelines (p. 2, 3) Std.IV.20 - Written Notice of Change to DCH	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Written Materials Guidelines policy and procedure indicated that Amerigroup would provide written requests for approval of changed or new materials at least 30 calendar days before implementation.		
Required Actions: None.		
21. The Contractor shall provide DCH a GF 360° Member Education and Outreach Plan within 150 calendar days of the operations start date and shall adhere to all requirements included in Section 4.4.3 of the contract. The Outreach Plan will address: ◆ GF 360° Member Information Packet. ◆ GF 360° Member Handbook. ◆ GF 360° Member Identification (ID) Card. ◆ 24-hour call center. ◆ Other outreach or education activities identified by the CMO and approved by DCH. *Addendum #1: 4.3.3.6*	Amerigroup provided DCH a GF 360° Member Education and Outreach Plan within 150 calendar days of the operation state date. Amerigroup adheres to all requirements included in Section 4.4.3 of our contract. Our Outreach Plan addresses the following information outlined in this provision. Evidence: Std.IV.21 - Member Education and Outreach Plan	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup Foster Care Member Education and Outreach Plan indicated that the CMO considered the member packet, Amerigroup GF 360° member handbooks, and ID card materials complete and approved in January 2014. The CMO also established a call center and developed other outreach/ educational activities in the creation of the plan.		
Required Actions: None.		
22. For Foster Care (FC) and Department of Juvenile Justice Population (DJJP) members: ◆ The Contractor shall send electronically via	Amerigroup adhered to a decision made by the Department of Community Health (DCH), in collaboration with DFCS, to **not** send information packets electronically to DFCS case managers for newly enrolled members. As an alternative,	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
secure methods an information packet to the DFCS case managers for members who are newly enrolled in the CMO within five calendar days of receipt of the eligibility file from DCH. Upon request, the CMO will mail the member information packet to the Foster Parent, Caregiver, Residential Placement Provider, or State Agency staff. For Adoption Assistance (AA) members: ◆ The contractor shall mail the member information packet to the member/parent for members who are newly enrolled in the CMO within five calendar days of receipt of the eligibility file from DCH. The information packet shall include: ▪ A welcome letter that includes the name and contact information for the GF 360° member's care coordinator. ▪ GF 360° Member Handbook. ▪ GF 360° member ID card. ▪ A PCP change form. ▪ A dentist change form. ▪ Special health care needs/specific services needs form for which the CMO may need to coordinate services. ▪ Information about the roles of the care coordination team and how to seek help in scheduling appointments, and accessing care coordination services. ▪ Information about the role of the call center and how to access the call center.	Amerigroup was advised to place member information packets in each Regional DFCS Office for Case Managers to distribute to new enrollees as needed. However, as of June 5, 2015, Amerigroup was advised by the Department of Community Health to remove all Marketing Materials from State/County government offices. Amerigroup mails the member information packets to the member/parent of newly enrolled AA members within 5 calendar days of receipt of the eligibility file from DCH. The information packet includes the information outlined in this provision. Evidence: Std.IV.22 - PnP Member Id Cards -pgs. 3-4 Std.IV.22 - PnP Mailing of Correspondences to members in Foster Care and DJJ Std.IV.22- MCD/PCFK/AA Member Handbook (Second unmarked page; PDF p. 3) Std.IV.22 - GF 360° Member Handbook (First unmarked page; PDF pg. 2) Std.IV.22 -Marketing Items Document Removal DCH Directive Std.IV.22 -FW Placement of New Member Info into the DFCS Offices	

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
▪ Explanation of disenrollment procedures. ▪ Information about 72-hour emergency prescription drug supply. ▪ Information regarding the ombudsman liaison. ▪ For FC members in DFCS custody in DeKalb and Fulton counties, information on Kenny A. health care requirements. ▪ Information on the Ombudsman Liaison. *Addendum #1: 4.3.3.7*		
Findings: Amerigroup staff indicated that DFCS case managers were notified through electronic means when member ID cards were available on the Amerigroup website. The case manager logged into a secure portal and printed ID cards as needed. Amerigroup made member materials/new member packets available in hard copy at DFCS facilities, and the CMO mailed hard copies of member materials upon request from a FC/DJJP member's guardian. According to the Member ID Cards policy and procedure, for AA members, once the ID card production file was received by the vendor, a new member packet mailing label file was created and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. The new member packet for AA members did not include the dentist change form.		
Required Actions: Amerigroup must develop and implement a mechanism to provide all of the information listed in this element to new AA members.		
23. The CMO will develop within 120 calendar days of the operations start date a GF 360° Member Handbook specific to the GF 360° population and shall adhere to all requirements included in Section 4.3.3 of the contract. *Addendum #1: 4.3.3.8*	Amerigroup developed a GF 360° Member Handbook specific to the GF 360° population within 120 calendar days of our operation start date. Amerigroup adheres to all requirements included in Section 4.3.3 of our contract. Evidence: Std.IV.23 - Member Education and Outreach Plan Std.IV.23 - GF 360° Member Handbook Std.IV.23 - MCD/PCFK/AA Member Handbook	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Amerigroup Foster Care Member Education and Outreach Plan indicated that the CMO completed the development of the Amerigroup new member packets on January 1, 2014. The new member packet included the member handbook.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
24. At a minimum the GF 360° Member Handbook will include: ◆ Roles of the DFCS and DJJ in consenting to the FC members' and DJJP members' health care services. ◆ How to access the care coordination team. ◆ Role of the care coordination team related to coordination of care and services. ◆ Continuity of care transition issues. *Addendum #1: 4.3.3.9*	Amerigroup's GF 360° Member Handbooks the information outlined in this provision. Evidence: Std.IV.24 -MCD/PCFK/AA Member Handbook: Roles of the DFCS and DJJ – pgs. 4-5 (PDF pgs. 66-67) Access the care coordination team – pgs. 1 (PDF pg. 63) Role of the care coordination team – pg. 1 (PDF pg. 63) Continuity of care transition – pg. 2 (PDF pg. 64) Std.IV.24 -GF 360° Member Handbook: Roles of the DFCS and DJJ – pgs. 4-5 (PDF pgs. 56-57) Access the care coordination team – pgs. 2 (PDF pg. 54) Role of the care coordination team – pg. 1 (PDF pg. 53) Continuity of care transition – pg. 2-3 (PDF pg. 54-55)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Both of the Amerigroup GF 360° member handbooks included the mandatory requirements listed in Section 4.3.3 of the contract.		
Required Actions: None.		
25. The Contractor shall reissue the FC member ID card within five calendar days of a request for reissue by the Foster Care and Adoption Assistance populations (FCAAP) member, DFCS staff, caregiver, or foster parent for the following events: ◆ A lost card. ◆ Name change. ◆ A new PCP is requested. ◆ The member is moved to a new placement. ◆ Any other reason that results in a change to the information disclosed on the ID card. *Addendum #1: 4.3.6.7*	AGP will reissue the FC member ID card within five calendar days of a request to reissue by the Foster Care and Adoption Assistance populations (FCAAP) member, DFCS staff, caregiver, or foster parent for the events outlined in this provision. Evidence: Std.IV.25 - Member ID Card P&P (pg. 2-3, #3-4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member ID Card policy and procedure indicated that FC member ID cards were reissued within five calendar days of a request for reissue of the card. The policy also indicated that an ID card was reissued if the card was lost or when any information on the card changed.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
26. The Contractor shall reissue the AA member ID card within five calendar days of a request for reissue by the AA member or adoptive parent for the following events: ◆ A lost card. ◆ Name change. ◆ A new PCP is requested. ◆ Any other reason that results in a change to the information disclosed on the ID card. *Addendum #1: 4.3.6.8*	AGP will reissue the AA member ID card within five calendar days of a request to reissue by the AA member or adoptive parent for the events outlined in this provision. Evidence: Std. IV.26 -Member ID Card P&P (pg. 2-3, #3-4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member ID Card policy and procedure indicated that AA member ID cards were reissued within five calendar days of a request for reissue of the card. The policy also indicated that an ID card was reissued if the card was lost or when any information on the card changed.		
Required Actions: None.		
27. The Contractor shall reissue the DJJP member ID card within five calendar days of a request for reissue by the Juvenile Probation and Parole Specialist (JPPS) or residential placement provider for the following events: ◆ A lost card. ◆ Name change. ◆ A new PCP is requested. ◆ The DJJP member moves to a new placement. ◆ Any other reason that results in a change to the information disclosed on the ID card. *Addendum #1: 4.3.6.9*	AGP will reissue the DJJP member ID card within five calendar days of a request for reissue by the Juvenile Probation and Parole Specialist (JPPS) or residential placement provider for the events outlined in this provision. Evidence: Std. IV. 27 -Member ID Card P&P (pg. 2-3, #3-4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member ID Card policy and procedure indicated that DJJP member ID cards were reissued within five calendar days of a request for reissue of the card. The policy also indicated that an ID card was reissued if the card was lost or when any information on the card changed.		
Required Actions: None.		

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for Amerigroup Community Care for Georgia Families 360°

Standard IV—Member Information						
Met	=	25	X	1.00	=	25
Not Met	=	2	X	.00	=	0
Not Applicable	=	0		*NA*		*NA*
Total Applicable	=	27	**Total Score**		=	25
Total Score ÷ Total Applicable					=	**92.6%**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has a system in place that includes a grievance process, an appeal (administrative review) process, and access to the State Administrative Law hearing process. The contractor's appeal process shall include an internal process that must be exhausted by the member prior to accessing an Administrative Law Hearing. *42CFR438.402(a)* *Contract: 4.14.1.1*	Amerigroup has a system in place that includes a grievance process, an appeal (administrative review) process, and access to the State Administrative Law hearing process. Amerigroup's appeal process includes an internal process that must be exhausted by the member prior to assessing and Administrative Law Hearing. Evidence: Std.V.1- Member Grievance Resolution – GA(pgs. 1-4) Std.V.1- Member Provider Action and Administrative Review Process - GA (pg. 1, 5, 11 and references throughout)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure indicated that Amerigroup had a system which included a grievance process. The Member Provider Action and Administrative Review Process indicated that Amerigroup had a system which included an administrative review and administrative law hearing process. Amerigroup's appeals process included an internal process that must be exhausted by the member prior to requesting an administrative law hearing.		
Required Actions: None.		
2. The Contractor has written Grievance System and appeal process policies and procedures that detail the operation of the Grievance System and appeal process. The Contractor's policies and procedures shall be available in the member's primary language. The Grievance System and appeal process policies and procedures shall be submitted to DCH for review and approval as updated. *42CFR438.400(a)(3)* *Contract: 4.14.1.2*	Amerigroup has written Grievance System and appeal process policies and procedures that detail the operation of the Grievance System and appeal process. Upon request, Amerigroup's policies and procedures is available in the member's primary language. The Grievance System and appeal process policies and procedures are submitted to DCH for review and approval as updated. Evidence: Std.V.2 - Member Grievance Resolution – GA (pgs. 1-4) Std.V.2 - Member Provider Action and Administrative Review Process - GA (pgs. 1, 16)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: Both the Member/Provider Action and Administrative Review Process and the Member Grievance Resolution procedure detailed the operation of the grievance system and appeals process. The Member/Provider Action and Administrative Review Process indicated that Amerigroup would provide "this procedure" in the member's primary language upon request. The Member Grievance Resolution procedure indicated that information about how to file a grievance was available in English and Spanish, and as needed, in other languages, as well as in formats accessible to the visually impaired and via TDD/TTY lines. During the interview Amerigroup staff stated that all policies and procedures were submitted to DCH for approval.		
Required Actions: None.		
3. The Contractor defines action (proposed action) as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the timeframes for resolution of grievances and appeals specified at 438.408(b). *42CFR438.400(b)* *Contract: 1.4*	Amerigroup defines action (proposed action) as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner or the failure to act within the timeframes for resolution of grievances and appeals specified in 42 CFR 438.408(b). Evidence: Std.V.3 - Member Provider Action and Administrative Review Process – GA (pg. 1)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Provider Action and Administrative Review Process indicated that an "action" was defined as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part of payment for a service; the failure to provide a service in a timely manner; or the failure of Amerigroup to act within the time frames provided in 42 CFR 438.408(b).		
Required Actions: None.		
4. The Contractor defines appeal (administrative review) as a request for review of an action, as action is defined in 42 C.F.R. §438.400. *42CFR438.400(b)* *Contract: 1.4*	Amerigroup defines appeal (administrative review) as a request for review of an action, as action is defined in 42 C.F.R. §438.400. Evidence: Std.V.4 - Member Provider Action and Administrative Review Process – GA (pg. 1-2)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.4 - Scion -Amerigroup Appeal PnP	
Findings: The Member Provider Action and Administrative Review Process indicated that an "appeal" was defined as a request for review of an action, as "action" is defined in 42 CFR 438.400. The policy also defined "action."		
Required Actions: None.		
5. The Contractor defines grievance as an expression of dissatisfaction about any matter other than an action. ◆ Possible subjects for grievances include but are not limited to, the quality of care or services provided or aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights. *42CFR438.400(b)* *Contract: 1.4*	Amerigroup defines grievance as an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include but are not limited to, the quality of care or services provided or aspects of interpersonal relationship such as rudeness of a provider or employee, or failure to respect the member's rights. Evidence: Std.V.5 - Member Grievance Resolution - GA (pg. 1) Std.V.5 - MCD/PCFK/AA Member Handbook- pg. 36 (PDF pg. 43) Std.V.5 - P4HB Member Handbook– pg. 32 (PDF pg.38)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure defined a "grievance" as an oral or written expression of dissatisfaction by a member, parent, legal guardian, or member's authorized representative concerning any aspect of Amerigroup's or a provider's operations other than a proposed action. Further, it indicated that possible subjects included, but were not limited to, the quality of care or services provided and perceptions of interpersonal relationships such as rudeness of provider or staff, failure to respect the member right's, or denial of a request for expedited administrative review.		
Required Actions: None.		
6. The Contractor has provisions for who may file a grievance: ◆ A member or member's authorized representative may file a grievance, either orally or in writing. ◆ A Grievance may be filed about any matter other than a proposed action. ◆ A provider cannot file a grievance on behalf of the member. *42CFR438.402(b)(1) and 42CFR438.402(b)(3)* *Contract: 4.14.2.1,*	Amerigroup has provisions for who may file a grievance: • A member or member's authorized representative may file a grievance, either orally or in writing. • A Grievance may be filed about any matter other than a proposed action. • A provider cannot file a grievance on behalf of the member. Evidence: Std.V.6 - Member Grievance Resolution - GA (pgs. 1 and 3,	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	#12)	
Findings: The Member Grievance Resolution procedure indicated that a member, parent, legal guardian, or member's authorized representative may file a grievance by fax, phone, or mail. The procedure also stated that a provider cannot file a grievance on behalf of a member and that a grievance may be filed about any matter other than a proposed action.		
Required Actions: None.		
7. The contractor shall ensure that the individuals who make decisions on grievances that involve clinical issues are health care professional who have the appropriate clinical expertise as determined by DCH, in treating the member's condition or disease and who were not involved in any previous level of review or decision-making. *Contract: 4.14.2.2*	Amerigroup ensures that the individuals who make decisions on grievances that involve clinical issues are health care professionals who have the appropriate clinical expertise as determined by DCH, in treating the member's condition or disease and were not involved in any previous level of review or decision-making. Evidence: Std.V.7 - Member Grievance Resolution - GA (pg. 3, #5) Std.V.7 - Final Upheld Notice Letter MCD Std.V.7 - Final Upheld Notice Letter PCK Std.V.7 - MCD/PCFK/AA Member Handbook(pg. 37, PDF pg. 44) Std.V.7 – P4HB Member Handbook(pg. 33, PDF pg. 39)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure indicated that grievance decisions involving clinical issues were made by healthcare professionals with the appropriate clinical expertise and who were not involved in any previous review or decision making.		
Required Actions: None.		
8. Contractor shall provide written notice of the disposition of the grievance as expeditiously as the member's health condition requires but must be completed within 90 days but not to exceed 90 calendar days of the filing date. *Contract: 4.14.2.3*	Amerigroup provides written notice of the disposition of the grievance as expeditiously as the member's health condition requires, not to exceed 90 calendar days of the filing date. Evidence: Std.V.8 - Member Grievance Resolution - GA (page 2, #7) Std.V.8 – GA Grievance Resolution Letter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure indicated that Amerigroup's acknowledgment, investigation, and written resolution of the total grievance process (all levels) were provided as expeditiously as the member's health condition required, not to exceed 90 calendar days from the date Amerigroup received the initial grievance. Amerigroup's standard for resolving the initial grievance (Level I) was stated in policy as within 30 days. All 10 grievance disposition letters		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
reviewed during the on-site audit met both the timeliness requirement of 90 calendar days and Amerigroup's internal requirement for Level 1 grievances of within 30 days.		
Required Actions: None.		
9. The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an appeal (administrative review) of a proposed action either orally or in writing within 30 calendar days from the date of the notice of "proposed action." A written request must be provided when an oral request has been made, unless the request is for expedited resolution. *42CFR438.402(b)(3)* *Contract: 4.14.4.1 and 4.14.4.2*	Amerigroup allows the member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent to file an appeal (administrative review) of a proposed action either orally or in writing within 30 calendar days from the date of the notice of "proposed action." A written request must be provided when an oral request has been made, unless the request is for expedited resolution. Evidence: Std.V.9 - Member Provider Action and Administrative Review Process - GA (pgs. 2-3 definition, pg. 8,#5-7) Std.V.9 - GA Admin Review Verbal Request Letter Std.V.9 - MCD/PCFK/AA Member Handbook– pg. 38 (PDF pg. 45) Std.V.9 – P4HB Member Handbook– pg. 34 (PDF pg.40)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that the member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an appeal of a proposed action either orally or in writing within 30 calendar days from the date of notice of the proposed action, and that an oral request must be followed with a written, signed administrative review request, unless the request was for an expedited review.		
Required Actions: None.		
10. An appeal (administrative review) shall be filed directly with the contractor or its delegated representatives. The Contractor may delegate this authority to an administrative review committee, but the delegation must be in writing. *Contract: 4.14.4.3*	Amerigroup retains the ultimate responsibility and accountability for all member complaints, grievances and appeals. Avesis does not perform any delegated appeals functions on behalf of Amerigroup. However, first level appeals are delegated to Scion for processing and resolution.	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Evidence: Std.V.10 - Quality Management – Oversight of Delegated Activities (pg. 5) Std.V.10 - Avesis_ Amerigroup Contract Amendment (page 1, #4) Std.V.10 - Scion - Amerigroup Contract Amendment (page 1 Exhibit F) Std.V.10 - Scion-Amerigroup Appeal PnP	
Findings: The Quality Management—Oversight of Delegated Activities policy and procedure indicated that processing of member complaints, grievances, and appeals was not delegated except in the case of dental and vision vendors. Amerigroup provided the Avesis (vision) contract amendment, which indicated that Amerigroup did not delegate appeals processing to Avesis. The Scion (dental) contract amendment indicated that Amerigroup delegated appeals processing to Scion. Although Amerigroup is in compliance with this element, the Quality Management—Oversight of Delegation Activities policy and procedure should be updated to reflect actual CMO practice (i.e., that the CMO's vision vendor is not a delegate for appeals processing).		
Required Actions: Amerigroup must update its Quality Management—Oversight of Delegated Activities policy and procedure to reflect that the CMO's vision vendor is not a delegate for appeals processing.		
11. For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action, or ◆ The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action. *42CFR438.402(b)(2) and 438.420(a)* *Contract: 4.14.4.2 and 4.14.7.1*	For termination, suspension, or reduction of previously authorized services, Amerigroup defines timely filing as outlined in this provision. Evidence: Std.V.11. - Medical Denial Process - Internal – GA Std.V.11. - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.20-29) Std.V.11. - Denial of Services- Desktop Process Std.V.11. - Member Provider Action and Administrative Review Process – GA (p. 6, 8)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that if the member wanted benefits continued while appealing the termination, suspension, or reduction of previously authorized services, timely filing was within 10 calendar days of the notice of action (NOA) or the intended effective date of the proposed action.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
12. The individuals who make the decisions on the administrative reviews are individuals who were not involved in any previous level of review or decision-making and will have the appropriate clinical expertise in treating the member's condition or disease when deciding the following: ◆ An administrative review of a denial that is based on lack of medical necessity. ◆ An administrative review that involves clinical issues. *Contract: 4.14.4.4*	The individuals who make the decisions on the administrative reviews are individuals who were not involved in any previous level of review of decision-making and have the appropriate clinical expertise in treating the member's condition or disease when deciding an administrative review of a denial that is based on lack of medical necessity and an administrative review that involves clinical issues. Evidence: Std.V.12 - Medical Denial Process - Internal – GA Std.V.12 -2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pg. 27) Std.V.12 -Denial of Services- Desktop Process Std.V.12 -Member Provider Action and Administrative Review Process – GA (pg. 8, #3; pg. 9 , #9-10)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action Administrative Review Process indicated that the review was conducted by a practitioner not involved in the initial determination and the decision maker was a licensed physician. The 2015 GA UM Program Description Final indicated that a physician must evaluate all medical necessity decisions for adverse appeal decisions. The UM Program Description also indicated that when medical necessity was in question, the clinical staff referred the case to the appropriate medical director for review. The UM Program Description indicated that a physician or other appropriate clinical practitioner would conduct a full investigation of the content of the appeal, including all aspects of clinical care involved. The 10 administrative review (appeal) files reviewed all complied with this element.		
Required Actions: None.		
13. A member must exhaust the Contractor's appeal (administrative review) process before requesting a State Administrative Law hearing. The member may request the State Administrative Law hearing 30 days from the date of the notice of appeal resolution (notice of adverse action). *42CFR438.402(b)(3)* *Contract: 4.14.3.3 and 4.14.6.3*	Amerigroup members must exhaust our appeal (administrative review) process before requesting a State Administrative Law hearing. The member may request the State Administrative Law hearing 30 days from the date of the notice of appeal resolution (notice of adverse action). Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.13 - Medical Denial Process - Internal – GA (pg. 3, 8(e)) Std.V.13 - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs. 23, 25-26) Std.V.13 - Member Provider Action and Administrative Review Process – GA (pg. 5, 11-12) Std.V.13. -Denial of Services Letter Example Std.V.13- Final Upheld Notice Letter MCD Std.V.13- Final Upheld Notice Letter PCK Std.V.13- MCD/PCFK/AA Member Handbook- pgs. 40-41(PDF pgs.47-48) Std.V.13 – P4HB Member Handbook– pg. 36 (PDF pg.42)	
Findings: The Member/Provider Action and Administrative Review Process indicated that a member must exhaust Amerigroup's internal administrative review (appeal) process prior to requesting a State administrative law hearing. It further indicated that a member had 30 calendar days from the date of notice of the proposed action in which to file a request for a pre- or post-service administrative review.		
Required Actions: None.		
14. Notices of proposed action must be in writing and meet the language and format requirements of 42CFR438.10 and Contract Section 4.3.2 to ensure ease of understanding and be sent in accordance with the timeframes described in Section 4.14.3.4. *42CFR438.404(a)* *Contract: 4.14.3.2*	Amerigroup's notice of proposed action meets the language and formatting requirements outlined in this provision to ensure ease of understanding, all of which are in writing and sent in accordance with the timeframes described in Section 4.14.3.4. Evidence: Std.V.14 - Medical Denial Process - Internal – GA (pg. 4) Std.V.14 - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 pgs.20-29 Std.V.14 - Member Provider Action and Administrative Review Process – GA (pg.6)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that the notices of proposed action would be in writing and would take into consideration the member's special needs, including those who were visually impaired or had limited reading proficiency. The policy also indicated that Amerigroup would make all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH. Finally, all		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
written materials would be worded such that they were understandable to a person reading at a fifth-grade level.		
Required Actions: None.		
15. All proposed actions are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease. *Contract: 4.14.3.1*	All Amerigroup proposed actions are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease. Evidence: Std.V.15. - Medical Denial Process - Internal – GA (pg.2) Std.V.15 - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.20-29) Std.V.15 - Denial of Services- Desktop Process Std.V.15 - Member Provider Action and Administrative Review Process – GA (pg. 4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medical Denial Process—Internal procedure stated that proposed actions and denial decisions were made by the CMO's medical director, a Georgia licensed physician, or a physician under the clinical direction of the CMO's medical director. The procedure further stated that the medical director consulted board-certified specialists from appropriate clinical areas to assist in making determinations of medical necessity when applicable.		
Required Actions: None.		
16. Notices of proposed action must contain: ◆ The action the Contractor has taken or intends to take, including the service or procedure that is subject to the action. ◆ Additional information, if any, that could alter the decision. ◆ The specific reason used as basis for the action (the reasons must have a factual basis and a legal/policy basis). ◆ The member's right to file an appeal (administrative review) through the Contractor's internal Grievance System and how to do so. ◆ The provider's right to file a provider complaint under the Contractor's provider complaint system. ◆ The requirement that a member exhaust the Contractor's internal administrative review process. ◆ The circumstances under which expedited review is available and how	Amerigroup's notices of proposed actions include the information outlined in this provision. Evidence: Std.V.16 - Medical Denial Process - Internal – GA (pgs. 3-4) Std.V.16 - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.20-29) Std.V.16 - Denial of Services- Desktop Process (pg. 4) Std.V.16 - Member Provider Action and Administrative Review Process – GA (pg. 3, 5-6) Std.V.16 - Denial Letter Services Update - Example	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
to request it. ◆ The member's right to have benefits continue pending resolution of the appeal (administrative review) and how to request that benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services if benefits are continued during the administrative review process. *42CFR438.404(b)* *Contract: 4.14.3.3*		
Findings: The Medical Denial—Internal procedure indicated that the notices of proposed action would contain the required information included in this element. The denial of service letter example provided by Amerigroup included the items listed in this element.		
Required Actions: None.		
17. The contractor shall mail the Notice of Proposed Action within the following timeframes: *Contract: 4.14.3.4*	Amerigroup mails the Notice of Proposed Action within the timeframes outlined in this provision. Evidence: Std.V.17 - Medical Denial Process - Internal – GA (pg.4) Std.V.17 - Denial of Services- Desktop Process (pg. 4) Std.V.17 - Member Provider Action and Administrative Review Process – GA (pg. 6, 8)	
(a) For termination, suspension, or reduction of previously authorized Medicaid-covered services the Notice of Proposed Action must be mailed at least 10 calendar days before the date of the proposed action except in the event of one of the following exceptions: ◆ The Contractor has factual information confirming the death of a member. ◆ The Contractor receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates he or she understands that this must be the result of supplying that information.	Amerigroup mails the notice of proposed action at least 10 calendar days before the date of the proposed action for termination, suspension or reduction of previously authorized Medicaid-covered services, except in the event of one of the following exceptions outlined in this provision. Evidence: Std.V.17(a) - Medical Denial Process - Internal – GA (pg. 4) Std.V.17(a) - Denial of Services- Desktop Process (pg. 4) Std.V.17(a) - Member Provider Action and Administrative Review Process – GA (pg. 6-7)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The member's whereabouts are unknown and the post office returns the Contractor's mail directed to the member indicating no forwarding address. ◆ A change in the level of medical care is prescribed by the member's physician. *42CFR438.404(c)* *Contract: 4.14.3.4.1*		
Findings: The Medical Denial Process—Internal procedure indicated that if the decision was to terminate, suspend, or reduce previously authorized covered services, Amerigroup mailed the notice of proposed action 10 calendar days before the date of the proposed action or not later than the date of the proposed action if one of the following exceptions occurred: (1) Amerigroup had factual information confirming the death of a member, (2) Amerigroup received a clear written statement signed by the member that he or she no longer wished services or gave information that required termination or reduction of services and indicated that he or she understood this must be the result of supplying that information, (3) the member's whereabouts were unknown and the post office returned Amerigroup's mail directed to the member indicating no forwarding address, or (4) the member's provider prescribed a change in the level of medical care.		
Required Actions: None.		
(b) The Contractor may shorten the period of advance notice to five (5) calendar days before the date of the proposed action if the Contractor has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources. *Contract: 4.14.3.4.3*	Amerigroup may shorten the period of advance notice to five (5) calendar days before the date of the proposed action if we have facts indicating that action should be taken because of probable member fraud and we have verified, when possible, through secondary sources. Evidence: Std.V.17(b) - Medical Denial Process - Internal – GA (pg. 4) Std.V.17(b) - Denial of Services- Desktop Process (pg. 4) Std.V.17(b) - Member Provider Action and Administrative Review Process – GA (pg. 7)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medical Denial Process—Internal procedure indicated that if the decision was to terminate, suspend, or reduce previously authorized covered services, Amerigroup may shorten the period of advance notice to five calendar days before the date of action if Amerigroup had facts indicating that action should be taken because of probable member fraud and the facts had been verified, if possible, through secondary sources.		
Required Actions: None.		
(c) For denial of payment, at the time of any proposed action affecting the claim. *42CFR438.404(c)(2)*	For any denial of payments, Amerigroup will provide a notice of action at the time of any action affecting the claim. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.14.3.4.5,	Std.V.17(c) - Medical Denial Process - Internal – GA (pg. 5) Std.V.17(c) - Denial of Services- Desktop Process (pg. 3) Std.V.17(c) - Member Provider Action and Administrative Review Process – GA (p. 5) Std.V.17(c) - EOB Example	
Findings: The Medical Denial Process—Internal procedure indicated that, for any denial of payment, Amerigroup would provide an NOA at the time of any action affecting the claim.		
Required Actions: None.		
(d) For standard service authorization decisions that deny or limit service, within 14 calendar days of the receipt of the request for service. *42CFR438.404 (c)(3)* *Contract: 4.11.2.5.1 and 4.14.3.4.6*	For standard service authorization decisions that deny or limit service, Amerigroup mails the notice of proposed action within 14 calendar days of the receipt of the request for service. Evidence: Std.V.17(d) - Medical Denial Process - Internal – GA (p.2) Std.V.17(d) - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.20-29) Std.V.17(d) - Denial of Services- Desktop Process (pg. 3) Std.V.17(d) - Member Provider Action and Administrative Review Process – GA (pg. 4-5)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medical Denial Process—Internal procedure indicated that for standard authorization decisions, Amerigroup would make a decision and provide notification (notice of proposed action) within 14 calendar days of the receipt of the request for services.		
Required Actions: None.		
(e) For expedited service authorization decisions, within 24 hours. *42CFR438.404 (c)(6)* *Contract: 4.11.2.5.2*	For expedited service authorization decisions, Amerigroup provides notice within 24 hours. Evidence: Std.V.17(e) - Medical Denial Process - Internal – GA (pg. 2) Std.V.17(e) - 2015 GA UM Program Description Final.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	MAC and QMC approved April 2015 (pgs. 20, 24) Std.V.17(e) - Denial of Services- Desktop Process (pg. 4) Std.V.17(e) - Member Provider Action and Administrative Review Process – GA (pg. 4-5)	
Findings: The Medical Denial Process—Internal procedure indicated that for pre-certification of expedited care, if a provider indicated, or Amerigroup determined that following the standard timeframe could seriously jeopardize the member's life or health, Amerigroup would make an expedited authorization determination and provide notice of any denial (notice of proposed action) within 24 hours.		
Required Actions: None.		
(f) For authorization decisions not reached within the timeframes required in Section 4.11.2.5, on the date the timeframes expire, as this constitutes a denial and is thus a proposed action. *42CFR438.404 (c)(5)* *Contract: 4.14.3.4.8*	For authorization decisions not reached within the required timeframes required in contract section §4.11.2.5, Amerigroup will mail the notice of action on the date the timeframe expires as this constitute a denial as is therefore an adverse action. Evidence: Std.V.17(f) - Medical Denial Process - Internal – GA (pg. 5) Std.V.17(f) - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.23-24) Std.V.17(f) - Denial of Services- Desktop Process (pg. 4) Std.V.17(f) - - Member Provider Action and Administrative Review Process – GA (pg. 7)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medical Denial Process—Internal procedure indicated that if the authorization decision was not reached within the required time frames according to contract section 4.11.2.5, Amerigroup would mail the NOA on the date the time frame expired as this constituted a denial and therefore an adverse action.		
Required Actions: None.		
18. If the Contractor extends the timeframe for authorization decisions and issuance of the notice of proposed action according to Section 4.11.2.5, it provides the member: ◆ Written notice of the reason for the decision to extend the timeframe. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as	In the event Amerigroup extends the timeframe for authorization decisions and issues the notice of proposed action according to Section 4.11.2.5, we provide the member with the information outlined in this provision. Evidence: Std.V.18 - Medical Denial Process - Internal – GA (pg.3)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
the member's health condition requires and no later than the date the extension expires. *Contract: 4.14.3.4.7*	Std.V.18 - 2015 GA UM Program Description Final. MAC and QMC approved April 2015 (pgs.20-29) Std.V.18 - Member Provider Action and Administrative Review Process – GA (pg. 5, #4)	
Findings: The Medical Denial Process—Internal procedure indicated that the member or member's representative could request a 14-calendar-day extension (or a five-business-day extension for expedited requests) when additional information could be provided and the information was in the member's best interest, and failure to extend the time frame would result in a denial of the authorization. The procedure stated that Amerigroup gave the member written notice of the reasons for the decision to extend the time frame and informed the member of the right to file a grievance if he or she disagreed with the decision. Including the time frame for extension, Amerigroup's procedure stated that the CMO made all decisions and notifications within 28 calendar days for standard requests and within five business days for expedited requests.		
Required Actions: None.		
19. In handling grievances and appeals (administrative reviews), the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *Contract: 4.14.1.4*	Amerigroup gives its members reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Evidence: Std.V.19 - Member Grievance Resolution - GA (pg. 2, #3) Std.V.19 - Member Provider Action and Administrative Review Process - GA (pg. 4, #6) Std.V.19 - MCD/PCFK/AA Member Handbook– (pgs. 36 &38, PDF pgs. 43&45) Std.V.19 – P4HB Member Handbook– (pgs.32-34, PDF pgs.38-40)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure indicated that Amerigroup's member services representatives would assist the member in initiating a grievance, to include providing language translations, formats accessible to the visually impaired, and TTD and TTY lines for hearing impaired members. The Member/Provider Action and Administrative Review Process indicated that Amerigroup's National Customer Care representative would assist members in writing an administrative review and that language translation, visual impairment services, and TTD and TTY lines were also available. Availability of this assistance was communicated to members through the member handbooks.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language. *42CFR438.406(a)(2)* *Contract: 4.14.1.5*	Amerigroup acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language. Evidence: Std.V.20 - Member Grievance Resolution - GA (pg. 3, #1) Std.V.20 - Member Provider Action and Administrative Review Process – GA (pg. 8, #7-8) Std.V.20 – GA Admin Review Verbal Request Letter Std.V.20 - Administrative Review - Written Request Confirmation Letter Std.V.20 - Administrative Review Weekly Report- June 2015 Std.V.20 - GA-Oral Acknowledgement Letter for Grievances Std.V.20 - GA Written Acknowledgement Letter for Grievances Std.V.20 - Grievance Weekly Report- June 2015 Std.V.20 - MCD/PCFK/AA Member Handbook (pgs. 36-37, 39, PDF pgs. 43-44,46) Std.V.20 – P4HB Member Handbook(pgs. 32-33,35 PDF pgs. 38-39,41)	☐ **Met** ☒ **Not Met** ☐ **NA**

Findings: The Member Grievance Resolution procedure indicated that the member complaint specialist, within 10 business days of receipt of the grievance, would send an acknowledgement letter which was used to acknowledge the date of Amerigroup's receipt of the grievance. The procedure also indicated that the member would be notified in writing in his or her primary language. The Member/Provider Action and Administrative Review Process indicated that Amerigroup would send an acknowledgement letter within 10 business days of receipt of the request for administrative review. That process document also indicated that all written materials distributed to members would be available in alternative formats and that Amerigroup would notify the member regarding how to access those formats; however, the process did not indicate that the administrative review (appeal) acknowledgement letter would be *sent* "in the member's primary language." All 10 administrative review (appeal) files reviewed during the on-site audit met the acknowledgement timeliness requirement.

Required Actions: Amerigroup must modify its processes, procedures, and policies so that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language.

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
21. The Contractor must resolve each administrative review and provide written notice of the disposition as expeditiously as the member's health condition requires, not to exceed: ◆ For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal. *42CFR438.408(b)* *Contract: 4.14.4.8*	Amerigroup resolves each grievance and provides written notice of the disposition as expeditiously as the member's health condition requires, not to exceed 90 calendar days from the day the Contractor receives the grievance. ◆ For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal Evidence: Std.V.21 - Member Grievance Resolution - GA (pg. 2 ,#7) Std.V.21 - Member Provider Action and Administrative Review Process - GA (pg. 9, #11-13) Std.V.21 - MCD/PCFK/AA Member Handbook(pgs. 36-37,39 -40, PDF pgs. 43-44,46-47) Std.V.21 – P4HB Member Handbook(pgs. 32,34-35, PDF pgs. 38,40-41)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would resolve each administrative review and provide written notification of the disposition as expeditiously as the member's health condition required. For resolution and written notification of a pre-service administrative review, Amerigroup's policy standard was 30 calendar days from the date it received the request for administrative review. For resolution and written notification of a post-service administrative review, Amerigroup's policy standard was not more than 45 calendar days from the date it received the request. For expedited administrative review resolutions, Amerigroup's policy standard was within 72 hours from the date of notification of the request for the review. These timelines met or exceeded the contract standards. The 10 administrative review (appeal) files reviewed met all applicable timeliness requirements, both State standards and Amerigroup's internal timeliness standards.		
Required Actions: None.		
22. The Contractor's appeal (administrative review) process must provide:		
(a) Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. *42CFR438.406(b)(1)*	Amerigroup treats oral inquiries seeking to appeal an action as an appeal. We send confirmation of the appeal in writing, unless the member or provider requests an expedited resolution.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Evidence: Std.V.22(a) - Member Provider Action and Administrative Review Process - GA - (pg. 8, #7) Std.V.22(a) – GA Admin Review Verbal Request Confirmation Letter	
Findings: The Member/Provider Action and Administrative Review Process indicated that when an oral request was received, it must be followed up with a written request unless the request was for an expedited review. Amerigroup had processes and written member correspondence templates in place for responding to the appeal request in writing. In addition, Amerigroup's processes also ensured that the oral request date was treated as the appeal filing date for timely resolution.		
Required Actions: None.		
(b) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent, must be given a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) *42CFR438.406(b)(2)* *Contract: 4.14.4.5*	Amerigroup gives the member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing at any time during the standard or expedited administrative review process. Evidence: Std.V.22(b) - Member Provider Action and Administrative Review Process - GA (pg. 4, #7) Std.V.22(b) - GA Member Admin Review Ack. Letter Std.V.22(b) - GA Admin Review Verbal Request Letter Std.V.22(b) – MCD/PCK/AA Member Handbook(pgs.38-39, PDF pgs. 45-46) Std.V.22(b) – P4HB Member Handbook(pgs. 35-36, PDF pgs.41-42)	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that the member must be given the opportunity to present evidence and allegations of fact or law in person as well as in writing at any time during the standard or expedited administrative review process. However, Amerigroup's policy, member acknowledgement letter, and member handbook did not contain a process or information for advising the member of the limited time available for presenting evidence in the case of an expedited administrative review.		
Required Actions: Amerigroup must develop and implement a mechanism to provide information that advises the member of the limited time available for		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
presenting evidence in the case of an expedited administrative review.		
(c) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent, must be given an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the administrative review process. *42CFR438.406(b)(3)* *Contract: 4.14.4.6*	Amerigroup provides the member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent with the opportunity before and during the standard or expedited administrative review process to examine or obtain a copy, free of charge, of the administrative review file, records and documents considered during the process. Evidence: Std.V.22(c) - Member Provider Action and Administrative Review Process - GA (pg. 4, #8) Std.V.22(c) - MCD/PCFK/AA Member Handbook(pgs.38-39, PDF pgs. 45-46) Std.V.22(c) – P4HB Member Handbook(pgs. 35-36, PDF pgs.41-42)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that the member had the opportunity before and during the standard or expedited administrative review process to examine or obtain a copy, free of charge, of the administrative review file. Other records and documents considered during the process were also available to the member.		
Required Actions: None.		
(d) Included, as parties to the appeal: ◆ The member and his or her representative. ◆ The provider, acting on behalf of the member with the member's written consent. ◆ The legal representative of a deceased member's estate. *42CFR438.406(b)(4)* *Contract: 4.14.4.7*	Amerigroup's appeal (administrative review) process includes, as parties to the appeal, the member and his or her representative, the provider, acting on behalf of the member with the member's written consent, and/or the legal representative of a deceased member's estate. Evidence: Std.V.22(d) - Member Provider Action and Administrative Review Process - GA (pgs. 2-3 definitions section) Std.V.22(d) - MCD/PCFK/AA Member Handbook(pgs.38-39, PDF pgs. 45-46) Std.V.22(d) – P4HB Member Handbook(pgs. 35-36, PDF	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	pgs.41-42) Std.V.22(d) - Authorized Representative Form	
Findings: The Member/Provider Action and Administrative Review Process included the following as parties to an appeal: the member and his or her representative; the provider, acting on behalf of the member with the member's written consent; or the legal representative of a deceased member's estate.		
Required Actions: None.		
23. The Contractor has an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the timeframe for standard resolution, and ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two (2) calendar days with a written notice. ◆ For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.410* *Contract: 4.14.4.8*	Amerigroup has an expedited administrative review process to accommodate the clinical urgency of the situation. Amerigroup's procedure allows for a physician or any other health care provider to advocate for medically appropriate health care services for his or her patients without retaliation. No member or provider is penalized for initiating a standard or expedited administrative review. If the request for expedited review is denied, the expedited administrative review is transferred to the standard administrative review process and timeframe for resolution and notification. Amerigroup will make reasonable efforts to notify the member and provider verbally of the decision to deny the request for expedited review. Written notification will be sent within two (2) calendar days. Evidence: Std.V.23 - Member Provider Action and Administrative Review Process - GA (pg. 2 definition, pgs. 3-4, #5; pg. 9 #13; pg. 15, #3-5) Std.V.23 - MCD/PCFK/AA Member Handbook(pgs. 39-40, PDF pgs.46-47) Std.V.23 - Administrative Review - Expedited Review Denial Letter Std.V.23 – P4HB Member Handbook(pg. 35-36, PDF pg.41-42)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that the expedited review process for appeals included all of the provisions		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
included in this element.		
Required Actions: None.		
24. The Contractor may extend the timeframes for resolution of the appeal (administrative review) (both expedited and standard) by up to 14 calendar days if: ◆ The member, member's authorized representative, or the provider acting on behalf of the member requests the extension, or ◆ The Contractor shows (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the member's interest. *42CFR438.408(c)* *Contract: 4.14.4.9*	Amerigroup may extend the timeframes for resolution of the standard and expedited administrative reviews up to fourteen (14) calendar days if the member, authorized representative or provider acting on behalf of member with member written consent requests an extension. Amerigroup may initiate an extension if there is a need for additional information and the extension is in the member's best interest. Evidence: Std.V.24 - Member Provider Action and Administrative Review Process - GA (pg. 9, #14) Std.V.24 - MCD/PCFK/AA Member Handbook(pg. 38, PDF pg. 45) Std.V.24 – P4HB Member Handbook(pg.34, PDF pg.40)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup could extend the time frames for resolution of standard and expedited appeals by up to 14 calendar days if the member requested the extension and if Amerigroup demonstrated that the extension was in the member's best interest to provide additional information.		
Required Actions: None.		
25. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *Contract: 4.14.4.9*	Written notice of the reason for the extension is provided to the member prior to the extension if it was initiated by Amerigroup. Evidence: Std.V.25 - Member Provider Action and Administrative Review Process – GA (pg. 9 ,#14) Std.V.25 - MCD/PCFK/AA Member Handbook(pg. 39, PDF pg.46) Std.V.25 - Administrative Review- Time Frame Extension	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Letter Std.V.25 – P4HB Member Handbook (pg.35, PDF pg.41)	
Findings: The Member/Provider Action and Administrative Review Process indicated that if Amerigroup wished to extend the time frame, the member was notified in writing of the reason for the extension.		
Required Actions: None.		
26. If the Contractor upholds the proposed action in response to an administrative review filed by the member, the contractor shall issue a notice of adverse action within the timeframes described in Section 4.14.4.8 and 4.14.4.9. *Contract: 4.14.5.1*	If Amerigroup upholds the proposed action in response to an administrative review filed by the member, Amerigroup shall issue a notice of adverse action within the timeframes described in Section 4.14.4.8 and 4.14.4.9. Evidence: Std.V.26 – Member Provider Action and Administrative Review Process - GA (pg. 9 ,#11-13) Std.V.26 – Final Upheld Notice Letter MCD Std.V.26 – Final Upheld Notice Letter PCK	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that if Amerigroup upheld the action related to an administrative review, Amerigroup would notify the member within 30 days (for a pre-service administrative review) and within 45 calendar days (for a post-service administrative review) from the date Amerigroup received the request. For expedited resolutions of administrative reviews, the determination and notification would be made within 72 hours from the date of notification or as expeditiously as the member's health condition required.		
Required Actions: None.		
27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes: ◆ The results and date of the adverse action including the service or procedure that is subject to the action. ◆ Additional information, if any, that could alter the decision. ◆ The specific reason used as the basis of the action. ◆ The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing date is stamped. ◆ The right to continue to receive benefits pending a State Administrative	Amerigroup's written notice of adverse action meets the language and format requirements specified in Section 4.3 and includes the information outlines in this provision. Evidence: Std.V.27 – Member Provider Action and Administrative Review Process - GA (pgs. 5-6 & 10-11) Std.V.27 – Final Upheld Notice Letter MCD Std.V.27 – Final Upheld Notice Letter PCK Std.V.27 – Denial of Services Letter Example	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Law hearing. ◆ How to request continuation of benefits. ◆ Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing. ◆ Circumstances under which expedited resolution is available and how to request it. *42CFR438.408(e)* *Contract: 4.14.5.2*	Std.V.27 – Denial letter attachments	
Findings: The Member/Provider Action and Administrative Review Process indicated that all notices of proposed action would meet the alternative language requirements and make all written materials available in English, Spanish, and all other prevalent non-English languages. The policy stated that materials would be worded in such a way to be understood by a person reading at a fifth-grade reading level. The notice of adverse action included each requirement listed in this element. The 10 administrative review (appeal) resolution letters reviewed included the required information; however, in some cases these letters did not meet the fifth-grade reading/understandability level. In several cases the rationale provided for upholding a denial was copied directly from the clinician reviewer notes or contained advanced medical terminology.		
Required Actions: Amerigroup must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.		
28. The Contractor continues the member benefits if:		
(a) The member, member's authorized representative, or the provider files a timely appeal—defined as on or before the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action. ◆ The intended effective date of the proposed action. *42CFR438.420(b)(1)* *Contract: 4.14.7.1*	Amerigroup will continue the member's benefits if the member, member's authorized representative, or the provider file a timely appeal within 10 calendar days of when Amerigroup mailed the notice or the intended effective date of the proposed action. Evidence: Std.V.28(a) - Member Provider Action and Administrative Review Process - GA (pg.13, #1a &e) Std.V.28(a) - Continuation of Benefits Approval Letter Std.V.28(a) - Continuation of Benefits Denial Letter Std.V.28(a) - MCD/PCFK/AA Member Handbook(pgs.41-42, PDF pgs. 48-49)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.28(a) – P4HB Member Handbook (pgs.37, PDF pgs.43)	
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would continue benefits if the appeal was received within 10 days of Amerigroup's mailing of the Notice of Action (NOA), or by the intended effective date of the proposed action.		
Required Actions: None.		
(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. *42CFR438.420(b)(2)* *Contract: 4.14.7.2*	Amerigroup will continue the member's benefits if the appeal involves the termination, suspension or reduction of a previously authorized course of treatment; Evidence: Std.V.28(b) - Member Provider Action and Administrative Review Process - GA (pg. 13, #1b) Std.V.28(b) - Continuation of Benefits Approval Letter Std.V.28(b) - Continuation of Benefits Denial Letter Std.V.28(b) - MCD/PCFK/AA Member Handbook(pgs.41-42, PDF pgs. 48-49) Std.V.28(b) – P4HB Member Handbook (pg.37,PDF pg.43)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would continue benefits if the administrative review involved the termination, suspension, or reduction of a previously authorized course of treatment.		
Required Actions: None.		
(c) The services were ordered by an authorized provider. *42CFR438.420(b)(3)* *Contract*: 4.14.7.2	Amerigroup will continue the member's benefits if the services were ordered by an authorized provider. Evidence: Std.V.28(c) - Member Provider Action and Administrative Review Process - GA (pg. 13, #1c) Std.V.28(c) - Continuation of Benefits Approval Letter Std.V.28(c) - Continuation of Benefits Denial Letter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would continue benefits if the service was ordered by an authorized provider.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
(d) The original period covered by the original authorization has not expired. *42CFR438.420(b)(4)* *Contract: 4.14.7.2*	Amerigroup will continue the member's benefits if the original period covered by the original authorization has not expired. Evidence: Std.V.28(d) - Member Provider Action and Administrative Review Process - GA (pg. 13, #1d) Std.V.28(d) - Continuation of Benefits Approval Letter Std.V.28(d) - Continuation of Benefits Denial Letter Std.V.28(d) - MCD/PCFK/AA Member Handbook(pgs.41-42, PDF pgs. 48-49) Std.V.28(d) – P4HB Member Handbook (pgs.37, PDF pgs.43)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would continue benefits if the original period covered by the original authorization had not expired.		
Required Actions: None.		
(e) The member requests an extension of benefits. *42CFR438.420(b)(5)* *Contract: 4.14.7.2*	Amerigroup will continue the member's benefits if the member requests an extension of benefits. Evidence: Std.V.28(e) - Member Provider Action and Administrative Review Process - GA (pg. 14, #1e) Std.V.28(e) - Continuation of Benefits Approval Letter Std.V.28(e) - Continuation of Benefits Denial Letter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup would continue benefits if the member requested an extension of the benefits within 10 calendar days of the NOA or by the intended effective date of the proposed action.		
Required Actions: None.		
29. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten (10) calendar days pass after the Contractor mails the notice of	If Amerigroup continues or reinstates a member's benefits while the appeal is pending, the benefits continue until one of the following provisions outlined in this requirement occurs.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
action providing the resolution of the appeal against the member, unless the member (within the 10-day timeframe) has requested a State Administrative Law hearing with continuation of benefits until a State Administrative Law hearing decision is reached. ◆ A State Administrative Law hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *Contract: 4.14.7.3*	Evidence: Std.V.29 - Member Provider Action and Administrative Review Process - GA (pg. 14, # 2) Std.V.29 - Continuation of Benefits Approval Letter Std.V.29 - Continuation of Benefits Denial Letter Std.V.29 - MCD/PCFK/AA Member Handbook (pgs.41-42, PDF pgs. 48-49) Std.V.29 – P4HB Member Handbook (pg.37, PDF pg.43)	
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup continued or reinstated the benefits while the appeal or State administrative law hearing was pending for any one of the reasons listed in this element.		
Required Actions: None.		
30. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section (contract section 4.14.7). *42CFR438.420(d)* *Contract: 4.14.7.4*	If the final resolution of the appeal is adverse to the member and upholds Amerigroup's proposed action, Amerigroup may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that the services were furnished solely because of the requirements of this rule. Evidence: Std.V.30 - Member Provider Action and Administrative Review Process - GA (pg. 14 , #5) Std.V.30 - MCD/PCFK/AA Member Handbook (pg. 42, PDF pg.49) Std.V.30 – P4HB Member Handbook (pg.37, PDF pg.43)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that if the final resolution of the appeal upheld Amerigroup's proposed action, Amerigroup could recover from the member the cost of the services furnished while the administrative review/appeal was pending to the extent the services were furnished solely because of the requirements under the grievance system.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
31. If the Contractor or the State Administrative Law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending: ◆ The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ◆ The Contractor must pay for those services. *42CFR438.424* *Contract: 4.14.7.5and 4.14.7.6*	If the State Administrative Law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Amerigroup authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires and pays for those services. Evidence: Std.V.31 - Member Provider Action and Administrative Review Process - GA (pg. 11, #5; pg.14 , #3-4) Std.V.31 - MCD/PCFK/AA Member Handbook (pg. 42, PDF pg. 49) Std.V.31 – P4HB Member Handbook (pg.37, PDF pg.43)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that if Amerigroup or the administrative law judge reversed a decision to deny, limit, or delay service that was adverse to the member and services were not provided while the administrative review/appeal or the State administrative law hearing was pending, Amerigroup would authorize or arrange to provide the disputed services promptly and as expeditiously as the member's health condition required. The policy further stated that Amerigroup was responsible for payment for those services in accordance with the State policy and regulation.		
Required Actions: None.		
32. The Contractor logs and tracks all grievances, proposed actions, appeals, and Administrative Law hearing requests as described in Section 4.18.4.5. *42CFR438.416* *Contract: 4.14.8.1*	Amerigroup logs and tracks all grievances, proposed actions, appeals and Administrative Law Hearing requests as described in Section 4.18.4.5. Evidence: Std.V.32 - Member Grievance Resolution - GA – GA (pg. 4, #1) Std.V.32 - Member Provider Action and Administrative Review Process - GA (pg. 15-16, #1) Std.V.32 - 1Q2015 Grievance System Report GF Std. V.32 - Amerigroup Member ALH Requests 07012014 - 06302015	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup tracked, trended, and reported on grievances, appeals, and		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
administrative law hearings through a centralized database. Amerigroup also provided a grievance system report as an example of its database reporting capabilities and screenshots from both its grievance and appeals tracking database applications.		
Required Actions: None.		
33. The Contractor shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the grievance, date of the decision, and the disposition. *Contract: 4.14.8.2*	Amerigroup maintains records of grievances (oral and written) that include a summary of the grievance, name of the grievant, date of the grievance, date of the decision, and the disposition. Evidence: Std.V.33 - Member Grievance Resolution – GA (pg. 4, #1) Std.V.33 - GF Grievance Database Screenshot	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Resolution procedure section on "Grievance Tracking and Reporting" contained a description of Amerigroup's grievance record-keeping standards. Amerigroup also provided a grievance system report and a grievance database screenshot that verified the information tracked in the database.		
Required Actions: None.		
34. The Contractor shall maintain records of appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. *Contract: 4.14.8.3*	Amerigroup maintains records of appeals (oral and written) that include a summary of the issue, name of the appellant, date of the appeal, date of the decision, and the resolution. Evidence: Std.V.34 - Member Provider Action and Administrative Review Process - GA (pg. 15-16, #1a-f) Std.V.34 - GF Appeal Database Screenshot	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that Amerigroup tracked, trended, and reported on appeals through a centralized database. This policy indicated specific items that were tracked in the database, and Amerigroup complied with the element. Amerigroup also provided an appeals system database screenshot that verified the information tracked in the database.		
Required Actions: None.		
35. The Contractor must provide the information about the member Grievance System specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. *42CFR438.414*	Amerigroup provides information about our member Grievance System as specified in 42CFR438.10(g)(1) to all providers and to applicable subcontractors at the time they enter into a contract. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Std.V.35 - GA Medicaid Provider Manual (pgs.49-52, 72, 106-111, 123-124, PDF pgs. 52-55, 75, 109-114, 126-127) Std.V.35 - Avesis_ Amerigroup Contract Amendment (page 1, #4) Std.V.35 - Scion - Amerigroup Contract Amendment (page 1 Exhibit F)	
Findings: The provider manual included information about Amerigroup's grievance, appeals, and State fair hearing processes and included filing time frames for each level of the grievance process. The provider manual included all information requirements listed in 42 CFR 438.10(g)(1). The requirements, policies, and procedures contained in the provider manual were incorporated by reference into Amerigroup's participating provider agreement (contract).		
Required Actions: None.		

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

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor shall accept all individuals for enrollment without restrictions. The Contractor shall not discriminate based on: ◆ Religion ◆ Gender ◆ Race ◆ Color ◆ National origin Contractor will not use any policy or practices that have the effect of discriminating on the above basis or on the basis of health, health status, pre-existing condition or need for health care services. *Contract: 4.1.1.4*	Amerigroup accepts all individuals without restrictions. We do not discriminate on the basis of religion, gender, race, color, sexual orientation, age or national origin. Furthermore, we do not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin, or on the basis of health, health status, pre-existing condition or need for health care services. Evidence: Std.VI.1 – Membership Load – Facets - (pg.1) Std.VI.1 - Non-Discrimination in Marketing Enrollment and Health Plan Operations (pg.1)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Membership Load—Facets policy and procedure indicated that Amerigroup did not discriminate based on religion, gender, race, color, national origin, health, health status, pre-existing condition, or need for healthcare services.		
Required Actions: None.		
2. Contractor shall enroll FCAAP and DJJP members in the CMO upon receipt of the eligibility file from DCH. *Addendum #1:4.1.1.5*	Amerigroup enrolls FCAAP and DJJP members upon receipt of the eligibility file from DCH Evidence: Std.VI.2 - Membership Load - Facets - (pg. 1, #3)	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Membership Load—Facets policy and procedure indicated that all members were enrolled using the "internal standard," which was identified as two business days, unless the market had a more stringent enrollment time frame, in which case Amerigroup would adhere to the State requirement. However, the policy also indicated that for the Georgia market, Amerigroup would adhere to the internal standard, which was two business days. During the on-site interview staff stated that members would be enrolled upon receipt of the eligibility file. Therefore, the policy and practice were in conflict.		
Required Actions: Amerigroup must update its Membership Load—Facets policy to indicate that GF 360° program members are enrolled upon receipt of the eligibility file from DCH.		
3. AA members may elect to disenroll without cause during the AA member Fee-For-Service Selection Period. AA members disenrolling shall return to the Medicaid FFS delivery system. ◆ *Addendum #1: 4.2.1.4*	Amerigroup allows AA members to disenroll without cause during the AA member Fee-For-Service Selection Period. AA members electing to disenroll return to the Medicaid FFS delivery system.	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Evidence: Std.VI.3 -Disenrollment GA (pg. 2, #2)	
Findings: The Disenrollment procedure did not indicate that an AA member may disenroll without cause during the FFS selection period and return to the Medicaid FFS delivery system.		
Required Actions: Amerigroup must change its policy to address voluntary disenrollment of AA members without cause during the FFS selection period and return the member to the Medicaid FFS delivery system.		
4. The AA member may disenroll for the following cause at any time and return to the Medicaid FFS delivery system: ◆ The Contractor does not, because of moral or religious objections, provide the covered services the AA member seeks. ◆ The AA member needs related services to be performed at the same time, and not all related services are available within the network. The AA member's provider or another provider have determined that receiving services separately would subject the member to unnecessary risk. ◆ Other reasons include, but are not limited to, poor quality of care, lack of access to services covered under the contract, or lack of provider's experienced in dealing with the member's health care needs. *Addendum #1: 4.2.1.5*	Amerigroup allows AA members to disenroll for the causes outlined in this provision at any time and return to the Medicaid FFS delivery system. Evidence: Std.VI.3 - Disenrollment GA (pg.6, 8(b)) Std.VI.3 -MCD/PCFK/AA Member Handbook - pgs.5-6 (PDF pgs. 67-68)	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated that AA members may voluntarily disenroll for the reasons listed in the element; however, it did not specify that the member would be returned to the Medicaid FFS delivery system.		
Required Actions: The CMO must update its policies and practices to ensure disenrolling AA members would be returned to the Medicaid FFS delivery system.		
5. If there is a change in enrollment status for a GF 360° member's eligibility category to an ineligible category, and the member remains eligible for Medicaid, the member shall remain enrolled with the CMO as a non-GF 360° member until the member's next enrollment period, unless the member is eligible for supplemental security income (SSI); then the member will be returned to Medicaid FFS. The disenrollment will be processed within three business days of the date the GF 360° member's eligibility category actually changes and will not be made retroactively.	Amerigroup acknowledges that if there is a change in enrollment status for a GF 360° member's eligibility category to an ineligible category, and the member remains eligible for Medicaid, the member shall remain enrolled with Amerigroup as a non-GF 360° member until the member's next enrollment period, unless the member is eligible for supplemental security income (SSI); then the member will be returned to Medicaid FFS. The	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Addendum #1: 4.2.5	disenrollment will be processed within three business days of the date the GF 360° member's eligibility category actually changes and will not be made retroactively. Eligibility for the GF 360° Program is handled by DCH, if a member changes from an eligible aid category for the GF 360° to an ineligible category for the program, but remains Medicaid eligible; Amerigroup will receive a termination via the 834 eligibility file received for GF 360° and a new member transaction would be received for the GF program and the member would fall in to the enrollment process for the Georgia Families Program. Evidence: Std. VI.5.- Disenrollment GA Std.VI.5 - Membership Load- Facets	
Findings: The Disenrollment and Membership Load—Facets policy did not include information pertaining to a GF 360° member's enrollment status changing from an eligible to ineligible category.		
Required Actions: Amerigroup must update its policies and practices to encompass the provisions and requirements pertaining to a GF 360° member's enrollment status changing from an eligible to ineligible category.		
6. A member may request disenrollment from a CMO for the following reasons: ◆ For cause at any time. ◆ Without cause: ▪ During 90 calendar days following the date of their initial enrollment or the day DCH or its agent sends the member notice of enrollment—whichever is later. ▪ Every 12 months thereafter. ▪ Upon automatic enrollment. *42CFR438.56(c)(i-iii)* *Contract: 4.2.1.1*	A member may request disenrollment from Amerigroup for the reasons outlined in this provision. Evidence: Std.VI.6 - Disenrollment – GA (p. 2) Std.VI.6 -MCD/PCFK/AA Member Handbook - pg. 43 (PDF pg.50) Std.VI.6 -GF 360° Member Handbook– pgs. 36-37 (PDF pgs. 43-44)	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated that a member may voluntarily request disenrollment without cause at any time during the first 90 days after the		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
initial enrollment date or the date DCH sent the member notice of the enrollment, whichever was later, and then every 12 months thereafter. The Disenrollment procedure did not indicate that a member may request disenrollment for cause at any time.		
Required Actions: Amerigroup must change its Disenrollment procedure and GF 360° member handbooks to include a provision that the member may request disenrollment for cause at any time.		
7. The following constitutes cause for disenrollment requested by the member: ◆ The member moves out of the service area. ◆ The Contractor does not, because of moral or religious objections, provide the covered service the member seeks. ◆ The member needs related services performed at the same time and not all the related services are available within the network. A provider has determined that providing the services separately would subject the member to unnecessary risk. ◆ The member requests to be assigned to the same Contractor as family members. ◆ The member's Medicaid eligibility category changes to ineligible for GF. ◆ Other reasons include but are not limited to poor quality of care, lack of access to services covered under the Contract, or lack of providers experienced in dealing with the member's mental health care needs. *42CFR438.56(d)(2)(i-iv)* *Contract: 4.2.1.2*	The reasons outlined in this provision constitute cause for disenrollment when requested by the Member. Evidence: Std.VI.7 - MCD/PCFK/AA Member Handbook - pg. 43 (PDF pg.50) Std.VI.7 -GF 360° Member Handbook– pgs. 36-37 (PDF pgs. 43-44)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated what constituted cause for disenrollment requested by the member. All of the causes for disenrollment listed in this element were included in the policy.		
Required Actions: None.		
8. The Contractor provides assistance to members seeking to disenroll. Assistance consists of providing forms to the member and referring the member to DCH or its agent who makes disenrollment determinations. *Contract: 4.2.1.3*	Amerigroup provides assistance to members seeking to disenroll. Assistance consists of providing forms to the member and referring the member to DCH or its agent who makes disenrollment determinations. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.VI.8 - Std. VI-Disenrollment – GA (pg.6, #8(b)) Std.VI.8 - Disenrollment Desktop Process (Entire Policy)	
Findings: The Disenrollment procedure indicated that Amerigroup would provide disenrollment forms to a member seeking to disenroll and refer him/her to DCH, which made disenrollment determinations.		
Required Actions: None.		
9. For disenrollment initiated by the Contractor, the Contractor notifies DCH or its agent upon identification of a member who it knows or believes meets the criteria for disenrollment, as defined in Contract Section 4.2.3. and completes all disenrollment paperwork for members it is seeking to disenroll. *Contract: 4.2.2.1 and 4.2.2.2*	Amerigroup notifies DCH or its agent upon identification of a member believed to meet disenrollment criteria, as defined in Contract Section 4.2.3. We complete all disenrollment paperwork for members we seek to disenroll. Evidence: Std.VI.9 - Disenrollment – GA (pg.5) Std.VI.9 - GF Disenrollment Request Form Std.VI.9 - Disenrollment JAN 2015 Std.VI.9 - CM Disenrollment Letter (English).example Std.VI.9 - Disenrollment Desktop Process (pgs. 3-5) Std.VI.9 - Disenrollment Report 2014-2015 Std.VI.9 -Member Disenrollment Screenshot example Std.VI.9 - 0652 Disenrollment Activity Notification M0615	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated that Amerigroup notified and submitted to DCH information about members the CMO knew or believed met the criteria for disenrollment, and the CMO completed all disenrollment paperwork for the member seeking to disenroll.		
Required Actions: None.		
10. The Contractor may request disenrollment if: ◆ The member's utilization of services is fraudulent or abusive; ◆ The member has moved out of the service region; ◆ The member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded; ◆ The member's Medicaid eligibility category changes to a category ineligible for GF and/or the member otherwise becomes ineligible to participate in GF;	Amerigroup may request to disenroll a member for one of the reasons outlined in this provision. Evidence: Std.VI.10 - Disenrollment – GA (pg. 3-4) Std.VI.10 - GF Disenrollment Request Form Std.VI.10 - Disenrollment JAN 2015 Std.VI.10 - CM Disenrollment Letter (English).example	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The member has any other condition as so defined by DCH; or ◆ The member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid. *Contract: 4.2.3*	Std.VI.10 - Disenrollment Desktop Process (pgs. 3-5) Std.VI.10 - Disenrollment Report 2014-2015 Std.VI.10 -Member Disenrollment Screenshot example Std.VI.10 - 0652 Disenrollment Activity Notification M0615 Std.VI.10 - GA Screen shots for disenrollment information	
Findings: The Disenrollment procedure indicated the circumstances under which Amerigroup may request disenrollment of a member. The procedure included all of the requirements in this element.		
Required Actions: None.		
11. Prior to requesting Disenrollment of a member, the Contractor shall document: ◆ At least three (3) interventions over a period of ninety (90) calendar days that occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request. ◆ Provide at least one (1) written warning to the member, certified return receipt requested, regarding implications of his or her actions. DCH recommends that this notice be delivered within ten (10) business days of the member's action. *Contract: 4.2.2.3*	Prior to requesting disenrollment of a member, Amerigroup documents at least three (3) interventions over a period of ninety (90) calendar days that occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request. We provide at least one (1) written warning to the member, certified return receipt requested, regarding implications of his or her actions. This notice shall be delivered within ten (10) business days of the member's action. Evidence: Std.VI.11 - Disenrollment – GA (pg.5, #5) Std.VI.11 - CM Disenrollment Letter (English).example Std.VI.11 - Disenrollment Desktop Process (pg.4)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated that the CMO would document three interventions over a period of 90 calendar days in attempts to resolve issues. Further, the CMO would provide a written warning to the member, certified return receipt requested to inform the member of the implications of his or her actions.		
Required Actions: None.		
12. The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for disenrollment outlined in Section 4.2.3 before requesting disenrollment of the member. *Contract: 4.2.2.4*	Amerigroup cites at least one acceptable reason for disenrollment requests submitted to DCH or its agent. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.VI.12 - Disenrollment – GA (pg. 5, #6) Std.VI.12 - CM Disenrollment Letter (English).example Std.VI.12 - Disenrollment JAN 2015 Std.VI.12 - Disenrollment Report 2014-2015 Std.VI.12 - 0652 Disenrollment Activity Notification M0615	
Findings: The Disenrollment procedure indicated that Amerigroup would cite at least one acceptable reason for disenrollment and submit it to DCH prior to requesting the member's disenrollment.		
Required Actions: None.		
13. The Contractor may not request disenrollment of a member for discriminating reasons, including: ◆ Adverse changes in a member's health status; ◆ Missed appointments; ◆ Utilization of medical services; ◆ Diminished mental capacity; ◆ Pre-existing medical condition; ◆ Uncooperative or disruptive behavior resulting from his or her special needs; or ◆ Lack of compliance with the treating physician's plan of care. ◆ Member attempts to exercise his/her rights under the Grievance System. *Contract: 4.2.4.1 and 4.2.4.2*	Amerigroup does not request to disenroll a member for the discriminating reasons outlined in this provision. Evidence: Std.VI.13 - Disenrollment – GA (pgs. 5-6) Std.VI.13 - Disenrollment Desktop Process (pg. 5) Std.VI.13- 0652 Disenrollment Activity Notification M0615	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Disenrollment procedure indicated that Amerigroup would not terminate a member for discriminating reasons including those listed in this element.		
Required Actions: None.		
14. The request of one PCP to have a member assigned to another provider is not sufficient cause for the Contractor to request the member be disenrolled from the plan. The Contractor shall utilize its PCP assignment process to assign the member a new PCP. *Contract: 4.2.4.3*	Amerigroup's PCP assignment process is utilized to assign members to a new PCP. We do not disenroll a member if a PCP requests to have the member assigned to another provider. Evidence: Std.VI.14 – Disenrollment Desktop Process (p. 5)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Std.VI.14 - GA Medicaid Provider Manual – pg. 75 (PDF pg.78)	
Findings: The Disenrollment procedure indicated that the request of one PCP to have a member assigned to a different provider was not sufficient cause for Amerigroup to request disenrollment of that member. Instead, Amerigroup would use its PCP assignment process and assign the member a new PCP.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations						
Met	=	9	X	1.00	=	9
Not Met	=	5	X	.00	=	0
Not Applicable	=	0		***NA***		***NA***
Total Applicable	=	14	**Total Score**		=	9
Total Score ÷ Total Applicable					=	64.3%

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

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

Review Dates

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

Table B-1—Review Dates	
Date of On-Site Review	July 28–30, 2015

Participants

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

Table B-2—HSAG Reviewers and Amerigroup Community Care for Georgia Families 360°/Other Participants		
HSAG Review Team		**Title**
Team Leader	Elizabeth Stackfleth , MPA	Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, LPCC-S	Senior Project Manager, State & Corporate Services
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
Amerigroup Community Care for Georgia Families 360° Participants		**Title**
Fran Gary		Plan President
William Alexander, MD		Regional Vice President (VP), Medical Director
Greg Powell		Regional VP, Provider Solutions
Bhavini Solanki-Vasan		Project Manager
Leon Greene		Behavioral Health Manager
Kelli Ferrell		Pharmacist Program Manager
Kathy Burke		Title not provided
Robert Dinwiddie		Regional Pharmacy Director
Lisa Maleski		Quality Management (QM) Manager
Yvette Terry		Title not provided
Bridget McKenzie		Healthcare Management Services (HCMS)
Tawanna Ingram		QM Manager
Aviance Jenkins		Regulatory Compliance Consultant
Urcel Fields		Regional VP of Provider Solutions
Michelle Rush		Director, Provider Solutions
Charmaine Bartholomew		QM Director
Marquette Moore		Regulatory Oversight Manager
Donna McIntosh		Plan Compliance Officer
Shonnie Cooper		Director, Clinical Compliance
Kathleen King		Manager, Vendor Contracting and Management
Aaron Lambert		Director of State Operations

Table B-2—HSAG Reviewers and Amerigroup Community Care for Georgia Families 360°/Other Participants	
Michelle Anderson-Johnson	Manager
Rochelle Simmons	Medical Compliance Analyst
Amy Martinez	Director of Credentialing
Tita Stewart	Director, Marketing
Gerry Stoner	Title not provided
Joyce LeTourneau	Title not provided
Earlie Rockette	Title not provided
Cynthia Brown	Title not provided
Lisa Ross-Jones	Manager, Healthcare Management
Jeanette Davis	Manager, Utilization Management
Sigama Drake	Director, Intake and Compliance
Tonia Austin	Title not provided
Lavarne McCloud	Title not provided
Department of Community Health Participants	**Title**
Kina DeWitt, LCSW	Manager, Performance Improvement
Suzanne Lindsey	Director of GF 360°

Appendix C. **Review Methodology**

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families 360° CMO addresses HSAG's:

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

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

Objective of Conducting the Review of Compliance With Standards

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

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

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

- Standard I—Provider Selection, Credentialing, and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protections
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations

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

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

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

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

Pre-on-site review activities included:

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

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

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents and files HSAG requested that the CMOs have available on-site.

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

- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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

Description of Data Obtained

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

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

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

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

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

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

Data Aggregation and Analysis

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

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

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

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

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

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

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

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

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

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

Appendix D. **Corrective Action Plan**

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

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

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

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

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

Appendix D. State of Georgia
Department of Community Health (DCH)
Corrective Action Plan
for Amerigroup Community Care for Georgia Families 360°

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

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

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

Standard I—Provider Selection, Credentialing, and Recredentialing			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
6. The Contractor makes credentialing decisions on all completed application packets within 120 calendar days of receipt. *Contract: 4.8.15.1*			
Findings: Amerigroup's Credentialing and Recredentialing policy for licensed, independent providers stated, **"**unless otherwise mandated by state regulation the requirement for timeliness of credentialing a physician or practitioner is 180 calendar days from the date the provider signs the attestation to the date of the credentialing committee's final decision." Staff reported that the decision time frame for the credentialing process started when the providers file was considered clean and the 120-day time frame for credentialing decisions did not begin until the providers file was considered clean by the corporate credentialing office. Completion time frames for credentialing decisions, according to NCQA, are counted back from the credentialing decision date to the date the provider signed the attestation. During the file review HSAG noted two provider files for which credentialing decisions had been made greater than 120 days from the attestation date. One was credentialed 187 days after receipt of the application, and another was credentialed 132 days after receipt of the application.			
Required Actions: As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, Amerigroup will no longer be responsible for credentialing and recredentialing the majority of providers in its network. The CMO should work with DCH to identify any needed actions based on HSAG's findings.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard I—Provider Selection, Credentialing, and Recredentialing

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

12. The Contractor shall provide training for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ, and attorneys ad litem about the requirements of the contract and needs of GF 360° members. These training sessions should also be open to DCH, DFCS, DJJ, and other sister agencies.

Addendum #1: 4.9.3.5

Findings: Amerigroup GF 360° staff members reported working with attorneys and judges to provide information and training during court staff meetings. The CMO provided an opportunity for law enforcement officials to complete training components via online training. There were no actual requirements for completing this training, and the CMO was unable to track who completed the training. Training staff reached out to police academies in Georgia to provide training for incoming cadets and set up information booths at conferences for judges and law enforcement. Amerigroup staff reported that the main obstacle was obtaining buy-in from law enforcement to complete this training. Amerigroup continued to build its GF 360° training plan and provided all identified entities with access to training. However, the CMO was unable to determine if this training was being completed or utilized.

Required Actions: Amerigroup must continue to work with law enforcement officials to provide face-to-face training opportunities and to develop tracking tools to identify which training modules are being completed, who is completing the training, and when it is being completed.

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

Standard IV—Member Information

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

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

42CFR438.10(f)(3)

Contract: 4.3.3.1 Contract: 4.3.3.2

Findings: For the AA population, Amerigroup staff confirmed that the member handbook was included in the new member packet. When the ID card production file was received by the vendor, a new member packet mailing label file was created, and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. For the FC/DJJP population, the member handbook was supplied in hard copy in the case worker's office. Amerigroup staff indicated that DCH approved its request to discontinue the annual mailing of the member handbook. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request. The policies submitted for review did not reflect how Amerigroup notified members that the handbook was available for review on its website or that the handbook could be mailed upon request.

Required Actions: Amerigroup must update its applicable policies to include a description of how the CMO notifies existing members (not newly enrolled members) that the member handbook was available on the CMO's website or how to obtain a hard copy. The policy and procedure must also reflect how often existing members receive the notice.

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

Standard IV—Member Information

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

22. For Foster Care (FC) and Department of Juvenile Justice Population (DJJP) members:

- The Contractor shall send electronically via secure methods an information packet to the DFCS case managers for members who are newly enrolled in the CMO within five calendar days of receipt of the eligibility file from DCH. Upon request, the CMO will mail the member information packet to the Foster Parent, Caregiver, Residential Placement Provider, or State Agency staff.

For Adoption Assistance (AA) members:

- The contractor shall mail the member information packet to the member/parent for members who are newly enrolled in the CMO within five calendar days of receipt of the eligibility file from DCH. The information packet shall include:
  - A welcome letter that includes the name and contact information for the GF 360° member's care coordinator.
  - GF 360° Member Handbook.
  - GF 360° member ID card.
  - A PCP change form.
  - A dentist change form.
  - Special health care needs/specific services needs form for which the CMO may need to coordinate services.
  - Information about the roles of the care coordination team and how to seek help in scheduling appointments, and accessing care coordination services.
  - Information about the role of the call center and how to access the call center.
  - Explanation of disenrollment procedures.
  - Information about 72-hour emergency prescription drug supply.
  - Information regarding the ombudsman liaison.
  - For FC members in DFCS custody in DeKalb and Fulton counties, information on Kenny A. health care requirements.
  - Information on the Ombudsman Liaison.

Addendum #1: 4.3.3.7

Findings: Amerigroup staff indicated that DFCS case managers were notified through electronic means when member ID cards were available on the Amerigroup website. The case manager logged into a secure portal and printed ID cards as needed. Amerigroup made member materials/new member packets available in hard copy at DFCS facilities, and the CMO mailed hard copies of member materials upon request from a FC/DJJP member's guardian.

According to the Member ID Cards policy and procedure, for AA members, once the ID card production file was received by the vendor, a new member packet mailing label file was created and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. The new member packet for AA members did not include the dentist change form.

Required Actions: Amerigroup must develop and implement a mechanism to provide all of the information listed in this element to new AA members.

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard V—Grievance System

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

10. An appeal (administrative review) shall be filed directly with the contractor or its delegated representatives. The Contractor may delegate this authority to an administrative review committee, but the delegation must be in writing.

Contract: 4.14.4.3

Findings: The Quality Management—Oversight of Delegated Activities policy and procedure indicated that processing of member complaints, grievances, and appeals was not delegated except in the case of dental and vision vendors. Amerigroup provided the Avesis (vision) contract amendment, which indicated that Amerigroup did not delegate appeals processing to Avesis. The Scion (dental) contract amendment indicated that Amerigroup delegated appeals processing to Scion. Although Amerigroup is in compliance with this element, the Quality Management—Oversight of Delegation Activities policy and procedure should be updated to reflect actual CMO practice (i.e., that the CMO's vision vendor is not a delegate for appeals processing).

Required Actions: Amerigroup must update its Quality Management—Oversight of Delegated Activities policy and procedure to reflect that the CMO's vision vendor is not a delegate for appeals processing.

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

Standard V—Grievance System

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

20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language.
42CFR438.406(a)(2)
Contract: 4.14.1.5

Findings: The Member Grievance Resolution procedure indicated that the member complaint specialist, within 10 business days of receipt of the grievance, would send an acknowledgement letter which was used to acknowledge the date of Amerigroup's receipt of the grievance. The procedure also indicated that the member would be notified in writing in his or her primary language. The Member/Provider Action and Administrative Review Process indicated that Amerigroup would send an acknowledgement letter within 10 business days of receipt of the request for administrative review. That process document also indicated that all written materials distributed to members would be available in alternative formats and that Amerigroup would notify the member regarding how to access those formats; however, the process did not indicate that the administrative review (appeal) acknowledgement letter would be sent "in the member's primary language." All 10 administrative review (appeal) files reviewed during the on-site audit met the acknowledgement timeliness requirement.

Required Actions: Amerigroup must modify its processes, procedures, and policies so that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language.

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

Standard V—Grievance System

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

22. The Contractor's appeal (administrative review) process must provide:

    (b) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent, must be given a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.)

42CFR438.406(b)(2)

Contract: 4.14.4.5

Findings: The Member/Provider Action and Administrative Review Process indicated that the member must be given the opportunity to present evidence and allegations of fact or law in person as well as in writing at any time during the standard or expedited administrative review process. However, Amerigroup's policy, member acknowledgement letter, and member handbook did not contain a process or information for advising the member of the limited time available for presenting evidence in the case of an expedited administrative review.

Required Actions: Amerigroup must develop and implement a mechanism to provide information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review.

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

Standard V—Grievance System

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

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

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

42CFR438.408(e)

Contract: 4.14.5.2

Findings: The Member/Provider Action and Administrative Review Process indicated that all notices of proposed action would meet the alternative language requirements and make all written materials available in English, Spanish, and all other prevalent non-English languages. The policy stated that materials would be worded in such a way to be understood by a person reading at a fifth-grade reading level. The notice of adverse action included each requirement listed in this element. The 10 administrative review (appeal) resolution letters reviewed included the required information; however, in some cases these letters did not meet the fifth-grade reading/understandability level. In several cases the rationale provided for upholding a denial was copied directly from the clinician reviewer notes or contained advanced medical terminology.

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

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

Standard VI—Disenrollment Requirements and Limitations

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

2. Contractor shall enroll FCAAP and DJJP members in the CMO upon receipt of the eligibility file from DCH.

Addendum #1:4.1.1.542CFR438.56(c)(i-iii)
Contract: 4.2.1.1

Findings: The Membership Load—Facets policy and procedure indicated that all members were enrolled using the "internal standard," which was identified as two business days, unless the market had a more stringent enrollment time frame, in which case Amerigroup would adhere to the State requirement. However, the policy also indicated that for the Georgia market, Amerigroup would adhere to the internal standard, which was two business days. During the on-site interview staff stated that members would be enrolled upon receipt of the eligibility file. Therefore, the policy and practice were in conflict.

Required Actions: Amerigroup must update its Membership Load—Facets policy to indicate that GF 360° program members are enrolled upon receipt of the eligibility file from DCH.

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

Standard VI—Disenrollment Requirements and Limitations

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

3. AA members may elect to disenroll without cause during the AA member Fee-For-Service Selection Period. AA members disenrolling shall return to the Medicaid FFS delivery system.

Addendum #1: 4.2.1.4

Findings: The Disenrollment procedure did not indicate that an AA member may disenroll without cause during the FFS selection period and return to the Medicaid FFS delivery system.

Required Actions: Amerigroup must change its policy to address voluntary disenrollment of AA members without cause during the FFS selection period and return the member to the Medicaid FFS delivery system.

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

Standard VI—Disenrollment Requirements and Limitations

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

4. The AA member may disenroll for the following cause at any time and return to the Medicaid FFS delivery system:
   - The Contractor does not, because of moral or religious objections, provide the covered services the AA member seeks.
   - The AA member needs related services to be performed at the same time, and not all related services are available within the network. The AA member's provider or another provider have determined that receiving services separately would subject the member to unnecessary risk.
   - Other reasons include, but are not limited to, poor quality of care, lack of access to services covered under the contract, or lack of provider's experienced in dealing with the member's health care needs.

Addendum #1: 4.2.1.5Addendum #1: 4.2.1.4

Findings: The Disenrollment procedure indicated that AA members may voluntarily disenroll for the reasons listed in the element; however, it did not specify that the member would be returned to the Medicaid FFS delivery system.

Required Actions: The CMO must update its policies and practices to ensure disenrolling AA members would be returned to the Medicaid FFS delivery system.

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

Standard VI—Disenrollment Requirements and Limitations

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

5. If there is a change in enrollment status for a GF 360° member's eligibility category to an ineligible category, and the member remains eligible for Medicaid, the member shall remain enrolled with the CMO as a non-GF 360° member until the member's next enrollment period, unless the member is eligible for supplemental security income (SSI); then the member will be returned to Medicaid FFS. The disenrollment will be processed within three business days of the date the GF 360° member's eligibility category actually changes and will not be made retroactively.

Addendum #1: 4.2.5

Findings: The Disenrollment and Member Load—Facets policy did not include information pertaining to a GF 360° member's enrollment status changing from an eligible to ineligible category.

Required Actions: Amerigroup must update its policies and practices to encompass the provisions and requirements pertaining to a GF 360° member's enrollment status changing from an eligible to ineligible category.

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

Standard VI—Disenrollment Requirements and Limitations

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

6. A member may request disenrollment from a CMO for the following reasons:
   - For cause at any time.
   - Without cause:
     - During 90 calendar days following the date of their initial enrollment or the day DCH or its agent sends the member notice of enrollment—whichever is later.
     - Every 12 months thereafter.
     - Upon automatic enrollment.

42CFR438.56(c)(i-iii)
Contract: 4.2.1.1

Findings: The Disenrollment procedure indicated that a member may voluntarily request disenrollment without cause at any time during the first 90 days after the initial enrollment date or the date DCH sent the member notice of the enrollment, whichever was later, and then every 12 months thereafter. The Disenrollment procedure did not indicate that a member may request disenrollment for cause at any time.

Required Actions: Amerigroup must change its Disenrollment procedure and GF 360° member handbooks to include a provision that the member may request disenrollment for cause at any time.

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