State of Georgia

Department of Community Health (DCH)

EXTERNAL QUALITY REVIEW OF COMPLIANCE WITH STANDARDS

for

AMERIGROUP COMMUNITY CARE

November 2015

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations (MCOs), 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]

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, and marked the second year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of Amerigroup Community Care's (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 seven performance categories. Six of the seven review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR 438.214–438.230, while the seventh area focused specifically on noncompliant standards

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

from the prior review period. 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
- Re-review of all *Not Met* elements from the prior year's review.

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

- Section 2—A summary of HSAG's findings regarding 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 completed review tool HSAG used to evaluate Amerigroup's performance in each of the areas identified as noncompliant from the prior year's review.
- Appendix C—The dates of the on-site review and a list of HSAG reviewers, DCH observers, and all Amerigroup staff members who participated in the interviews that HSAG conducted.
- Appendix D—A description of the methodology HSAG used to conduct the review and to draft its findings report.
- Appendix E—A template for 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 D—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 as well as the follow-up review.

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	**10**	**10**	**9**	**1**	**0**	**90.0%**
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	**20**	**20**	**19**	**1**	**0**	**95.0%**
V	Grievance System	**47**	**47**	**43**	**4**	**0**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**10**	**9**	**1**	**0**	**90.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**12**	**12**	**3**	**9**	**0**	**25.0%**
	Total Compliance Score	**112**	**112**	**96**	**16**	**0**	**85.7%**

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

**** Total # of Applicable Elements**: The total number of elements within each standard minus any elements that received a designation of *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 and the follow-up corrective actions recommended for Amerigroup.

Standard I—Provider Selection, Credentialing, and Recredentialing

Performance Strengths

Amerigroup maintained its 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, the CMO implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status.

HSAG reviewed 10 credentialing case files and noted that eight 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. Files were completed within 36 months of the initial or most recent credentialing/recredentialing decision, and the CMO used primary sources (i.e., Office of Inspector General [OIG] and State licensure boards) to verify licensure, credentialing, and exclusion 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 two 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.

Standard II—Subcontractual Relationships and Delegation

Performance Strengths

Amerigroup had an appointed CMO delegation designee who was responsible for providing findings and recommendations, identified by the corporate delegation designee, to the appropriate staff and committees. The CMO maintained its policies and procedures to ensure compliance with industry and State CMO standards. The CMO monitored delegate performance through ongoing

assessment of individual delegate functions and took corrective action when deficiencies were identified.

HSAG reviewed delegation files for three of the CMO's identified delegates. All of the delegation files contained a written agreement that specified delegated activities and reporting responsibilities, performance expectations, and options for addressing any deficiencies identified during annual reviews. HSAG noted that the CMO had reviewed all delegates, and all files were found to be 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 included its member rights and responsibilities in the member handbook, provider manual, and in its policy and procedure documents. To ensure members were aware of their rights, all members received the member handbook upon enrollment with the CMO, and it was also available on Amerigroup's website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights.

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 handbooks were provided to Amerigroup's members upon enrollment. The handbook was thorough and described member benefits, rights, responsibilities, both member and provider roles, what to do in case of an emergency, and the CMO's contact information. Member information was available for visually impaired and limited reading proficient members. The member handbook was also available in Spanish. Provider directories were available on Amerigroup's website and included provider office addresses, office hours, phone numbers, languages spoken, and if the provider was accepting new patients.

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.

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 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.

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 written 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, or health status. The possible reasons for disenrollment without cause were appropriately documented, and Amerigroup staff assisted the member with disenrollment paperwork if needed.

Areas Requiring Corrective Action

The Amerigroup Disenrollment procedure and member handbook did not include information indicating that members could request disenrollment for cause at any time. Both the procedure and handbook must be updated to include the required information.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

Amerigroup corrected three of the 12 elements that were re-reviewed during the on-site review. All elements related to Coverage and Authorization of Services were *Met* upon reevaluation.

Areas Requiring Corrective Action

The nine reevaluated elements (within the Furnishing of Services, Coordination and Continuity of Care, Clinical Practice Guidelines [CPGs], and Quality Assessment and Performance Improvement [QAPI] standards) that will require continued corrective action are as follows:

- Amerigroup must address timely access issues to ensure providers return calls after-hours within the appropriate time frames. The CMO must continue to apply current and new interventions until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved 90 percent of the time.
- Amerigroup did not meet the minimum geographic access requirements in both urban and rural areas. Specifically, the CMO did not have sufficient provider coverage for primary care physicians (PCPs), specialists, dental subspecialty providers, mental health providers, and

pharmacies. Amerigroup must continue its efforts to close its network adequacy gaps by implementing new network strategies, and keep DCH informed of its progress.

- Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. The CMO must develop a mechanism to evaluate the effectiveness of staff training. In addition, all auditing results should be documented and shared with applicable staff.
- Amerigroup must identify an implementation strategy to include time frames that clearly delineate the initiation and completion of its core system update. The CMO must provide this documentation to DCH and should work with DCH to identify when the CAP is completed.
- Amerigroup must continue to monitor provider compliance and corrective action when providers fail the audit to ensure that 90 percent of its providers use CPGs.
- Amerigroup must meet all of the DCH-established performance measure targets. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.
- Amerigroup must continue to incorporate DCH's suggested revisions and evaluate the overall effectiveness of its QAPI plan. The CMO should also ensure that it measures the effectiveness of the quality initiatives on the care provided to its membership, assesses its evaluation methods, and implements modifications as needed.

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**

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 specialize 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.	☒ **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**
	Evidence: 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	☒ **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
	Network (pg.1) Std.I-3 Avesis Credentialing Committee PnP (pg.2) 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:	☒ **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 Recred LIP (pgs. 9-21) 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 (pg.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 credentialing or recredentialing. 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 of 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 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's written 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 and Recred for LIP PnP (pgs. 1, 27, 30) 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**
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		

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
credentialing committee's final decision." Staff reported that the decision time frame for the credentialing process started when the provider's file was considered clean and the 120-day time frame for credentialing decisions did not begin until the provider's 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.		

Standard I—Provider Selection, Credentialing, and Recredentialing					
Met	=	9	X 1.00	=	9
Not Met	=	1	X .00	=	0
Not Applicable	=	0	*NA*		*NA*
Total Applicable	=	10	**Total Score**	=	9
Total Score ÷ Total Applicable				=	90%

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. HSAG noted that the written agreement with AIM® Specialty Health Outpatient Imaging Utilization Manager was a memorandum of understanding (MOU) and did not have language for revoking delegation or imposing other sanctions if the subcontractor's performance was inadequate. Amerigroup staff reported that the MOU was provided to DCH for review and approval. CMO staff provided the email that was sent to DCH on September 25, 2014. DCH reviewed and provided questions and feedback on the same date. The CMO sent a response to the DCH questions on 10/1/2014. The DCH made final language changes to page 4 of the MOU and approved the MOU for use with AIM® on 10/21/2014.		
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.	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	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
42CFR438.230(b)(3) *Contract: 16.1.3*	industry standards or state CMO laws and regulations. Evidence: Std.II.4 - Health Plan Oversight for Delegate Activities PnP (pgs. 1, 3-4) 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) Supplemental Documentation: 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)	

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: Amerigroup provided policies and procedures that met all aspects of this element. During the on-site audit, CMO staff reported the subject matter experts (SMEs) from the corporate office completed quarterly reviews of delegate performance. The SMEs completed the review and provided the findings to Georgia CMO staff for dissemination to appropriate staff members and committees. 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 (pg. 3-5) 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 an 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 a timeline was developed based on completion within 60 to 90 days. This information was provided to the vendor oversight team 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 submits a listing, including detailed contract information, for all of our subcontractors involved in the execution of the contract, including description of the subcontractor's organization and the responsibilities that are delegated to DCH biannually. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.6 - Subcontractor Agreement Report Q0414 Std.V.6 - Subcontractor Information Report Q314	
Findings: Amerigroup provided a listing of delegates that included detailed contact information, a description of the subcontractors' organizations, and delegated 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 - Vendor Selection and Oversight Program PnP (pgs. 7)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Amerigroup 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	=	0	***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 member handbook.		
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 associates 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	Amerigroup ensures that the rights outlined in this requirement are included in the member handbook. Evidence: Std.III.3. Member Rights and Responsibilities - GA	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
and privacy. ◆ 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*	Std.III.3. GAGA Rights and Responsibilities ENG Webpage – Amerigroup Link: (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 member handbook 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-	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	23) Grievance, appeal, law hearing - pgs.32-37 (PDF pgs. 38-43) 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 member handbook. Amerigroup staff indicated that members were given the member handbook upon enrollment and that it was 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 member handbook 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	Amerigroup uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
requirements are applicable. *42CFR438.224*	(HIPAA) as evidenced by the policies and procedures listed below. Each policy or procedure addresses a specific use or 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	

Standard III—Member Rights and Protections		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Std.III.6 - Minimum Necessary Requirements Procedure MBU Std.III.6 - Member Privacy Rights Procedure MBU – 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

Standard III—Member Rights and Protections					
Met	=	6	X 1.00	=	6
Not Met	=	0	X .00	=	0
Not Applicable	=		*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: Amerigroup staff confirmed that the member handbook was included in the new member packet. Once the ID card production file was received by the vendor, a new member packet mailing file was created, and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. 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) Std.IV.2 - MCD/PCFK/AA MEMBER HANDBOOK-	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	(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 member handbook directed members to the CMO's 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- Cover page, unmarked second page and marked p. 2 (PDF pgs. a, c, 2)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 handbook 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) Std.IV.4.- P4HB Member Handbook: Unmarked second page & marked pg. 2 (PDF pg. b, 2 & 8)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The member handbook 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 Flesh-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 Unmarked second page & marked p. 2 (PDF pg. 2 & 8)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The member handbook indicated that the member should call member services for verbal translation. The handbook 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 member handbook 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 member handbook 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 member handbook included information on the roles and responsibilities of the member and 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 member handbook 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 member handbook 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 member handbook 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 member handbook 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 handbook.		
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 member handbook 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 the State's Survey and Certificate Agency.	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
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 member handbook 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 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.		
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	Amerigroup's Member Handbook includes information in the Grievance System as outlined in this provision. Evidence:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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*	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)	
Findings: The member handbook 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 member handbook 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.		
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:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Std.IV.20 - PnP Written Materials and Guidelines (p. 2, 3) Std.IV.20 - Written Notice of Change to DCH	
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.		

Standard IV—Member Information					
Met	=	19	X 1.00	=	19
Not Met	=	1	X .00	=	0
Not Applicable	=		*NA*		*NA*
Total Applicable	=	20	**Total Score**	=	19
Total Score ÷ Total Applicable				=	95%

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 contractors' 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) Std.V.4 - Scion -Amerigroup Appeal PnP	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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's rights, 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, #12)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 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**

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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 was 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.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
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 Utilization Management (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).	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Evidence: 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**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 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.	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	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ The requirement that a member exhaust the Contractor's internal administrative review process. ◆ The circumstances under which expedited review is available and how 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*	Review Process – GA (pg. 3, 5-6) Std.V.16 - Denial Letter Services Update - Example	
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	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)	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
information that requires termination or reduction of services and indicates he or she understands that this must be the result of supplying that information. ◆ The member's whereabouts are unknown and the post office returns the 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*	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)	
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		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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)* *Contract: 4.14.3.4.5,*	For any denial of payments, Amerigroup will provide a notice of action at the time of any action affecting the claim. Evidence: 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	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Medical Denial Process—Internal procedure indicated that, for any denial of payment, Amerigroup would provide a Notice Of Action (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.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
(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. 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)	☒ **Met** ☐ **Not Met** ☐ **NA**
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 time frame 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.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 the member's health condition requires and no later than the date the extension expires. *Contract: 4.14.3.4.7*	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) 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)	☒ **Met** ☐ **Not Met** ☐ **NA**
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)	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.19 – P4HB Member Handbook– (pgs.32-34, PDF pgs.38-40)	
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 handbook.		
Required Actions: None.		
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**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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.		
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		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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. 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	☒ **Met** ☐ **Not Met** ☐ **NA**
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)	☐ **Met** ☒ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	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)	
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.		
(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.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 pgs.41-42) Std.V.22(d) - Authorized Representative Form	☒ **Met** ☐ **Not Met** ☐ **NA**
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	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	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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*	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)	
Findings: The Member/Provider Action and Administrative Review Process indicated that the expedited review process for appeals included all of the provisions 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)	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.24 – P4HB Member Handbook(pg.34, PDF pg.40)	
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 Letter Std.V.25 – P4HB Member Handbook (pg.35, PDF pg.41)	☒ **Met** ☐ **Not Met** ☐ **NA**
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**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 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*	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 Std.V.27 – Denial letter attachments	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Member/Provider Action and Administrative Review Process indicated that all notices of proposed action would meet the alternative language requirements and all written materials would be 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 the 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.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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) Std.V.28(a) – 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 appeal was received within 10 days of Amerigroup's mailing of the 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)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.V.28(b) – P4HB Member Handbook (pg.37,PDF pg.43)	
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.		
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.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 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*	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. 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)	☒ **Met** ☐ **Not Met** ☐ **NA**
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.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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.		
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**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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 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-		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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: 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)	☒ **Met** ☐ **Not Met** ☐ **NA**
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 42CFR438.10(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	=			*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 – P&P for 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 status, or pre-existing conditions, or need for healthcare services.		
Required Actions: None.		
2. 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.2. - Disenrollment – GA (p. 2) Std.VI.2.- MCD/PCFK/AA Member Handbook - pg. 43 (PDF pg.50) Std.VI.2.-P4HB Member Handbook– (pgs. 38-39, PDF pgs. 44-45)	☐ **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 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.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: Amerigroup must update its Disenrollment procedure and member handbook to include a provision that the member may request disenrollment for cause at any time.		
3. 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.3- 0652 Disenrollment Activity Notification M0615 Std.VI.3 -Disenrollment - GA (pgs. 3-5) Std.VI.3. MCD/PCFK/AA Member Handbook –(pg. 43, PDF pg.50) Std.VI.3. P4HB Member Handbook– (pgs. 38-39, PDF pgs. 44-45)	☒ **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.		
4. 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: Std.VI.4. - VI-Disenrollment – GA (pg.6, #8(b)) Std.VI.4 - Disenrollment Desktop Process (Entire Policy)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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.		
5. 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.5 - Disenrollment – GA (pg.5, #6) Std.VI.5 - GF Disenrollment Request Form Std.VI.5 - Disenrollment JAN 2015 Std.VI.5 - CM Disenrollment Letter (English).example Std.VI.5 - Disenrollment Desktop Process (pgs. 3-5) Std.VI.5 - Disenrollment Report 2014-2015 Std.VI.5 -Member Disenrollment Screenshot example Std.VI.5 - 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.		
6. 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; ◆ The member has any other condition as so defined by DCH; or ◆ The member has died, been incarcerated, or moved out of State, thereby	Amerigroup may request to disenroll a member for one of the reasons outlined in this provision. Evidence: Std.VI.6 - Disenrollment – GA (pg. 3-5) Std.VI.6 - GF Disenrollment Request Form Std.VI.6 - Disenrollment JAN 2015 Std.VI.6 - CM Disenrollment Letter (English).example Std.VI.6 - Disenrollment Desktop Process (pgs. 3-5) Std.VI.6- Disenrollment Report 2014-2015	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
making them ineligible for Medicaid. *Contract: 4.2.3*	Std.VI.6 -Member Disenrollment Screenshot example Std.VI.6 - 0652 Disenrollment Activity Notification M0615 Std.VI.6 - GA Screen shots for disenrollment information	
Findings: The Disenrollment procedure indicated the circumstances under which Amerigroup may request disenrollment, and they met the requirements for this element.		
Required Actions: None.		
7. 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.7 - Disenrollment – GA (pg. 5, #5) Std.VI.7 - CM Disenrollment Letter (English).example Std.VI.7 - 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.		
8. 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: Std.VI.8 - Disenrollment – GA (pg. 5, #6)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Std.VI.8 - CM Disenrollment Letter (English).example Std.VI.8 - Disenrollment JAN 2015 Std.VI.8 - Disenrollment Report 2014-2015 Std.VI.8- 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.		
9. 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.9 - Disenrollment – GA (pgs. 5-6) Std.VI.9 - Disenrollment Desktop Process (pg. 5) Std.VI.9- 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.		
10. 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.10 – Disenrollment Desktop Process (p.5) Std.VI.10 - GA Medicaid Provider Manual – pg. 75 (PDF pg.78)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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	=	1	X .00	=	0
Not Applicable	=		*NA*		*NA*
Total Applicable	=	10	Total Score	=	9
Total Score ÷ Total Applicable				=	90%

Appendix B. **Follow-Up Review Tool**

Following this page is the completed follow-up 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 B. State of Georgia
Department of Community Health (DCH)
Follow-Up On Reviews From Previous Noncompliant Review Findings
for Amerigroup Community Care

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

- Intervention(s) planned by your organization to achieve compliance with the requirement
- Individual(s) responsible for ensuring that the planned interventions are completed
- Proposed timeline for completing each planned intervention

This plan is due to DCH no later than 30 calendar days following receipt of this 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 II—Furnishing of Services

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

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines—Returning Calls After-Hours:** *Contract 4.8.14.4*

The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: Amerigroup monitors timeliness of returned calls after hours and provided its GA After-hours Survey document as evidence. The CMO's providers did not meet the requirements to return urgent calls within 20 minutes or routine calls within one hour.

Required Actions: The CMO needs to continue its monitoring activities and ensure providers return urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will continue monitoring activities of providers regarding urgent and other call timelines in accordance with contractual requirements. Providers are monitored through our quarterly survey process regarding timely access standards. Amerigroup's current policy includes in-office education and corrective action for those providers that do not meet waiting maximums and appointment requirements as outlined in the contract. In addition we monitor any member complaints and address any identified concerns. In an effort to	Coordination of monthly secret shopper calls to monitor progress. Hiring of additional resources to assist with face to face meetings. Interventions related to sole providers in Rural areas as it relates to auto assignment of members.	**Michelle Rush**	By 6/1/2015, we expect to see an improvement with compliance of this report. **Update**: We continue to monitor activities of providers regarding urgent and other call timelines in accordance with contractual requirements. Implementation of some interventions were delayed. We determined that the mode of operation to influence behavioral changes in the physicians was not sufficient by hosting web-ex trainings alone. We are acquiring additional resources (i.e. new consultants) that will conduct face to face trainings with those providers that have consecutively failed the after-hours access survey with no shown improvement. Additionally, the implementation of the removal of failed providers from the auto assignment algorithm has been delayed to take into account those providers that are failing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
increase compliance with these standards, Amerigroup will begin to remove providers from the auto assignment algorithm to prevent auto- assignment of new members. This however, will not prohibit a member from selecting a specific provider. In the event a provider fails repeatedly and they are the sole provider in a community, we will have a practice management consultant work with them in an attempt to: ◆ Develop after hour's efficiency by working with the practice to provide access to routine and urgent-care appointments outside regular business hours. ◆ Provide continuity of medical record information for care and advice when the office is not open. ◆ Provide timely clinical advice using a secure, interactive electronic system when the office is not open and documenting after-hours clinical advice in patient records. For those providers that have failed the survey, Amerigroup will conduct monthly lunch and learn sessions to			because they are the only provider available in Rural areas. Therefore, the new date of implementation for both will be 8/15/15 as we operationalize this process to take into account the impact it will have on those sole providers in Rural areas. With regard to the practice management consultant working with those providers that fail the survey repeatedly, we will use our current share point tracker as a source to identify providers allowing the assignment of team members for specific provider outreach to review the following PCMH standards: ◆ Develop after hour's efficiency by working with the practice to provide access to routine and urgent-care appointments outside regular business hours. ◆ Provide continuity of medical record information for care and advice when the office is not open. ◆ Provide timely clinical advice using a secure, interactive electronic system when the office is not open and documenting after-hours clinical advice in patient records. The goal is to enhance the providers' efficiency in scheduling and managing appointment availability**.**

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
educate providers on their responsibilities to return calls within contractual timeframes and assist with strategies to ensure that the providers meet the requirement as outlined in our DCH contract. Amerigroup will continue to send quarterly fax blasts to the entire network outlining the contract requirements specific to the availability and accessibility requirements. We have seen consistent improvement in our survey results. Our aggregate total for after-hours calls in 2014 was 86% for Urgent and Routine calls returned. We will continue to monitor this measure in 2015.			
Other Evidence/Documentation: Std.II.1 Furnishing of Services – CAP 2014-2015 1 After hours screen print II Std.II.1 Furnishing of Services – CAP 2014-2015 1 Michael Deal – Evidence After hours CAP Std.II.1 Furnishing of Services – CAP 2014-2015 1 NART – example Std.II.1 Furnishing of Service CAP 2014-2015 1 NART – continued Std.II.1 Furnishing CAP 2014 15 #1 After Hrs Results 15Q2-14Q3 Std.II.1 Furnishing CAP 2014-15 #1 Availability Standards_Will Cover_Pg2 Std.II.1 Furnishing CAP 2014-2015 #1 GAPEC 0912-15 Invitation 062415 Std.II.1 Furnishing CAP 2014-15 # 1 Facilitator Guide Availability Standards Requirements Std.II.1 Furnishing CAP 2014-15 #1 New Provider Orientation Pgs 2_12			
July 2015 Re-review Findings: The after-hours survey results indicated that 85 percent of providers that were surveyed in quarter 1, 2015, returned urgent calls within 20 minutes. This rate was 5 percentage points higher than quarter 1, 2014. The after-hours survey also indicated that 88 percent of providers surveyed in quarter 1, 2015, returned routine calls within 60 minutes, which falls just below the 90 percent goal. Compared to the quarter 1, 2014 survey, Amerigroup improved this rate by 3 percentage points.			

Standard II—Furnishing of Services

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

July 2015 Required Actions: Amerigroup must continue to apply current and new interventions with providers until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved 90 percent of the time.

Standard II—Furnishing of Services

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

5. Geographic Access: *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO monitored the appropriate geographic access standards, but the CMO did not meet all of the standards in this element. Amerigroup submitted a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- Dental subspecialty providers
- Mental health providers
- Pharmacies

The CMO was also deficient in time/distance evaluation related to general dental providers in rural areas.

Required Actions: The CMO must meet the geographic standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, mental health providers, and pharmacies, and for general dental providers in rural areas.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
Amerigroup will continue its efforts to add providers to our network to meet all geographic standards as outlined in our contract. Amerigroup completes a quarterly deficiency report detailing all areas where we are not meeting access and what actions have been taken. Currently, we have (716) specialties that fall into DCH CAP code (1) – "*providers do not exist within contract access standard"*. As a continuation of AGP industry setting telemedicine strategic interventions, we will continue to support the proliferation of telemedicine sites within the public school environment. Telemedicine is one access point in the cadre of our initiatives to ensure access for our members. Although a member may not have a pediatric rheumatologist within 30 miles or even 45 miles of their home, AGP has ensured that those members get access to those services if needed by providing access via telemedicine providers. As part of the Georgia Tele health network, AGP has access to all presentation sites and all boards of health throughout the state in its entirety. NET services are also coordinated as needed. In the counties where providers do not exist or have a Medicaid ID number to participate in GA Families, we will continue to encourage their participation in Medicaid and continue our	Expansion of Telemedicine Presentation sites Targeted recruitment	**Urcel Fields**	**12/31/2015 (This is an ongoing process)** **Update:** Through our efforts, we have seen the expansion of Telemedicine by the additional presentation sites. Furthermore, our Network Relations Consultants have been provided targeted recruitment lists for outreach to providers to join the Georgia Partnership for Telemedicine Network with particular emphasis on recruiting pediatric sub-specialties (pediatric endocrinology). These interventions have generated additional access points to assist with areas in which we are not meeting all geographic standards due to the lack of provider availability.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
practice of quarterly outreach to providers that have chosen not to accept Medicaid members. Amerigroup recognizes the public health implications for the areas that do not have providers available. We use multiple sources to determine if providers are available which includes but is not limited to non-Medicaid publicly available provider networks and published provider compendiums. As such, it is our assessment that the further proliferation of Tele-Health will ease access concerns for some of our rural communities. Furthermore, we will continue our practice of constantly monitoring the DCH provided 7400 file for new Medicaid providers.			
Other Evidence/Documentation: Std.II.5 New Par Providers 1.1.15-6.1.15			
July 2015 Re-review Findings: HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories: ◆ PCPs ◆ Specialists ◆ Dental subspecialty providers ◆ Mental health providers ◆ Pharmacies The CMO was also deficient in time/distance evaluation related to general dental providers in rural areas.			
July 2015 Required Actions: The CMO must meet the geographic standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, mental health providers, and pharmacies, and for general dental providers in rural areas. Amerigroup must continue its efforts to close its network adequacy gaps by implementing new network strategies, and keep DCH informed of its progress.			

Standard IV—Coordination and Continuity of Care

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

8. Care Coordination Functions: *Contract 4.11.8.1*

In addition to the above requirements, the CMO's care coordination system includes the following related and additional functions:

- Case Management
- Disease Management
- Transition of Care
- Discharge Planning

Findings: Amerigroup provided policies and procedures outlining case management, disease management, transition of care, and discharge planning activities. However, during the file review HSAG was unable to identify that the case manager talked with the provider pre- or post-discharge. The audit team was also unable to identify specific discharge orders for members who had been hospitalized while in case management.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's electronic health record (EHR).

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure completion of all identified discharge protocols, Amerigroup will conduct a training session for all case management and concurrent review nurses on the discharge planning requirements. The training will include demonstrations of competence in each step of the discharge planning process. All associates will be trained using the Discharge Planning Documentation Standards and understand how to document within the core case management system. The documentation standards link to the members' EHRs (where available) and identifies all of the discharge planning activities that will occur prior to the member leaving the inpatient setting. The concurrent review nurse collaborates with the case management nurse to	Discharge Planning Auditing	Lisa Ross-Jones Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-

Standard IV—Coordination and Continuity of Care			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
ensure the discharge documentation is obtained from the facility and uploads it into the core member documentation system. We will monitor cases through the monthly auditing process to demonstrate adherence to these requirements. Associates that fail to meet these standards will be performance managed. Performance management consists of the following: ◆ 1:1 counseling with their manager ◆ A performance plan which indicates the steps for correction and timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement Policy. During discussion with DCH a potential solution was identified regarding discharge plans that cannot be obtained from facilities as requested. We discussed the opportunity to add the CMS transitional care form as part of the GMCF portal requirement. Adding this form to the portal will make it a mandatory requirement to complete this information in an electronic format and an automatic compliance requirement for completing discharge information. AGP will work directly with DCH in getting this initiative executed.			training was provided during the next staff meeting on May 13, 2015. During this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was delayed beyond the March timeframe and occurred as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015 ◆ Will continue to work with DCH on an electronic solution through the GMCF portal for transition of care/discharge forms.

Standard IV—Coordination and Continuity of Care

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

Other Evidence/Documentation:
The referenced documents demonstrate compliance with this action item.
Std.IV.8. - Example of Discharge Planning Audit_June 2015
Std.IV.8 - Example of Discharge Planning Audit_May 2015
Std.IV.8 - Discharge Audit Grid
Std.IV.8 - Discharge Planning Training_June 2015
Std.IV.8 - Hospital Discharge Orders_June Audit
Std.IV.8 - CM Desk Top Policy_Discharge Planning
Std.IV.8 - CM Discharge Notes_June Audit
Std.IV.8 - CM Discharge Notes_May Audit
Std.IV.8 - Discharge Plan Training_ 5.13.14
Std.IV.8 - Hospital Discharge Orders_May Audit
Std.IV.8 - Discharge Stabilization Audit Tool Desktop Policy
Std.IV.8 - Combined audit tool_CAPS 2015
Std.IV.8 - Discharge planning BH training 3_18_15
Std.IV.8 - Discharge planning BH training 5_06_15
Std.IV.8 - UM Conference Agenda (1)
UM Conference Power Point
Std.IV.8 - UM Team Meeting
2nd Example of Discharge Planning Audit June 2015

Discharge Planning Audit Results- All CM Benchmark is> =90%		
Month	**Results**	**Comments**
May	**16%**	**Some of the cases audited in May were created prior to the Discharge Planning training which impacted the low passing rate**

Standard IV—Coordination and Continuity of Care			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
June	**100%**	**Reauditing conducted in June resulted in 100% pass rate due to the Discharge Planning training conducted in May 2015 & June 2015**	
July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff compliance with transitions of care/discharge planning.			
July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.			

Standard IV—Coordination and Continuity of Care

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

9. Case Management—Components: *Contract 4.11.9.1-2*

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:

(c) Development of a care plan.

Findings: During the case file review, it was identified that care plans were developed based on the assessment; staff reported that the member's agreement to the care plan showed that the care plan was member-centered. One area of improvement would involve developing a member-centered care plan that included member, family, and/or provider input. After a review of the care plan document, it was identified that the care plan does not have a start date, review date(s), and/or date of change/update(s). HSAG was unable to determine when the care plan was developed, or when (or if) it was updated or reviewed.

Required Actions: Amerigroup should use the comprehensive assessment as an adjunct document when developing the care plan. Primary input into care plan goal(s) should come from the member, member's provider, and family/guardian/caregiver in the care plan development process. Amerigroup needs to document the care plan start date, review date, and/or date of changes/updates to the care plan.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup's core case management system is managed and created by the larger organization of Amerigroup/Anthem and used in all markets. Changes to the system are based upon approval by the senior leadership team of Amerigroup/Anthem. Based on feedback from DCH, Amerigroup will make the following suggestions as an update request to the core system: ◆ Assessment templates with specific sections for member, provider and family input. ◆ Advanced customization that will allow the ability to create care plans uniquely catered to the identified member.	Case Management Audits	Lisa Ross-Jones	3/31/15 ◆ Training on any updates to the current case management system will be dependent on the changes being accepted by corporate and the timeline for implementation. Suggestions have been made to the corporate clinical systems team but updates have not been approved at this time. Will continue to

Standard IV—Coordination and Continuity of Care			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
◆ Automatic system alerts that prompt the case manager to review and make revisions to the member's care plan. Until the new system is functional, the case management team will be retrained on the requirements for care plan documentation by the Director for Care Management/CM Team Leader with the training scheduled to be completed by March 31, 2015. The CM leader will ensure that all required input is obtained for the care plan and that start and end dates along with review dates are documented on the care plan. The CM Auditing lead will conduct random audits of the care plans on a monthly basis to ensure the case managers are compliant with the documentation requirements for care plans and will provide immediate follow up to non-compliant case management team members. Associates that fail to meet these standards will be performance managed which consists of the following: ◆ 1:1 counseling with their manager. ◆ A performance plan which indicates the steps for correction and a timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement follows the steps outlined in the Corporate Conduct and Performance Improvement Policy.			monitor through corporate workgroup meetings. **Update:** ◆ At this time a proposed date for implementation has not been offered. We will continue to monitor through our corporate workgroup meetings. ◆ Care plan training occurred on 4/14/15 and was hosted by our corporate Performance Improvement and Enhancement team. During this training session we discussed the requirements needed for documentation within Care Compass (our internal case management system) to ensure that the cases meet quality indicators as well as NCQA requirements.

Standard IV—Coordination and Continuity of Care

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

Other Evidence/Documentation:
The referenced documents demonstrate compliance with this action item.
Std.IV.9 BH Care Planning Example with Start Date_Review Date_Updates
Std.IV.9 CareCompass Care Planning Training 04.12.2015
Std.IV.9 OB Care Planning Example with Start Date_Review Date_Updates
Std.IV.9 Training Attendance List_April 2015
Std.IV.9Training Attendance List_June 2015

July 2015 Re-review Findings: Amerigroup staff members reported that they were working with the corporate office to revise the CMO's core systems based on recommendations and feedback from DCH. No date for implementation of these changes had been identified.

July 2015 Required Actions: Amerigroup must identify an implementation strategy to include time frames that clearly delineate the initiation and completion of the core system update. The CMO must provide this documentation to DCH and should work with DCH to identify when the CAP is completed.

Standard IV—Coordination and Continuity of Care

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

12. Discharge Planning: *Contract 4.11.11*

The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: Amerigroup provided policies and procedures that identified the CMO's formalized discharge planning program. However, during the case file review HSAG was unable to identify any discharge planning for members who had been hospitalized.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's case notes.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure completion of all identified discharge protocols, Amerigroup will conduct a training session for all case management and concurrent review nurses on the discharge planning requirements. The training will include demonstration of competence in each step of the discharge planning process. All associates will be trained using the Discharge Planning Documentation Standards and understand how to document within the core case management system. The documentation standards link to the members "EHRs (where available) and identify all of the discharge planning activities that will occur prior to the member leaving the inpatient setting. The concurrent review nurse collaborates with the case management nurse to ensure the discharge documentation is obtained from the facility and uploads it into the core member documentation system. We will monitor cases through the monthly auditing process to demonstrate adherence to these	Discharge Planning Auditing	Lisa Ross-Jones Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-training was provided during the next staff meeting on May 13, 2015. During

Standard IV—Coordination and Continuity of Care			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
requirements. Associates that fail to meet these standards will be performance managed which consists of the following: ◆ 1:1 counseling with their manager ◆ A performance plan which indicates the steps for correction and a timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement policy.			this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was delayed beyond the March timeframe and occurred as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015
Other Evidence/Documentation: The referenced documents demonstrate compliance with this action item. Std.IV.12 - Example of Discharge Planning Audit_May 2015 Std.IV.12.- Example of Discharge Planning Audit_June 2015 Std.IV.12 - Discharge Audit Grid Std.IV.12 - Discharge Planning Training_June 2015 Std.IV.12 - Hospital Discharge Orders_June Audit Std.IV.12 - CM Desk Top Policy_Discharge Planning Std.IV.12 - CM Discharge Notes_June Audit Std.IV.12 - CM Discharge Notes_May Audit Std.IV.12 - Discharge Plan Training_ 5.13.14 Std.IV.12 - Hospital Discharge Orders_May Audit			

Standard IV—Coordination and Continuity of Care

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

Std.IV.12 - Discharge Stabilization Audit Tool Desktop Policy
Std.IV.12 - Combined Audit Tool_CAP
Std.IV.12 - Discharge planning BH training 3_18_15 (1)
Std.IV.12 - Discharge planning BH training 5_06_15
Std.IV.12 - UM Conference Agenda (1)
Std.IV.12 – Example 2 June Discharge Audit
UM Conference Power Point Final
Std.IV.12 - UM Team Meeting
2nd Example of Discharge Planning Audit June 2015

July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff.

July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.

Standard V—Coverage and Authorization of Services

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

12. Timelines—Standard Authorization Decisions and Notifications: *42 CFR 438.210(d)(1); Contract 4.11.2.5.1; 4.14.3.4.5*

The CMO makes prior authorization decisions and provides notice to the provider and member for non-urgent services as expeditiously as the member's health care condition requires and within 14 calendar days of receipt of the request for service.

Findings: The written documentation and staff interviews demonstrated compliance with this element. Overall, the CMO demonstrated compliance with the required turnaround times for a standard prior authorization request. During file review, it was noted that a pharmacy prior authorization request was not decided within the 24-hour time frame. The final medical director review occurred beyond the time frame. The Prior Authorization Aging Report was reviewed to ensure monitoring and oversight of prior authorization request time frames.

Additionally, during file reviews it was noted that Avesis had implemented an electronic document management system, reducing or eliminating most of the manual processing of requests, representing an important process improvement.

Required Actions: The CMO needs to enhance monitoring of the pharmacy decision time frames and ensure staff visibility to aging requests.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
During the audit, it was demonstrated that Amerigroup's monitoring process includes the use of a Prior Authorization tool which quickly identifies each request as either "Standard" or "Urgent". All urgent requests are placed at the top of the queue, whether it is in a CST, RPh or Medical Director queue. This prioritizes urgent cases and allows them to be reviewed and closed first. Also, there is a "clock"/"time received stamp" for each prior authorization request stating when the request was received. This will allow anyone to determine where in the 24-hours the request is. The current Prior Authorization system was enhanced as a result of audit findings. This upgrade has resulted in the creation of two distinct work queues, one for standard Prior Authorizations and the other for	Monitor the Prior Authorizations progressing through the PAR Tool with specific attention to 24 hour TAT urgent requests and 24 hour TAT market requirement requests. Escalate communication to RPh, MD and Dir. Pharmacy Operations appropriately for any Prior Authorization Request with a TAT close to expiring (Per Procedure A-60).	**Robert Dinwiddie** **Kelli Ferrell** **Christopher Monette**	6/30/2015 (current process in place now)

Standard V—Coverage and Authorization of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
those requests with a known 24-hr turnaround time requirement. This upgrade will separate standard Prior Authorizations from those with a 24-hour turnaround time request allowing for easy identification and review as priority.			
Other Evidence/Documentation: Std.V.12 – Prior Authorization Monitoring in PAR Tool (Policy#A-60) Std.V.12 – Prior Authorization Monitoring in PAR Tool screen shot			
July 2015 Re-review Findings: Pharmacy staff reported that monitoring of prior authorizations was completed through the PAR Tool, with specific attention to 24-hour urgent requests and 24-hour market requirement requests. Review of documentation provided by Amerigroup showed the enhancements made to the CMO's pharmacy monitoring system. These system enhancements allowed for CMO staff to have real-time access to data concerning pharmacy decision time frames and ensured that staff had visibility to aging requests.			
July 2015 Required Actions: None.			

Standard V—Coverage and Authorization of Services

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

14. Timelines—Expedited Authorizations Decisions and Notifications: *42 CFR 438.210(d)(2)(i); Contract 4.11.2.5.2*

If the provider indicates, or the CMO determines, that following the standard timeframes could seriously jeopardize the member's life or health, the CMO makes an expedited authorization determination and provides notice within 24 hours.

Findings: The CMO received requests marked "urgent" and reached out to the provider to determine whether the request was a true expedited request or a request of provider convenience. The CMO would not issue a written notice to the member if it denied a request for an expedited review; the provider would be notified.

Required Actions: The CMO needs to develop a notice of action (NOA) for members, to address denial of a request for an expedited review.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In review of Amerigroup's current process, it was identified that the current process was deficient as it contained informal processes related to expedited reviews that were not available in the written formal policy. To correct this, Amerigroup will create a departmental procedure that outlines its process on communication and documentation with providers regarding authorization requests that may have more appropriately met the standard request definition but was submitted as expedited and how it is managed in the authorization process. This departmental procedure will include the specific criteria of how Amerigroup will work with the providers to clarify expedited vs. standard service requests.	Creation of new departmental desktop procedure	Bridget McKenzie	3/31/15 ◆ New Departmental procedure created to outline the process as per the intervention as of 3/31/15. Training for the new process for all associates will be completed as part of all departmental staff meetings in April. ▪ Training of the expedited authorization request from provider's process occurred on 4/14/15 and 4/22/15.

Other Evidence/Documentation:
Std.V.-. Provider Modification of Expedited Authorization Request
Std.V. - CCU Expedited Request employee acknowledgement agenda

Standard V—Coverage and Authorization of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
Std.V. - Expedited authorization policy training 4.16.15 OP BH agenda Std.V.14 - CCRN Expedited Training Agenda Std.V.14 - Expedited Auth Decisions and Notifications 4_29_15 BHUM agenda Std.V. - Desktop Process for Denial of Svc-BHUM 1_07_15 acknowledgement Std.V - CCRN Agenda 3-11-15 Std.V - CCRN Agenda 3-12-15 Std.V - Denial Process Training- BH acknowledgement Std.V - The Desktop Process for Denial of Services_CCU Training acknowledgement Std.V - UM Conference 2015 PP March 2015 Std.V. - UM Denial letter audit example Std.V. – Provider Modification of Expedited Authorization Request
July 2015 Re-review Findings: Amerigroup, via the corrective action process with DCH, updated its policy and procedure regarding provider requests for expedited decisions. Specifically, if Amerigroup denies a provider's request for the CMO to make an expedited decision, it is not necessary to send a notice of action. During the on-site audit, Amerigroup provided the email from DCH approving the updated policy and procedure.
July 2015 Required Actions: None.

Standard V—Coverage and Authorization of Services

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

24. Notice of Action—Decisions Not Reached Within the Required Timeframes: *42 CFR 438.404(c)(5) and (6); Contract 4.14.3.4.8*

For both standard and expedited authorization decisions not reached within the required timeframes according to 4.11.2.5, the CMO mails the notice of action on the date the timeframe expires, as this constitutes a denial and is thus an adverse action**.**

Findings: The written policy and staff interviews demonstrated compliance with the element. During staff interviews it was indicated that the CMO's practice was to approve, not deny, for decisions not reached within the required time frame. The explanation for this practice was that expiration of the time frame would be of no fault to the member and the CMO would not penalize the member by issuing a denial.

Required Actions: The CMO needs to operationalize the Denial of Services desktop process as outlined on pages 4 and 16 of the process document.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Effective immediately and upon audit findings, Amerigroup operationalized the written policy for both standard and expedited authorization decisions not reached within the required timeframe and in accordance with contract section 4.14.3.4.8 to demonstrate its compliance with federal and state law. Re-education of our UM teams will occur within the next 60 days. We will monitor compliance of this requirement through our UM auditing process and associates who do not adhere to the policy will be corrected through the performance improvement process. The performance process consists of the following: ◆ Weekly meetings with the identified associate to review current progress ◆ Documentation of action steps for the associate and manager. ◆ Continued failure to meet the required standards leads to the next level of performance management which may	Retraining of team and Auditing For timeliness of decisions.	**Bridget McKenzie**	Re-education of all associates on the denial process for both expedited and standard authorizations was completed on 1/7/15, 3/4/15 and 3/12/15 and compliance is measured during the auditing process.

Standard V—Coverage and Authorization of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
include termination. This performance improvement process follows steps outlined in the Corporate Conduct and Performance Improvement policy.			

Other Evidence/Documentation:
Std.V. - Provider Modification of Expedited Authorization Request
Std.V - CCU Expedited Request employee acknowledgement
Std.V - Expedited authorization policy training 4.16.15 OP BH agenda
Std.V. - CCRN Expedited Training Agenda
Std.V. -Expedited Auth Decisions and Notifications 4_29_15 BHUM agenda
Std.V. - Desktop Process for Denial of Svc-BHUM 1_07_15 acknowledgement
Std.V- CCRN Agenda 3-11-15
Std.V - CCRN Agenda 3-12-15
Std.V - Denial Process Training- BH acknowledgement
Std.V - The Desktop Process for Denial of Services_CCU Training acknowledgement
Std.V - UM Conference 2015 PP March 2015
Std.V. - UM Denial letter audit example
Std.V CCRN NOFA Agenda 1-29-15
Std.V. CCRN NOFA Agenda 3-4-5

July 2015 Re-review Findings: During the on-site interview staff reported that the additional process that was used during the SFY 2014 review was no longer being used. Staff members were following the 14-day time limit for decisions, and the current process was being followed. Policies and procedures reviewed by HSAG identified the appropriate time frames for decisions, and training provided by the CMOs identified the correct time frames for decisions.

July 2015 Required Actions: None.

Standard I—Clinical Practice Guidelines

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

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

Contract: 4.12.7.5

Findings: Amerigroup provided its Clinical Practice Guideline Compliance Monitoring report for January–December 2013. This report was due to the State in July 2014, but was not final. It indicated that providers were not in compliance with the CMO's Attention Deficit Hyperactivity Disorder (ADHD) CPG goal.

Required Actions: The CMO must ensure that 90 percent of providers are compliant with Amerigroup's CPGs.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will continue to monitor and educate providers of CPG compliance in an effort to ensure adherence to requirements. On April 1, 2014, the health plan moved from annual to quarterly CPG monitoring for providers. Medical records are requested from a random sample of providers who bill for services with diagnosis codes for the CPG's monitored (i.e. ADHD, Diabetes etc.) and are reviewed in house by licensed nurses. Written feedback is provided to the practitioner on compliance to guidelines. If a provider does not meet the 80% passing score they are issued a corrective action plan. Providers that are non-compliant will: ◆ Receive a letter notification with a copy of the CPG's and other resource materials ◆ Develop and submit a corrective action plan that will be monitored by Amerigroup for compliance within 14	Monitored and educated providers of CPG compliance in an effort to ensure adherence to requirements. Moved to quarterly CPG monitoring for providers. Providers that do not meet the 80% passing score they will: ◆ Receive a letter notification with a copy of the CPG's and other resource materials ◆ Develop and submit a corrective action plan that will be monitored by Amerigroup for compliance within 14 days of notification. ◆ Be re-audited quarterly to ensure that they are in compliance. ◆ If those providers remain non-compliant after, the re-audit, they will be referred to the Peer Review Committee for review and recommendation.	Yvette Terry	6/30/2015

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
days of notification. ◆ Be re-audited quarterly to ensure that they are in compliance. • If those providers remain non-compliant after, the re-audit, they will be referred to the Peer Review Committee for review and recommendation. Clinical Practice Guidelines are evidence based recommendations that assist providers with patient decisions regarding care. Amerigroup follows guidance on creating CPG's from nationally reviewed literature, data and evidence or adopts existing guidelines. These guidelines are reviewed by our corporate entity and approved locally by our MAC committee. Recommendations for changes may come from the committee and be incorporated into the CPG. The CAP process has been effective in evaluating the root causes for why CPG's are not always followed. Using an approach similar to the Health Check Audit process that increased Health Check compliance overall from 91% in 2011 to 97% in 2014, the number of unique CPG indicators increased from 22 in 2011 to 26 in 2014. The overall CPG compliance rate increased 12 % from 64% in 2012 to 76% in 2013. The increase was driven primarily by improved compliance with the DM CPG. Further improvement in DM CPG compliance will help us get to the 90% goal. Provider feedback is discussed internally to			

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
determine any opportunities for education to all providers. We have identified that there are differing opinions in the provider community regarding ADHD guidelines and drug holidays. The most frequently cited study was conducted by Martins and colleagues.[1] This study of 40 children showed that weekend holidays from methylphenidate treatment tended to reduce insomnia and appetite suppression, and did not significantly increase ADHD symptoms on weekends (as reported by parents) and on the Monday in school following the drug holiday (reported by teachers). (Marins S, Tramontina S, Polanczyk G, Eizirik M, Swanson J, Rohde L. Weekend holidays during methylphenidate use in ADHD children: a randomized clinical trial. J Child Adolesc Psychopharmacol. 2004; 14:195-206,). Amerigroup has taken the lead in scheduling a meeting with the Quality Committee of the Georgia Chapter of the American Academy of Pediatrics to discuss the potential impact of these data on the CPG. Lastly, Amerigroup has worked directly to increase the number of practices with PCHM designation. The PCMH model includes a commitment to high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management and CPG adherence. Frequent auditing, timely follow up on corrective action plans and re-auditing efforts in addition to			

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
sharing audit results and opportunities for improvement with the entire network will help to achieve this requirement.			
Other Evidence/Documentation: Std.VI.6 CPG re-audit #1 Std.VI.6 CPG re-audit #2 Std.VI.6 2015 Clinical Practice Guidelines Audit Results (1) Std.VI.6. 2015 GF 360 Clinical Practice Guidelines Audit Results Std.VI.6 Clinical Practice Guidelines Measuring Practitioner Compliance Std.VI.6 Screenshot of CPG re-audit database			
July 2015 Re-review Findings: Amerigroup provided its Clinical Practice Guideline Compliance Monitoring report for quarter 3, 2014 (86 percent), quarter 4, 2014 (76 percent), and quarter 1, 2015 (86 percent), along with its CY 2014 annual analysis, which indicated 86 percent compliance. Comparatively, the CY 2013 annual analysis showed a rate of 76 percent compliance, indicating Amerigroup increased its CPG compliance rate by 10 percentage points.			
July 2015 Required Actions: The CMO must continue to monitor provider compliance and corrective action when providers fail the audit to ensure that 90 percent of providers are compliant with Amerigroup's CPGs.			

Standard II—Quality Assessment and Performance Improvement

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

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: Amerigroup did not meet all of the DCH-established performance goals for CY 2013. The following deficiencies were noted:

Measure	CY2013 Targets	Amerigroup CY2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE—6 or more visits (HYBRID)	70.70	63.59
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	90.55
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	81.38
CHILDHOOD IMMUNIZATION STATUS—Combo 3	82.48	80.56
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	81.71
WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION & PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (HYBRID)		
Total Nutrition	54.88	54.63
CERVICAL CANCER SCREENING (HYBRID)	78.51	69.34
PRENATAL AND POSTPARTUM CARE (HYBRID)		
Timeliness of Prenatal Care	90.39	75.92
Postpartum Care	71.05	60.78
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	52.98
CHLAMYDIA SCREENING IN WOMEN	58.40	52.81
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.70
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	90.56	88.79
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HbA1c test	87.01	80.50
HbA1c Control <8%	48.72	35.11
HbA1c control <7%	36.72	27.71
Eye Exam	52.88	43.97
LDL Screen	76.16	73.23
LDL Control	35.86	26.95
Attention to Nephropathy	78.71	73.94
BP Control <140/80 mm Hg	39.10	30.85
BP Control <140/90 mm Hg	63.50	53.19
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	43.12
Continuation	63.11	59.22
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	69.57	50.85

Standard II—Quality Assessment and Performance Improvement

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

30 DAY	84.28	72.40
AMBULATORY CARE per 1000 Member Months		
OP VISITS	388.71	345.73
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	50.45
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.84
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	52.74	48.76
Effective Continuation Phase Treatment	37.31	34.39
ANTIBIOTIC UTILIZATION—% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	40.94
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	48.36
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Initiation of Treatment	43.62	39.29
Engagement of Treatment	18.56	9.62
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	88.42
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	83.78
ELECTIVE DELIVERY (HYBRID)	2.00	5.11
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years		
Medication Compliance 50% Total	52.31	47.81
Medication Compliance 75% Total	29.14	22.59

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

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup continues to monitor performance specific to performance outcomes. Key strategies for improving performance, include: i. Expanding practices with PCHM designation ii. Expanding and evaluating the impact of pay for performance programs on performance outcomes. Improvements in performance outcomes have been shown in most of the groups participating in Amerigroup's PQIP	◆ PIP evaluation/Control Charts ◆ Monitor volume of covered members and outcome tracking for providers in P4P programs ◆ Monitor volume of covered members and outcome tracking for providers in PCMHs ◆ Monitor YOY changes in performance and Monthly Performance Measure Reports ◆ MHD reporting	Charmaine Bartholomew Tawonna Ingram	12/31/2015

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
(P4P) program. We have expanded groups participating in P4P programs beginning in 2010 starting with 5 groups covering 10K members. We currently have 29 groups serving 70K members. iii. Hiring two (2) additional Health promotions coordinators increased our ability to work directly with primary care practices on education around billing, scheduling patients directly for Clinic Days and tracking performance over time. This has proven to be effective for the targeted high volume practices as demonstrated in Table 1.  Table 1 Impact of Health Promotions on iv. Clinical Practice Consultants are nurses who focus on improving outcomes by directly working with providers. We have two (2) nurses who worked on the Diabetes, URI, Post-partum and ADHD measures. Once improvements are sustained, new practices are approached to participate in performance improvement activities. In the example below an initiative was implemented to decrease unnecessary antibiotic use (URI measure). Use of the Clinical Practice Consultants has proven to be effective in improving URI rates for the targeted practices as demonstrated in Table 2.	◆ Health Promotion event tracking ◆ Increases in Level II billing ◆ Changes in performance measure rates following data exchange		

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
 Table 2 Impact of CPC on URI rates of ta v. Quality Based PCP assignments were implemented in December 2014. Providers are assigned members based on performance. Higher quality providers in the same geographic areas are assigned more members than those providers with lower performance. The plan will monitor overall impact to performance measures scores through analysis of panel sizes and changes in year over year performance. ◆ Execute on PIPs and spread plan for those interventions that are successful ◆ Increase providers participating in P4P programs ◆ Increase covered membership in PCMH ◆ Monitor impact of Quality Based PCP assignment process ◆ Monitor provider performance and issue quarterly performance reports ◆ Increase direct booked appointments through MHD ◆ Increase Clinic Day Events ◆ Rollout OB provider incentive ◆ Execute on EMR Data exchange			
Other Evidence/Documentation: QAPI evaluation 6.30.15 annotated 2014-2015 Diabetes Action Plan update 6-2015 2014-2015 URI HEDIS Action Plan Update 6-2015 2014-2015 ADHD HEDIS Initial Phase Action Plan – Updated 6-2015			

Standard II—Quality Assessment and Performance Improvement
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)
Action Plan Barrier Analysis 2014 EOY 10_27_14 AGP GA OutreachResults2014 Cycle1-2 Focus Measures Final EHR Presentation to Provider GAPEC-0451-13 Childhd Immun HEDIS Flier GAPEC-0622-14 EHR Questionnaire Final GAPEC-0661-14 Intro Fax for Patient 360 Tool_Fax_Final GAPEC-0861-15 2015 Postpartum Incentive Final GF360 Performance Measures Training Part II 4-7-15 HP C 1561 14 GA TCOBAM Postcard E S Final Missed Opp Report Sample PEC ALL 0856 13 Weight Assessment Nutrition Flier GA Final QAPI ER Scorecard example QAPI Report Card example Scheduler Incentive Report RA 2015
July 2015 Re-review Findings: At the time of the on-site visit, Amerigroup's performance measures were being validated and final rates were not available for review. Post-audit review of the finalized rates indicated that Amerigroup did not achieve all of the DCH targets.
July 2015 Required Actions: Amerigroup must meet all DCH-established performance targets before this element will be given a *Met* status. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.

Standard II—Quality Assessment and Performance Improvement

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

16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.

42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: Amerigroup continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of Amerigroup's quality programs.

Required Actions: Amerigroup must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup received feedback from Dr. Carson regarding the 2013 QAPI report. All comments, suggestions and revisions will be incorporated into the 2014 QAPI for DCH review and approval. Recommendations included seeking assistance with strategic planning teams on defining objectives, goals, and measuring effectiveness.	Amerigroup incorporated the feedback from the 2014 QAPI submission for the 2015 evaluation.	Charmaine Bartholomew	6/30/2015

Other Evidence/Documentation:
QAPI evaluation 6.30.15 Annotated

July 2015 Re-review Findings: Amerigroup provided its QAPI plan. Documentation which would demonstrate that the improvement of quality elements such as the performance improvement measures, care gaps reports, and Consumer Assessment of Healthcare Providers and Systems (CAHPS)[B-1] results were not submitted to demonstrate the QAPI's effectiveness.

July 2015 Required Actions: Amerigroup must continue to incorporate DCH's suggested revisions and to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members. The CMO should assess its evaluation methods and implement modifications as needed.

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

Standard VII—Coordination and Continuity of Care—Focused Review

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)

5. Discharge Planning: Contract §4.11.11

The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: Amerigroup provided policies and procedures that identified the CMO's formalized discharge planning program. However, during the case file review, HSAG was unable to identify any discharge planning for members who had been hospitalized.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's case notes.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will re-train associates on the discharge planning requirements. We will also provide one-on-one (1:1) training for associates who are not meeting performance standards. There will be monitoring of cases through the monthly auditing process to demonstrate adherence to the requirements that the case manager has collaborated with the concurrent review nurse at the associated facility. The audit process will include ensuring that documentation of the case manager's collaboration and discussions with the member, provider and any agencies that provided post discharge care is noted in the core Amerigroup CM documentation system. These efforts will assist in completion of all identified discharge protocols for members receiving services in the IP and/or OP setting and that the information is available in Amerigroup's core CM and UM	Discharge Planning Auditing	Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-training was provided during the next staff

Standard VII—Coordination and Continuity of Care—Focused Review			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)			
documentation system. Associates not meeting these requirements are managed through the performance management process. The performance process consists of weekly meetings with the identified associate to review current progress, documentation of action steps for the associate and manager. Continued failure to meet the required standards leads to the next level of performance management which may include termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement Policy.			meeting on May 13, 2015. During this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was been delayed beyond the March timeframe and will occur as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015
Other Evidence/Documentation: Std.IV.12 - Example of Discharge Planning Audit_May 2015 Std.IV.12. - Example of Discharge Planning Audit_June 2015 Std.IV.12 - Discharge Audit Grid Std.IV.12 - Discharge Planning Training_June 2015 Std.IV.12 - Hospital Discharge Orders_June Audit			

Standard VII—Coordination and Continuity of Care—Focused Review
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)
Std.IV.12 - CM Desk Top Policy_Discharge Planning Std.IV.12 - CM Discharge Notes_June Audit Std.IV.12 - CM Discharge Notes_May Audit Std.IV.12 - Discharge Plan Training_ 5.13.14 Std.IV.12 - Hospital Discharge Orders_May Audit Std.IV.12 - Discharge Stabilization Audit Tool Desktop Policy Std.IV.12 - Combined Audit Tool_CAP Std.IV.12 - Discharge planning BH training 3_18_15 (1) Std.IV.12 - Discharge planning BH training 5_06_15 Std.IV.12 - UM Conference Agenda (1) UM Conference Power Point Std.IV.12 - UM Team Meeting 2nd Example of Discharge Planning Audit June 2015
July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff.
July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with the applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.

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

The document following this page includes the dates of HSAG's on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals who participated in or observed some or all of the on-site review activities, including 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 C-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 C-2—HSAG Reviewers and Amerigroup Community Care/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 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
Michelle Anderson-Johnson		Manager
Rochelle Simmons		Medical Compliance Analyst

Table C-2—HSAG Reviewers and Amerigroup Community Care/Other Participants	
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 D. **Review Methodology**

Introduction

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

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

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

Objective of Conducting the Review of Compliance With Standards

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

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

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

- Standard I—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
- Follow-up on areas of non-compliance from the prior year's review

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

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

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

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

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

Pre-on-site review activities included:

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

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

- 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.
- 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 E. **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 E. State of Georgia
Department of Community Health (DCH)
Corrective Action Plan
for Amerigroup Community Care

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. 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 provider's file was considered clean and the 120-day time frame for credentialing decisions did not begin until the provider's 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 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

Findings: Amerigroup staff confirmed that the member handbook was included in the new member packet. Once the ID card production file was received by the vendor, a new member packet mailing file was created and the packet was mailed within five calendar days after receiving notice of the enrollment from DCH. 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 V—Grievance System

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 was 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.

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)

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 the 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. 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 update its Disenrollment procedure and member handbook 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

Standard II—Furnishing of Services

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

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines—Returning Calls After-Hours:** *Contract 4.8.14.4*

The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: Amerigroup monitors timeliness of returned calls after hours and provided its GA After-hours Survey document as evidence. The CMO's providers did not meet the requirements to return urgent calls within 20 minutes or routine calls within one hour.

Required Actions: The CMO needs to continue its monitoring activities and ensure providers return urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will continue monitoring activities of providers regarding urgent and other call timelines in accordance with contractual requirements. Providers are monitored through our quarterly survey process regarding timely access standards. Amerigroup's current policy includes in-office education and corrective action for those providers that do not meet waiting maximums and appointment requirements as	Coordination of monthly secret shopper calls to monitor progress. Hiring of additional resources to assist with face to face meetings. Interventions related to sole providers in Rural areas as it relates to auto assignment of members.	**Michelle Rush**	By 6/1/2015, we expect to see an improvement with compliance of this report. **Update**: We continue to monitor activities of providers regarding urgent and other call timelines in accordance with contractual requirements. Implementation of some interventions were delayed. We determined that the mode of operation to influence behavioral changes in the physicians was not sufficient by hosting web-ex trainings alone. We are acquiring additional resources (i.e. new consultants) that will conduct face to face trainings with those providers that have consecutively failed the after-hours access survey with no shown improvement. Additionally, the implementation of the removal of failed providers from the auto assignment algorithm has been delayed to take into account those providers that are failing

Standard II—Furnishing of Services

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

outlined in the contract. In addition we monitor any member complaints and address any identified concerns. In an effort to increase compliance with these standards, Amerigroup will begin to remove providers from the auto assignment algorithm to prevent auto- assignment of new members. This however, will not prohibit a member from selecting a specific provider. In the event a provider fails repeatedly and they are the sole provider in a community, we will have a practice management consultant work with them in an attempt to: ◆ Develop after hour's efficiency by working with the practice to provide access to routine and urgent-care appointments outside regular business hours. ◆ Provide continuity of medical record information for care and advice when the office is not open. ◆ Provide timely clinical advice using a secure,			because they are the only provider available in Rural areas. Therefore, the new date of implementation for both will be 8/15/15 as we operationalize this process to take into account the impact it will have on those sole providers in Rural areas. With regard to the practice management consultant working with those providers that fail the survey repeatedly, we will use our current share point tracker as a source to identify providers allowing the assignment of team members for specific provider outreach to review the following PCMH standards: ◆ Develop after hour's efficiency by working with the practice to provide access to routine and urgent-care appointments outside regular business hours. ◆ Provide continuity of medical record information for care and advice when the office is not open. ◆ Provide timely clinical advice using a secure, interactive electronic system when the office is not open and documenting after-hours clinical advice in patient records. The goal is to enhance the providers' efficiency in scheduling and managing appointment availability**.**

Standard II—Furnishing of Services

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

interactive electronic system when the office is not open and documenting after-hours clinical advice in patient records. For those providers that have failed the survey, Amerigroup will conduct monthly lunch and learn sessions to educate providers on their responsibilities to return calls within contractual timeframes and assist with strategies to ensure that the providers meet the requirement as outlined in our DCH contract. Amerigroup will continue to send quarterly fax blasts to the entire network outlining the contract requirements specific to the availability and accessibility requirements. We have seen consistent improvement in our survey results. Our aggregate total for after-hours calls in 2014 was 86% for Urgent and Routine calls returned. We will continue to monitor this measure in 2015.			

Other Evidence/Documentation:
Std.II.1 Furnishing of Services – CAP 2014-2015 1 After hours screen print II
Std.II.1 Furnishing of Services – CAP 2014-2015 1 Michael Deal – Evidence After hours CAP

Standard II—Furnishing of Services

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

Std.II.1 Furnishing of Services – CAP 2014-2015 1 NART – example
Std.II.1 Furnishing of Service CAP 2014-2015 1 NART – continued
Std.II.1 Furnishing CAP 2014 15 #1 After Hrs Results 15Q2-14Q3
Std.II.1 Furnishing CAP 2014-15 #1 Availability Standards_Will Cover_Pg2
Std.II.1 Furnishing CAP 2014-2015 #1 GAPEC 0912-15 Invitation 062415
Std.II.1 Furnishing CAP 2014-15 # 1 Facilitator Guide Availability Standards Requirements
Std.II.1 Furnishing CAP 2014-15 #1 New Provider Orientation Pgs 2_12

July 2015 Re-review Findings: The after-hours survey results indicated that 85 percent of providers that were surveyed in quarter 1, 2015, returned urgent calls within 20 minutes. This rate was 5 percentage points higher than quarter 1, 2014. The after-hours survey also indicated that 88 percent of providers surveyed in quarter 1, 2015, returned routine calls within 60 minutes, which falls just below the 90 percent goal. Compared to the quarter 1, 2014 survey, Amerigroup improved this rate by 3 percentage points.

July 2015 Required Actions: Amerigroup must continue to apply current and new interventions with providers until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved 90 percent of the time.

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

Standard II—Furnishing of Services

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

5. Geographic Access: *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO monitored the appropriate geographic access standards, but the CMO did not meet all of the standards in this element. Amerigroup submitted a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- Dental subspecialty providers
- Mental health providers
- Pharmacies

The CMO was also deficient in time/distance evaluation related to general dental providers in rural areas.

Required Actions: The CMO must meet the geographic standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, mental health providers, and pharmacies, and for general dental providers in rural areas.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
Amerigroup will continue its efforts to add providers to our network to meet all geographic standards as outlined in our contract. Amerigroup completes a quarterly deficiency report detailing all areas where we are not meeting access and what actions have been taken. Currently, we have (716) specialties that fall into DCH CAP code (1) – "*providers do not exist within contract access standard"*. As a continuation of AGP industry setting telemedicine strategic interventions, we will continue to support the proliferation of telemedicine sites within the public school environment. Telemedicine is one access point in the cadre of our initiatives to ensure access for our members. Although a member may not have a pediatric rheumatologist within 30 miles or even 45 miles of their home, AGP has ensured that those members get access to those services if needed by providing access via telemedicine providers. As part of the Georgia Tele health network, AGP has access to all presentation sites and all boards of health throughout the state in its entirety. NET services are also coordinated as needed. In the counties where providers do not exist or have a Medicaid ID number to participate in GA Families, we will continue to encourage their	Expansion of Telemedicine Presentation sites Targeted recruitment	**Urcel Fields**	**12/31/2015 (This is an ongoing process)** **Update:** Through our efforts, we have seen the expansion of Telemedicine by the additional presentation sites. Furthermore, our Network Relations Consultants have been provided targeted recruitment lists for outreach to providers to join the Georgia Partnership for Telemedicine Network with particular emphasis on recruiting pediatric sub-specialties (pediatric endocrinology). These interventions have generated additional access points to assist with areas in which we are not meeting all geographic standards due to the lack of provider availability.

Standard II—Furnishing of Services

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participation in Medicaid and continue our practice of quarterly outreach to providers that have chosen not to accept Medicaid members. Amerigroup recognizes the public health implications for the areas that do not have providers available. We use multiple sources to determine if providers are available which includes but is not limited to non-Medicaid publicly available provider networks and published provider compendiums. As such, it is our assessment that the further proliferation of Tele-Health will ease access concerns for some of our rural communities. Furthermore, we will continue our practice of constantly monitoring the DCH provided 7400 file for new Medicaid providers.			

Other Evidence/Documentation:
Std.II.5 New Par Providers 1.1.15-6.1.15

July 2015 Re-review Findings: HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- Dental subspecialty providers
- Mental health providers
- Pharmacies

The CMO was also deficient in time/distance evaluation related to general dental providers in rural areas.

July 2015 Required Actions: The CMO must meet the geographic standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, mental health providers, and pharmacies, and for general dental providers in rural areas. Amerigroup must continue its efforts to close its network adequacy gaps by implementing new network strategies, and keep DCH informed of its progress.

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

Standard IV—Coordination and Continuity of Care

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

8. Care Coordination Functions: *Contract 4.11.8.1*

In addition to the above requirements, the CMO's care coordination system includes the following related and additional functions:

- Case Management
- Disease Management
- Transition of Care
- Discharge Planning

Findings: Amerigroup provided policies and procedures outlining case management, disease management, transition of care, and discharge planning activities. However, during the file review HSAG was unable to identify that the case manager talked with the provider pre- or post-discharge. The audit team was also unable to identify specific discharge orders for members who had been hospitalized while in case management.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's electronic health record (EHR).

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure completion of all identified discharge protocols, Amerigroup will conduct a training session for all case management and concurrent review nurses on the discharge planning requirements. The training will include demonstrations of competence in each step of the discharge planning process. All associates will be trained using the Discharge Planning Documentation Standards and understand how to document within the core case management system. The documentation standards link to the members' EHRs (where available) and identifies all of the discharge planning activities that will occur prior to the member leaving the inpatient setting. The	Discharge Planning Auditing	Lisa Ross-Jones Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-training was

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concurrent review nurse collaborates with the case management nurse to ensure the discharge documentation is obtained from the facility and uploads it into the core member documentation system. We will monitor cases through the monthly auditing process to demonstrate adherence to these requirements. Associates that fail to meet these standards will be performance managed. Performance management consists of the following: ◆ 1:1 counseling with their manager ◆ A performance plan which indicates the steps for correction and timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement Policy. During discussion with DCH a potential solution was identified regarding discharge plans that cannot be obtained from facilities as requested. We discussed the opportunity to add the CMS transitional care form as part of the GMCF portal requirement. Adding this form to the portal will make it a mandatory requirement to complete this information in an electronic format and an automatic compliance requirement for completing discharge			provided during the next staff meeting on May 13, 2015. During this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was delayed beyond the March timeframe and occurred as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015 ◆ Will continue to work with DCH on an electronic solution through the GMCF portal for transition of care/discharge forms.

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information. AGP will work directly with DCH in getting this initiative executed.			

Other Evidence/Documentation:
The referenced documents demonstrate compliance with this action item.
Std.IV.8. - Example of Discharge Planning Audit_June 2015
Std.IV.8 - Example of Discharge Planning Audit_May 2015
Std.IV.8 - Discharge Audit Grid
Std.IV.8 - Discharge Planning Training_June 2015
Std.IV.8 - Hospital Discharge Orders_June Audit
Std.IV.8 - CM Desk Top Policy_Discharge Planning
Std.IV.8 - CM Discharge Notes_June Audit
Std.IV.8 - CM Discharge Notes_May Audit
Std.IV.8 - Discharge Plan Training_ 5.13.14
Std.IV.8 - Hospital Discharge Orders_May Audit
Std.IV.8 - Discharge Stabilization Audit Tool Desktop Policy
Std.IV.8 - Combined audit tool_CAPS 2015
Std.IV.8 - Discharge planning BH training 3_18_15
Std.IV.8 - Discharge planning BH training 5_06_15
Std.IV.8 - UM Conference Agenda (1)
UM Conference Power Point
Std.IV.8 - UM Team Meeting
2nd Example of Discharge Planning Audit June 2015

Discharge Planning Audit Results- All CM Benchmark is> =90%		
Month	**Results**	**Comments**
May	**16%**	**Some of the cases audited in May were created prior to the Discharge Planning training which impacted the low passing rate**

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June	**100%**	**Reauditing conducted in June resulted in 100% pass rate due to the Discharge Planning training conducted in May 2015 & June 2015**	

July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff compliance with transitions of care/discharge planning.

July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.

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

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

9. Case Management—Components: *Contract 4.11.9.1-2*

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:

(c) Development of a care plan.

Findings: During the case file review, it was identified that care plans were developed based on the assessment; staff reported that the member's agreement to the care plan showed that the care plan was member-centered. One area of improvement would involve developing a member-centered care plan that included member, family, and/or provider input. After a review of the care plan document, it was identified that the care plan does not have a start date, review date(s), and/or date of change/update(s). HSAG was unable to determine when the care plan was developed, or when (or if) it was updated or reviewed.

Required Actions: Amerigroup should use the comprehensive assessment as an adjunct document when developing the care plan. Primary input into care plan goal(s) should come from the member, member's provider, and family/guardian/caregiver in the care plan development process. Amerigroup needs to document the care plan start date, review date, and/or date of changes/updates to the care plan.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup's core case management system is managed and created by the larger organization of Amerigroup/Anthem and used in all markets. Changes to the system are based upon approval by the senior leadership team of Amerigroup/Anthem. Based on feedback from DCH, Amerigroup will make the following suggestions as an update request to the core system: ◆ Assessment templates with specific sections for member, provider and family input. ◆ Advanced customization that will allow the ability to create care plans uniquely catered to the identified member.	Case Management Audits	Lisa Ross-Jones	3/31/15 ◆ Training on any updates to the current case management system will be dependent on the changes being accepted by corporate and the timeline for implementation. Suggestions have been made to the corporate clinical systems team but updates have not been approved at this time. Will continue to

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◆ Automatic system alerts that prompt the case manager to review and make revisions to the member's care plan. Until the new system is functional, the case management team will be retrained on the requirements for care plan documentation by the Director for Care Management/CM Team Leader with the training scheduled to be completed by March 31, 2015. The CM leader will ensure that all required input is obtained for the care plan and that start and end dates along with review dates are documented on the care plan. The CM Auditing lead will conduct random audits of the care plans on a monthly basis to ensure the case managers are compliant with the documentation requirements for care plans and will provide immediate follow up to non-compliant case management team members. Associates that fail to meet these standards will be performance managed which consists of the following: ◆ 1:1 counseling with their manager. ◆ A performance plan which indicates the steps for correction and a timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement follows the steps outlined in the Corporate Conduct and			monitor through corporate workgroup meetings. **Update:** ◆ At this time a proposed date for implementation has not been offered. We will continue to monitor through our corporate workgroup meetings. ◆ Care plan training occurred on 4/14/15 and was hosted by our corporate Performance Improvement and Enhancement team. During this training session we discussed the requirements needed for documentation within Care Compass (our internal case management system) to ensure that the cases meet quality indicators as well as NCQA requirements.

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Performance Improvement Policy.			

Other Evidence/Documentation:
The referenced documents demonstrate compliance with this action item.
Std.IV.9 BH Care Planning Example with Start Date_Review Date_Updates
Std.IV.9 CareCompass Care Planning Training 04.12.2015
Std.IV.9 OB Care Planning Example with Start Date_Review Date_Updates
Std.IV.9 Training Attendance List_April 2015
Std.IV.9Training Attendance List_June 2015

July 2015 Re-review Findings: Amerigroup staff members reported that they were working with the corporate office to revise the CMO's core systems based on recommendations and feedback from DCH. No date for implementation of these changes had been identified.

July 2015 Required Actions: Amerigroup must identify an implementation strategy to include time frames that clearly delineate the initiation and completion of the core system update. The CMO must provide this documentation to DCH and should work with DCH to identify when the CAP is completed.

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

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12. Discharge Planning: *Contract 4.11.11*

The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: Amerigroup provided policies and procedures that identified the CMO's formalized discharge planning program. However, during the case file review HSAG was unable to identify any discharge planning for members who had been hospitalized.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's case notes.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure completion of all identified discharge protocols, Amerigroup will conduct a training session for all case management and concurrent review nurses on the discharge planning requirements. The training will include demonstration of competence in each step of the discharge planning process. All associates will be trained using the Discharge Planning Documentation Standards and understand how to document within the core case management system. The documentation standards link to the members "EHRs (where available) and identify all of the discharge planning activities that will occur prior to the member leaving the inpatient setting. The concurrent review nurse collaborates with the case management nurse to ensure the discharge documentation is obtained from the facility and uploads it	Discharge Planning Auditing	Lisa Ross-Jones Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-training was provided during the next staff meeting on May 13, 2015. During this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was delayed

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into the core member documentation system. We will monitor cases through the monthly auditing process to demonstrate adherence to these requirements. Associates that fail to meet these standards will be performance managed which consists of the following: ◆ 1:1 counseling with their manager ◆ A performance plan which indicates the steps for correction and a timeframe for compliance. ◆ Continued failure would lead to further corrective action up to and including termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement policy.			beyond the March timeframe and occurred as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015

Other Evidence/Documentation:
The referenced documents demonstrate compliance with this action item.
Std.IV.12 - Example of Discharge Planning Audit_May 2015
Std.IV.12.- Example of Discharge Planning Audit_June 2015
Std.IV.12 - Discharge Audit Grid
Std.IV.12 - Discharge Planning Training_June 2015
Std.IV.12 - Hospital Discharge Orders_June Audit
Std.IV.12 - CM Desk Top Policy_Discharge Planning
Std.IV.12 - CM Discharge Notes_June Audit
Std.IV.12 - CM Discharge Notes_May Audit
Std.IV.12 - Discharge Plan Training_ 5.13.14
Std.IV.12 - Hospital Discharge Orders_May Audit
Std.IV.12 - Discharge Stabilization Audit Tool Desktop Policy

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Std.IV.12 - Combined Audit Tool_CAP
Std.IV.12 - Discharge planning BH training 3_18_15 (1)
Std.IV.12 - Discharge planning BH training 5_06_15
Std.IV.12 - UM Conference Agenda (1)
Std.IV.12 – Example 2 June Discharge Audit
UM Conference Power Point Final
Std.IV.12 - UM Team Meeting
2nd Example of Discharge Planning Audit June 2015

July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff.

July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.

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

Standard I—Clinical Practice Guidelines

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

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

Contract: 4.12.7.5

Findings: Amerigroup provided its Clinical Practice Guideline Compliance Monitoring report for January–December 2013. This report was due to the State in July 2014, but was not final. It indicated that providers were not in compliance with the CMO's Attention Deficit Hyperactivity Disorder (ADHD) CPG goal.

Required Actions: The CMO must ensure that 90 percent of providers are compliant with Amerigroup's CPGs.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will continue to monitor and educate providers of CPG compliance in an effort to ensure adherence to requirements. On April 1, 2014, the health plan moved from annual to quarterly CPG monitoring for providers. Medical records are requested from a random sample of providers who bill for services with diagnosis codes for the CPG's monitored (i.e. ADHD, Diabetes etc.) and are reviewed in house by licensed nurses. Written feedback is provided to the practitioner on compliance to guidelines. If a provider does not meet the 80% passing score they are issued a corrective action plan. Providers that are non-compliant will: ◆ Receive a letter notification with a copy of the CPG's and other resource materials ◆ Develop and submit a corrective action plan that will be monitored by Amerigroup for compliance within 14	Monitored and educated providers of CPG compliance in an effort to ensure adherence to requirements. Moved to quarterly CPG monitoring for providers. Providers that do not meet the 80% passing score they will: ◆ Receive a letter notification with a copy of the CPG's and other resource materials ◆ Develop and submit a corrective action plan that will be monitored by Amerigroup for compliance within 14 days of notification. ◆ Be re-audited quarterly to ensure that they are in compliance. ◆ If those providers remain non-compliant after, the re-audit, they will be referred to the Peer Review Committee for review and recommendation.	Yvette Terry	6/30/2015

Standard I—Clinical Practice Guidelines

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

days of notification. ◆ Be re-audited quarterly to ensure that they are in compliance. • If those providers remain non-compliant after, the re-audit, they will be referred to the Peer Review Committee for review and recommendation. Clinical Practice Guidelines are evidence based recommendations that assist providers with patient decisions regarding care. Amerigroup follows guidance on creating CPG's from nationally reviewed literature, data and evidence or adopts existing guidelines. These guidelines are reviewed by our corporate entity and approved locally by our MAC committee. Recommendations for changes may come from the committee and be incorporated into the CPG. The CAP process has been effective in evaluating the root causes for why CPG's are not always followed. Using an approach similar to the Health Check Audit process that increased Health Check compliance overall from 91% in 2011 to 97% in 2014, the number of unique CPG indicators increased from 22 in 2011 to 26 in 2014. The overall CPG compliance rate increased 12 % from 64% in 2012 to 76% in 2013. The increase was driven primarily by improved compliance with the DM CPG. Further improvement in DM CPG compliance will help us get to the 90% goal.			

Standard I—Clinical Practice Guidelines

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

Provider feedback is discussed internally to determine any opportunities for education to all providers. We have identified that there are differing opinions in the provider community regarding ADHD guidelines and drug holidays. The most frequently cited study was conducted by Martins and colleagues.[1] This study of 40 children showed that weekend holidays from methylphenidate treatment tended to reduce insomnia and appetite suppression, and did not significantly increase ADHD symptoms on weekends (as reported by parents) and on the Monday in school following the drug holiday (reported by teachers). (Marins S, Tramontina S, Polanczyk G, Eizirik M, Swanson J, Rohde L. Weekend holidays during methylphenidate use in ADHD children: a randomized clinical trial. J Child Adolesc Psychopharmacol. 2004; 14:195-206,). Amerigroup has taken the lead in scheduling a meeting with the Quality Committee of the Georgia Chapter of the American Academy of Pediatrics to discuss the potential impact of these data on the CPG. Lastly, Amerigroup has worked directly to increase the number of practices with PCHM designation. The PCMH model includes a commitment to high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management and CPG adherence. Frequent			

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
auditing, timely follow up on corrective action plans and re-auditing efforts in addition to sharing audit results and opportunities for improvement with the entire network will help to achieve this requirement.			
Other Evidence/Documentation: Std.VI.6 CPG re-audit #1 Std.VI.6 CPG re-audit #2 Std.VI.6 2015 Clinical Practice Guidelines Audit Results (1) Std.VI.6. 2015 GF 360 Clinical Practice Guidelines Audit Results Std.VI.6 Clinical Practice Guidelines Measuring Practitioner Compliance Std.VI.6 Screenshot of CPG re-audit database			
July 2015 Re-review Findings: Amerigroup provided its Clinical Practice Guideline Compliance Monitoring report for quarter 3, 2014 (86 percent), quarter 4, 2014 (76 percent), and quarter 1, 2015 (86 percent), along with its CY 2014 annual analysis, which indicated 86 percent compliance. Comparatively, the CY 2013 annual analysis showed a rate of 76 percent compliance, indicating Amerigroup increased its CPG compliance rate by 10 percentage points.			
July 2015 Required Actions: The CMO must continue to monitor provider compliance and corrective action when providers fail the audit to ensure that 90 percent of providers are compliant with Amerigroup's CPGs.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement

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

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: Amerigroup did not meet all of the DCH-established performance goals for CY 2013. The following deficiencies were noted:

Measure	CY2013 Targets	Amerigroup CY2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE—6 or more visits (HYBRID)	70.70	63.59
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	90.55
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	81.38
CHILDHOOD IMMUNIZATION STATUS—Combo 3	82.48	80.56
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	81.71
WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION & PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (HYBRID)		
Total Nutrition	54.88	54.63
CERVICAL CANCER SCREENING (HYBRID)	78.51	69.34
PRENATAL AND POSTPARTUM CARE (HYBRID)		
Timeliness of Prenatal Care	90.39	75.92
Postpartum Care	71.05	60.78
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	52.98
CHLAMYDIA SCREENING IN WOMEN	58.40	52.81
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.70
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	90.56	88.79
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HbA1c test	87.01	80.50
HbA1c Control <8%	48.72	35.11
HbA1c control <7%	36.72	27.71
Eye Exam	52.88	43.97
LDL Screen	76.16	73.23
LDL Control	35.86	26.95
Attention to Nephropathy	78.71	73.94
BP Control <140/80 mm Hg	39.10	30.85
BP Control <140/90 mm Hg	63.50	53.19
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	43.12
Continuation	63.11	59.22

Standard II—Quality Assessment and Performance Improvement

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

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	69.57	50.85
30 DAY	84.28	72.40
AMBULATORY CARE per 1000 Member Months		
OP VISITS	388.71	345.73
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	50.45
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.84
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	52.74	48.76
Effective Continuation Phase Treatment	37.31	34.39
ANTIBIOTIC UTILIZATION—% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	40.94
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	48.36
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Initiation of Treatment	43.62	39.29
Engagement of Treatment	18.56	9.62
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	88.42
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	83.78
ELECTIVE DELIVERY (HYBRID)	2.00	5.11
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years		
Medication Compliance 50% Total	52.31	47.81
Medication Compliance 75% Total	29.14	22.59

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

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup continues to monitor performance specific to performance outcomes. Key strategies for improving performance, include: i. Expanding practices with PCHM designation ii. Expanding and evaluating the impact of pay for performance programs on performance outcomes. Improvements in performance	◆ PIP evaluation/Control Charts ◆ Monitor volume of covered members and outcome tracking for providers in P4P programs ◆ Monitor volume of covered members and outcome tracking for providers in PCMHs ◆ Monitor YOY changes in performance and	Charmaine Bartholomew Tawonna Ingram	12/31/2015

Standard II—Quality Assessment and Performance Improvement

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outcomes have been shown in most of the groups participating in Amerigroup's PQIP (P4P) program. We have expanded groups participating in P4P programs beginning in 2010 starting with 5 groups covering 10K members. We currently have 29 groups serving 70K members. iii. Hiring two (2) additional Health promotions coordinators increased our ability to work directly with primary care practices on education around billing, scheduling patients directly for Clinic Days and tracking performance over time. This has proven to be effective for the targeted high volume practices as demonstrated in Table 1.  Table 1 Impact of Health Promotions on iv. Clinical Practice Consultants are nurses who focus on improving outcomes by directly working with providers. We have two (2) nurses who worked on the Diabetes, URI, Post-partum and ADHD measures. Once improvements are sustained, new practices are approached to participate in performance improvement activities. In the example below an initiative was implemented to decrease unnecessary antibiotic use (URI measure). Use of the Clinical Practice Consultants has proven to be	Monthly Performance Measure Reports ◆ MHD reporting ◆ Health Promotion event tracking ◆ Increases in Level II billing ◆ Changes in performance measure rates following data exchange		

Standard II—Quality Assessment and Performance Improvement

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

effective in improving URI rates for the targeted practices as demonstrated in Table 2.

Table 2 Impact of CPC on URI rates of ta

v. Quality Based PCP assignments were implemented in December 2014. Providers are assigned members based on performance. Higher quality providers in the same geographic areas are assigned more members than those providers with lower performance. The plan will monitor overall impact to performance measures scores through analysis of panel sizes and changes in year over year performance.

- Execute on PIPs and spread plan for those interventions that are successful
- Increase providers participating in P4P programs
- Increase covered membership in PCMH
- Monitor impact of Quality Based PCP assignment process
- Monitor provider performance and issue quarterly performance reports
- Increase direct booked appointments through MHD
- Increase Clinic Day Events
- Rollout OB provider incentive
- Execute on EMR Data exchange

Other Evidence/Documentation:
QAPI evaluation 6.30.15 annotated

Standard II—Quality Assessment and Performance Improvement

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2014-2015 Diabetes Action Plan update 6-2015
2014-2015 URI HEDIS Action Plan Update 6-2015
2014-2015 ADHD HEDIS Initial Phase Action Plan – Updated 6-2015
Action Plan Barrier Analysis 2014 EOY 10_27_14
AGP GA OutreachResults2014
Cycle1-2 Focus Measures Final
EHR Presentation to Provider
GAPEC-0451-13 Childhd Immun HEDIS Flier
GAPEC-0622-14 EHR Questionnaire Final
GAPEC-0661-14 Intro Fax for Patient 360 Tool_Fax_Final
GAPEC-0861-15 2015 Postpartum Incentive Final
GF360 Performance Measures Training Part II 4-7-15
HP C 1561 14 GA TCOBAM Postcard E S Final
Missed Opp Report Sample
PEC ALL 0856 13 Weight Assessment Nutrition Flier GA Final
QAPI ER Scorecard example
QAPI Report Card example
Scheduler Incentive Report RA 2015

July 2015 Re-review Findings: At the time of the onsite visit, Amerigroup's performance measures were being validated and final rates were not available for review. Post-audit review of the finalized rates indicated that Amerigroup did not achieve all of the DCH targets.

Measure	CY2014 Targets	Amerigroup CY2014 Rate
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.85	90.68
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.32	79.69
CHILDHOOD IMMUNIZATION STATUS		
COMBO 3	82.64	79.12
ANNUAL DENTAL VISIT		
2 TO 3 YEARS	55.78	47.54
TOTAL	69.92	68.78
CERVICAL CANCER SCREENING (HYBRID)	76.64	66.40
PRENATAL AND POSTPARTUM CARE (HYBRID)		
TIMELINESS OF PRENATAL CARE	89.72	79.02

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POSTPARTUM CARE	70.20	62.94
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	73.97	48.02
CHLAMYDIA SCREENING IN WOMEN	57.25	56.96
USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	89.76	89.23
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HBA1C TEST	87.32	85.37
HBA1C POOR >9	43.02	58.54
HBA1C CONTROL <8%	48.57	35.02
HBA1C CONTROL <7%	34.76	25.21
EYE EXAM	54.43	46.86
ATTENTION TO NEPHROPATHY	79.28	76.66
BP CONTROL <140/90 MM HG	60.93	36.93
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	51.86	45.04
Continuation	63.75	59.36
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	68.79	51.01
30 DAY	81.98	70.29
AMBULATORY CARE per 1000 Member Months		
ER VISITS	<53.98	56.83
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	53.21
PERCENTAGE OF ELIGIBLES WHO RECEIVED DENTAL TREATMENT SERVICES – Use 416 specifications; run combined PCK and Medicaid	31.50	24.13
DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE (HYBRID)	45.00	38.19
CESAREAN SECTION FOR NULLIPAROUS SINGLETON VERTEX (HYBRID)	15.23	17.05
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	7.99	8.87
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	56.17	46.99
Effective Continuation Phase Treatment	40.17	31.83
ADULT BMI ASSESSMENT (HYBRID)	78.71	68.51
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	56.20	29.07
FLU SHOTS FOR ADULTS AGES 18–64	34.65	26.28
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Engagement of Treatment	16.17	12.84

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ELECTIVE DELIVERY (HYBRID)	2.00	23.58
ADHERENCE TO ANTIPSYCHOTICS FOR INDIVIDUALS WITH SCHIZOPHRENIA	61.34	44.57
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.14	19.72
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years Medication Compliance 75% for 5–11 yrs old	29.46	21.27
MATERNITY CARE-BEHAVIORAL HEALTH RISK ASSESSMENT (HYBRID)	10.42	4.57

July 2015 Required Actions: Amerigroup must meet all DCH-established performance targets before this element will be given a *Met* status. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.

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

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16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.

42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: Amerigroup continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of Amerigroup's quality programs.

Required Actions: Amerigroup must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup received feedback from Dr. Carson regarding the 2013 QAPI report. All comments, suggestions and revisions will be incorporated into the 2014 QAPI for DCH review and approval. Recommendations included seeking assistance with strategic planning teams on defining objectives, goals, and measuring effectiveness.	Amerigroup incorporated the feedback from the 2014 QAPI submission for the 2015 evaluation.	Charmaine Bartholomew	6/30/2015

Other Evidence/Documentation:
QAPI evaluation 6.30.15 Annotated

July 2015 Re-review Findings: Amerigroup provided its QAPI plan. Documentation which would demonstrate that the improvement of quality elements such as the performance improvement measures, care gaps reports, and CAHPS results were not submitted to demonstrate the QAPI's effectiveness.

July 2015 Required Actions: Amerigroup must continue to incorporate DCH's suggested revisions and to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members. The CMO should assess its evaluation methods and implement modifications as needed.

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

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5. Discharge Planning: Contract §4.11.11

The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: Amerigroup provided policies and procedures that identified the CMO's formalized discharge planning program. However, during the case file review, HSAG was unable to identify any discharge planning for members who had been hospitalized.

Required Actions: Complete all identified discharge protocols for members receiving services in the inpatient and/or outpatient setting. Ensure that all discharge documentation is available in the member's case notes.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
Amerigroup will re-train associates on the discharge planning requirements. We will also provide one-on-one (1:1) training for associates who are not meeting performance standards. There will be monitoring of cases through the monthly auditing process to demonstrate adherence to the requirements that the case manager has collaborated with the concurrent review nurse at the associated facility. The audit process will include ensuring that documentation of the case manager's collaboration and discussions with the member, provider and any agencies that provided post discharge care is noted in the core Amerigroup CM documentation system. These efforts will assist in completion of all identified discharge protocols for members receiving services in	Discharge Planning Auditing	Bridget McKenzie	3/31/2015 ◆ Discharge requirements training was completed on March 6th and March 25th for Case Management and Concurrent Review team members. ▪ Although discharge requirements training occurred in March, a discharge planning re-training was provided during the next staff meeting on May 13, 2015. During this training session the staff was provided with copies of the Discharge Checklist that will be completed going forward. ◆ The auditing process was been

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the IP and/or OP setting and that the information is available in Amerigroup's core CM and UM documentation system. Associates not meeting these requirements are managed through the performance management process. The performance process consists of weekly meetings with the identified associate to review current progress, documentation of action steps for the associate and manager. Continued failure to meet the required standards leads to the next level of performance management which may include termination. This performance improvement process follows the steps outlined in the Corporate Conduct and Performance Improvement Policy.			delayed beyond the March timeframe and will occur as follows due to transitional changes with our auditing team. ▪ Discharge Planning Audits began the week of May 18th, 2015

Other Evidence/Documentation:
Std.IV.12 - Example of Discharge Planning Audit_May 2015
Std.IV.12. - Example of Discharge Planning Audit_June 2015
Std.IV.12 - Discharge Audit Grid
Std.IV.12 - Discharge Planning Training_June 2015
Std.IV.12 - Hospital Discharge Orders_June Audit
Std.IV.12 - CM Desk Top Policy_Discharge Planning
Std.IV.12 - CM Discharge Notes_June Audit
Std.IV.12 - CM Discharge Notes_May Audit
Std.IV.12 - Discharge Plan Training_ 5.13.14
Std.IV.12 - Hospital Discharge Orders_May Audit
Std.IV.12 - Discharge Stabilization Audit Tool Desktop Policy
Std.IV.12 - Combined Audit Tool_CAP
Std.IV.12 - Discharge planning BH training 3_18_15 (1)

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Std.IV.12 - Discharge planning BH training 5_06_15
Std.IV.12 - UM Conference Agenda (1)
UM Conference Power Point
Std.IV.12 - UM Team Meeting
2nd Example of Discharge Planning Audit June 2015

July 2015 Re-review Findings: During the on-site review and interview, Amerigroup staff members reported that they had completed discharge training with all current case managers and were training all incoming staff on discharge procedures. In review of the documentation provided and information provided during the interview, HSAG identified that Amerigroup had only completed one review of case management case files for discharge plans in June 2015. The audit, completed in May 2015, was conducted prior to completion of staff training and did not provide any indication of what impact training had on staff.

July 2015 Required Actions: Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. All auditing results should be documented and shared with the applicable staff. The CMO must develop a mechanism to evaluate the impact of staff training. HSAG will review this finding again during the next compliance audit.

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