State of Georgia

Department of Community Health (DCH)

EXTERNAL QUALITY REVIEW OF COMPLIANCE WITH STANDARDS *for* AMERIGROUP COMMUNITY CARE

December 2014

HSAG HEALTH SERVICES ADVISORY GROUP

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid managed care and CHIP programs. The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids®. For the purposes of this report, *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 CMO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid CMO'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.

In addition to the Georgia Families population, which includes both Medicaid managed care and CHIP populations, DCH contracted with AMERIGROUP Community Care (AMERIGROUP) to provide managed care coverage beginning in March 2014 for the following populations.

1. Children in state custody
2. Children receiving adoption assistance
3. Certain youth in the custody of the Department of Juvenile Justice (DJJ)

Within this document these three populations are collectively referred to as the Georgia Families 360° program.

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

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 09/2014."

conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2013–June 30, 2014, and marked the first year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of AMERIGROUP's documents and an on-site review that included reviewing additional documents, conducting interviews with key AMERIGROUP staff members, file reviews, case reviews, and a management information system demonstration. 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 measurement and improvement standards found at 42 CFR §438.236–§438.240, and §438.242, while the seventh area focused specifically on noncompliant standards from the prior review period. The standards HSAG evaluated included requirements that addressed the following areas:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Poststabilization Services
- Re-review of all *Partially Met* and *Not Met* elements from the prior year's review.

Additionally, HSAG performed a focused, case-specific file review of a sample of AMERIGROUP's members in the case management program between January 1, 2014, and May 30, 2014. HSAG also reviewed a sample of members enrolled in the disease management program between January 1, 2014, and May 30, 2014. Furthermore, HSAG reviewed a sample of cases involving members whose covered services/authorizations were denied between July 1, 2013, and June 30, 2014.

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 final report.
- Appendix F—The completed review tool HSAG used to evaluate AMERIGROUP's Georgia Families 360° program.
- Appendix G—The completed review tools HSAG used to evaluate AMERIGROUP's case management cases.
- Appendix H—The completed review tools HSAG used to evaluate AMERIGROUP's disease management cases.

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.
- Systems demonstrations during the on-site review.
- File review during the on-site review.

HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix D—Review Methodology. If a requirement was not applicable to 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	Availability of Services	**17**	**17**	**17**	**0**	**0**	**100.0%**
II	Furnishing of Services	**22**	**22**	**20**	**2**	**0**	**90.9%**
III	Cultural Competence	**14**	**14**	**14**	**0**	**0**	**100.0%**
IV	Coordination and Continuity of Care	**21**	**21**	**18**	**3**	**0**	**85.7%**
V	Coverage and Authorization of Services	**25**	**25**	**22**	**3**	**0**	**88.0%**
VI	Emergency and Poststabilization Services	**20**	**20**	**20**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**5**	**5**	**1**	**4**	**0**	**20.0%**
	Total Compliance Score	**124**	**124**	**112**	**12**	**0**	**90.3%**

*** 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—Availability of Services

Performance Strengths

AMERIGROUP monitored its provider network to ensure all services were available to Georgia Families members. The CMO maintained a mix of provider types such that most services were available within the network. AMERIGROUP generated provider panel reports which aided the CMO in ensuring providers were accepting new patients and that continuity of care was maintained. When out-of-network providers were needed, the CMO coordinated payment and care accordingly to minimize the impact to the member.

Areas Requiring Corrective Action

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

Standard II—Furnishing of Services

Performance Strengths

The CMO ensured that its contracted providers offered access to services for Georgia Families members consistent with Georgia Medicaid fee-for-service or commercial members.

Areas Requiring Corrective Action

The State established a goal that 90 percent of providers must meet timeliness requirements. AMERIGROUP monitored these timeliness requirements for compliance, and the CMO's network providers did not meet the 90 percent goal for the following timeliness targets:

- Timelines—Returning Calls After Hours

Also, AMERIGROUP was required to meet certain time and distance geographic access standards. The CMO did not meet the following geographic access standards:

- PCPs
  - Urban areas: Two within eight miles.
  - Rural areas: Two within 15 miles.
- Specialists
  - Urban areas: One within 30 minutes or 30 miles.

- Rural areas: One within 45 minutes or 45 miles.
- General dental providers
  - Rural areas: One within 45 minutes or 45 miles.
- Dental subspecialty providers
  - Urban areas: One within 30 minutes or 30 miles.
  - Rural areas: One within 45 minutes or 45 miles.
- Mental health providers
  - Urban areas: One within 30 minutes or 30 miles.
  - Rural areas: One within 45 minutes or 45 miles.
- Pharmacies
  - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
  - Rural areas: One 24 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.

Standard III—Cultural Competence

Performance Strengths

AMERIGROUP served its member population in a culturally competent manner by educating staff and providers on expected conduct. Its cultural competency plan was available in a PowerPoint format, and the full version was located on the AMERIGROUP Web site and was accessible to providers. Member materials were produced in English and Spanish, and each version was available on the Web site. The CMO offered free linguistic services to members and providers as needed.

Areas Requiring Corrective Action

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

Standard IV—Coordination and Continuity of Care

Performance Strengths

AMERIGROUP's Coordination and Continuity of Care program provided for prompt identification of members who were able to benefit from case management services; ensured the comprehensive assessment was completed in a timely manner; and addressed members' physical, behavioral, and psychosocial needs. Member care plans were linked to the comprehensive assessment, and members were stratified by the case manager for monitoring purposes.

Areas Requiring Corrective Action

HSAG identified the following areas for improvement:

AMERIGROUP's policy and procedure outlined the process for coordinating care for case management, disease management, transitions of care, and discharge planning. The process for discharge planning was identified in the policy as an ongoing process throughout treatment and included member participation whenever possible. However, during the case file review, HSAG was unable to identify that AMERIGROUP followed its process for discharge planning. HSAG was unable to locate documented evidence of discharge plans being obtained from the hospital.

HSAG found that AMERIGROUP's process for considering member consent to the care plan was not sufficient to be considered demonstration of their inclusion as part of the care plan development process.

While HSAG was able to identify communication between the case manager and the member post discharge to discuss the member's follow-up needs HSAG did not find documentation of a discharge plan being completed for members being released from an inpatient setting, or of planning between the CMO and inpatient facility.

Standard V—Coverage and Authorization of Services

Performance Strengths

AMERIGROUP demonstrated strong knowledge and overall compliance with the requirements for processing prior authorization requests within the Utilization Management (UM) department. Delegation oversight and monitoring was evidenced with consistent reporting of utilization metrics to the Medical Advisory Committee.

Areas Requiring Corrective Action

During the file reviews, demonstration of pharmacy decision timeliness required further review and discussion. AMERIGROUP verbally confirmed appropriate data points for calculating turnaround times for pharmacy prior authorization requests. AMERIGROUP needs to review the current process and document how turnaround times are calculated to ensure accuracy of reporting.

While AMERIGROUP's UM policy demonstrated compliance with the notice of action (NOA) for authorization requests that exceeded the required time frames, the described practice conflicted with the policy. AMERIGROUP's practice was to approve authorization requests that exceed the timely review requirements. Operational practice should be consistent with written policy.

AMERIGROUP staff indicated that the CMO did not provide notice to members if an expedited request was denied. While the provider was notified of the denial, AMERIGROUP needs to ensure that members are notified as well.

Denial File Review Summary

AMERIGROUP demonstrated overall compliance with the requirements of the denial file reviews. The files represented internal utilization management cases in addition to delegated vendor case files. With the exception of one pharmacy file case, all standard decisions were timely; no expedited requests were in the denial files sample. All cases were reviewed by a qualified clinician, with evidence of clinical review and rationale for the denial decision. There was appropriate notification of action to both members and providers. While the decisions and notifications were within the required time frames, it was noted that at times there was a delay between the decision and the notifications.

Standard VI—Emergency and Poststabilization Services

Performance Strengths

AMERIGROUP ensured that members were able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. The CMO did not deny payment for any emergency services regardless of network status and ensured payment for all triage/screening services. Medical records submitted were reviewed by appropriate clinical staff.

Areas Requiring Corrective Action

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

Case and Disease Management Focused Review

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on the assessment of the member's needs, the development of the care plan, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and process for handling transitions of care, including discharge planning.

Methodology

HSAG developed a case management evaluation guide in collaboration with DCH, which HSAG used to conduct the review at the individual case level. The case management evaluation guide covered the following areas:

- Identification
- Assessment
- Care Plan Development
- Monitoring and Follow-up
- Transition of Care and Discharge Planning

HSAG selected eight member sample cases, plus an oversample of three cases to review. The sample cases were pulled from a file provided by the CMO and contained members with open enrollment in the case management program between January 1, 2014, and May 30, 2014. HSAG provided the CMO with the selected sample cases HSAG would review on-site by uploading the information to the HSAG file transfer protocol (FTP) site on June 30, 2014. The CMO was responsible for assuring the identified sample cases were available for the reviewers during the on-site review.

An HSAG audit team composed of clinicians with care management experience reviewed case documentation from the selected cases of members enrolled in case management. The manager from each AMERIGROUP case management program was included in the case review process, to present the case to the HSAG audit team, navigate through the CMO's care management system, and respond to any questions.

Identification

HSAG reviewed the CMO's process for identifying members who were able to benefit from case management services.

Observations:

Members were identified for case management through predictive modeling software (CI3), staff referral, member self-referral, and provider referral. Members were placed in either physical health

case management, behavioral health case management, or emergency room case management and stratified based on need.

Recommendations:

HSAG has no recommendations at this time.

Assessment

HSAG reviewed the CMO's process for assessing member needs and for including family, caregiver, and provider input into the assessment process.

Observations:

The assessment was completed in a timely manner and addressed the member's physical, mental, and psychosocial needs to include cultural issues/concerns and linguistic needs.

Recommendations:

HSAG has no recommendations at this time.

Care Plan Development

HSAG reviewed the CMO's process for care plan development to determine if the care plan addressed needs identified in the assessment and included input from family, caregivers, and providers.

Observations:

Care plans were developed based on the assessment and identified need. HSAG was unable to identify the member, family, and/or provider being included in the development of the care plan and staff reported that the member's agreement to the care plan showed that the care plan was member-centered. During the review of case files HSAG staff also noted that the care plan did not have a start date, review date(s), and/or date of change/update(s).

Recommendations:

- Individualize the care plan to the member. Member, family, and/or provider input should be included during development of the care plan.
- Ensure that the care plan is discussed with the provider(s) and that discussions are documented in the notes.
- Ensure that all care plans have a start date, review date(s), and/or date of change/update(s).

Monitoring and Follow-up

HSAG reviewed the CMO's process for monitoring and follow-up of members enrolled in case management.

Observations:

Follow-up needs were identified by the case manager, and members were monitored based on the stratified risk level. Documentation showed that the case manager was in contact with the members and external providers. However, during the case file reviews HSAG noted that the CMO did not use a multidisciplinary team approach.

Recommendations:

- Establish a multidisciplinary team review process to discuss and review current treatment and treatment options available to the member.

Transition of Care and Discharge Planning

Observations:

During the file review, CMO staff reported that case managers monitor members' status while they are inpatient and consult with the "appropriate parties" to develop the discharge plan. HSAG identified one occurrence in which the case manager conducted a face-to-face visit with a member during the second inpatient stay and continued monitoring the member post-discharge. However, HSAG was unable to identify the following: consistent monitoring of members during inpatient stays; consultation with "appropriate parties" for discharge plan development; or discharge orders for the members being discharged.

Recommendations:

- Ensure monitoring of member status during inpatient stays.
- Ensure coordination of discharge planning with "appropriate parties."
- Ensure that discharge plans are obtained from inpatient stays.

Disease Management

HSAG performed case-specific file reviews which focused on members in disease management. Reviews focused on disease management identification, assessment, education, monitoring, and measureable outcomes.

Methodology

HSAG conducted on-site disease management record reviews at AMERIGROUP. Eight records were randomly selected with an oversample of three records. Each record file was reviewed with AMERIGROUP staff and discussed during the review process.

The review sample consisted of asthma, diabetes, and hypertension disease management cases.

Program Type and Identification

Observations:

Good effort to use disease management as a mechanism to address HEDIS care gaps was observed for AMERIGROUP members. This was a special initiative directed by AMERIGROUP to its corporate office, which is responsible for disease management. Cases identified for disease management were contacted in a timely manner for enrollment into the program.

Recommendations:

HSAG has no recommendations at this time.

Assessment and Guidelines

Observations:

HSAG noted good improvement in aligning disease management programs with clinical practice guidelines (CPGs), which was identified as an area of concern during the previous audit.

Recommendations:

HSAG has no recommendations at this time.

Education

Observations:

Education was provided using AMERITIPS; the disease manager also provided verbal education and coaching.

Recommendations:

HSAG has no recommendations at this time.

Monitoring

Observations:

Documentation indicated that many members had requested help to reach a healthier weight or had verbalized their weight loss goals. However, HSAG did not find evidence that care plan goals were created to help members achieve these goals. HSAG noted some issues with the CMO helping members obtain necessary durable medical equipment (DME). HSAG noted that disease management members experienced both denials and delays in obtaining DME, such as blood pressure cuffs. The CMO had difficulty engaging members beyond one or two contacts. Consequently, HSAG did not see evidence of members achieving goals. The CMO did not have the ability to or did not use metrics to manage and monitor members' progress. For members with diabetes and hypertension, HSAG expected that every discussion would involve blood glucose levels or blood pressure readings. The reviewer noted that lab results, medical record review, etc., appeared to overwrite what may have been self-reported by the member.

Recommendations:

- Develop care plans that include small, manageable, and measureable steps to help members reach their care plan goals.
- Review and revise the CMO's internal process for providing DME for disease management members so that any barriers preventing members from receiving this equipment are removed.
- Explore strategies to increase member engagement in disease management.
- Incorporate a mechanism to track member indicators such as blood glucose and blood pressure readings over time.

Measureable Outcomes

Observations:

AMERIGROUP had difficulty demonstrating measures of success for the disease management programs.

Recommendations:

- Develop measures of success for each disease management program.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

AMERIGROUP corrected one of the five elements requiring corrective action. The CMO demonstrated improvement over the previous year with its case management program.

Areas Requiring Corrective Action

Four areas still require corrective action. While the CMO changed its Quality Assessment and Performance Improvement (QAPI) report in accordance with the State's direction, the program evaluation does not ensure that all quality elements are addressed and that they are integrated in terms of overall program impact. AMERIGROUP must ensure that at least 90 percent of providers comply with the CMO's CPGs. AMERIGROUP must meet all of the DCH-established performance targets, and maintain a formalized discharge planning program that includes a comprehensive evaluation of the member's health needs and identifies the services and supplies required for appropriate care following discharge.

Georgia Families 360°

DCH requested that HSAG provide early feedback on AMERIGROUP's processes and procedures for the Georgia Families 360° program that the CMO began administering in March 2014. HSAG's review was limited to areas with overlapping federal requirements. HSAG provides the following observations and recommendations:

- The HSAG review team noted substantial resources dedicated to working with both traditional and non-traditional partners including various state agencies, community advocate groups, and provider communities, to assist with the transition of members from Medicaid FFS to Medicaid managed care.
- HSAG had some concerns that AMERIGROUP was not meeting some contractual requirements due to external challenges. The CMO staff members reported continued challenges concerning member eligibility, accuracy of the member's current PCP, accuracy of current placement information, and accuracy of the current DFCS case worker. Staff members also reported that during the first 8 to 10 weeks of the program, they were only able to complete health risk screenings with approximately 500 members due to the inability to contact members. At the time of the on-site audit, staff members reported that the health risk screenings were 65 to 70 percent completed. CMO staff members reported that they were working with DCH to revise the contract to better reflect expectations and lessons learned.
- No concerns were identified with receiving the eligibility file and processing members into AMERIGROUP systems. However, HSAG noted during the case file review that some members were entered in case management on March 3, 2014, were not contacted, and did not have an assessment or a care plan developed by a case manager until July 2014. AMERIGROUP staff members reported that they were grouping members into levels for prioritization of contact and were just beginning to work with level one members. AMERIGROUP staff members reported that there was a 90-day transition period for incoming members; however, it was noted that members being reviewed had not been contacted prior to the end of the 90-day transition period.
- HSAG identified no concerns with AMERIGROUP's implemented process for allowing a 90-day transition period to ensure continuity of care for previously provided authorized services.
- AMERIGROUP is responsible for completing the EPSDT component of the Comprehensive Child and Family Assessment (CCFA) medical assessments, and the remainder of the components are completed or compiled by the agency contracted to complete the CCFA. As contractually written, AMERIGROUP is required to complete the CCFAs; however, staff members reported that CCFA medical assessments were not being completed by AMERIGROUP because it was unable to hold the providers to a standard since they were identified and contracted by the Division of Family and Children Services (DFCS). HSAG noted that the CMO was not meeting the timelines for conducting member health risk screenings within 30 days.
- AMERIGROUP provided documentation that outlined the process for conducting trauma assessments for foster care (FC) members. The policy stated that providers were to complete the trauma assessment within 15 calendar days of the notification to AMERIGROUP of the youth remaining in care beyond the preliminary placement hearing. This 15-calendar-day standard identified in AMERIGROUP's policy did not meet the 10-calendar-day requirement. AMERIGROUP should revise its policy to be consistent with the requirement.

- Regarding AMERIGROUP's process for auto-assigning a PCP, HSAG identified some inconsistencies between staff members' descriptions of this process and AMERIGROUP policy. In addition, the policy as written did not meet the requirement to auto-assign a PCP within two business days. AMERIGROUP should update its policy and procedure in this area.
- AMERIGROUP provided a Scion Dental policy to meet the intent of selection of a primary care dentist for the adoption assistance, juvenile justice, and FC populations; however, HSAG determined that AMERIGROUP did not have its own policy for auto-assignment of a primary care dentist for Georgia Families 360° members, and Scion's policy did not identify the required time frames for auto-assignment. AMERIGROUP should create its own policy to address the required time frames for auto-assignment of a primary care dentist and/or require the delegate to revise its time frames to meet the requirement.
- HSAG identified inconsistencies related to AMERIGROUP's case management policies for Georgia Families 360° members. This population is required to have case management for all members; however, AMERIGROUP did not follow the CMO's regular case management process for this population. The policies related to stratifying members need to be clear as to which members follow the regular case management process and which follow the Georgia Families 360° case management process.
- HSAG noted that the health risk assessment (HRA) was not comprehensive and primarily captured health history. AMERIGROUP needs to design an HRA for the Georgia Families 360° population to include all medical, behavioral, functional, cognitive, and social needs.
- Health risk screenings were not always fully completed. In several cases, questions were skipped, and it was unclear what was and was not completed.
- HSAG saw evidence that the CMO made good attempts to communicate with DFCS and treating providers to obtain medical and dental information.
- HSAG identified that some care plans were being developed before the health risk screening was completed. The care plan should be a dynamic document, but HSAG was not able to determine the start date or the goals of the care plan.

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 final 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, 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.

HSAG HEALTH SERVICES ADVISORY GROUP

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—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. Availability of Services—Establishing and Maintaining an Adequate Network of Providers: *42 CFR 438.206(b); Contract 4.8.1.2; 4.8.1.6;* Addendum 4.8.1.13 The care management organization (CMO) has written provider selection and retention policies and procedures and maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the CMO considers:	Amerigroup maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract by completing Timely Access Surveys monitoring provider terminations, GEO access reports and appointment after hour's accessibility surveys. The provider agreement requires all providers to maintain adequate service and coverage standards such as: Emergency Coverage and Appointment wait times.	
(a) The anticipated Medicaid/Georgia Families (GF) enrollment.	Amerigroup enrollment and anticipated enrollment is provided in the following report: • Std.I.1a Georgia Plan Membership June 2013-June 2014 <u>Additional supporting documents</u> • Std.I.1a GA ATL Access Analysis 3Q13 • Std.I.1a GA ATL Access Analysis 4Q13 • Std.I.1a GA ATL Access Analysis 1Q14 • Std.I.1a GA Central Access Analysis 3Q13 • Std.I.1a GA Central Access Analysis 4Q13 • Std.I.1a GA Central Access Analysis 1Q14 • Std.I.1a GA East Access Analysis 3Q13 • Std.I.1a GA East Access Analysis 4Q13 • Std.I.1a GA East Access Analysis 1Q14 • Std.I.1a GA North Access Analysis 3Q13 • Std.I.1a GA North Access Analysis 4Q13	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.I.1a GA North Access Analysis 1Q14 • Std.I.1a GA SE Access Analysis 3Q13 • Std.I.1a GA SE Access Analysis 4Q13 • Std.I.1a GA SE Access Analysis 1Q14 • Std.I.1a GA Southwest Access Analysis 3Q13 • Std.I.1a GA Southwest Access Analysis 4Q13 • Std.I.1a GA Southwest Access Analysis 1Q14 • Std.I.1a Monitoring Primary Care Provider (PCP) and Physician Extender (PE) Capacity	
Findings: AMERIGROUP provided quarterly GeoAccess analysis for each region, and the network was sufficient to provide services for existing and anticipated membership.		
Required Actions: None.		
(b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CMO.	Amerigroup takes into consideration the health care needs of our specific Medicaid population. In addition to geographic reports and access monitoring, Amerigroup also monitors the types of services needed for our populations to ensure the provider network includes such providers and services. • Std.I.1c GA ATL Access Analysis 3Q13 • Std.I.1c GA ATL Access Analysis 4Q13 • Std.I.1c GA ATL Access Analysis 1Q14 • Std.I.1c GA Central Access Analysis 3Q13 • Std.I.1c GA Central Access Analysis 4Q13 • Std.I.1c GA Central Access Analysis 1Q14 • Std.I.1c GA East Access Analysis 3Q13 • Std.I.1c GA East Access Analysis 4Q13 • Std.I.1c GA East Access Analysis 1Q14 • Std.I.1c GA North Access Analysis 3Q13 • Std.I.1c GA North Access Analysis 4Q13	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.I.1c GA North Access Analysis 1Q14 • Std.I.1c GA SE Access Analysis 3Q13 • Std.I.1c GA SE Access Analysis 4Q13 • Std.I.1c GA SE Access Analysis 1Q14 • Std.I.1c GA Southwest Access Analysis 3Q13 • Std.I.1c GA Southwest Access Analysis 4Q13 • Std.I.1c GA Southwest Access Analysis 1Q14 • Std.I.1c AGP GA After Hours Report2013 Q4 • Std.I.1c AGP GA After Hours Report2013 Q3 • Std.I.1c AGP GA After Hours Report2013 Q2 • Std. I.1c AGP GA After Hours Report2014 Q1 • Std.I.1c GA AfterHours Survey-FINAL2013 Q3 L	
Findings: AMERIGROUP provided quarterly GeoAccess analysis for each region, and the network was sufficient to provide services for existing and anticipated membership.		
Required Actions: None.		
(c) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	AMERIGROUP monitors providers through several reporting tools, such as through: the GEO Access Summary, the SCA report, and the Credentialing process. We contract with providers who are trained and experienced to meet our members' needs. The Single Case Agreements report identifies specialties that are not in our network but are needed to meet the needs of the members. Once identified, the contracting process is implemented. During the credentialing process, we verify all of our providers' board certifications, training, and experience within their specialty. • Std.I.1d Desktop Process SCA Comp Process – Final • Std.I.1d SCA Tracker Report_06192014	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.I.1d Credentialing Recredentialing for Lic Independent Practitioners • Std.I.1d Network Deficiency Report2014 Q1 • Std.I.1d Network Deficiency Report2013 Q4 • Std.I.1d Network Deficiency Report2013 Q3 • Std.I.1d Network Deficiency Report2013 Q2 • Std.I.1d Provider Listing Q313 • Std.I.1d Provider Listing Q413 • Std.I.1d Provider Listing Q114	
Findings: AMERIGROUP provided a quarterly GeoAccess analysis for each region, and the network had a sufficient number and types of providers to provide services for existing and anticipated membership. The CMO had a procedure documented in the Single Case Agreement Process – Contracting file along with evidence summarized in the Credentialing and Recredentialing for Licensed Independent Practitioners policy which provided evidence that the CMO considered training, experience, and specialization of providers when contracting and credentialing/recredentialing the providers to fulfill the needs of the Medicaid population.		
Required Actions: None.		
(d) The number of network providers who are not accepting new Medicaid patients.	AMERIGROUP monitors all open and closed panels of our Primary Care providers. This is performed through the Provider Network Status report as well as provider relation office visits. • Std.I.1e Closed Panel Document updated docx 2014 • Std I.1e Georgia_Panel_Status_-_May 2014 • Std.I.1e PCP Closed Panel Request SBS2014_vs revision • Std.I.1e PR Visit Form update 2014 • Std.I.1ePanel and Provider count Q313 • Std.I.1ePanel and Provider count Q413 • StdI.1ePanel and Provider count Q114	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO monitored providers with a closed panel via its Georgia Panel Status report. Staff members indicated that provider representatives reach out to providers with a closed panel and ask them to continue accepting new patients.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
(e) The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	AMERIGROUP monitors the geographic locations of our providers through our GEO Access reports. AMERIGROUP developed our networks with the travel time and transportation guidelines established by DCH. This is also monitored through member complaints tracking. • Std .I.1f GAGA_CAID_PC_MHB_ENG 6_14 pg 10 • Std.I.1f GAGA CAID Provider Manual 3 14 pg 22 • Std.I.1f GA ATL Access Analysis 3Q13 • Std.I.1f GA ATL Access Analysis 4Q13 • Std.I.1f GA ATL Access Analysis 1Q14 • Std.I.1f GA Central Access Analysis 3Q13 • Std.I.1f GA Central Access Analysis 4Q13 • Std.I.1f GA Central Access Analysis 1Q14 • Std.I.1f GA East Access Analysis 3Q13 • Std.I.1f GA East Access Analysis 4Q13 • Std.I.1f GA East Access Analysis 1Q14 • Std.I.1f GA North Access Analysis 3Q13 • Std.I.1f GA North Access Analysis 4Q13 • Std.I.1f GA North Access Analysis 1Q14 • Std.I.1f GA SE Access Analysis 3Q13 • Std.I.1f GA SE Access Analysis 4Q13 • Std.I.1f GA SE Access Analysis 1Q14 • Std.I.1f GA Southwest Access Analysis 3Q13 • Std.I.1f GA Southwest Access Analysis 4Q13 • Std.I.1f GA Southwest Access Analysis 1Q14	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: AMERIGROUP provided a quarterly GeoAccess analysis for each region, and the CMO monitored time and distance between members and providers.		
Required Actions: None.		
2. Availability of Services—Direct Access to Women's Health Specialist: *42 CFR 438.206(b)(2); Contract 4.8.3.1* The CMO provides female members with direct in-network access to a women's health specialist for covered care necessary to provide a woman's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.	AMERIGROUP provides direct access to women's healthcare providers such as OB/GYN, GYN, and Primary Care Physicians. • Std.I.2 GAGA CAID PC MHB ENG 6_14-Pgs 6 & 7(16&17 of the PDF view) - Choosing an OB/GYN. The member handbook is descriptive. AMERIGROUP does not require a referral from par providers for E&M level of care. • Std.I.2 GAGA_CAID_ProviderManual_HealthyBabies	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that female members had direct in-network access to women's health providers for routine and preventive health services.		
Required Actions: None.		
3. Availability of Services—Direct Access to Specialists: *42 CFR 438.208(c)(4); Contract 4.8.3.2* The CMO has a process in place that ensures that (i) members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the member's condition and identified needs, and (ii) the CMO Medical Director oversees this process.	AMERIGROUP ensures members have direct access to a specialist as appropriate for their conditions and needs. HCMS will assist in directing them through the Care Management program to the needed specialist. • Std.I.3 GAGA CAID PC MHB ENG 6_14 o Pg 6 (15 PDF doc) Seeing a Doctor not your primary care o Pg 7 (16 PDF doc) Specialists o Pg 7-8 (17 PDF doc) Wait times o Pg 12 (21 PDF doc) Extra AMERIGROUP CC Benefits, CoPayments o Pg 14 (Services that do not need a Referral Pg.34 o Rights and Responsibilities	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.I.3 GAGA CAID Provider Manual o Pgs 75 & 76 - Specialist as a PCP o Pgs 78 & 80 – Specialist Access and o Availability • Std.I.3- Case Management Program Overview – GA • Std.I.3 CM Program Description-Georgia 2014 • Std. I.3 Specialty Referral-GA • Std. I.3 Specialty Referral • Std.I.3 Pre-certification of Requested Services - Core Process	
Findings: The member handbook indicated that for members under treatment, the CMO coordinates care and ensures direct access to specialists when appropriate. AMERIGROUP staff described that coordination may include three-way calls and home visits, as needed.		
Required Actions: None.		
4. Availability of Services—Direct Access/Treatment Plans: *42 CFR 438.208(c)(3)(i-iii); Contract 4.8.3.3* The CMO ensures that members who are determined to need a course of treatment or regular care monitoring have a treatment plan and that the treatment plan is: (i) developed by the member's primary care provider (PCP) with member participation, and in consultation with any specialists caring for the member; and (ii) approved in a timely manner by the CMO medical director and in accord with any applicable State quality assurance and utilization review standards.	Amerigroup ensures that members who are determined to need a course of treatment or regular care monitoring have a treatment plan. • Std.I.4 CM Program Description-Georgia 2014, Pgs. 3,6-7 and 23-26 • Std. I.4 - Specialty Referral-GA • Std. I.4 - Specialty Referral • Std. I.4 -Pre-certification of Requested Services - Core Process • Std. I.4 Coordination of Care GA • Std. I.4 Case Mgmt. Care Coordination - Members w Special Healthcare Needs-GA • Std. I.4 Services for Members in Waiver Programs- GA • Std. I.4 Coordination of Care Between Behavioral Health and Medical Management	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. I.4 Care Coordination Through Community Based Organizations – GA • Std. I.4 Continuity of Care Core Process • Std. I .Case Management Program Overview - GA	
Findings: The Case Management Program Description indicated that the CMO had an integrated service delivery approach which included the primary care practitioners and other CMO services to integrate care. AMERIGROUP staff described that coordination may include three-way calls and home visits, as needed.		
Required Actions: None.		
5. Availability of Services—Second Opinion: *42 CFR 438.206(b)(3); Contract 4.11.7.1-3* The CMO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.	Amerigroup provides a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. • Std I.5 Second Medical Opinion • Std I.5 Second Opinion • Std.I.5 GAGA CAID Provider Manual – page 77 (79 PDF) • Std.I.5 GAGA CAID PC MHB ENG 6_14 Pg. 5 – Second Opinion • Std. I.5 Second Opinion P&P • Std. I.5Second Medical Opinion	☒ Met ☐ Not Met ☐ N/A
Findings: The provider manual indicated that a member was able to obtain a second opinion at no cost to the member. The member handbook advised the member of this and informed the member that the second opinion was at no cost.		
Required Actions: None.		
6. Availability of Services—Coverage Out of Network: *42 CFR 438.206(b)(4); Contract 4.8.19.1*; Addendum 4.8.19.4 If the CMO's network is unable to provide necessary services, covered under the contract, to a particular member, the CMO: Adequately and in a timely manner covers these services out of network for the member, for as long as the CMO is unable to provide them.	• Std I.6 Emergency Care GA • Std I.6 Emergency Care BH • Std I.6 Emergency Room services reimbursement • Std I.6 Emergency Core Process • Std I.6 Out of Service area – Out of network • Std I.6 Pre-Certification of Requested Services • Std I.6 Single Case agreement Form	☒ Met ☐ Not Met ☐ N/A

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Informs the out-of-network provider that the member cannot be balance billed.	• Std I.6 Single Case Agreement Process • Std I.6 Emergency Care Policy P4HB Member – GA • Std.I.6 GAGA CAID Provider Manual pg.149 • Std.I.6 GAGA CAID PC MHB ENG 6_14	
Findings: AMERIGROUP staff indicated that only very specialized services were not available within the network. The member would call AMERIGROUP for assistance, and member services staff would search within the network for the desired service. If the service was not available, member services staff would search outside the network and coordinate the needed appointments.		
Required Actions: None.		
7. Availability of Services—Out-of-Network Provider Payment and Cost to Member: *42 CFR 438.206(b)(5); Contract 4.8.19.2* The CMO, consistent with the scope of contracted services, requires out-of-network providers to coordinate with the CMO with respect to payment.	• Std I.7 Desktop Process SCA Comp Process • Std I.7 GAGA_ Caid –PC MHB _ENG • Std.I.7 Appeals and Grievances 1_30 • Std.1.7 2013 Grievances-Balance Billing	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP staff indicated that the cost to the member for out-of-network services not available within the network would be no more than the cost of the services within the network. The Single Case Agreement Form indicated that the payment in full would be negotiated and included on the form.		
Required Actions: None.		
8. Availability of Services—Out-of-Network Provider Payment and Cost to Member: *Contract 4.8.19.2* The CMO coordinates with out-of-network providers regarding payment according to the following DCH contract provisions:		
(a) If the CMO offers the service through an in-network provider(s), and the member chooses to access the service (i.e., it is not an emergency) from an out-of-network provider, the CMO is not responsible for payment.	• Std I.8a Desktop Process SCA Comp Process • Std I.8a GAGA_caid_provider Manual • Std I.8a GAGA_Caid-PC_MHB_ENG • Std I.8a Single case agreement _Template	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP staff indicated that a member may insist on seeing an out-of-network provider. When this happens, the member is told that he or she would be responsible for the cost since the provider is not contracted.		
Required Actions: None.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(b) If the service is not available from an in-network provider, but the CMO has three documented attempts to contract with the provider, the CMO is not required to pay more than Medicaid fee for service (FFS) rates for the applicable service, less ten percent (10%).	• Std I.8b GAPEC-0147-11 Invitation to negotiate • Std I.8b GAPEC-0147-11 OON provider reimbursement letter • Std I.8bGeorgia Out-of Service area – Out of network care process	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP staff indicated that all provider recruitment activities are tracked. The Out-of-Area—Out-of-Network Care policy indicated that once the CMO had three documented attempts to contract with a provider, the CMO was not required to pay more than fee-for-service rates, less 10 percent.		
Required Actions: None.		
(c) If the service is available from an in-network provider, but the service meets the emergency medical condition standard, and the CMO has three documented attempts to contract with the provider, the CMO is not required to pay more than the Medicaid FFS rates for the applicable service, less ten percent (10%). *(Note: When paying out-of-state providers in an emergency situation, the CMO does not allow members to be held accountable for payment under these circumstances.)*	• Std I.8c GAPEC- 0147-11 OON Provider Reimbursement limit ltr • StdI.8c Out of service area network care process • Std I.8c GAPEC- 0147-11 Invitation to negotiate a contract ltr	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP staff indicated that all provider recruitment activities are tracked. The Out-of-Area—Out-of-Network Care policy indicated that once the CMO had three documented attempts to contract with a provider, the CMO was not required to pay more than fee-for-service rates, less ten percent.		
Required Actions: None.		
(d) If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the CMO and the out-of-network provider.	• Std.I.8d Single case agreement template • Std.I.8d GAGA CAID Provider Manual • Std I.8d Desktop Process SCA Comp Process • Std.I.8d GAGA CAID PC MHB 6_14	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP staff indicated that if an approved service was only available outside the network, then the payment would be accomplished in accordance with the Single Case Agreement Form, which indicated the payment in full would be negotiated and included on the form. Staff members also indicated that if a member receives a bill for the services, they should call member services, and the CMO would notify the provider that balance-billing should not occur.		
Required Actions: None.		

Standard I—Availability of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
9. Services Not Available In-Network—Cost to Member: *42 CFR 438.206(b)(5); Contract 4.8.19.3* In the event that needed services are not available from an in-network provider and the member must receive services from an out-of-network provider, the CMO ensures that the member is not charged more than it would have if the services were furnished within the network.	• Std.I.9 GAGA CAID Provider Manual– page 148/149 • Std 1.9 Desktop process SCA Comp Process • STD I.9 GAGA_caid –PC MHB_ ENG • Std I.9 Single case agreement Template • Std I.9 GAGA Caid provider Manual	☒ Met ☐ Not Met ☐ N/A
Findings: The provider manual indicated that a provider must inform the member if a service was not covered by the CMO and that the provider cannot bill the member for those services. The single case agreement indicated that out-of-network providers will accept the payment outlined in the agreement as payment in full and not bill the member.		
Required Actions: None.		

Standard 1––Availability of Services Results					
Met	=	17	X 1.00	=	17.0
Not Met	=	0	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	17	**Total Score**	=	100.0%

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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:		
(a) **Provider Office Hours—Comparable for Medicaid Members:** *42 CFR 438.206(c)(1)(ii); Contract 4.8.14.1* The CMO requires that all its network providers offer hours of operation that are no less than the hours of operation offered to commercial and FFS patients and encourages the providers to offer after-hours office care in the evenings and on weekends.	Amerigroup requires all providers to meet DCH standards for timely access to care and services. This is monitored through our GEO Access Report and through the administration of Timely Access. • Std. II.1(a) - GA_ATL_Access_Analysis_3Q13 • Std. II.1(a) - GA_Central_Access_Analysis_3Q13 • Std. II.1(a) - GA_East_Access_Analysis_3Q13 • Std. II.1(a) - GA_North_Access_Analysis_3Q13 • Std. II.1(a) GA_Southwest_Access_Analysis_3Q13 • Std. II.1(a) GA_SE_Access_Analysis_3Q13 • Std. II.1(a) - AGP GA Timely Access Report2014 1Q • Std. II.1(a) - AGP GA Timely Access Report2013 4Q • Std. II.1(a) - AGP GA Timely Access Report2013 3Q • Std. II.1(a) - AGP GA Timely Access Report2013 2Q • Std. II.1(a) - Appointment After-hours and Telephone Accessibility_GA.doc • Std. II.1(a) – GA Physician Agreement_template • Std. II.1(a) – GA – Physician AHP Agreement 3	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	14.pdf – see page 14 • Std. II.1(a) - GAGA CAID Provider Manual 3 14.pdf • PCP Access & Availability – pgs. 72-73 Specialty Access & Availability – pgs. 78	
Findings: The provider agreement indicated that providers shall not discriminate and shall provide the same access to services as the provider gives to all other patients.		
Required Actions: None.		
(b) **Provider Appointments—Office Wait Times:** *Contract 4.8.14.3* The CMO informs providers and has processes to ensure that wait times for appointments do not exceed the following: ◆ Scheduled Appointments—Sixty (60) minutes. After 30 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment. ◆ Work-in or Walk-in Appointments—Ninety (90) minutes. After 45 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.	Amerigroup requires its providers to meet DCH standards for office hours. Amerigroup monitors through our GEO access report and timely access surveys. If a provider fails to meet compliance during the appointment availability survey they are then requested to complete a corrective action plan within 10 days and notified that a provider relations representative will follow up within 30 days. We monitor the provider's progress and resurvey the following quarter. • Std. II.1(b) - AGP GA Timely Access Report2014 1Q • Std. II.1(b) - AGP GA Timely Access Report2013 4Q • Std. II.1(b) - AGP GA Timely Access Report2013 3Q • Std. II.1(b) - AGP GA Timely Access Report2013 2Q • Std. II.1(b) AGP GA Dental Timely Access Report2014 Q1 • Std. II.1(b) AGP GA Dental Timely Access	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Report2013 Q4 • Std. II.1(b) AGP GA Dental Timely Access Report2013 Q3 • Std. II.1(b) AGP GA Dental Timely Access Report2013 Q2 • Std. II.1(b) AGP GA Vision Timely Access Report2014 Q1 • Std. II.1(b) AGP GA Vision Timely Access Report2013 Q4 • Std. II.1(b) AGP GA Vision Timely Access Report2013 Q3 • Std. II.1(b) AGP GA Vision Timely Access Report2013 Q2 • Std. II.1(b) – GA – Physician Agreement_template.pdf – pg. 13 Section 6.6 • Std. II. 1(b) GAPEC0615-14 Access and Availability Standards Blast Fax • Std. II. 1(b) Appointment After-hours and Accessibility-GA doc • Std. II. 1(b) GA Ancillary.pdf, Appointment Waiting Times- pg. 13.	
Findings: The CMO provided its GA Provider Agreement template, which indicated the wait time standards outlined in this element. The monitoring process was accomplished through an after-hours survey. The CMO staff described the corrective action process for providers not complying with the standard.		
Required Actions: None.		
(c) **Appointment Wait Times:** *Contract 4.8.14.2* The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(i) PCPs (Routine Visits)—14 calendar days	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II. 1(c) Appointment After-hours and Accessibility-GA doc	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of PCP routine visit appointment wait times.		
Required Actions: None.		
(ii) PCP (Adult Sick Visit)—24 hours	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(c) - AGP GA Timely Access	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II.1(c) Appointment After-hours and Accessibility-GA doc	
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of PCP sick visit appointment wait times.		
Required Actions: None.		
(iii) PCP (Pediatric Sick Visit)—24 hours	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II. 1(c) Appointment After-hours and Accessibility-GA doc	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of PCP pediatric sick visit appointment wait times.		
Required Actions: None.		
(iv) Specialist—30 calendar days	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II. (c) Appointment After-hours and Accessibility-GA doc • Std. II.1(c) AGP GA Vision Timely Access Report2014 Q1 • Std. II.1(c) AGP GA Vision Timely Access Report2013 Q4 • Std. II.1(c) AGP GA Vision Timely Access Report2013 Q3 • Std. II.1(c) AGP GA Vision Timely Access Report2013 Q21 Amerigroup vendors are held to the same requirements.	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of specialist appointment wait times.		
Required Actions: None.		
(v) Dental Providers (Routine-21 calendar days; Urgent-48 hours)	• Std. II.1(c) AGP GA Dental Timely Access Report2014 Q1 • Std. II.1(c) AGP GA Dental Timely Access Report2013 Q4 • Std. II.1(c) AGP GA Dental Timely Access Report2013 Q3 • Std. II.1(c) AGP GA Dental Timely Access Report2013 Q2 Amerigroup vendors are held to the same requirements.	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of dental provider routine and urgent appointment wait times.		
Required Actions: None.		
(vi) Non-emergency Hospital Stays—30 calendar days	Amerigroup requires its providers to meet DCH standards for non-emergency hospital stays. Amerigroup monitors this data through timely access survey data. • Std. II.1(c) - GAGA CAID Provider Manual 3 14.pdf, PCP Access & Availability – pgs. 72-73 • Std. II.1(c) GA AGP Access Avail Script Updated GF360 – 6.4-14 • Std. II.1(c) Appointment After-hours and Accessibility-GA doc	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of non-emergency hospital stay wait times.		
Required Actions: None.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(vii) Mental Health Providers—14 calendar days	Amerigroup requires its providers to meet DCH standards for mental health providers. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II.1(c)– GA – After Hours Failed Survey Tracker Screenshot • Std. II.1(c) – GA – Failed Survey Tracker Screenshot • Std. II.1(c) – GA – After Hours Failed Provider Ltr 2013 Q 4- EXAMPLE.pdf • Std. II.1(c) – GA – Failed Provider Ltr 2014 Q1-EXAMPLE.pdf • Std. II.1(c) Appointment After-hours and Accessibility-GA doc • Std. II.1(c) GA Ancillary.pdf • Std. II.1(c) GA Facility_template.pdf	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of mental		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
health provider appointment wait times.		
Required Actions: None.		
(viii) Urgent Care Providers—24 hours	Amerigroup requires its providers to meet DCH standards for urgent care providers. AMERIGROUP monitors this through our Timely Access Surveys. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q • Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II.1(c) Appointment After-hours and Accessibility-GA doc • Std. II.1(c) GA Ancillary • Std. II.1(c) –GA Facility_template	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of urgent care provider appointment wait times.		
Required Actions: None.		
(ix) Emergency Providers—Immediately (24 hours a day, 7 days a week) and without prior authorization	Amerigroup requires its providers to meet DCH standards for emergency providers. Amerigroup monitors this through our Timely Access Surveys. • Std. II.1(c) - AGP GA Timely Access Report2014 1Q • Std. II.1(c) - AGP GA Timely Access Report2013 4Q • Std. II.1(c) - AGP GA Timely Access Report2013 3Q	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. II.1(c) - AGP GA Timely Access Report2013 2Q • Std. II.1(c) Appointment After-hours and Accessibility-GA doc	
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of emergency provider appointment wait times.		
Required Actions: None.		
(d) **Timelines–Visits for Pregnant Women:** *Contract 4.8.14.5* The CMO provides adequate capacity for initial visits for pregnant women within 14 calendar days of enrollment into the CMO plan.	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(d) - AGP GA Timely Access Report2014 1Q • Std. II.1(d) - AGP GA Timely Access Report2013 4Q • Std. II.1(d) - AGP GA Timely Access Report2013 3Q • Std. II.1(d) - AGP GA Timely Access Report2013 2Q • Std. II.1(d) - GA_ATL_Access_Analysis_3Q13 • Std. II.1(d) - GA_Central_Access_Analysis_3Q13 • Std. II.1(d) - GA_East_Access_Analysis_3Q13 • Std. II.1(d) - GA_North_Access_Analysis_3Q13 • Std. II.1(d)	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	GA_Southwest_Access_Analysis_3Q13 • Std. II.1(d) GA_SE_Access_Analysis_3Q13 • Std. II.1(d) Appointment After-hours and Accessibility-GA doc • Std. II.1(d)-GA - SBS - OB Case Management Workflow	
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of visits for pregnant women appointment wait times.		
Required Actions: None.		
(e) **Timelines—Visits for Children Eligible for Health Checks:** *Contract 4.8.14.5* The CMO provides adequate capacity to provide initial visits for children eligible for health checks within ninety (90) calendar days of enrollment into the CMO plan.	Amerigroup requires its providers to meet DCH standards for wait times. Amerigroup monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to Amerigroup within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std. II.1(e) - AGP GA Timely Access Report2014 1Q • Std. II.1(e) - AGP GA Timely Access Report2013 4Q • Std. II.1(e) - AGP GA Timely Access Report2013 3Q • Std. II.1(e) - AGP GA Timely Access Report2013 2Q • Std. II.1(e) – GA AfterHours Survey-FINAL2013 Q3 • Std. II.1(e) – GA AGP Access Avail Script Update GF360 6.4.14 • Std. II.1(e) Appointment After-hours and	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Accessibility-GA doc • Std. II.1(e)- 0652 EPSDT Initial Screening Report Q0114 • Std. II.1(e)- 0652 EPSDT Initial Screening Report Q0413 • Std. II.1(e)- 0652 EPSDT Initial Screening Report Q0313 • Std. II.1(e)- 0652 EPSDT Initial Screening Report Q0213	
Findings: The CMO provided quarterly, timely access reports indicating compliance with this element. These reports indicated adequate monitoring of health check appointment wait times. AMERIGROUP staff described the CMO's 30-, 60-, and 90-day report monitoring and the CMO's efforts to encourage members to obtain the health check.		
Required Actions: None.		
(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	Amerigroup requires its providers to meet DCH standards for returning calls after hours. Amerigroup monitors this through after hours surveys. • Std. II.1(g) – GA AfterHours Survey-FINAL2013 Q3 • Std. II.1(g) - Appointment After-hours and Accessibility-GA doc • Std. II.1(g) -GAPEC-0615-14 Access and Availability Blast Fax • Std. II.1(g) - GAGA _CAID_ProviderManual pg. 73	☐ Met ☒ Not Met ☐ N/A
Findings: AMERIGROUP monitored 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 take action with noncompliant providers to ensure that their performance is brought into alignment with returning urgent calls within 20 minutes and other calls within one hour.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
2. Services Available Twenty-Four/Seven: *42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1; 4.6.2.1; 4.9.5.5* The CMO makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	AMERIGROUP requires its providers to meet DCH standards for 24/7 availability. AMERIGROUP monitors this through our GEO Access Report and Timely Access Surveys. If during the Appointment Availability Survey, the provider is found deficient; a completed Corrective Action Plan must be submitted to AMERIGROUP within 10 days of the failure notice. The provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std.II.2 – GA Physician and AHP Agreement_SAMPLE.doc – pg. 6 (section 3-1) and pg. 14 (section 6.6) • Std.II.2 – GAGA CAID Provider Manual: Primary Care -Provider Access and Availability – pg. 74-75 of PDF document (pgs.72-73 if printed), Specialist Access and Availability – pg. 80 of PDF document (pg. 78 if printed) • Std. II.2 - GAGA CAID PC MHB ENG – pg. 56 of PDF document (pg. 47 of printed) • Std. II.2 - Scion GA Provider Services Agreement (pg. 5 - section 3.2) • Std. II.2 - Avesis Georgia Medicaid Provider Manual - pg.8 <u>Additional Supporting Documentation:</u> • Std. II.2 - Scion UM_4020 P&P • Std. II.2 - Avesis UR-07 Expedited Reviews	☒ Met ☐ Not Met ☐ N/A
Findings: The GA Provider Services Agreement indicated that services should be available 24 hours a day, seven days a week for CMO members. This requirement was also summarized in the Georgia Provider Manual. CMO staff members indicated monitoring of this requirement was accomplished through after-hours call surveys and via grievances.		
Required Actions: None.		

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
3. Ensures Compliance: *42 CFR 438.206(c)(1)(iv-v); Contract 4.8.1.11* The CMO has mechanisms to monitor and ensure the CMO and its providers comply with the access and timeliness requirements and that members have timely access to quality care.	Amerigroup monitors its providers to ensure compliance with the access and timeliness requirements and that members have timely access to quality care. • Std.II.3 – Failed Survey Tracker Screenshot.docx (Screenshot shows internal tool used to track provider representative outreach & education) • Std.II.3 – After Hours Failed Survey Tracker Screenshot.docx (Screenshot shows internal tool used to track provider representative outreach & education) • Std.II.3 – After Hours Failed Provider 4Q2013 - Example • Std.II.3 - Failed Provider Letter 1Q2014- Example • Std.II.3 – GAGA CAID Provider Manual: Primary Care -Provider Access and Availability – pg. 74-75 of PDF document (pgs.72-73 if printed), Specialist Access and Availability – pg. 80 of PDF document (pg. 78 if printed) <u>Additional Supporting Documentation:</u> • Std. II. 3 Scion CS_3015 P&P	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided After-Hours Failed Survey Tracker screenshots of its tracking database. The CMO included the After-Hours Failed Provider example along with a Failed Provider Letter example, and the CMO complies with the access and timeliness requirements.		
Required Actions: None.		
4. Takes Corrective Action: *42 CFR 438.206(c)(1)(vi); Contract 4.8.14.6* The CMO takes corrective action if there is a failure to perform in compliance with the timely access requirements.	Amerigroup takes corrective action if there is a failure to perform in compliance with the timely access requirements. If during the Appointment Availability Survey, the provider is found deficient, a completed Corrective Action Plan must be submitted to AMERIGROUP within 10 days of the failure notice. The	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	provider's progress is monitored and he/she/they are resurveyed within 60 days. • Std.II.4 – Failed Survey Tracker Screenshot.docx (Screenshot shows internal tool used to track provider representative outreach & education) • Std.II.4 – After Hours Failed Survey Tracker Screenshot.docx (Screenshot shows internal tool used to track provider representative outreach & education) • Std. II.4 – After Hours Failed Provider 4Q2013 - Example • Std. II.4 – Failed Provider Letter 1Q2014- Example • Std. II.4 - GA AGP Access Avail Script Update GF360 - 6.4.14 • Std.II.4 - GA AfterHours Survey-FINAl2013 Q3 • Std. II.4- GA_ATL_Access_Analysis_3Q13 Std. II.4- GA_Central_Access_Analysis_3Q13 • Std. II.4- GA_East_Access_Analysis_3Q13 Std. II.4- GA_North_Access_Analysis_3Q13 • Std. II.4- GA_Southwest_Access_Analysis_3Q13 • Std. II.4- GA_SE_Access_Analysis_3Q13 • Std. II.4 - Scion UM_1290 P&P • Std. II.4 - Scion PA_5120 P&P	
Findings: CMO staff members summarized the corrective action process and provided example provider letters used during the corrective action process.		
Required Actions: None.		

Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
5. Geographic Access: *Contract 4.8.13.1* The CMO meets the following geographic access standards for all members:	Amerigroup meets the following geographical access standards for all members. • Std. II.5 - GA_ATL_Access_Analysis_3Q13 • Std. II.5 - GA_ATL_Access_Analysis_4Q13 • Std. II.5- GA_ATL_Access_Analysis_1Q14 • Std. II.5- GA_Central_Access_Analysis_3Q13 • Std. II.5 - GA_Central_Access_Analysis_4Q13 • Std. II.5- GA_Central_Access_Analysis_1Q14 • Std. II.5- GA_East_Access_Analysis_3Q13 • Std. II.5 - GA_East_Access_Analysis_4Q13 • Std. II.5 - GA_East_Access_Analysis_1Q14 • Std. II.5- GA_North_Access_Analysis_3Q13 • Std. II.5 - GA_North_Access_Analysis_4Q13 • Std. II.5 - GA_North_Access_Analysis_1Q14 • Std. II.5- GA_Southwest_Access_Analysis_3Q13 • Std. II.5 -GA_Southwest_Access_Analysis_4Q13 • Std. II.5 -GA_Southwest_Access_Analysis_1Q14 • Std. II.5 - GA_SE_Access_Analysis_3Q13 • Std. II.5 -GA_SE_Access_Analysis_4Q13 • Std. II.5 - GA_SE_Access_Analysis_1Q14 • Std II.5 - Network Deficiency Report 2013 Q2 • Std II.5 - Network Deficiency Report 2013 Q3 • Std II.5 - Network Deficiency Report 2013 Q4 • Std II.5 - Network Deficiency Report 2014 Q1 • Std.II.5 - Georgia_Panel_Status_-_Detail(1) May2014 Revised • Std II.5 - PCP Closed Panel Request SBS 2014_vs revision • Std. II.5 - Scion PA_1010 P&P	☐ Met ☒ Not Met ☐ N/A

	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

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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.		
6. Assurances of Adequate Capacity and Services: *42 CFR 438.207(a)* The CMO assures DCH and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DCH's standards for access to care and in accordance with the following requirements:		
(a) **Nature of Supporting Documentation:** *42 CFR 438.207(b)(1-2); Contract; 4.18.6.1; 5.7–8* The CMO submits documentation to DCH in a format specified by the State to demonstrate that it complies with the following requirements:	AMERIGROUP submits reports to DCH on a monthly and quarterly basis in the format provided by DCH. The reports demonstrate evidence of a provider network with various types of specialties in geographic locations based on membership by region. • Std. II. 6(a) - GA_ATL_Access_Analysis_3Q13 • Std. II. 6(a) GA_Central_Access_Analysis_3Q13 • Std. II. 6(a) - GA_East_Access_Analysis_3Q13 • Std. II. 6(a) - GA_North_Access_Analysis_3Q13 • Std. II.6(a) - GA_SW_Access_Analysis_3Q13 • Std. II.6(a) - GA_SE_Access_Analysis_3Q13	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Additional Supporting Documentation • Std. II.6(a) - Scion PA_1010 P&P	
Findings: AMERIGROUP conducted a GeoAccess analysis to verify its geographic access requirements, and these reports were formatted in an acceptable manner for the State.		
Required Actions: None.		
(i) Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.	Amerigroup offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area. • Std. II. 6(a) - GA_ATL_Access_Analysis_3Q13 • Std. II. 6(a) GA_Central_Access_Analysis_3Q13 • Std. II. 6(a) - GA_East_Access_Analysis_3Q13 • Std. II. 6(a) - GA_North_Access_Analysis_3Q13 • Std. II.6(a) - GA_SW_Access_Analysis_3Q13 • Std. II.6(a) - GA_SE_Access_Analysis_3Q13 Additional Supporting Documentation • Std. II.6(a) - Scion PA_1010 P&P	☒ Met ☐ Not Met ☐ N/A
Findings: The GeoAccess reports provided evidence that the CMO offers an appropriate range of preventive, primary care, and specialty services that were adequate for anticipated membership.		
Required Actions: None.		
(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	AMERIGROUP maintains a provider network based on the number, mix, and geographic distribution in the each service area. This is based on current membership and all anticipated membership changes. Quarterly GEO Access Reports are completed for geographic review, monitoring of monthly membership numbers, and expected changes in membership. AMERIGROUP also reviews all complaints regarding access. This Quarterly review occurs by specialty in each region (CAP report for DCH), review of appointment availability studies as well as a review of utilization by types of services. This review	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	ensures all provider specialties are covered to meet the needs of our population. • Std. II.5 - GA_ATL_Access_Analysis_3Q13 • Std. II.5 - GA_Central_Access_Analysis_3Q13 • Std. II.5 - GA_East_Access_Analysis_3Q13 • Std. II.5 - GA_North_Access_Analysis_3Q13 • Std. II.5 GA_Southwest_Access_Analysis_3Q13 • Std. II.5 - GA_SE_Access_Analysis_3Q13 • Std II.5 - Network Deficiency Report 2013 Q2 • Std II.5 - Network Deficiency Report 2013 Q3 • Std II.5 - Network Deficiency Report 2013 Q4 • Std II.5 - Network Deficiency Report 2014 Q1	
Findings: The GeoAccess reports provided evidence that the CMO maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated membership.		
Required Actions: None.		
(b) **Timing of Documentation:** *42 CFR 438.207(c)(1-2); Contract 5.7-8* The CMO submits the DCH-required documentation according to the DCH contract requirements, but no less frequently than at any time that there has been either of the following: ◆ A significant change (as defined by DCH) in the CMO's operations that would affect adequate capacity and services including changes in the CMO's services, benefits, geographic service area, or payments ◆ Enrollment of a new population	AMERIGROUP submits the DCH required documentation according to contractual requirements when there is a significant change as defined by DCH or enrollment of a new population. AMERIGROUP submits this information through our Termination Report, GEO Access Report and Payment report. • Std. II. 5(b) - GA_ATL_Access_Analysis_3Q13 • Std. II. 5(b) - GA_Central_Access_Analysis_3Q13 • Std. II. 5(b) - GA_East_Access_Analysis_3Q13 • Std. II. 5(b) - GA_North_Access_Analysis_3Q13 • Std. II. 5(b) - GA_SW_Access_Analysis_3Q13 • Std. II. 5(b) - GA_SE_Access_Analysis_3Q13 • Std. II. 5(b) - 0652 Provider Termination Report	☒ Met ☐ Not Met ☐ N/A

Standard II—Furnishing of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	- Avesis M0514 • Std. II. 5(b) - 0652 Provider Termination Report - Cred M0514 • Std. II. 5(b) - 0652 Provider Termination Report - Scion M0514 • Std. II.5(b) - Scion PA_1010 P&P	
Findings: The GeoAccess reports provided evidence that the CMO maintains a network of providers sufficient to meet the needs of the anticipated membership.		
Required Actions: None.		

Standard II––Furnishing of Services Results					
Met	=	20	X 1.00	=	20.0
Not Met	=	2	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	22	**Total Score**	=	90.9%

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Furnishing of Services—Cultural Considerations: *42 CFR 438.206(c)(2)* The CMO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds as demonstrated by the following:		
1. Comprehensive Written Plan: *Contract 4.3.9.1* The CMO has a comprehensive written cultural competency plan that describes how the CMO ensures that services are provided in a culturally competent manner to all members, including those with limited English proficiency.	Amerigroup has a comprehensive written cultural competency plan that describes how we ensure services are provided in a culturally competent manner to all of our members, including those with limited English proficiency. • Std. III.1-WEB GA 0024 13 Cultural Competency Strategic Plan.	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP provided its Cultural Competency Strategic Plan, which described how the CMO ensured services were provided in a culturally competent manner to its members including those with limited English proficiency.		
Required Actions: None.		
2. Comprehensive Written Plan—Content: *Contract 4.3.9.1* The CMO's cultural competency plan describes how providers, individuals, and systems within the CMO plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each.	Amerigroup's cultural competency plan describes how providers, individuals, and systems within the plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. • Std. III.2 – WEB GA 0024 13 Cultural Competency Strategic Plan and Cultural Competency Action Plan Final.	☒ Met ☐ Not Met ☐ N/A
Findings: The Cultural Competency Strategic Plan indicated how providers and individuals within AMERIGROUP's plan provided services in a culturally competent manner.		
Required Actions: None.		

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
3. Plan Submitted to DCH: *Contract 4.3.9.2* The CMO submits its cultural competency plan to DCH for review and approval as updated.	Amerigroup submitted the 2013 Cultural Competency Plan to the DCH. The 2014 Cultural Competency Plan was submitted to the DCH in June 2014. There were no material changes to the plan. As such, it was submitted as an informational submission for 2014. • Std. III.3 –WEB GA 0024 13 Cultural Competency Plan.	☒ Met ☐ Not Met ☐ N/A
Findings: CMO staff members provided evidence that the cultural competency plan was submitted to DCH annually with changes highlighted. The State recommended changes or approved the competency plan when it was appropriate.		
Required Actions: None.		
4. Provides Plan Summary to Providers: *Contract 4.3.9.3* The CMO provides a summary of its cultural competency plan to its in-network providers, which includes information on how the providers (i) may access the full plan on the CMO's Web site and (ii) can request a hard copy from the CMO at no charge to the provider.	Amerigroup provides a summary of its cultural competency plan to its in-network providers, which includes information on how the providers (i) may access the full plan on our Web site and (ii) can request a hard copy from Amerigroup at no charge to the provider. • Std.III.4- WEB GA 0024 13 Cultural Competency Plan and GAGA CAID Provider Manual pages 81-83 of the PDF document and pages 79-81 if printed.	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO provided a copy of the full cultural competency plan that was posted on its Web site. The CMO also summarized the cultural competency plan in its provider manual.		
Required Actions: None.		
5. Provides Oral Interpretation: *42 CFR 438.10(c)(4); Contract 4.3.10.1* The CMO provides oral translation services of information to any member who speaks any non-English language regardless of whether a member speaks a language that meets the threshold for "prevalent non-English" language.	Amerigroup provides oral translation services of information to any member who speaks any non-English language regardless of whether a member speaks a language that meets the threshold for "prevalent non-English" language. • Std.III.5- GAGA CAID PC MHB ENG 6_14 pgs. 2-3 of the PDF document.	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP provided oral translation services, and a summary of those services was provided in the member handbook. CMO staff members		

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
indicated they have had many conversations with the State about whether the provider was responsible for these services or if the CMO was responsible, and AMERIGROUP holds the provider responsible for these services.		
Required Actions: None.		
6. Notifies Members—Oral Interpretation: *42 CFR 438.10(c)(5); Contract 4.3.10.1* The CMO notifies members of the availability of oral interpretation services and informs them of how to access the services.	Amerigroup notifies members of the availability of oral interpretation services and informs them of how to access the services. • Std.III.6- GAGA CAID PC MHB ENG 6_14 pgs. 2-3 of PDF document.	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook provided evidence that the member should call the member services line to obtain oral interpretation services.		
Required Actions: None.		
7. Oral Interpretation—Free to Members: *42 CFR 438.10(c)(4); Contract 4.3.10.1* The CMO does not charge members for translation services.	Amerigroup does not charge members for translation services. • Std.III.7 GAGA CAID PC MHB ENG 6_14 pg. 11 of the PDF document and page 2 if printed.	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook provided evidence that oral translation services were available by calling the member services line and that the service was at no cost to the member.		
Required Actions: None.		
8. Written Materials—Alternative Formats: *42 CFR 438.10(d)(1)(ii); Contract 4.3.2.1* The CMO makes all written member materials 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.	Amerigroup makes all written member materials 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. • Std.III.8 -GAGA CAID PC MHB ENG 6_14 page 11 of the PDF document. If printed it is on page 2.	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed the member that the handbook was available in large printer, on audio tape, and in Braille. Members needing any of these formats should call member services.		
Required Actions: None.		

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
9. Informs Members—Alternative Formats: *42 CFR 438.10(d)(2); Contract 4.3.2.1* The CMO notifies all members and potential members that information is available in alternative formats and how to access those formats.	Amerigroup notifies all members and potential members that information is available in alternative formats and how to access those formats. • Std.III.9 -GAGA CAID PC MHB ENG 6_14 - page 11 of the PDF document. If printed it is on pages 1-2. • Std.III.9 - WEB GA 0024 13 Cultural Competency Plan – pg.9	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook informed the member that the handbook was available in large printer, on audio tape, and in Braille. Members needing any of these formats should call member services.		
Required Actions: None.		
10. Written Materials—Available Languages: *42 CFR 438.10(c)(3); Contract 4.3.2.2* The CMO makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH (i.e., a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State).	Amerigroup makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH (i.e., a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State). • Std.III.10 -GAGA CAID PC MHB ENG 6_14 - page 11 of the PDF document. If printed it is on pages 1-2. • Std. III. 10 - Written Materials Guidelines – GA. • Std.III.10- WEB GA 0024 13 Cultural Competency Plan – pg.9	☒ Met ☐ Not Met ☐ N/A
Findings: The member handbook indicated that if a member does not speak English, oral translation services were available if needed. Both the English and Spanish versions of the member handbook were available on AMERIGROUP's Web site.		
Required Actions: None.		
11. Written Materials—Language Block: *Contract 4.3.2.3* All written materials the CMO distributes to members include a language block, printed in Spanish and all other prevalent non-English languages, that	All written materials that Amerigroup distributes to members include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important	☒ Met ☐ Not Met ☐ N/A

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
informs the member that the document contains important information and directs the member to call the CMO to request the document in an alternative language or to have it orally translated.	information and directs the member to call the CMO to request the document in an alternative language or to have it orally translated. • Std.III.11- GAGA CAID PC MHB ENG pgs. 2-3 of the PDF document • Std. III. 11- Written Materials Guidelines – GA. Examples of additional written materials will be provided during the on-site visit • Std.III.11- WEB GA 0024 13 Cultural Competency Plan – pg.9	
Findings: The member handbook included language blocks in many languages, including Spanish.		
Required Actions: None.		
12. Written Materials—Understandable: *42 CFR 438.10(b)(i); Contract 4.3.2.4* The CMO has and follows processes to ensure that its written member materials are worded such that they are understandable to a person who reads at the fifth (5th) grade level.	Amerigroup has and follows processes to ensure that its written member materials are worded such that they are understandable to a person who reads at the fifth (5th) grade level. • Std. III.12 - Written Materials Guidelines – GA. • Std.III.12- WEB GA 0024 13 Cultural Competency Plan – pg.9	☒ Met ☐ Not Met ☐ N/A
Findings: CMO staff members indicated that the CMO used Flesch-Kincaid software to verify the reading level of its written materials, and the CMO complies with this element.		
Required Actions: None.		
13. Medicaid Members Not Segregated: *Contract 4.8.16.1* The CMO ensures that all in-network providers (i) accept members for treatment, unless they have a full panel and are accepting no new GF or commercial patients and (ii) do not intentionally segregate members in any way from other persons receiving services.	Amerigroup ensures that all in-network providers (i) accept members for treatment, unless they have a full panel and are accepting no new GF or commercial patients and (ii) do not intentionally segregate members in any way from other persons receiving services. • Std.III.13 - GAGA CAID Provider Manual pages 81-83 of the PDF document and pages 79-81 if printed	☒ Met ☐ Not Met ☐ N/A

Standard III—Cultural Competence		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.III.13- WEB GA 0024 13 Cultural Competency Plan	
Findings: The provider manual provided evidence that AMERIGROUP providers must accept all members referred to them, which was also consistent with the CMO's cultural competency plan.		
Required Actions: None.		
14. Nondiscrimination: *42 CFR 438.6(d)(iv); 42 CFR 438.100(d); Contract 4.8.16.2* The CMO ensures that members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.	Amerigroup ensures that members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability. • Std.III.14 - GAGA CAID Provider Manual pages 81-83 of the PDF document and pages 79-81 if printed • Std.III.14- WEB GA 0024 13 Cultural Competency Plan	☒ Met ☐ Not Met ☐ N/A
Findings: The AMERIGROUP provider manual indicated that the CMO accepted all eligible people regardless of age, sex, race, or disability.		
Required Actions: None.		

Standard III––Cultural Competence Results					
Met	=	14	X 1.00	=	14.0
Not Met	=	0	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	14	**Total Score**	=	100.0%

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. CMO Responsibilities: *42 CFR 438.208(b); Contract 4.11.8.1–2* The CMO assumes responsibility for care coordination that is designed to ensure and promote timely access to care/services, continuity of care, and coordination/integration of care.	Amerigroup assumes responsibility for care coordination to ensure timely access to care/services, continuity of care, and coordination/integration of care for its members. • Std.IV.1 GAGA CAID PC MHB ENG: Care Coordination pg. 66 of PDF document (pg. 1 if printed). Case Management pgs. 43-44 of PDF document (pgs. 34-35 if printed) • Std.IV.1 GAGA CAID Provider Manual: Care Coordination and Case Management pg. 126-128 of PDF document (pgs. 124-126 if printed) Additional Supporting Documentation: • Std. IV.1 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.1 - Case Management Program Overview - GA • Std. IV.1 Coordination of Care Between Behavioral Health and Medical Management • Std. IV.1 - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg. 4-7, 12-27, 36-37. • Std. IV.1 - Care Coordination Through Community Based Organizations – GA • Std. IV.1 - Continuity of Care Core Process • Std. IV.1 - Coordination of Care-GA • Std. IV.1 - Specialty Referral • Std. IV.1 - Specialty Referral-GA • Std. IV.1 - Services for Members in Waiver Programs- GA • Std. IV.1 - Complex Case Management Description.2014-GA Final • Std. IV.1 - Care Coordination Team. Members	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	transferring from FFS or another CMO • Std. IV.1 - Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.1 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.1 - Single Case Agreement Process • Std. IV.1 - Out-of-Service Area - Out-of-Network Care • Std. IV.1 - Single Case Agreement Form • Std. IV.1 - Second Opinion • Std. IV.1 - Second Medical Opinion	
Findings: AMERIGROUP had policies and procedures in place that promoted timely access to care and ensured continuity and coordination of physical and behavioral health care needs.		
Required Actions: None.		
2. Policies and Procedures: *42 CFR 438.208(b); Contract 4.11.8.3* The CMO has policies and procedures designed to accommodate the specific cultural and linguistic needs of its members and include, at a minimum: ◆ Provision of an individual needs assessment and diagnostic assessment; development of an individual treatment plan, as necessary, based on the needs assessment; establishment of treatment objectives; monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary. ◆ A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning. ◆ Procedures and criteria for making referrals to specialists and sub-specialists. ◆ Procedures and criteria for maintaining care plans and referral	Amerigroup has policies and procedures designed to accommodate the specific cultural and linguistic needs of its members. Please see the policies below: • Std. IV.14 Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV. 14 Case Management Program Overview - GA • Std. IV.14 Coordination of Care Between Behavioral Health and Medical Management • Std. IV.14 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.14 Care Coordination Through Community Based Organizations – GA • Std. IV.14 Continuity of Care Core Process	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
services when the member changes PCPs. ◆ Capacity to implement, when indicated, case management functions such as individual needs assessments, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plans.	• Std. IV.14 Coordination of Care-GA • Std. IV.14 Specialty Referral (Corporate) • Std. IV.14 Specialty Referral-GA Std. IV.14 Services for Members in Waiver Programs- GA • Std. IV.14 Complex Case Management Description.2014-GA Final • Std. IV.14 Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.14 Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.14 - GAGA CAID PC MHB ENG – pg. 11 (Care Coordination, pg 34-35 (PDF pages - 43-44) (Case Management) • Std. IV.14 - GAGA CAID Provider Manual pg. 124 (PDF page 126) (Care Coordination and Case Management)	
Findings: AMERIGROUP presented a comprehensive assessment process that addressed the member's physical and behavioral health, psychosocial, cultural, and linguistic needs. The assessment process was inclusive of the member, family/caregivers, and the member's provider(s) and was used to develop individual treatment plan goals and objectives that were measurable, realistic, and obtainable for the member.		
Required Actions: None.		
3. Ongoing Source of Primary Care: *42 CFR 438.208(b)(1); Contract 4.1.2; 4.8.2.1; 4.8.2.3; 4.8.2.5* The CMO: ◆ Has written PCP selection policies and procedures describing how members select their PCP. ◆ Ensures that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished.	Amerigroup has PCP selection policies and procedures which describe how each member selects their PCP and ensures that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity (PCP) formally designated as primarily responsible for coordinating the member's health care services. • Std. IV.15 - Primary Care Provider Selection Assignment and Change Requests Std. IV.15 - GAGA CAID PC MHB ENG: pgs. 13-15,20 of PDF document (pgs. 4-6,11 if printed)	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.15 -GAGA CAID Provider Manual: Member Eligibility pgs. 19-22 of PDF document (pgs. 17-20 if printed). Provider Responsibilities, PCP Access and Availability - pgs. 71-74 of PDF document (pgs. 69-72 if printed) <u>Additional Supporting Documentation:</u> • Std. IV.15 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.15 - Case Management Program Overview - GA • Std. IV.15 - Coordination of Care Between Behavioral Health and Medical Management • Std. IV.15 - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg. 4-7, 12-28, and 36-37. • Std.IV.15 - Care Coordination Through Community Based Organizations – GA • Std. IV.15 - Continuity of Care Core Process • Std. IV.15 - Coordination of Care-GA • Std. IV.15 - Specialty Referral • Std. IV.15 - Specialty Referral-GA • Std. IV.15 - Services for Members in Waiver Programs- GA • Std. IV.15 - Complex Case Management Description.2014-GA Final • Std. IV.15 - Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.15 - Care Coordination Team. Members transitioning out of Foster Care and DJJ.	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: AMERIGROUP provided policies and procedures as evidence of the formalized process for a member to select a PCP. AMERIGROUP ensured that all members had an ongoing source of primary care that met their needs. Members were offered freedom of choice in selecting an in-network PCP at any time during their enrollment with AMERIGROUP.		
Required Actions: None.		
4. PCP Responsibility for Coordinating Care: *42 CFR 438.208(b)(1); Contract 4.8.2.5* The CMO ensures that the primary care providers fulfill their responsibilities for: ◆ Supervising, coordinating, and providing all primary care to each assigned member. ◆ Coordinating and/or initiating referrals for specialty care (both in and out of network). ◆ Maintaining continuity of care. ◆ Maintaining member medical records, which includes documenting all services provided by the PCP as well as the specialty services.	Amerigroup ensures that the primary care providers fulfill responsibilities for coordinating care for its members. • Std. IV.20 Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.20 Case Management Program Overview - GA • Std. IV.20 Coordination of Care Between Behavioral Health and Medical Management • Std. IV.20 - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.20 - Care Coordination Through Community Based Organizations – GA • Std. IV.20 - Continuity of Care Core Process • Std. IV.20 - Coordination of Care-GA • Std. IV.20 - Specialty Referral • Std. IV.20 - Specialty Referral-GA • Std. IV.20 - Services for Members in Waiver Programs- GA • Std. IV.20 - Complex Case Management Description.2014-GA Final • Std. IV.20 - Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.20 - Care Coordination Team. Members transitioning out of Foster Care and DJJ.	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.20 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.20 - GAGA_CAID-PC_MHB_ENG 6_14 (Care Coordination, pg 34-35 (Case Management) • Std. IV.20 - GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management) • Std. IV.20 - GAGA_CAID-PC_MHB_ENG 6_14 • STD IV.20 - GAGA_CAID_ProviderManual (Member Eligibility),51-53(Provider Responsibilities, PCP Access and Availability)pg. 69-72 • Std. IV.20 - Second Opinion • Std. IV.20 - Second Medical Opinion	
Findings: AMERIGROUP provided documentation that in-network providers were expected to participate in any reasonable internal or external quality assurance, utilization review, continuing education, and/or other similar programs established by AMERIGROUP.		
Required Actions: None.		
5. Coordination and Transition Across Providers/Settings, Including Other CMOs, PIHPs, PAHPs: *42 CFR 438.208(b)(2); Contract 4.8.17.1; 4.11.4.1*; Addendum 4.8.17.11 The CMO's care coordination system includes:		
(a) Advocating for and linking or transitioning members to services as necessary across providers and settings, including, as applicable, other CMOs, PIHPs, PAHPs, and fee-for-service providers.	Amerigroup's care coordination system includes transitioning members to services as necessary across providers and settings, including, as applicable, other CMOs, PIHPs, PAHPs, and fee-for-service providers. • Std. IV.21a Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.21a Case Management Program Overview - GA • Std. IV. 21a Coordination of Care Between	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Behavioral Health and Medical Management • Std. IV.21a 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.21a Care Coordination Through Community Based Organizations – GA • Std. IV.21a Continuity of Care Core Process • Std. IV.21a Coordination of Care-GA • Std. IV.21a Specialty Referral • Std. IV.21a Specialty Referral-GA • Std. IV.21a Services for Members in Waiver Programs- GA • Std. IV.21a Complex Case Management Description.2014-GA Final • Std. IV.21a Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.21a Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.21a Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.21a -Transition of Care-State • STD IV.21a-GF Universal TOC Form • Std. IV.21a -Second Opinion • Std. IV.21a -Second Medical Opinion • Std. IV.21a- Out-of-Service Area - Out-of-Network Care • Std. IV.21a- Single Case Agreement Process • Std. IV.21a- Single Case Agreement Form Additional Supporting Documentation:	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.IV.21a- GAGA CAID PC MHB ENG: Care Coordination - pg. 66 of PDF document (pg. 1 if printed), pgs. 13-15 of PDF format (pgs. 4-6 if printed), Case Management – pgs. 43-44 of PDF document (pgs. 34-35 if printed) • Std.IV.21a- GAGA CAID Provider Manual: Care Coordination and Case Management – pgs. 126-128 of PDF document (pgs. 124-126 if printed) • Care Coordination Team- Members transferring from FFS or another CMO Workflow • Transition of Care-Process	
Findings: AMERIGROUP provided documentation as evidence and reported during the on-site audit that members were supported across the continuum of care. The care management program assessed member needs, and helped staff to coordinate and monitor care to provide service options that supported the members overall health care needs.		
Required Actions: None.		
(b) Coordinating the member care with these other entities.	Amerigroup coordinates member care with other entities as evidenced in the following: • Std. IV.21b Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV .Case Management Program Overview - GA • Std. IV.21b Coordination of Care Between Behavioral Health and Medical Management • Std. IV. 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.21b Care Coordination Through Community Based Organizations – GA • Std. IV.21b Continuity of Care Core Process • Std. IV.21b Coordination of Care-GA • Std. IV.21b Specialty Referral	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV. Specialty Referral-GA • Std. IV.21b Services for Members in Waiver Programs- GA • Std. IV.21b Complex Case Management Description.2014-GA Final • Std. IV.21b Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.21b Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.21b Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.21b -Transition of Care-State • STD IV.21b -GF Universal TOC Form • Std. IV.21b Second Opinion • Std. IV.21b Second Medical Opinion • Std. IV.21b E-Form 05-9-2014 DJJ Only • Std. IV.21b E-Form 05-9-2014 DFCS Only • Std. IV.21b Out-of-Service Area - Out-of-Network Care • Std. IV.21b Single Case Agreement Process • Std. IV.21b Single Case Agreement Form <u>Additional Supporting Documentation:</u> • Std.IV.21b GAGA CAID PC MHB ENG: Care Coordination - pg. 66 of PDF document (pg. 1 if printed), Case Management – pgs. 43-44 of PDF document (pgs. 34-35 if printed) • Std.Iv.21b GAGA CAID Provider Manual: Care Coordination and Case Management – pgs. 126-128 of PDF document (pgs. 124-126 if printed)	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: AMERIGROUP provided policies and procedures that outlined the coordination of member services. AMERIGROUP staff members collaborated with the member to coordinate clinical care to ensure quality, cost-efficient health care services.		
Required Actions: None.		
6. Coordinates and Shares Information With Other Organizations Serving the Member (e.g., CMOs, PIHPs, and PAHPS, Education, etc.): *42 CFR 438.208(b)(3); Contract 4.8.17.1–5*; Addendum 4.11.8.5 The CMO coordinates and shares information with: ◆ All divisions within DCH, as well as with other State agencies, and with other health plans operating within the same service region. ◆ Local education agencies in the referral and provision of children's intervention services provided through the school to ensure medical necessity and prevent duplication of services. ◆ The services furnished to its members with the service the member receives outside the CMO plan, including services received through any other managed care entity. ◆ Non-Emergency Transportation (NET) Providers. ◆ Ideally, with CMO-contracted providers of essential community services who would normally contract with the State as well as other public agencies and with non-profit organizations that have maintained a historical base in the community.	Amerigroup coordinates and shares information with other organizations serving the member including (CMOs, PIHPs, and PAHPS, Education, etc.) • Std. IV.22 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.22 - Case Management Program Overview - GA • Std. IV.22 - Coordination of Care Between Behavioral Health and Medical Management • Std. IV.22 - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.22 - Care Coordination Through Community Based Organizations – GA • Std. IV.22 - Continuity of Care Core Process • Std. IV.22 - Coordination of Care-GA • Std. IV.22 - Specialty Referral • Std. IV.22 - Specialty Referral-GA • Std. IV.22 - Services for Members in Waiver Programs- GA • Std. IV.22 - Complex Case Management Description.2014-GA Final • Std. IV.22 - Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.22 - Care Coordination Team. Members transitioning out of Foster Care and DJJ.	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.22 - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.22 - Transition of Care-State • Std IV.22 - GF Universal TOC Form • Std. IV.22 - GAGA_CAID-PC_MHB_ENG 6_14, pg 11 (Care Coordination, pg 33-34 (Case Management) • Std IV.22 - GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management) • Std. IV.22 - GAGA_CAID-PC_MHB_ENG 6_14, pgs. 4-6 • Std. IV.22 - GAGA_CAID_ProviderManual pgs., 17-20 (Member Eligibility),51-53(Provider Responsibilities, PCP Access and Availability)pg. 69-72 • Std. IV.22 - Second Opinion • Std. IV.22 - Second Medical Opinion • Std. IV.22 - Exceptional Transportation- In State-Out of Area Form • Std. IV.22 - Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.22 - Exceptional Transportation • Std. IV.22 - NET Transportation • Std. IV.22 - Social Work Referrals • Std. IV.22 - Exceptional Transportation-Out of State Form	
Findings: AMERIGROUP provided documentation and reported during the on-site interview that the CMO collaborates with DCH and other organizations to ensure continuity of care through coordination and sharing of members' needs. CMO staff also reported that case managers worked with eligible members to facilitate transportation services when necessary for Medicaid services.		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
7. Protects Member Privacy: *45 CFR 160 and 164, subparts A and E; Contract 4.8.17.6* The CMO implements procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements.	Amerigroup has procedures to ensure each Member's privacy is protected consistent with the confidentiality requirements in the process of coordinating care. • Std. IV.23 - Member Privacy Rights (Corporate Policy) • Std. IV.23 - Privacy and Security Incident Reporting (Corporate Policy) • Std. IV.23 - GAGA CAID Provider Manual: Members Rights and Responsibilities – pgs. 47-50 of PDF format (pgs. 45-48 if printed), Confidentiality – pg. 105 of PDF format (pg. 103) • Std. IV.23 - GAGA CAID PC MHB ENG: Notice of Privacy Practices – pg. 59 of PDF format (pg. 48 if printed), Member Rights – pg. 56-59 of PDF format (pg. 47-50 if printed) • Std. IV.23 -2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg. 36- Case management Ethics	☒ Met ☐ Not Met ☐ N/A
Findings: AMERIGROUP provided policies and procedures that outlined the CMO's established method of documenting and tracking members' privacy rights.		
Required Actions: None.		
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	Amerigroup's care coordination system includes case management, disease management, transition of care and discharge planning. • Std. IV.24 Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV .24Case Management Program Overview - GA • Std. IV.24 Coordination of Care Between Behavioral	☐ Met ☒ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Health and Medical Management • Std. IV.24 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.24 Care Coordination Through Community Based Organizations – GA • Std. IV.24 Continuity of Care Core Process • Std. IV.24 Coordination of Care-GA • Std. IV.24 Specialty Referral • Std. IV.24 Specialty Referral-GA • Std. IV.24 Services for Members in Waiver Programs- GA • Std. IV.24 Complex Case Management Description.2014-GA Final • Std. IV.24 Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.24 Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.24 Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.24 -Transition of Care-State • Std. IV.24 -GF Universal TOC Form • Std.IV.24 GAGA CAID PC MHB ENG: Care Coordination – pg. 66 of PDF format (pg. 1 if printed), Disease/Case Management - pgs.42-44 of PDF format (pgs. 33-35 if printed) • Std.IV.24 GAGA-CAID Provider Manual Care Coordination and Case Management – pg. 126 of PDF format (pg.124 if printed), Discharge Planning – pg. 104 of PDF format (pg. 102 if printed)	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.24 Second Opinion • Std. IV.24 Second Medical Opinion • Std. IV.24-Exceptional Transportation- In State-Out of Area Form • Std. IV.24 Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.24 Exceptional Transportation • Std. IV.24 NET Transportation • Std. IV.24 Social Work Referrals • Std. IV.24-Exceptional Transportation-Out of State Form • Std. IV.24 Discharge Planning for Behavioral Health Care-GA • Std. IV.24 Discharge Planning From a Facility – GA • Std. IV.24 Disease Management Program Description • Std. IV. 24 Out-of-Service Area - Out-of-Network Care	
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 setting. Ensure that all discharge documentation is available in the member's electronic health record (EHR).		
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:		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
(a) Early identification of members who have or may have special needs.	Amerigroup's case management system emphasizes prevention, continuity of care, and coordination of care for early identification of members who may have special needs. • Std. IV.25a - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25a - Case Management Program Overview - GA • Std. IV.25a - Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25a - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25a - Care Coordination Through Community Based Organizations – GA • Std. IV.25a - Continuity of Care Core Process • Std. IV.25a - Coordination of Care-GA • Std. IV.25a - Specialty Referral • Std. IV. Specialty Referral-GA • Std. IV.25a- Services for Members in Waiver Programs- GA • Std. IV.25a - Complex Case Management Description.2014-GA Final • Std. IV.25a - Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25a - Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25a - Transition of Care-State • Std. IV.25a - GF Universal TOC Form • Std. IV.25a - GAGA_CAID-PC_MHB_ENG 6_14,	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25a - GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25a - Second Opinion • Std. IV.25a - Second Medical Opinion • Std. IV.25a - Exceptional Transportation- In State-Out of Area Form • Std. IV.25a - Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25a - Exceptional Transportation • Std. IV.25a - NET Transportation • Std. IV.25a - Social Work Referrals • Std. IV.25a - Exceptional Transportation-Out of State Form • Std. IV.25a - Discharge Planning for Behavioral Health Care-GA • Std. IV.25a - Discharge Planning From a Facility – GA	
Findings: AMERIGROUP reported during the case file review that members were identified for case management through predictive modeling (CI3), staff referral, member self-referral, and provider referral. Members were placed in physical health case management, behavioral health case management, or ER case management and stratified based on need.		
Required Actions: None.		
(b) Assessment of member's risk factors.	• Std. IV.25b - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25b - Case Management Program Overview - GA • Std. IV.25b - Std. IV. Coordination of Care Between	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Behavioral Health and Medical Management • Std. IV.25b - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25b - Care Coordination Through Community Based Organizations – GA • Std. IV.25b - Continuity of Care Core Process • Std. IV.25b - Coordination of Care-GA • Std. IV.25b - Specialty Referral • Std. IV.25b - Specialty Referral-GA • Std. IV.25b - Services for Members in Waiver Programs- GA • Std. IV.25b - Complex Case Management Description.2014-GA Final • Std. IV.25b - Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25b - Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25b - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25b - Transition of Care-State • Std. IV.25b - GF Universal TOC Form • Std. IV.25b - GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25b - GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25b - Second Opinion	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25b - Second Medical Opinion • Std. IV.25b - Exceptional Transportation- In State-Out of Area Form • Std. IV.25b - Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25b - Exceptional Transportation • Std. IV.25b - NET Transportation • Std. IV.25b - Social Work Referrals • Std. IV.25b - Exceptional Transportation-Out of State Form • Std. IV.25b - Discharge Planning for Behavioral Health Care-GA Std. IV.25b- Discharge Planning From a Facility – GA	
Findings: AMERIGROUP used complexity leveling to assess member risk factors. A case manager completed an overall assessment to identify the severity of illness and the member's readiness to change, and assigned an acuity level. AMERIGROUP had identified five acuity levels: low, medium, high, severe, and complex/catastrophic. Intensity of services was based on the member's identified acuity level.		
Required Actions: None.		
(c) Development of a care plan.	• Std. IV.25c Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25c Case Management Program Overview - GA • Std. IV.25c Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25c - 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25c Care Coordination Through Community Based Organizations – GA	☐ Met ☒ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25c Continuity of Care Core Process • Std. IV.25c Coordination of Care-GA • Std. IV.25c Specialty Referral • Std. IV.25c Specialty Referral-GA • Std. IV.25c Services for Members in Waiver Programs- GA • Std. IV.25c Complex Case Management Description.2014-GA Final • Std. IV.25c Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25c Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25c Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25c Transition of Care-State • Std. IV.25c GF Universal TOC Form • Std. IV.25c GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25c - GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25c Second Opinion • Std. IV.25c Second Medical Opinion • Std. IV.25c Exceptional Transportation- In State-Out of Area Form • Std. IV.25c Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25c Exceptional Transportation	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25c NET Transportation • Std. IV.25c Social Work Referrals • Std. IV.25c Exceptional Transportation-Out of State Form • Std. IV.25c. Discharge Planning for Behavioral Health Care-GA • Std. IV.25c Discharge Planning From a Facility – GA	
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. HSAG was unable to identify the inclusion of the member, family, and/or provider during care plan development. 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 must include the member, guardian (if applicable), family, and providers in care plan development. AMERIGROUP needs to document the care plan start date, review date, and/or date of changes/updates to the care plan.		
(d) Referrals and assistance to ensure timely access to providers.	• Std. IV.25d Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25d Case Management Program Overview - GA • Std. IV.25d Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25d 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25d Care Coordination Through Community Based Organizations – GA • Std. IV.25d Continuity of Care Core Process • Std. IV.25d Coordination of Care-GA • Std. IV.25d Specialty Referral • Std. IV.25d Specialty Referral-GA	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25d Services for Members in Waiver Programs- GA • Std. IV.25d Complex Case Management Description.2014-GA Final • Std. IV.25d Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25d Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25d Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25d Transition of Care-State • Std. IV.25d GF Universal TOC Form • Std. IV.25d GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25d GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25d Second Opinion • Std. IV.25d Second Medical Opinion • Std. IV.25d Exceptional Transportation- In State-Out of Area Form • Std. IV.25d Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25d Exceptional Transportation • Std. IV.25d NET Transportation • Std. IV.25d Social Work Referrals • Std. IV.25d Exceptional Transportation-Out of State Form	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25d Discharge Planning for Behavioral Health Care-GA • Std. IV.25d Discharge Planning From a Facility – GA	
Findings: AMERIGROUP provided policies and procedures that outlined the CMO's referral process, and staff reported that the CMO's goal was to assist members in addressing care gaps and, based on individual needs, aid in the planning and facilitation of member-centric services and empower members to complete condition-specific self-care. HSAG noted during the case file review that case managers were identifying needs and making appropriate referrals.		
Required Actions: None.		
(e) Coordination of care actively linking the member to providers, medical services, residential, social and other support services where needed.	• Std. IV.25e Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25e.Case Management Program Overview - GA • Std. IV.25e Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25e CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25e Care Coordination Through Community Based Organizations – GA • Std. IV.25e Continuity of Care Core Process • Std. IV.25e Coordination of Care-GA • Std. IV.25e Specialty Referral • Std. IV.25e Specialty Referral-GA • Std. IV.25e Services for Members in Waiver Programs- GA • Std. IV.25e Complex Case Management Description.2014-GA Final • Std. IV.25e Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25e Care Coordination Team. Members	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	transitioning out of Foster Care and DJJ. • Std. IV.25e Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25e Transition of Care-State • Std. IV.25e GF Universal TOC Form • Std. IV.25e GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25e GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25e Second Opinion • Std. IV.25eSecond Medical Opinion • Std. IV.25e Exceptional Transportation- In State-Out of Area Form • Std. IV.25e Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25e Exceptional Transportation • Std. IV.25e NET Transportation • Std. IV.25e Social Work Referrals • Std. IV.25e Exceptional Transportation-Out of State Form • Std. IV.25e Discharge Planning for Behavioral Health Care-GA • Std. IV.25e Discharge Planning From a Facility – GA	
Findings: AMERIGROUP provided policies and procedures that outlined the CMO's coordination of member care. During the case file review, HSAG identified that case managers were actively supporting members in service coordination through contact with members' PCPs, and in the initiation and completion of referrals for residential, social, and other support services when identified.		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: None.		
(f) Monitoring.	• Std. IV.25f Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25f.Case Management Program Overview - GA • Std. IV.25f Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25f 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25f Care Coordination Through Community Based Organizations – GA • Std. IV.25f Continuity of Care Core Process • Std. IV.25f Coordination of Care-GA • Std. IV.25f Specialty Referral • Std. IV.25f Specialty Referral-GA • Std. IV.25f Services for Members in Waiver Programs- GA • Std. IV.25f Complex Case Management Description.2014-GA Final • Std. IV.25f Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25f Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25f Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25f Transition of Care-State • Std. IV.25f GF Universal TOC Form • Std. IV.25f GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Management) • Std. IV.25f. GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25f Second Opinion • Std. IV.25f Second Medical Opinion • Std. IV.25f Exceptional Transportation- In State-Out of Area Form • Std. IV.25f Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25f Exceptional Transportation • Std. IV.25f NET Transportation • Std. IV.25f Social Work Referrals • Std. IV.25f Exceptional Transportation-Out of State Form • Std. IV.25f Discharge Planning for Behavioral Health Care-GA • Std. IV.25f Discharge Planning From a Facility – GA	
Findings: During the case file review it was noted that the member's follow-up needs were identified by the case manager and the member was monitored based on the stratified risk level. Documentation presented during the file review demonstrated continued case manager contact with the member and outside providers.		
Required Actions: None.		
(g) Continuity of care.	• Std. IV.25g Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25g Case Management Program Overview - GA • Std. IV.25g Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25g 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28,	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	36-37. • Std. IV.25g Care Coordination Through Community Based Organizations – GA • Std. IV.25g Continuity of Care Core Process • Std. IV.25g Coordination of Care-GA • Std. IV.25g Specialty Referral • Std. IV.25g Specialty Referral-GA • Std. IV.25g Services for Members in Waiver Programs- GA • Std. IV.25g Complex Case Management Description.2014-GA Final • Std. IV.25g Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25g Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25g Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25g - Transition of Care-State • Std. IV.25g GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25g GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25g Second Opinion • Std. IV.25g Second Medical Opinion • Std. IV.25g Exceptional Transportation- In State-Out of Area Form • Std. IV.25g Therapy for Children's Disabilities -	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Georgia Plan - 2014 Final • Std. IV.25g Exceptional Transportation • Std. IV.25g NET Transportation • Std. IV.25g Social Work Referrals • Std. IV.25g Exceptional Transportation-Out of State Form • Std. IV.25g Discharge Planning for Behavioral Health Care-GA • Std. IV.25g Discharge Planning From a Facility – GA	
Findings: AMERIGROUP provided policies and procedures that outline the continuity of care process for member care. Case managers were responsible for coordination and continuity of care for members in case management, including transitioning member care.		
Required Actions: None.		
(h) Follow-up.	• Std. IV.25h Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25h Case Management Program Overview - GA • Std. IV.25h Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25h 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25h Care Coordination Through Community Based Organizations – GA • Std. IV.25h Continuity of Care Core Process • Std. IV.25h Coordination of Care-GA • Std. IV.25h Specialty Referral • Std. IV.25h Specialty Referral-GA • Std. IV.25h Services for Members in Waiver	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Programs- GA • Std. IV.25h Complex Case Management Description.2014-GA Final • Std. IV.25h Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25h Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25h Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25h Transition of Care-State • Std. IV.25h GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25h GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25h Second Opinion • Std. IV.25h Second Medical Opinion • Std. IV.25h Exceptional Transportation- In State-Out of Area Form • Std. IV.25h Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25h Exceptional Transportation • Std. IV.25h NET Transportation • Std. IV.25h Social Work Referrals • Std. IV.25h Exceptional Transportation-Out of State Form • Std. IV.25h Discharge Planning for Behavioral Health Care-GA	

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. IV.25h Discharge Planning From a Facility – GA	
Findings: AMERIGROUP staff reported during the case file review that the case manager was responsible for developing a schedule with the member to facilitate follow-up that could include, but was not limited to, counseling, referral to disease management, and self-management support. Follow-up schedules were based on acuity levels and on changes in the member's health status and progress made with treatment goals.		
Required Actions: None.		
(i) Documentation.	• Std. IV.25i Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.25i Case Management Program Overview - GA • Std. IV.25i Coordination of Care Between Behavioral Health and Medical Management • Std. IV.25i 2014 CM Program Description-GA MAC and QMC approved 04.28.14, pg 4-7, 12-28, 36-37. • Std. IV.25i Care Coordination Through Community Based Organizations – GA • Std. IV.25i Continuity of Care Core Process • Std. IV.25i Coordination of Care-GA • Std. IV.25i Specialty Referral • Std. IV.25i Specialty Referral-GA • Std. IV.25i Services for Members in Waiver Programs- GA • Std. IV.25i Complex Case Management Description.2014-GA Final • Std. IV.25i Care Coordination Team. Members transferring from FFS or another CMO • Std. IV.25i Care Coordination Team. Members transitioning out of Foster Care and DJJ. • Std. IV.25i Case Mgmt Care Coordination -	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Members w Special Healthcare Needs-GA • Std. IV.25i Transition of Care-State • Std. IV.25i GF Universal TOC Form • Std. IV.25i GAGA_CAID-PC_MHB_ENG 6_14, pg 12 (Care Coordination, pg 34-35 (Case Management) • Std. IV.25i GAGA_CAID_ProviderManual pg 124(Care Coordination and Case Management), Discharge Planning, pg 102 • Std. IV.25i Second Opinion • Std. IV.25i Second Medical Opinion • Std. IV.25i Exceptional Transportation- In State-Out of Area Form • Std. IV.25i. Therapy for Children's Disabilities - Georgia Plan - 2014 Final • Std. IV.25i Exceptional Transportation • Std. IV.25i NET Transportation • Std. IV.25i Social Work Referrals • Std. IV.25i Exceptional Transportation-Out of State Form • Std. IV.25i Discharge Planning for Behavioral Health Care-GA • Std. IV.25i Discharge Planning From a Facility – GA	
Findings: AMERIGROUP provided policies and procedures that outlined documentation expectations. During the case file review it was noted that documentation by case managers was all-inclusive and provided clear indication of all interventions, referrals, and communications between the case manager and the member, family/caregiver/guardian, and/or provider.		
Required Actions: None.		

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
10. Case Management—Identify Members With the Greatest Need: *42 CFR 438.208(c); Contract 4.11.9.3* The CMO makes a special effort to identify members who have the greatest need for case management, including those who have catastrophic or other high-cost or high-risk conditions, including pregnant women under 21, high risk pregnancies, and infants and toddlers with established risk for developmental delay.	Amerigroup makes every effort to identify members who have the greatest need for case management, including those who have catastrophic or other high-cost or high-risk conditions, including pregnant women under 21, high risk pregnancies, and infants and toddlers with established risk for developmental delay. • Std. IV.26 - Care Coordination - Members w Special Healthcare Needs-GA • Std. IV.26 -Case Management Program Overview – GA • Std. IV.26- 2014 CM Program Description-GA MAC and QMC approved 04.28.14 • Std. IV.26 - Care Coordination Through Community Based Organizations – GA • Std.IV.26 - Complex Case Management Description.2014-GA Final • Std.IV.26- Continuity of Care Core Process • Std.IV.26 - Coordination of Care-GA • Std.IV.26- Social Work Referrals • Std.IV.26- Services for Members in Waiver Programs- GA • Std.IV - Case Mgmt Care Coordination - Members w Special Healthcare Needs-GA Std. IV.26 GAGA CAID PC MHB ENG: Care Coordination- pg.66 of PDF document (pg. 1 if printed), Case Management – pgs. 43-44 of PDF document (pgs.34-35 if printed) • Std. IV.26 GAGA CAID Provider Manual: Care Coordination and Case Management – pgs. 126-127 of PDF document (pgs.124-125 if printed), Discharge	☒ Met ☐ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Planning – pg. 104 of PDF document (pg. 102 if printed)	
Findings: AMERIGROUP staff reported the use of predictive modeling to identify members with the greatest need for case management. The goal of the case management program was to assess member needs to facilitate the implementation of interventions that promoted the use of available resources, monitor and evaluate treatment options, and promote quality, cost-effective member outcomes.		
Required Actions: None.		
11. Disease Management: *Contract 4.11.10.1-3* The CMO has disease management programs for individuals with chronic conditions that include, at a minimum: ◆ Programs for members with diabetes and members with asthma ◆ Two additional programs from among the following: perinatal case management, obesity, hypertension, sickle-cell disease, or HIV/AIDS.	Amerigroup has disease management programs for individuals with chronic conditions that include members with diabetes and asthma, in addition to two additional programs from among the following: perinatal case management, obesity, hypertension, sickle-cell disease, or HIV/AIDS. • Std. IV.27 - Disease Management Program Description • Std. IV.27 - TCOBAM Program Description • Std. IV.27 GAGA CAID Provider Manual: Disease Management – pgs. 65-67 of PDF format (pgs. 63-65 if printed) • Std. IV.27 GAGA CAID PC MHB ENG: Disease Management – pgs. 21, 42-43 of PDF format (pgs. 12, 33-34 if printed)	☒ Met ☐ Not Met ☐ N/A
Findings: The CMO demonstrated compliance with having the required asthma and diabetes programs as well as hypertension and perinatal case management.		
Required Actions: None.		
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	Amerigroup 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. • Std. IV.28 - Discharge Planning From a Facility – GA	☐ Met ☒ Not Met ☐ N/A

Standard IV—Coordination and Continuity of Care		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
clinical setting.	• Std. IV.28 - Discharge Planning for Behavioral Health Care-GA • Std. IV.28 - 2014 UM Program Description Template-GA .MAC and QMC approved 04.28.14. pg. 13-19 • Std. IV.28 GAGA CAID PC MHB ENG: Care Coordination- pg.66 of PDF document (pg. 1 if printed), Case Management – pgs. 43-44 of PDF document (pgs.34-35 if printed) • Std. IV.28 GAGA CAID Provider Manual: Care Coordination and Case Management – pgs. 126-127 of PDF document (pgs.124-125 if printed), Discharge Planning – pg. 104 of PDF document (pg. 102 if printed	
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.		

Standard IV––Coordination and Continuity of Care Results					
Met	=	18	X 1.00	=	18.0
Not Met	=	3	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	21	**Total Score**	=	85.7%

Standard V—Coverage and Authorization of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. Comparable Coverage: *42 CFR 438.210(a)(2); 42 CFR 440.230; Contract 4.5.1.1*; Addendum 4.5.7.1 The CMO provides to members DCH-contracted medically necessary services in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services to beneficiaries under fee-for-service Medicaid.	Amerigroup provides to members DCH-contracted medically necessary services in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services to beneficiaries under fee-for-service Medicaid. • Std. V.1 - Covered Services-GA • Std. V.1 - Denial of Services-GA • Std. V.1 - Non-Covered and Cost Effective Alternative Services • Std. V.1 - Medical Denial Process - Internal – GA • Std. V.1 -Denial of Services- Desktop Process • Std. V.1 - Healthcare Management Services Denial Core Process • Std. V.1 - GAGA CAID PC MHB ENG pp. 10-11 if printed; pp. 19-20 in PDF view) • Std. V.1 - GAGA CAID Provider Manual (pp. 27-34 if printed; pp. 29-36 in PDF view) • Std. V.1 - 2014 UM Program Description pg. 12-19 • Std. V.1 - GAGA_Scion Dental Provider Manual (p. 16 if printed; p. 18 on PDF view) • Std. V.1 - Avesis Georgia Medicaid Provider Manual (p. 15 if printed; p. 15 on PDF view) • Std. V.1 Avesis Provider Agreement (p. 3, Section D (2) if printed and on PDF view)	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with the element. Staff indicated that, due to the merging with WellPoint, there was now a general or shared prior authorization list; the list was no more restrictive than fee-for-service Medicaid.		
Required Actions: None.		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
2. Sufficiency of Services: *42 CFR 438.210(a)(3)(i); Contract 4.5.4.1* The CMO has and follows processes to ensure that the services provided to each member are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are provided.	Amerigroup has and follows processes to ensure that the services provided to each member are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are provided. • Std. V.2 - Covered Services-GA • Std. V. 2 - 2014 UM Program Description pg. 12-19 • Std. V. 2 - GAGA CAID PC MHB ENG - pg. 10-12 if printed (Medical Necessity/Covered Services) • Std. V. 2 – GAGA CAID Provider Manual (pg. 22-34 if printed; pp. 24-36 in PDF view) • Std. V. 2 - Scion UM_1400 P&P • Std. V.2 - Avesis Georgia Medicaid Provider Manual (p. 15 if printed and viewed in PDF)	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO monitored for care delays and care gaps to identify areas of underutilization of service, such as lack of asthma controller medications and associated emergency department utilization.		
Required Actions: None.		
3. Prohibited Reasons for CMO Decisions: *42 CFR 438.210(a)(3)(ii); Contract 4.5.1.1* The CMO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	Amerigroup does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. • Std. V.3 - Covered Services-GA • Std. V.3 - Denial of Services-GA • Std. V.3 - Non-Covered and Cost Effective • Std. V.3 - Denial of Services-GA • Std. V.3 - Medical Denial Process - Internal – GA	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.3 - Denial of Services- Desktop Process • Std. V. 3 - Healthcare Management Services Denial Core Process • Std. V.3 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.3 - Clinical Information for Utilization Management Reviews Core Process • Std. V.3 - GAGA CAID PC MHB ENG pg. 10-12 • Std. V.3 - GAGA CAID Provider Manual pg. 22-34 • Std. V.3 - 2014 UM Program Description pg. 12-19 Std. V. Scion UM_4020 P&P • Std. V.3 - Scion UM_4080 P&P • Std. V.3 - Scion UM_4090 P&P • Std. V.3 - Avesis Eye Medical UR Program 2014 (p. 4 if printed and PDF view—Clinical Protocols)	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The medical director was interviewed and indicated that no diagnosis, illness, or condition would be denied or services reduced without a medical necessity review.		
Required Actions: None.		
4. Decisions Based on Medical Necessity: *42 CFR 438.210(a)(3)(i-iii); Contract 1.4; 4.5.1.1; 4.5.4.1-3; 4.11.1.1* The CMO provides all medically necessary services that meet the criteria as defined by DCH in its definition of "medical necessity" included in its contract with the CMO.	Amerigroup provides all medically necessary services that meet the criteria as defined by DCH in its definition of "medical necessity" included in its contract with Amerigroup. • Std. V.4 - Denial of Services-GA • Std. V.4 - Medical Denial Process - Internal – GA • Std. V.4 - Denial of Services- Desktop Process	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.4 - Healthcare Management Services Denial Core Process • Std. V.4 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.4 - Clinical Information for Utilization Management Reviews Core Process • Std. V.4 - GAGA CAID PC MHB ENG - pg. 10-12 if printed • Std. V. 4 - GAGA CAID Provider Manual (pg. 22-34 if printed; pp. 24-36 in PDF view) • Std. V.4 - 2014 UM Program Description pg. 12-19 • Std. V.4 - Scion UM_4020 P&P • Std. V.4 - Avesis GA Medicaid Contract Addendum (p. 2; #7 if printed and in PDF)	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The medical necessity review was concisely described by the medical director, and expectations related to EPSDT requirements were additionally outlined. All prior authorization requests for persons under the age of 21 were reviewed for medical necessity regardless of benefit limitations.		
Required Actions: None.		
5. Written Policies and Procedures: *42 CFR 438.210(b)(1); Contract 4.11.1.1* The CMO has and follows written utilization management policies and procedures that include protocols and criteria for evaluating medical necessity and authorizing initial and continuing services.	Amerigroup has and follows written utilization management policies and procedures that include protocols and criteria for evaluating medical necessity and authorizing initial and continuing services. • Std. V.7 - GAGA_CAID-PC_MHB_ENG 6_14, pg. 10-12 • Std. V.7 - GAGA CAID Provider Manual 3 14.pdf, pg. 22-34 • Std. V.7 - 2014 UM Program Description pg. 12-19	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.7 - Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process Core Process • Std. V.7 - Pre-Certification of Requested Services Core Process • Std. V.7 - Continued Stay Review-GA • Std. V.7 - Approval and Application of Medical Necessity Criteria-GA • Std. V.7 - Clinical Information for Utilization Management Reviews Core Process • Std. V.7 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.7 - Scion UM_4080 P&P • Std. V.7 - Avesis UR-11-v IRR	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO used several evidence-based criteria across the scope of services. InterQual was used for inpatient medical necessity review, and WellPoint's established medical policy was used for pre-service and behavioral health review. Scion and Avesis used established specialty criteria for decision making. Additional criteria, such as Hayes (for new technology) and provider specialty experts were used when current criteria did not address the medical necessity review.		
Required Actions: None.		
6. Written Policies and Procedures—Authorizations and Reviews: *42 CFR 438.210(b)(1); Contract 4.11.1.1* The CMO's written policies and procedures address which services require prior authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective, or prospective review.	Amerigroup's written policies and procedures address which services require prior authorization and how requests for initial and continuing services are provided, and which services will be subject to concurrent, retrospective, or prospective review. • Std. V.8 - GAGA_CAID-PC_MHB_ENG 6_14, pg. 10-12 • Std. V.8 - GAGA CAID Provider Manual 3 14.pdf, pg. 113 • Std. V.8 - 2014 UM Program Description pg.	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	12-19, 32-33(IRR) • Std. V.8 - Approval and Application of Medical Necessity Criteria-GA • Std. V.8 - Clinical Information for Utilization Management Reviews Core Process • Std. V.8 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.8 - Inter-Rater Reliability (IRR) Assessments • Std. V.8 - BH IRR rates 2013 • Std. V.8 - Medical Director IRR results-2013 • Std. V.8 - 2013 Georgia IRR Spreadsheet 2 Std. V.8- Scion UM4010 P&P • Std. V.8 - Avesis Georgia Medicaid Provider Manual (p. 34 in printed and PDF view) • Std. V.8 - Avesis UR-11-v IRR	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The services requiring prior authorization and the associated processes were communicated in several mediums, and the CMO accepted requests via multiple venues.		
Required Actions: None.		
7. Authorization of Services—Consistent Application of Review Criteria: *42 CFR 438.210(b)(2)(i); Contract 4.11.1.1* The CMO has mechanisms to ensure consistent application of review criteria.	Amerigroup has mechanisms in place to ensure consistent application of review criteria. • Std.V.9 GAGA CAID PC MHB: pgs. 19-21 of PDF document (pgs. 10-12 if printed) • Std.V.9 GAGA CAID Provider Manual: Medical Management – pgs. 89-91 of PDF document (pgs. 87-89 if printed) • Std. V.9 2014 UM Program Description pg. 12-19, 32-33(IRR)	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.9 Approval and Application of Medical Necessity Criteria-GA • Std. V.9 Clinical Information for Utilization Management Reviews Core Process • Std. V.9 Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.9 Scion UM_4080 P&P • Std. V.9 - Avesis UR-11-v IRR <u>Additional Supporting Documentation:</u> • Std. V.9 BH IRR rates 2013 • Std. V.9 Medical Director IRR results-2013 • Std. V.9 2013 Georgia IRR Spreadsheet 2 • Std. V.9 - Inter-Rater Reliability (IRR) Assessments	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO demonstrated appropriate inter-rater reliability testing for first-line review staff members based on their area of review, such as inpatient adult, home care, and durable medical equipment (DME). The medical directors completed testing across several domains.		
Required Actions: None.		
8. Authorization of Services—Consults With Requesting Physician: *42 CFR 438.210(b)(2)(ii); Contract 4.11.2.6* The CMO's policies and procedures include consulting with the requesting physician when appropriate.	Amerigroup's policies and procedures include consulting with the requesting physician when appropriate. • Std.V.10 GAGA CAID PC MHB: pgs. • Std.V.10 GAGA CAID Provider Manual: Medical Management – pg. 90 of PDF document (pg. 89 if printed) • Std. V.10 2014 UM Program Description pg. 12-19	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.10 Clinical Information for Utilization Management Reviews Core Process • Std. V.10 Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.10 Peer to Peer Telephone Calls-GA • Std. V.10 Medical Information Received From Providers for Utilization Management Reviews-GA • Std. V.10 Scion UM_1230 P&P • Std. V.10 - Avesis UR 14 Using Board Certified Consultants <u>Additional Supporting Documentation:</u> • Std. V.10 Approval and Application of Medical Necessity Criteria-GA	
Findings: The written documentation and staff interviews demonstrated compliance with this element. Several documents indicated that the CMO "may contact the attending physician to review the case." Staff indicated that outbound calls to providers would be completed as necessary, such as for clarification on a request or for additional clinical information. The denial file reviews demonstrated a peer-to-peer discussion after the denial decision, at the request of the requesting provider.		
Required Actions: None.		
9. Required Clinical Expertise: *42 CFR 438.210(b)(3); Contract 4.11.2.4; 4.14.3.1* The CMO ensures that: ◆ Prior authorization and pre-certification is conducted by a currently licensed, registered, or certified health care professional who is appropriately trained in the principles, procedures, and standards of utilization review. ◆ All proposed actions (i.e., any decision to deny a service authorization	Amerigroup ensures prior authorizations and pre-certifications are conducted by currently licensed, registered, or certified health care professionals who are appropriately trained in the principles, procedures, and standards of utilization review; and that 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. • Std. V.11 2014 UM Program Description pg. 7-	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
request or to authorize a service in an amount, duration, or scope that is less than requested) are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease.	12 • Std. V.11 Use of Board Certified External Consultants (Medical and Behavioral Health) - Core Process • Std. V.11 Associates Performing Utilization Reviews Core Process • Std. V.11 Medical Denial Process - Internal – GA • Std. V.11 Denial of Services- Desktop Process • Std.V.11 Healthcare Management Services Denial Core Process • Std. V.11 Avesis UR-07 Expedited Reviews • Std. V.11 Scion UM_2000 P&P • Std. V.11 Scion UM_2010 P&P • Std. V.11 Scion UM_3000 P&P <u>Additional Supporting Documentation:</u> • Std. V.11 Denial of Services-GA • Std. V.11 Governance of Utilization Management Practice	
Findings: The written documentation and staff interviews demonstrated compliance with this element. It was noted that the medical director made the final denial decision for pharmacy prior authorization requests, based on the pharmacist's recommendations. This practice was necessary due to not having a Georgia-licensed pharmacist on staff. The denial file reviews demonstrated appropriate clinical credentials for the review and decision-making processes.		
Required Actions: None.		
10. Utilization Management (UM) Committee: *Contract 4.11.1.3* The CMO has a utilization management committee comprised of network providers within each service area (which could be one committee if each service area is represented on the committee) that is accountable to the Medical Director and governing body of the CMO.	Amerigroup has a utilization management committee comprised of network providers within each service area (which could be one committee if each service area is represented on the committee) that is accountable to the Medical Director and governing body of Amerigroup. • Std. V.12 - Approval and Application of	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Medical Necessity Criteria-GA • Std. V.12 -Clinical Information for Utilization Management Reviews Core Process • Std. V.12 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.12 - Contracting with professional advisory committee participants-GA • Std. V.12 -Contractual Arrangements for External Medical Advisory Committee Participants • Std. V.12 - Medical Operations Committee • Std. V.12 - Review of Policies and Procedures by Health Plan Committees • Std. V. GAGA CAID Provider Manual 3 14.pdf , pg. 113 • Std. V.12 - MAC Committee 2014 Std. V (12) Scion UM4010 P&P • Std. V.12 - Avesis Eye Medical UR Program 2014 • Std. V.12 - Scion UM4010 P&P	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The committee represented all service areas and was chaired by the medical director. The committee reporting structure and the Quality Management Committee meeting minutes were reviewed and demonstrated appropriate reporting avenues and oversight.		
Required Actions: None.		
11. UM Committee Meetings and Records: *Contract 4.11.1.3* The CMO's UM committee(s) meets on a regular basis and maintains records of activities, findings, recommendations, and actions.	Amerigroup's UM committee(s) meets on a regular basis and maintains records of activities, findings, recommendations, and actions. • Std. V.13 - Approval and Application of Medical Necessity Criteria-GA • Std. V.13 - Clinical Information for Utilization	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Management Reviews Core Process • Std. V.13 - Clinical Criteria for Utilization Management Decisions - Core Process • Std. V.13 - Contracting with professional advisory committee participants-GA • Std. V.13 - Contractual Arrangements for External Medical Advisory Committee Participants • Std. V.13 - Medical Operations Committee • Std. V.13 - Review of Policies and Procedures by Health Plan Committees • Std. V.13 - GAGA CAID Provider Manual 3 14.pdf, pg. 113 • Std. V.13 - MAC minutes 2-14-13 • Std. V.13 - MAC Minutes 10-10-13 • Std. V.13 - MAC Minutes 06-13-13 • Std. V.13 - MAC Minutes 04-11-13 • Std. V.13 - MAC Minutes 02-27-14 • Std. V.13 - MAC Minutes 02-14-13 • Std. V.13 - MAC Minutes 01-10-13 • Std. V.13 - MAC Minutes 05-19-13 • Std. V.13 - MAC Minutes 8-8-13 • Std. V.13 - MAC Minutes 4-10-14 • Std. V.13 - MAC Minutes 11-14-13 • Std. V.13 - MAC Minutes 05-08-14 • Std. V.13 - Georgia Dental Advisory Committee_011014rev1 0 • Std. V.13 - Avesis Eye Medical UR Program 2014	

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: The written documentation and staff interviews demonstrated compliance with this element. The committee meeting minutes were robust and well documented. Meetings occurred at regular intervals, and upward reporting was demonstrated in the Quality Management Committee minutes.		
Required Actions: None.		
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.	Amerigroup 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. • Std. V.14 - 2014 UM Program Description pg. 20-24 • Std. V.14 - Pre-Certification of Requested Services Core Process • Std. V.14 - Member Provider Action and Administrative Review Process – GA • Std. V.14 - Denial of Services-GA • Std. V.14 - Medical Denial Process - Internal – GA • Std. V.14 - Denial of Services- Desktop Process • Std. V. 14 -GAGA_CAID-PC_MHB_ENG 6_14, pg. 11-12 • Std. V.14 - GAGA CAID Provider Manual 3 14.pdf , pg. 100 • Std. V.14 - Healthcare Management Services Denial Core Process • Std. V. 14 - Scion UM_4020 P&P • Std. V. 14 - Avesis UR-07 Expedited Reviews	☐ Met ☒ Not Met ☐ N/A
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		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
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, thereby reducing or eliminating most of the manual processing of requests. This represented 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.		
13. Timelines—Extension for Standard Authorization Decisions and Notifications: *42 CFR 438.210(d)(1)(i-ii); Contract 4.11.2.5.1* The CMO may extend the timeline for up to an additional 14 calendar days if: ◆ The member or the provider requests an extension of the timeline, or ◆ The CMO justifies to DCH a need for additional information and how the extension is in the member's interest.	Amerigroup may extend the timeline for up to an additional 14 calendar days if: The member or the provider requests an extension of the timeline, or Amerigroup justifies to DCH a need for additional information and how the extension is in the member's interest. • Std. V.15 - 2014 UM Program Description pg. 20-24 • Std. V. 15 -Pre-Certification of Requested Services Core Process • Std. V.15 - Member Provider Action and Administrative Review Process – GA • Std. V.15 - Denial of Services-GA • Std. V.15 - Medical Denial Process - Internal – GA • Std. V.15 - Denial of Services- Desktop Process • Std. V. 15 -GAGA_CAID-PC_MHB_ENG 6_14, pg. 11-12 • Std. V.15 - GAGA CAID Provider Manual 3 14.pdf , pg. 100 • Std V.15 - GA Extension Services Facets FINAL • Std.V.15 - Healthcare Management Services	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Denial Core Process • Std. V. 15 - Scion UM_4020 P&P • Std. V. 15 - Avesis UR-07 Expedited Reviews (p. 2, # 7)	
Findings: The written documentation and staff interviews demonstrated compliance with this element. Staff members indicated that they have had no extension requests from members or providers, and the CMO had requested no extensions.		
Required Actions: None.		
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.	If the provider indicates, or Amerigroup determines, that following the standard timeframes could seriously jeopardize the member's life or health, Amerigroup makes an expedited authorization determination and provides notice within 24 hours. • Std. V.16 - 2014 UM Program Description pg. 20-24 • Std. V.16 - Pre-Certification of Requested Services Core Process • Std. V.16 - Member Provider Action and Administrative Review Process – GA • Std. V.16 - Denial of Services-GA • Std. V.16 - Medical Denial Process - Internal – GA • Std. V.16 - Denial of Services- Desktop Process • Std. V. 16 -GAGA_CAID-PC_MHB_ENG 6_14, pg. 11-12 • Std. V.16 - GAGA CAID Provider Manual 3 14.pdf, pg. 100 • Std. V.16 - Healthcare Management Services Denial Core Process • Std. V. 16 - Scion UM_4020 P&P	☐ Met ☒ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V. 16 - Avesis UR-07 Expedited Reviews	
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 provider indicated it was a standard request and the request was appropriately processed. However, the CMO did not provide a formal process for determining whether a request meets expedited criteria nor a formal process for determining how to process requests labeled as expedited that do not meet the expedited criteria.		
Required Actions: The CMO needs to formalize the process for management of expedited review requests and associated provider education.		
15. Timelines—Extension for Expedited Authorizations Decisions and Notifications: *42 CFR 438.210(d)(2)(ii); Contract 4.11.2.5.2* The CMO may extend the 24 hour timeframe for up to five business days if: ◆ The member or the provider requests an extension, or ◆ The CMO justifies to DCH a need for additional information and the extension is in the member's interest.	Amerigroup may extend the 24 hour timeframe for up to five business days if: The member or the provider requests an extension, or Amerigroup justifies to DCH a need for additional information and the extension is in the member's interest. • Std. V.17 – 2014 UM Program Description pg. 20-24 • Std. V. 17 - Pre-Certification of Requested Services Core Process • Std. V.17 - Member Provider Action and Administrative Review Process – GA • Std. V.17 - Denial of Services-GA • Std. V.17 - Medical Denial Process - Internal – GA • Std. V.17 - Denial of Services- Desktop Process • Std. V. 17- GAGA_CAID-PC_MHB_ENG 6_14, pg. 11-12 • Std. V.17 - GAGA CAID Provider Manual 3 14.pdf, pg. 100 • Std V.17 - GA Extension Services Facets FINAL	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.V.17 - Healthcare Management Services Denial Core Process • Std. V.17 - Scion UM_4020 P&P	
Findings: The written documentation and staff interviews demonstrated compliance with this element. Staff members indicated that they have had no extension requests from members or providers, and the CMO had requested no extensions.		
Required Actions: None.		
16. Authorization for Services Delivered: *Contract 4.11.2.5.3* The CMO makes authorization determinations involving health care services that have been delivered within 30 calendar days of receipt of the necessary information.	Amerigroup makes authorization determinations involving health care services that have been delivered within 30 calendar days of receipt of the necessary information. • Std. V.18 - 2014 UM Program Description - pgs. 20-28 • Std. V.18 - Member Provider Action and Administrative Review Process – GA • Std. V.18 - Administrative Review Process – Ga • Std. V.18 - Avesis Review Process Post-Service Approval • Std. V.18 Avesis UR -07 Review Process Prior Approval • Std. V.18 - Scion UM_4020 P&P	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. Retrospective reviews were completed within the local office. Staff described proactive provider education efforts due to early overuse of retrospective reviews. Staff members indicated they did not receive many retrospective review requests, and the majority of requests received were not timely.		
Required Actions: None.		
17. Notice of Adverse Action: *42 CFR 438.210(c); Contract 4.14.3.2* The CMO notifies the requesting provider in writing and gives the member written notice of any CMO proposed decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less	Amerigroup notifies the requesting provider in writing and gives the member written notice of any proposed decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
than requested.	• Std.V.19 - 2014 UM Program Description - pgs. 20-28 • Std.V.19 Member Provider Action and Administrative Review Process – GA • Std. V.19 Denial of Services-GA • Std. V.19 Medical Denial Process - Internal – GA • Std. V.19 Denial of Services- Desktop Process • Std. V.19 Healthcare Management Services Denial Core Process • Std.V.19 GAGA CAID PC MHB – pgs. 47-51 of PDF document (pgs. 38-42) • Std.V.19GAGA CAID Provider Manual - pgs. 14-15,22 (12-13, 20 if printed) • Std. V.19 Scion UM_4020 P&P • Std. V.19 Avesis UR-07 Expedited Reviews • Std. V.19 Avesis Review Process Prior Approval • Std. V.19 Avesis Review Process Post-Service Approval <u>Additional Supporting Documentation:</u> • Std. V.19 Administrative Review Process – GA	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The written notification was provided, but there may be a delay in notification from date of decision to mail date of the letter; however, the notification was within the required decision time frames.		
Required Actions: None.		
18. Notice of Proposed Adverse Action—Language and Format: *42 CFR 438,404(a); Contract 4.14.3.2*	As applicable, Amerigroup's written notice of adverse action to the member meets the language and format requirements of 42 CFR 438(10)(c) and (d) and	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
As applicable**,** the CMO's written notice of adverse action to the member meets the language and format requirements of 42 CFR 438(10)(c) and (d) and Contract 4.3.2.	Contract 4.3.2. • Std. V.20 2014 UM Program Description pg. 20-28 • Std. V.20 Member Provider Action and Administrative Review Process – GA • Std. V.20 Administrative Review Process – Ga • Std. V.20 Denial of Services-GA • Std. V.20 Medical Denial Process - Internal – GA • Std. V.20 Denial of Services- Desktop Process • Std.V.20 Healthcare Management Services Denial Core Process • Std. V.20 NIA Denial Letter • Std. V.20 GA-MEM-0190-12 Denial Letter Update - Not a Covered Benefit ENG FINAL • Std. V.20 GA-MEM-0190-12 Denial Letter Update - Not a Covered Benefit SPN FINAL • Std. V.20 GA-MEM-0191-12 Denial Letter Update - Confinement ENG FINAL • Std. V.20 GA-MEM-0191-12 Denial Letter Update - Confinement SPN FINA • Std. V.20 GA-MEM-0192-12 Denial Letter Update - Services ENG FINAL • Std. V.20 GA-MEM-0192-12 Denial Letter Update - Services SPN FINAL • Std. V.20 - AGP Outpt Denial Letter • Std. V.20 - Avesis Denial Letter • Std. V.20 - Scion UM_4020 P&P	
Findings: The written documentation and staff interviews demonstrated compliance with this element. There was evidence of the required language in the notice		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
template and narrative summary to members and providers. While the letter addressed continuation of benefits, it did not specify that the continuation of benefits was in reference to only those previously approved services that had been terminated, reduced, or suspended. Continuation of the benefit did not apply if the denial was in reference to a new request for services, such as for ongoing therapy or home health services. The reviewer did not assess appeals to determine if the language was impactful to the appeal process. However, the CMO indicated that this was model language directed by the State.		
Required Actions: None.		
19. Content of Notice of Proposed Adverse Action: *42 CFR 438,404(b)(1-7); Contract 4.14.3.3* The CMO's notice of adverse action contains the following: ◆ 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 the basis for the action which must have a factual basis and legal/policy basis). ◆ The member's right to file an administrative review through the CMO's internal grievance system as described in Contract 4.14. ◆ The provider's right to file a provider complaint as described in Contract 4.9.7. ◆ The requirement that the member exhaust the CMO'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 administrative review with the CMO, member instructions on how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.	Amerigroup's notice of adverse actions contains language as required. • Std. V21. 2014 UM Program Description pg. 20-28 • Std. V.21 Member Provider Action and Administrative Review Process – GA • Std. V.21 Administrative Review Process – Ga • Std. V.21 Denial of Services-GA • Std. V.21 Medical Denial Process - Internal – GA • Std. V.21 Denial of Services- Desktop Process • Std.V. Healthcare Management Services Denial Core Process • Std. V.21 NIA Denial Letter • Std. V.21 GA-MEM-0190-12 Denial Letter Update - Not a Covered Benefit ENG FINAL • Std. V.21 GA-MEM-0190-12 Denial Letter Update - Not a Covered Benefit SPN FINAL • Std. V.21 GA-MEM-0191-12 Denial Letter Update - Confinement ENG FINAL • Std. V.21 GA-MEM-0191-12 Denial Letter Update - Confinement SPN FINA • Std. V.21 GA-MEM-0192-12 Denial Letter Update - Services ENG FINAL	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. V.21 GA-MEM-0192-12 Denial Letter Update - Services SPN FINAL • Std. V.21 - Scion Notice of Action • Std. V.21 - Scion UM_4020 P&P • Std. V.21 -Scion UM_4050 P&P • Std. V. 21- Scion UM_4100.200 P&P • Std. V.21 - Avesis Denial Letter	
Findings: The written documentation and staff interviews demonstrated compliance with the element. During staff interviews it was indicated that the CMO did not terminate, suspend, or reduce services once authorized.		
Required Actions: None.		
20. Notice of Proposed Action Timeframe—Termination, Suspension, or Reduction of Previously Authorized Covered Services: *42 CFR 438 404(c)(1); Contract 4.14.3.4.1–4* For proposed actions to terminate, suspend, or reduce previously authorized covered services, the CMO mails the notice of proposed action at least 10 calendar days before the date of the proposed action or not later than the date of the proposed action in the event of one of the following exceptions: ◆ The CMO has factual information confirming the death of a member. ◆ The CMO receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that 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 CMO mail directed to the member indicating no forwarding address. ◆ The member's provider prescribes a change in the level of medical care. ◆ The date of action will occur in less than 10 calendar days in accordance with 42 CFR 483.12(a)(5)(ii). ◆ The CMO may shorten the period of advance notice to five calendar	Amerigroup adheres to Notice of Proposed Action Timeframes for Termination, Suspension or Reduction of Previously Authorized Covered Services. • Std. V.22 2014 UM Program Description pg. 20-28 • Std. V.22 Member Provider Action and Administrative Review Process – GA • Std. V.22 Administrative Review Process – Ga • Std. V.22 Denial of Services-GA • Std. V.22 Medical Denial Process - Internal – GA • Std. V.22 Denial of Services- Desktop Process • Std.V.22 Healthcare Management Services Denial Core Process • Std. V.22 Scion Notice of Action • Std. V.22 Scion UM_4050 P&P • Std. V.22 Scion UM_4100.200 P&P • Std. V.22 Scion UM 4310.200.GA P&P • Std. V.22 Scion -UM Program Description-2014	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
days before the date of action if the CMO has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources.		
Findings: The written documentation and staff interviews demonstrated compliance with the element. During staff interviews it was indicated that the CMO did not terminate, suspend, or reduce services once authorized.		
Required Actions: None.		
21. Notice of Proposed Action Timeframe—Denial of Payment: *42 CFR 438 404(c)(2); Contract 4.14.3.4.5* The CMO provides notice of action at the time of any action/proposed action affecting the claim.	Amerigroup provides notice of action at the time of any action/proposed action affecting the claim. • Std. V.23 2014 UM Program Description pg. 20-28 • Std. V.23 Member Provider Action and Administrative Review Process – GA • Std. V.23 Administrative Review Process – Ga • Std. V.23 Denial of Services-GA • Std. V.23 Medical Denial Process - Internal – GA • Std. V.23 Denial of Services- Desktop Process • Std.V.23 Healthcare Management Services Denial Core Process • Std. V.23-EOB Denial Language Sample • Std. V.23 Scion PR_1000.200 P&P	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with the element.		
Required Actions: None.		
22. Written Notice of Reasons—Decisions to Extend Timeframes: *42 CFR 438.404(c)(4)(i); Contract 4.14.3.4.7* If the CMO extends the timeframe for decision and sending the notice of action/proposed action according to Section 4.11.2.5, the CMO gives the member written notice of the reasons for the decision to extend the timeframe and informs the member of the right to file a grievance if he or	If Amerigroup extends the timeframe for decision and sending the notice of action/proposed action according to Section 4.11.2.5, Amerigroup gives the member written notice of the reasons for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with the decision.	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
she disagrees with the decision.	• Std. V.24 2014 UM Program Description pg. 20-28 • Std. V.24 Member Provider Action and Administrative Review Process – GA • Std. V.24 Administrative Review Process – Ga • Std. V.24 Denial of Services-GA • Std. V.24 Medical Denial Process - Internal – GA • Std. V.24 Denial of Services- Desktop Process • Std.V. 24 Healthcare Management Services Denial Core Process • Std. V.24 Scion UM_4020 P&P	
Findings: The written documentation and staff interviews demonstrated compliance with the element. Staff members indicated that they have had no extension requests from members or providers, and the CMO requested no extensions.		
Required Actions: None.		
23. Extensions of Timelines—CMO Responsibility: *42 CFR 438.404(c)(4)(ii); Contract 4.14.3.4.7* If the CMO extends the timeframe for decision and sending the notice of action/proposed action, the CMO carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	If the Amerigroup extends the timeframe for decision and sending the notice of action/proposed action, Amerigroup carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. • Std.V.25 2014 UM Program Description pg. 20-28 • Std.V.25 Member Provider Action and Administrative Review Process – GA • Std.V.25 Administrative Review Process – Ga • Std.V.25 Denial of Services-GA • Std.V.25 Medical Denial Process - Internal – GA • Std.V.25 Denial of Services- Desktop Process	☒ Met ☐ Not Met ☐ N/A

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.V.25 Healthcare Management Services Denial Core Process • Std. V.25 Scion UM_4020 P&P	
Findings: The written documentation and staff interviews demonstrated compliance with the element. Staff members indicated that they have had no extension requests from members or providers, and the CMO requested no extensions.		
Required Actions: None.		
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**.**	For both standard and expedited authorization decisions not reached within the required timeframes according to 4.11.2.5, Amerigroup mails the notice of action on the date the timeframe expires, as this constitutes a denial and is thus an adverse action. • Std.V.26 2014 UM Program Description pg. 20-28(23) • Std.V.26 Member Provider Action and Administrative Review Process – GA • Std.V.26 Administrative Review Process – Ga • Std. V.26 Denial of Services-GA • Std. V. 26 Medical Denial Process - Internal – GA • Std.V.26 Denial of Services- Desktop Process • Std.V.26 Healthcare Management Services Denial Core Process • Std. V.26 - Scion UM_4020 P&P • Std. V.26 - Avesis UR-07 Expedited Reviews • Std. V.26 - Avesis Review Process Post-Service Approval	☐ Met ☒ Not Met ☐ N/A
Findings: The written policy demonstrated compliance with the element. During staff interviews it was indicated that the 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.		

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: The CMO needs to operationalize the Denial of Services desktop process as outlined on pages 4 and 16 of the process document.		
25. Compensation for Utilization Management Activities: *42 CFR 438.210(e); Contract 4.11.1.4* The CMO does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member (i.e., the CMO, and any delegated utilization review agent), and does not permit or provide compensation or anything of value to its employees, agents, or contractors based on: ◆ Either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment, or ◆ Any other method that encourages the rendering of a proposed action.	Amerigroup does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member (i.e., the CMO, and any delegated utilization review agent), and does not permit or provide compensation or anything of value to its employees, agents, or contractors as required by contract. • Std.V.27 Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations • Std.V.27 2014 UM Program Description pg. 6 • Std.V.27 GAGA CAID PC MHB ENG 6_14 pg.10 (19 PDF) • Std.V.27 GAGA CAID Provider Manual pg. 26 (28 PDF)	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with the element. The CMO communicated this notice widely to members, providers, and staff. The e-mail notice to staff did not require acknowledgement or an attestation of agreement.		
Required Actions: None.		

Standard V—Coverage and Authorization of Services Results					
Met	=	22	X 1.00	=	22.0
Not Met	=	3	X .00	=	0.0
Not Applicable	=	0	*N/A*		*N/A*
Total Applicable	=	25	**Total Score**	=	88.0%

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. Availability of Emergency Services: *42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1* The CMO has emergency services available 24 hours a day, seven days a week to treat an emergency medical condition.	Amerigroup has emergency services available 24 hours a day, seven days a week to treat an emergency medical condition. • Std.VI.1- 2014 UM Program Description MAC and QMC approved 04.28.14 • Std.VI.1-Coverage for Post Stabilization Care Services • Std.VI.1-. Emergency Care – GA • Std.VI.1- Emergency Care Policy P4HB Members – GA • Std.VI.1 - Emergency Care-Behavioral Health • Std.VI.1- Emergency Room Services Reimbursement – GA • Std.VI.1- Emergency Services Core Process • Std.VI.1- Member Manual pgs. 8(17 of the PDF) Wait Times for Appointments, 11(20 of the PDF) Covered Services, 13 (22 of the PDF Co-payments and 15(24 of the PDF) Emergency Care • Std.VI.1 – GAGA CAID Provider Manual pgs. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105).	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. Emergency services were accessible to members 24 hours a day, seven days a week without restriction, regardless of the provider's network status.		
Required Actions: None.		
2. Definition of Emergency Medical Services and Condition: *42 CFR 438.114(a)(1-3); Contract 1.4; 4.6.1.2* The CMO defines emergency services and an emergency medical condition consistent with the DCH contractually required definition.	Amerigroup defines emergency services and an emergency medical condition consistent with the DCH contractually required definition. • Std.VI.2-2014 UM Program Description MAC and QMC approved 04.28.14	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.VI.2- Emergency Care – GA • Std.VI.2- Emergency Care Policy P4HB Members – GA • Std.VI.2- Emergency Care-Behavioral Health • Std.VI.2 Emergency Services Core Process • Std. VI.5 Emergency Room Services Reimbursement – GA • Std.VI.2- Member Manual pgs. 8(17 of the PDF) Wait Times for Appointments, 11(20 of the PDF) Covered Services, 13 (22 of the PDF Co-payments and 15(24 of the PDF) Emergency Care • Std.VI.2 - GAGA CAID Provider Manual pgs. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105).	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO's emergency medical condition definition was consistent with the DCH contract definition.		
Required Actions: None.		
3. Does Not Limit/Define Emergency Medical Condition: *42 CFR 438.114(d)(i); Contract 4.6.1.2* The CMO does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.	Amerigroup does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Std.VI.3- 2014 UM Program Description .MAC and QMC approved 04.28.14 • Std.VI.3- Coverage for Post Stabilization Care Services • Std.VI.3- Emergency Care – GA • Std. VI.3 Emergency Room Services Reimbursement – GA • Std.VI.3- Emergency Care Policy P4HB Members – GA	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.VI-3. Emergency Care-Behavioral Health • Std.VI-3. Emergency Services Core Process • Std.VI.3- Member Manual pgs. 11(20 of the PDF) Covered Services, 13 (22 of the PDF Co-payments and 15(24 of the PDF) Emergency Care • Std.VI.3 - GAGA CAID Provider Manual pgs. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105).	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not limit what constitutes an emergency but may question the consistency of a billed level of care, such as a trauma level of care, with the associated diagnosis code. An emergent diagnosis code list was used to ensure that certain diagnosis codes are reimbursed, without review, at the emergency level. The CMO had contractual agreements with facilities as to emergency facility reimbursement. The CMO indicated that claims for Planning for Healthy Babies® (P4HB®) emergency services needed to be billed with the family planning modifier for reimbursement. The DCH ER monitoring report was reviewed during the on-site review.		
Required Actions: None.		
4. Prior Authorization Not Required: *Contract 4.6.1.3; 4.6.3* The CMO does not require prior authorization or pre-certification for emergency or urgent care services.	Amerigroup does not require prior authorization or pre-certification for emergency or urgent care services. • Std. VI.4 2014 UM Program Description.MAC and QMC approved 04.28.14 • Std. VI.4 Coverage for Post Stabilization Care Services • Std. VI.4 Emergency Care – GA. • Std. VI.4 Emergency Room Services Reimbursement – GA • Std. VI.4 Emergency Care Policy P4HB Members – GA. • Std. VI.4 Emergency Care-Behavioral Health • Std. VI.4 Emergency Services Core Process • Std.VI.4 GAGA_CAID-PC_MHB_ENG 6_14 pg. 11 (covered services) 15(Emergency Care)	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. VI.4 GAGA CAID Provider Manual Provider Manual pg. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105). • Std. VI.4 2013 GA- SESE IDs - Auth Rules	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for emergency or urgent care services. Reimbursement was based on place of service and revenue codes.		
Required Actions: None.		
5. Coverage Decisions—Prudent Layperson Standard: *42 CFR 438.114(a); Contract 4.6.1.2; 4.6.1.4* The CMO bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.	Amerigroup bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. • Std. VI.5 2014 UM Program Description.MAC and QMC approved 04.28.14 • Std. VI.5 Coverage for Post Stabilization Care Services • Std. VI.5 Emergency Care – GA • Std. VI.5 Emergency Care Policy P4HB Members – GA • Std. VI.5 Emergency Care-Behavioral Health • Std. VI.5 Emergency Room Services Reimbursement – GA • Std. VI.5 Emergency Services Core Process • Std.VI.5 GAGA_CAID-PC_MHB_ENG 6_14 pg. 11 (covered services) 15(Emergency Care) • Std. VI.5 GAGA CAID Provider Manual Provider Manual pg. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105).	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. Based on contractual agreements, the CMO may reimburse a		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
triage/screening rate for services. The facility could submit medical records to support a higher level of reimbursement. Nurse reviewers could approve a higher level of reimbursement based on the medical record review. If the nurse reviewer did not approve additional reimbursement, the facility could further appeal and the review was completed by a medical director.		
Required Actions: None.		
6. Coverage and Payment—Providers: *42 CFR 438.114(c)(i); Contract 4.6.1.3* The CMO covers and pays for emergency services when furnished by a qualified provider, regardless of whether that provider is in the CMO's network.	Amerigroup covers and pays for emergency services when furnished by a qualified provider, regardless of whether that provider is in the CMO's network. • Std. VI.6 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.6 Coverage for Post Stabilization Care Services • Std. VI.6 Emergency Care – GA • Std. VI.6 Emergency Care Policy P4HB Members – GA • Std. VI.6 Emergency Care-Behavioral Health • Std. VI.6 Emergency Services Core Process • Std. VI.6 Emergency Room Services Reimbursement – GA • Std.VI.6 GAGA_CAID-PC_MHB_ENG 6_14 pg. 11 (covered services) 15(Emergency Care) • Std. VI.6 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103 (PDF pages – 30, 47-50, 93, 105 • Std. VI.6 2013 GA- SESE IDs - Auth Rules • Std. VI.6-ER CLAIMS BY LEVEL FY2013 xls - 06 13 2014	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. Reimbursement was based on the place of service and did not restrict for out-of-network providers or facilities. The CMO might pay the facility triage/screening rate if there was not agreement between the level of care and the emergent diagnosis code list.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
7. Coverage and Payment—Screening Examination: *42 CFR 438.114(d)(2); Contract 4.6.1.3* The CMO pays for any screening examination services conducted to determine whether an emergency medical condition exists.	Amerigroup pays for any screening examination services conducted to determine whether an emergency medical condition exists. • Std. VI.7 2014 UM Program Description .MAC and QMC approved 04.28.14. Pg.38 • Std. VI.7 Coverage for Post Stabilization Care Services • Std. VI.7 Emergency Care – GA. Pg. 2 • Std. VI.7 Emergency Care Policy P4HB Members – GA. Pg. 2-3 • Std. VI.7 Emergency Care-Behavioral Health. Pg. 2 • Std. VI.7 Emergency Room Services Reimbursement – GA • Std. VI.7 Emergency Services Core Process. Pg. 3 • Std.VI.7 GAGA CAID PC MHB ENG 6_14 pg. 11 (covered services)15(Emergency Care)13(co Payments) • GAGA CAID Provider Manual pg. 28, 45-48, 91, 103 • Std. VI.7 2013 GA- SESE IDs - Auth Rules • Std. VI.7 ER CLAIMS BY LEVEL FY2013 xls - 06 13 2014	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not restrict payment for triage/screening services. Payment was based on contractual agreements.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
8. Coverage and Payment—Duration: *42 CFR 438.114(d)(3); Contract 4.6.1.3* The CMO pays for all emergency services that are medically necessary until the member is stabilized.	Amerigroup pays for all emergency services that are medically necessary until the member is stabilized. • Std. VI.8 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.8 Coverage for Post Stabilization Care Services • Std. VI.8 Emergency Care – GA • Std. VI.8 Emergency Care Policy P4HB Members – GA • Std. VI.8 Emergency Care-Behavioral Health • Std. VI.8 Emergency Room Services Reimbursement – GA • Std. VI.8 Emergency Services Core Process • Std.VI.8 GAGA CAID PC MHB ENG 6-14 pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.8 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO paid for all medically necessary emergency services, which might be subject to medical review, based on contractual agreements.		
Required Actions: None.		
9. Determining Status of Members' Conditions: *42 CFR 438.114(d)(3); Contract 4.6.1.5* The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CMO. (*Note: The CMO, however, may send one of its physicians with appropriate emergency room*	The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on Amerigroup. • Std. VI.9 Emergency Care – GA. Pg 3 • Std. VI.9 Emergency Care Policy P4HB Members – GA Pg. 2 Additional supporting documentation	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangements do not delay the provision of emergency service.)	• Std. VI.9 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.9 Coverage for Post Stabilization Care Services • Std. VI.9 Emergency Care-Behavioral Health • Std. VI.9 Emergency Room Services Reimbursement – GA • Std. VI.9 Emergency Services Core Process • Std.VI.9 GAGA CAID PC MHB ENG 6_14 pg. 11 (covered services)15(Emergency Care)13(co Payments) • Std.VI.9 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103 • Std. VI.9 2013 GA- SESE IDs - Auth Rules • Std. VI.9 -ER CLAIMS BY LEVEL FY2013 xls - 06 13 2014	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO deferred to the treating physician and did not send a CMO-affiliated physician to assume responsibility for member care.		
Required Actions: None.		
10. Retroactive Claim Denial Prohibited: *42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6* The CMO does not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.	Amerigroup does not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. • Std. VI.10 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.10 Coverage for Post Stabilization Care Services • Std. VI.10 Emergency Care – GA	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. VI.10 Emergency Care Policy P4HB Members – GA • Std. VI.10 Emergency Care-Behavioral Health • Std. VI.10 Emergency Room Services Reimbursement – GA • Std. VI.10 Emergency Services Core Process • Std.VI.10 GAGA CAID PC MHB ENG 6_14 pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std. VI.10 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not retroactively deny claims or initiate any take back of payment for triage/screening payments.		
Required Actions: None.		
11. Determining Factor for Payment Liability: *42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6* If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the determining factor for the CMO payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation, in which case the CMO pays for all screening and care services provided.	If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the determining factor for Amerigroup payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation, in which case the Amerigroup pays for all screening and care services provided. • Std. VI.11 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.11 Coverage for Post Stabilization Care Services • Std. VI.11 Emergency Care – GA • Std. VI.11 Emergency Care Policy P4HB Members – GA • Std. VI.11 Emergency Care-Behavioral Health	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std. VI.11 Emergency Room Services Reimbursement – GA • Std. VI.11 Emergency Services Core Process • Std. VI.11 GAGA CAID PC MHB ENG 6_14 pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.11 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO always paid the triage/screening rate without take back of payment.		
Required Actions: None.		
12. May Not Deny Coverage/Payment—Member Instructed to Seek Emergency Services: *42 CFR 438.114(c)(1)(ii)(B); Contract 4.6.1.8* The CMO does not deny coverage/payment of services if a representative of the CMO instructs the member to seek emergency services and is responsible for payment for the medical screening examination and for other medically necessary emergency services without regard to whether the member's condition meets the prudent layperson standard.	Amerigroup does not deny coverage/payment of services if a representative of Amerigroup instructs the member to seek emergency services and is responsible for payment for the medical screening examination and for other medically necessary emergency services without regard to whether the member's condition meets the prudent layperson standard. • Std.VI.12 2014 UM Program Description GA MAC and QMC approved 04.28.14 • Std.VI.12 Coverage for Post Stabilization Care Services • Std.VI.12 Emergency Care – GA • Std.VI.12 Emergency Care Policy P4HB Members – GA • Std.VI.12 Emergency Care-Behavioral Health • Std.VI.12 Emergency Room Services Reimbursement – GA • Std.VI.12 Emergency Services Core Process • Std.VI.12 GAGA CAID PC MHB ENG 6_14	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.12 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: Staff indicated that there was no difference in the management of the claim regardless of whether or not there was a CMO representative referral; the Nurse Line and claims payment systems did not communicate. The CMO did not deny payment of services if a representative instructed the member to seek emergency services. However, depending on the contractual arrangement with the facility, the service could be paid at the triage level, which would cover the screening examination. The facility would then need to submit medical records for reconsideration of higher reimbursement.		
Required Actions: None.		
13. May Not Deny Coverage/Payment—Provider Failure to Notify CMO: *42 CFR 438.114(d)(1)(ii): Contract 4.6.1.7* While the CMO may establish guidelines and timelines for submittal of notification regarding provision of emergency services, the CMO does not refuse to cover an emergency service based on the emergency room provider, hospital, or fiscal agent's failure to notify the member's PCP, CMO plan representative, or DCH of the member's screening and treatment within those guidelines/timelines.	Amerigroup does not refuse to cover an emergency service based on the emergency room provider, hospital, or fiscal agent's failure to notify the member's PCP, Amerigroup plan representative, or DCH of the member's screening and treatment within those guidelines/timelines. • Std.VI.13 Emergency Care – GA. Pg.4 • Std. VI.13 Emergency Services Core Process <u>Additional supporting documentation</u> • Std.VI.13 2014 UM Program Description Template-GA .MAC and QMC approved 04.28.14 • Std. VI.13 Coverage for Post Stabilization Care Services • Std.VI.13 Emergency Care Policy P4HB Members – GA • Std. VI.13 Emergency Care-Behavioral Health • Std. VI.13 Emergency Room Services Reimbursement – GA • Std.VI.13 GAGA CAID PC MHB ENG 6_14 pg. 11 (covered services)15(Emergency	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Care)13(Co Payments) • Std. VI.13 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require notification for any emergency services.		
Required Actions: None.		
14. Member Not Liable: *42 CFR 438.114(d)(2); Contract 4.6.1.9* The CMO ensures that members who have an emergency medical condition are not liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member.	Amerigroup ensures that members who have an emergency medical condition are not liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. • Std. VI.14 Emergency Care – GA. Pg.3 • Std.VI.14 GAGA CAID PC MHB ENG (If you get a bill) pg. 45(page 54 PDF) <u>Additional supporting documentation:</u> • Std. VI.14 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.14 Coverage for Post Stabilization Care Services • Std. VI.14 Emergency Care Policy P4HB Members – GA • Std. VI.14 Emergency Care-Behavioral Health • Std. VI.14 Emergency Room Services Reimbursement – GA • Std. VI.14 Emergency Services Core Process • STD.VI.14 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO paid all emergency services without prior authorization. If a member was billed and notified Member Services, the grievance team would contact the provider/facility to ensure the member was not balance billed.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
15. Poststabilization Services—Availability: *42 CFR 422.113(c); 42 CFR 438.114(c); Contract 4.6.2.1* The CMO provides poststabilization care services 24 hours a day, seven days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the member's condition.	Amerigroup provides post stabilization care services 24 hours a day, seven days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the member's condition. • Std. VI.15 Emergency Care – GA (beginning on page 2) • Std. VI.15 Emergency Care Policy P4HB Members – GA Pg.2 • Std. VI.15 Coverage for Post Stabilization Care Services • Std.VI.15 GAGA CAID PC MHB ENG (Emergency Care) pg.15(PDF 24) • Std.VI.15 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103(PDF 30,47-50,93,105) <u>Additional supporting documentation</u> • Std. VI.15 2014 UM Program Description Template-GA .MAC and QMC approved 04.28.14 • Std. VI.15 Emergency Care-Behavioral Health • Std. VI.15 Emergency Room Services Reimbursement – GA • Std. VI.15 Emergency Services Core Process	☒ Met ☐ Not Met ☐ N/A

Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for observation services up to 48 hours. The CMO paid all poststabilization services and then required notification of any inpatient admissions for completion of a medical necessity review.

Required Actions: None.

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
16. Financial Responsibility—Prior Authorized Services: *42 CFR 422.113(c)(2)(i); 438.114(c); Contract 4.6.2.2* The CMO is responsible/pays for poststabilization services that are prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether they are provided within or outside the CMO's network of providers.	Amerigroup is responsible/pays for post stabilization services that are prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether they are provided within or outside the CMO's network of providers. • Std. VI.16 Emergency Care – GA Pg.4 • Std. VI.16 Emergency Care Policy P4HB Members – GA Pg.2 • Std. VI.16 Coverage for Post Stabilization Care Services <u>Additional supporting documents</u> • Std. VI.16 2014 UM Program Description GA .MAC and QMC approved 04.28.14 • Std. VI.16 Emergency Care-Behavioral Health • Std. VI.16 Emergency Room Services Reimbursement – GA • Std. VI.16 Emergency Services Core Process • Std.VI.16 GAGA CAID MHB ENG 6_14 Member Manual pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.16 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	☒ Met ☐ Not Met ☐ N/A
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization, regardless of network status.		
Required Actions: None.		
17. Financial Responsibility—Services to Maintain Stabilization: *42 CFR 422.113(c)(2)(ii); 42 CFR 438.114(c); Contract 4.6.2.3* The CMO is financially responsible for poststabilization services obtained from any provider, regardless of whether they are within or outside the	Amerigroup is financially responsible for post stabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network that are administered to maintain the member's stabilized condition for one hour	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
CMO's provider network that are administered to maintain the member's stabilized condition for one hour while awaiting response on a pre-certification or prior authorization request.	while awaiting response on a pre-certification or prior authorization request. • Std. VI.17 Emergency Care – GA.Pg4 • Std. VI.17 Emergency Care Policy P4HB Members – GA Pg.2 • Std. VI.17 Coverage for Post Stabilization Care Services <u>Additional supporting documents</u> • Std. VI.17 2014 UM Program Description MAC and QMC approved 04.28.14 • Std. VI.17 Emergency Care-Behavioral Health • Std. VI.17 Emergency Room Services Reimbursement – GA • Std. VI.17 Emergency Services Core Process • Std.VI.17 GAGA CAID MHB ENG 6-14 pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.17 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for observation services up to 48 hours, regardless of network status.		
Required Actions: None.		
18. Financial Responsibility—Services Not Prior Authorized: *CFR 422.113(c)(2)(iii)(A–C); 42 CFR 438.114(c); Contract 4.6.2.4.1-3; 4.6.2.4* The CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if:	Amerigroup is financially responsible/pays for post stabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition as required. • Std. VI.18 Coverage for Post Stabilization Care	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
◆ The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour. ◆ The CMO cannot be contacted. ◆ The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met.	Services(pg.3) • Std. VI.18 Emergency Care – GA Pg.4 • Std. VI.18 Emergency Care Policy P4HB Members – GA Pg. 2 <u>Additional supporting documents</u> • Std. VI.18 2014 UM Program Description GA MAC and QMC approved 04.28.14 • Std. VI.18 Emergency Care-Behavioral Health • Std. VI.18 Emergency Room Services Reimbursement – GA • Std. VI.18 Emergency Services Core Process • Std.VI.18 GAGA CAID MHB ENG 6_14 pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.18 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for observation services up to 48 hours.		
Required Actions: None.		
19. End of Financial Responsibility: *42 CFR 422.113(c)(3); 42 CFR 438.114(c); Contract 4.6.2.5* The CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs: ◆ An in-network provider with privileges at the treating hospital assumes responsibility for the member's care; ◆ An in-network provider assumes responsibility for the member's care through transfer; ◆ The CMO's representative and the treating physician reach an agreement	Amerigroup retains financial responsibility for post stabilization services it has not approved in accordance with requirements. • Std. VI.19 Emergency Care – GA • Std. VI.19 Coverage for Post Stabilization Care Services <u>Additional supporting documentation.</u> • Std. VI.19 2014 UM Program Description Template-GA .MAC and QMC approved 04.28.14 • Std. VI.19 Emergency Care Policy P4HB	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
concerning the member's care; or ◆ The member is discharged.	Members – GA • Std. VI.19 Emergency Care-Behavioral Health • Std. VI.19 Emergency Room Services Reimbursement – GA • Std. VI.19 Emergency Services Core Process • Std.VI.19 GAGA CAID PC MHB ENG 6_14 Manual pg. 11 (covered services)15(Emergency Care)13(Co Payments) • Std.VI.19 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103	
Findings: The documentation and staff interviews demonstrated compliance with this element. The CMO did not require prior authorization for observation services up to 48 hours. The CMO required notification of any inpatient admits for completion of a medical necessity review.		
Required Actions: None.		
20. Limit on Charges for the Member: *42 CFR 422.113(c)(2)(iv); 42 CFR 438.114(c); Contract 4.6.2.6* In the event the member receives poststabilization services from a provider outside the CMO's network, the CMO does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider.	In the event the member receives post stabilization services from a provider outside the CMO's network, the CMO does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. • Std. VI.20 Emergency Care – GA • Std. VI.20 Coverage for Post Stabilization Care Services • Std.VI.20 GAGA CAID PC MHB ENG 6-14 Covered Services pg. 11 (pg. 20 PDF), Copayments pg. 13 (pg.22 PDF), Emergency Care pg. 15 (pg. 24 PDF). • Std.VI.20 GAGA CAID Provider Manual pg. 28, 45-48, 91, 103 <u>Additional supporting documentation</u> • Std.VI.20 2014 UM Program Description MAC and QMC approved 04.28.14	☒ Met ☐ Not Met ☐ N/A

Standard VI—Emergency and Poststabilization Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Std.VI.20 Emergency Care Policy P4HB Members – GA • Std.VI.20 Emergency Care-Behavioral Health • Std.VI.20 Emergency Room Services Reimbursement – GA • Std.VI.20 Emergency Services Core Process	
Findings: The documentation and staff interviews demonstrated compliance with this element. Staff noted that any inappropriate billing of the member from providers was managed through the grievance process.		
Required Actions: None.		

Standard VI—Emergency and Poststabilization Services Results						
Met	=	20	X	1.00	=	20.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0		***N/A***		N/A
Total Applicable	=	20	**Total Score**		=	100.0%

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.

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 CPG Compliance Monitoring tool, and it indicated that for the Diabetes CPG, 26 percent of the reviewed providers complied with 80 percent of the CPG requirements. Analysis of the Asthma CPG indicated that 62 percent for the reviewed providers complied, and 59 percent of the reviewed providers complied with the ADHD CPG components. When providers were issued a CAP, they were not specifically reevaluated for compliance with adherence to the CPGs. Noncompliant providers were returned to the pool of providers the next year and may not be re-reviewed.

Required Actions: AMERIGROUP needs to improve its CPG compliance rates so that 90 percent of participating providers comply with AMERIGROUP's CPGs. Additionally, the CMO must ensure that when a CAP is issued, those providers with a CAP are reevaluated until they are compliant.

Evidence/Documentation Submitted by the CMO

Amerigroup is consistently making efforts to improve its CPG compliance rates so that 90 percent of participating providers comply with Amerigroup's CPGs. This is evidenced by the following. Aggregate performance and was shared with the network via:

- Blast Fax - GAPEC-0567-14 CPG Provider Blast Fax, pp. 1-2
- Provider Relations Training - PR Training Power Point 2.24.14, p. 14
- Newsletter - GAPEC - 0386 - 13 Provider Newsletter, p. 7

Amerigroup is on track to ensure that when a CAP is issued; those providers with a CAP are reevaluated until they are compliant. Amerigroup ensured compliance with the updated policy and revised provider CAP letter:

- Clinical Practice Guidelines Measuring Practitioner Compliance Policy, p. 4
- CAPEC-0526-14 CPG Provider Revised CAP letter, p. 1

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.

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: The performance measures report analysis document indicated that AMERIGROUP used the DCH-established performance measures. The CMO met the State target on seven measures but did not meet the performance targets for the remaining measures during CY 2012.

Required Actions: AMERIGROUP must meet the DCH-established performance targets in order to comply with this element.

Evidence/Documentation Submitted by the CMO

Amerigroup has implemented the following activities in order to meet the DCH-established performance targets.

Exam rates on a monthly basis through an evaluation of these claims benchmark to ensure we are on track.

- HEDIS_Monthly Admin_GA_Mar 2014 Benchmark Report
- HEDIS_Monthly Admin_GA_April 2014 Benchmark Report

An example of a monthly provider performance report that is distributed to all providers and allows us to monitor their performance against state targets has been provided. In addition we create action plans with providers who are not at state target and an example of an action plan has also been provided.

- Choice Family Health Centers Performance Report
- Choice IPA Action Plan

The HP Coordinator Event Totals report monitors the quantity of clinic days and HP coordinators activities to ensure we are achieving volume enough to meet target on the measures.

- 2013 HP Coordinator Event Totals

Below are examples of how Amerigroup monitors effectiveness of interventions.

- Scion Dental Outreach Results 2013
- Case Mgmt. Disease Mgmt. Diabetes HEDIS 649 Effectiveness 2.27.14
- Year over Year Effective Analysis of HP coordinators
- MHD effective analysis 05-14

Standard II—Quality Assessment and Performance Improvement

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

Noted below are some milestones Amerigroup has achieved to reach state targets:

- Outreached the Deputy Director of the public health departments to solicit their assistance with blood lead screenings. Dr. Alexander confirmed he has a "meeting with Dr. Seema Csukas on July 2" and this lead topic will be discussed.
- Submitted study designs for quarterly reporting to DCH to complete rapid cycle evaluations of effectiveness of PIP interventions. Below is an example of the Postpartum rapid cycle PIP study design.

  *PIP Summary Form_Postpartum
- Engaged high volume/low performing providers for key HEDIS measures via face-to-face visits to discuss improvement opportunities. Below is a Year Over Year Analysis of AMERIGROUP's 19 highest-volume providers based on these face-to-face visits.

  *Year Over Year HP Analysis
- Consistently completing member outreach calls that result in at least 5% of appointments scheduled. For example, the month of April's successful calls resulted in 27% appointments scheduled.

  *Member Outreach Results April 2014
- Partnered with WarmHealth vendor to improve the number of pregnant members that receive outreach. Amerigroup received DCH approval of the Spanish translated Warm Health collaterals on June 19, 2014. These are meetings describing and confirming the WarmHealth training of Georgia associates in May 2014.

  *Georgia- Warm Health Administrator Training

  *Georgia-Warm Health Dashboard Onsite Training

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

Standard II—Quality Assessment and Performance Improvement

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

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
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

Standard II—Quality Assessment and Performance Improvement

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

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.

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: The QM evaluation is the mechanism that documents AMERIGROUP's assessment of the quality program; however, the evaluation report does not bring together all quality elements or provide an integrated assessment of the overall performance.
Required Actions: AMERIGROUP should revise the format of its annual assessment of its quality program to ensure all quality elements are addressed and that they are integrated in terms of overall program impact.
Evidence/Documentation Submitted by the CMO
Amerigroup ensured compliance by completing the DCH revised format of its annual quality program. ◆ 2014 DCH QAPI
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.

Standard VII—Coordination and Continuity of Care—Focused Review

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

2. 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:

- Early identification of members who have or may have special needs
- Assessment of member's risk factors
- Development of a care plan
- Referrals and assistance to ensure timely access to providers
- Coordination of care actively linking the member to providers, medical services, residential, social and other support services where needed
- Monitoring
- Continuity of care
- Follow-up documentation

Findings: The CMO partially met this requirement. AMERIGROUP's documents evidenced that the CMO has policies and procedures describing its case management activities of identification, assessment, and care plan development and monitoring as listed in the element above. On-site interviews with staff and file reviews of five case management cases (three OB cases and two complex cases—one HIV and one sickle cell anemia) revealed that the majority of cases identified and referred for case management are pregnant women. The CMO has well-constructed assessment tools that capture information about cultural belief and medical alert jewelry. Care plans contain problems, goals, and interventions that are forwarded to the member's PCP and evidence that the case managers are monitoring cases, using motivational interviewing to establish relationships with members, and keeping members engaged in the case management process. While the CMO's procedures for identification and assessment of member's risk factors are adequate, opportunities exist in the area of care treatment plans, monitoring and follow-up.

Required Actions: The CMO may consider dedicated prenatal case managers and assess the value of embedding prenatal case managers at the major OB/GYN centers where the case manager can be on-site at the point of service to attend appointments, conduct assessments, offer individualized education or classes, and provide in-person support to members. Additionally, the CMO should ensure that case managers are documenting not only that they reviewed claim and utilization data, but also whether there were any red flags or findings and how the case manager will use the information obtained as a result of the review.

Evidence/Documentation Submitted by the CMO

Std VII.2 Enhanced Case Management Report AGP Q4-2012

Std VII.2 OB Educ Class_Real Solut STS relaunch

Findings: AMERIGROUP provided its Enhanced Case Management Report for review, which demonstrates important documentation in the CMO's efforts to emphasize prevention, continuity of care, and coordination of care, including information about claims and utilization of services. While the report provides helpful information, there is no formal process by which the case manager reviews and documents review of this information. During the file reviews at the on-site audit, HSAG noticed that, for one case review, the member had accessed the emergency room multiple times within a six-month period. Four prescribers were providing opiates to this member; however, no documentation from the case manager indicated that a utilization data review was completed, which may

Standard VII—Coordination and Continuity of Care—Focused Review		
have alerted the case manager of the multiple prescriptions by multiple prescribers.		
Required Actions: The CMO should formalize its case manager review process to include a periodic review and documented findings from the utilization review. HSAG recommends that the CMO consider a quarterly review for members enrolled in case management. During the interview process, AMERIGROUP staff mentioned the CMO's new "Care 360" program, which documents claims and pharmacy data in a single location, whereas in the previous system, case managers would have to access three or four systems to gain the same information. This should be a valuable enhancement for the case management process, and HSAG looks forward to seeing the "Care 360" program in future site visits.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**
1. Amerigroup will continue to assess and evaluate the value of embedded prenatal case managers at major contracted OB facilities. Amerigroup will continue to work with Executive Leadership in the review for available funding to support embedded prenatal case management.	Lisa Ross-Jones, Director Health Care Management Services	90 days after acceptance of CAP interventions
2. Amerigroup will continue to update the Case Management program to ensure that member's utilization data is reviewed on initial admission into the case management program, with each follow-up call and at least monthly for continuity of care and coordination of care.		90 days after acceptance of CAP interventions
3. Amerigroup will continue to update core case management documentation requirements to ensure that utilization data is addressed in the initial and ongoing phases of case management and any findings are documented for intervention.		90 days after acceptance of CAP interventions
4. Amerigroup Case Manager's will continue to update the member's care plan when indicated post discharge to ensure that each member enrolled in case management is being followed after each hospitalization and any additional needs are identified.		90 days after acceptance of CAP interventions
5. The Case Management Team will enhance documentation and protocols to consistency ensure that updates are being provided to the member and to the provider.		90 days after acceptance of CAP interventions
6. The Case Managers will receive additional training on how to add barriers to		90 days after acceptance of CAP

Standard VII—Coordination and Continuity of Care—Focused Review		
the care plan and document progress towards goals. The Care Compass documentation system has been enhanced in which barriers can now be added and addressed on the care plan.		interventions
Findings: AMERIGROUP's process for case management showed improvement based on the case file reviews.		
Required Actions: None.		

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: The CMO partially met this requirement. Document review evidenced that AMERIGROUP conducts discharge planning activities. On-site file reviews revealed that the case managers are not consistently obtaining and documenting members' discharge plans and proactively ensuring that members are linked with post-hospital service needs.

Required Actions: The CMO needs to obtain discharge information directly from the provider in a timely manner to ensure that the member's real-time discharge and follow-up care needs are being met.

Evidence/Documentation Submitted by the CMO

1. Std VII.5_Post Discharge Assessment Template
2. Std VII.5_Stabilization Template

Std VII.5_DMCCU Case Manager Census Workflow

Findings: The CMO staff indicated that discharge plans are obtained and attached to the member's record. The case manager asks the member if discharge plans have been provided and if the member understands the discharge plans. Staff also indicated that as responsibilities move from Utilization Management to Care Management, the case managers frequently discuss the patient's needs and consult the medical director as needed.

Required Actions: During the focused reviews of emergency room admissions and hospital readmissions, review staff members discovered that the CMO was not consistently obtaining the discharge plan. AMERIGROUP needs to obtain discharge planning information from providers to ensure that the member understands the discharge plan and AMERIGROUP staff members can follow up with the member regarding his or her care.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date
1. Amerigroup will continue to update the Case Management program to ensure that the case managers are reviewing and consistently obtaining member's final discharge plans/instructions. The Case Manager will collaborate with the Inpatient Review Nurse at the designated hospital facility and with the Provider/Provider's Office Staff to ensure that copies of member's final discharge plan/instructions are received. The case manager will continue to assess their member's understanding of their discharge plans when the member is asked to verbally communicate their understanding of the discharge plan they received prior to discharge.	Lisa Ross-Jones, Director Health Care Management Services	90 days after acceptance of CAP interventions

Standard VII—Coordination and Continuity of Care—Focused Review		
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2012–June 30, 2013)		
Amerigroup will continue to outreach members within 1 business day post-discharge to ensure continuity of care and prevent re-admissions. 2. Amerigroup will enhance their case management program requirements to consistently participate in Inpatient Rounds biweekly on Tuesdays and Thursdays. The case manager or designee will document in the case management documentation tool (Care Compass) on the members who are enrolled in case management whom were discussed during the inpatient rounds which will include discharge planning and next step recommendations.		90 days after acceptance of CAP interventions
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.		

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 22–23, 2014

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	Jennifer Lenz , MPH, CHCA	Executive Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, PCC-S	Senior Project Manager
Reviewer	Terry Huysman, RN, BSN, CHC	Director, State & Corporate Services
Reviewer	Maureen McGurrin, BA	Executive Director, State & Corporate Services
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
AMERIGROUP Community Care Participants		Title
Urcel Fields		Director, PEC/ICM
Donna McIntosh		Plan Compliance Officer
Rochelle Simmons		Compliance Analyst
Tawanna Ingram		Manager, Quality Management
Vanessa Thompson		Manager, HCMS, OB Case Management
Charmaine Bartholomew		Vice President, Quality Management
Michelle Rush		Director, Network Development
Earlie Rockette		Director, Georgia Families 360°
Dr. Joel Axler		Medical Director, Behavioral Health
David Bolt		Community Education Lead
Tita Stewart		Marketing/Community Relations
Larry Brown		Clinical Team Lead—Georgia Families 360°
Bridgette McKenzie		Director, Medical Management
Aaron Lambert		Director, Medicaid Field Operations
Amani Mungo		Integrated Care Coordinator
Jeanette Davis		Manager, Utilization Management
Marquette Moore		Manager, Regulation Oversight
Francesca Gary		Chief Executive Officer
Fortuna Gyeltsen		Project Leader
Aviance Jenkins		Regulatory Compliance—Foster Care

Table C-2—HSAG Reviewers and AMERIGROUP Community Care/Other Participants	
Michelle Anderson-Johnson	Manager, Outpatient Pre-service
Simone Johnson-Rogers	Manager, HCMS
Candace Body	Manager, HCMS—Georgia Families 360°
Tonia Richardson	Manager, HCMS—Georgia Families 360°
Greg Powell	Vice President, Finance
Dr. Donald Paul	Medical Director
Robert Dinwiddie	Regional Director, Pharmacy
Cynthia Brown	Manager, Case Management—HCMS
Jeanine Davis	Chief Operating Officer
David Newton	Director, Behavioral Health
Lisa Ross-Jones	Health Care Management
Lisa Maleski	Manager, Quality Management
Tanya Chambers-Ashford	Regulatory Market Manager
Bonnie Messinger	Regulatory Oversight Analyst
Karen Jackson	Disease Management
Dr. William Alexander	Chief Medical Officer
Alison Barreiro-Jones	Manager, Georgia Families 360°
Becky Thatcher	Compliance Auditor
Mel Lindsey	Government Relations
Department of Community Health Participants	**Title**
Kimberly Foster, RN, BSN, MBA	Director
Terri Portis, MPA	Project Director
Tiffany Simmons, BSN	Compliance Auditor
Kina DeWitt, LCSW	Manager, Performance Improvement
Marcey Alter	Deputy Director, Aging & Special Population
Mike Polynice	Compliance Investigator Specialist

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—Availability of Services
- Standard II—Furnishing of Services
- Standard III—Cultural Competence
- Standard IV—Coordination and Continuity of Care
- Standard V—Coverage and Authorization of Services
- Standard VI—Emergency and Poststabilization Services
- Case and Disease Management Focused Review
- Follow-up on areas of partial compliance or 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 first 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 eight sample cases plus an oversample of three cases for case management, disease management, and service denial cases for the on-site CMO audit from the list of such members submitted to HSAG from the CMO.

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

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

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.
- A review of the member cases HSAG requested from the CMO.
- 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, 2013–June 30, 2014
Information obtained through interviews	July 1, 2013—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, 2013–June 30, 2014

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
- 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 final 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.

Interventions Planned	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.

Standard II—Furnishing of Services		
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 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.		
Interventions Planned	**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).

Interventions Planned	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)

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.

Interventions Planned	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)		
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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date

Standard V—Coverage and Authorization of Services		
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)		
16. 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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**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.		
Interventions Planned	**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.

Interventions Planned	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)		
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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

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.		
Interventions Planned	**Individual(s) Responsible**	**Proposed Completion Date**

Appendix F. **Georgia Families 360° Review Tool**

Following this page is the Review Tool HSAG used to evaluate AMERIGROUP's Georgia Families 360° Program.

Standard I—Availability of Services	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
1. The Georgia Families 360° members' anticipated need for providers who are trained or experienced in trauma care, addressing complex special needs, identifying child abuse and neglect, and rendering core services and intensive family intervention (IFI) services.	Amerigroup's Georgia Families 360° provider network includes providers who are trained or experienced in trauma care, address complex special needs, identify child abuse and neglect, and render core services and intensive family intervention (IFI) services. • Std. I.1b -Trauma Informed Care Proposal v2 • Std. I.1b –Trauma – SOC Invite • Std. I.1b –Trauma SOC Participant Roster • Std. I.1b - GAFC_Central_Access_Analysis • Std. I.1b - GAFC_East_Access_Analysis • Std. I.1b - GAFC_SE_Access_Analysis • Std. I.1b - GAFC_ATL_Access_Analysis • Std. I.1b - GAFC_North_Access_Analysis • Std. I.1b - GAFC_Southwest_Access_Analysis
Findings: Discussion with AMERIGROUP staff revealed that when members were enrolled into Georgia Families 360°, the CMO was not contracted with all of the providers seen by these members. AMERIGROUP offered a 90-day transition period for these members allowing them to see any provider. The CMO then contracted with the providers the members were seeing to minimize any transition of care issues.	
Recommendation: None.	
2. CMO Responsibility: Addenda 4.8.2.13; 4.8.2.14 The CMO ensures that every Georgia Families 360° member has a designated PCP who will serve as the Georgia Families 360° member's medical home within two (2) business days of receipt of the eligibility file from DCH and at all times during eligibility. The CMO allows the member or legal guardian, as appropriate, to change the PCP designation based on the needs of the child and with any change in placement.	Amerigroup ensures that every Georgia Families 360° member has a designated PCP who will serve as the Georgia Families 360° member's medical home within two (2) business days of receipt of the eligibility file from DCH and at all times during eligibility. Amerigroup allows the member or legal guardian, as appropriate, to change the PCP designation based on the needs of the child and with any change in placement. • Std. I.10 – Copy of GA PCP Assignment (Enrollment File) • Std. I.10 – Primary Care Provider Selection, Assignment and Change Requests • Std. I.10 – Step by Step FCDJJAA Guide – Change PCP/View ID Cards • Std. I.10 – Georgia Provider Manual (p.19 if printed; p. 21 on PDF view) • Std. I.10 – Member Handbook – FC/DJJ (p.6 if printed; p. 13 on PDF view)

Standard I—Availability of Services	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
Findings: AMERIGROUP provided its Georgia Provider Manual, which indicated that for the Georgia Families 360° population, the member should have a designated PCP within two business days of receipt of the eligibility file. The provider manual also indicated that the member or legal guardian was able to change the PCP assignment as needed. During the interview, AMERIGROUP staff members indicated if no PCP was assigned upon enrollment, the CMO would assign the member to a PCP.	
Recommendation: None.	
3. CMO Responsibility: Addenda 4.8.12.8; 4.8.12.9 The CMO ensures that every Georgia Families 360° member has a designated dentist who will serve as the Georgia Families 360° member's dental home within five (5) business days of receipt of the eligibility file from DCH and at all times during eligibility. The CMO allows the member or legal guardian, as appropriate, to change the PCP designation based on the needs of the child and with any change in placement.	Amerigroup ensures that every Georgia Families 360° member has a designated dentist who will serve as the Georgia Families 360° member's dental home within five (5) business days of receipt of the eligibility file from DCH and at all times during eligibility. Amerigroup allows the member or legal guardian, as appropriate, to change the PCP designation based on the needs of the child and with any change in placement. • Std. I.11 – Amerigroup GA Primary Care Dentist Selection: Juvenile Justice and Foster Care Population • Std. I.11 – Amerigroup GA Primary Care Dentist Selection: Adoption Assistance • Std. I.11- Member Handbook – FC/DJJ (p.21 if printed; p. 28 on PDF view) • Std. I.11 – Provider Manual (p.39 if printed; p. 41 on PDF view) • Std. I.11– Intake Team Processes • Std. I.11 – Step by Step FCDJJAA Guide – Change PCP/View ID Cards • Std. I.11- PCD Self-Assignment Demo • Std. I.11 – Scion PCD Member PCD Assignment Letter Template Note: Only DFCS and DJJ can make changes to PCP or PCD per DCH decision.
Findings: The provider manual indicated that Georgia Families 360° members should have a designated dentist within five business days of receipt of the eligibility file and that the dental provider could be changed based on the needs of the child. During the interview, AMERIGROUP staff members indicated that if no PCD was assigned upon enrollment, the CMO would assign the member to a PCD. The AMERIGROUP GA Primary Care Dentist Selection policy indicated that the frequency of the analysis to select a PCD was daily; however, the requirement was to auto-assign within five business days.	
Recommendation: AMERIGROUP should review its auto-assignment policies to ensure they are consistent with CMO staff practices.	

Standard II—Furnishing of Services	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
1. Timelines—Visits for Children Eligible for Health Checks (FC): Contract 4.5.7.2 (b) Medical assessments, which are Health Check visits, must be completed within ten (10) calendar days of receipt of the member's eligibility file from DCH.	Amerigroup ensures that medical assessments, which are Health Check visits, are completed within ten (10) calendar days of receipt of the member's eligibility file from DCH. • Std. II. 1(f) – Intake Compliance Team Procedure (3a) • Std. II. 1(f) – Intake Department Compliance Report (example) • Std. II .1(f) – Care Coordination Checklist • Std. II .1(f) –Georgia Provider Manual (p.66) • Std. II .1(f) – EPSDT Dental Assessment Example
Findings: The CMO provided a screenshot of its SharePoint site where compliance with this element was tracked. The staff indicated that Georgia Families 360° members were compliant approximately 60 percent of the time.	
Recommendation: The CMO needs to continue its monitoring activities and meet the requirement that health check visits are accomplished within 10 calendar days of receipt of the eligibility file.	

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
1. CMO Responsibilities: Addendum 4.1.1.5 The CMO enrolls Georgia Families 360° members in the CMO upon receipt of the Georgia Families 360° member's eligibility file from DCH.	Amerigroup enrolls Georgia Families 360° members upon receipt of the Georgia Families 360° member's eligibility file from DCH. • Std. IV.2 – Copy of GA PCP Assignment (Enrollment File) • Std. IV.2 – Primary Care Provider Selection, Assignment and Change Requests • Std. IV.2 – Step by Step FCDJJAA Guide – Change PCP/View ID Cards • Complex Care Coordination: Georgia Families 360° Program – GA • Intake Compliance Team Procedure – Georgia Families 360°- Draft 1 April 10, 2014 and Draft 2 May 19, 2014. • Barriers to Success: Amerigroup Barriers Encounter with Implementation of Georgia Families 360° Program
Findings: The CMO had a process in place to receive the eligibility files for Georgia Families 360° members. Once the file was received by the CMO, the CMO processed the Georgia Families 360° member as an AMERIGROUP member.	
Recommendation: None.	
2. CMO Responsibilities: Addenda 4.8.17.8; 4.8.17.9 The CMO requests information about the Georgia Families 360° members' needs, current medical necessity determinations, authorized care, and treatment plans within two (2) business days of receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS and DJJ. Requests are made as follows: ◆ For a Georgia Families 360° member transitioned from another CMO or from private insurance, a request is sent to the prior CMO or other insurer. ◆ For a Georgia Families 360° member transitioned from fee-for-service Medicaid, the CMO coordinates with DCH to send requests to the member's prior service providers.	Amerigroup requests information about the Georgia Families 360° members' needs, current medical necessity determinations, authorized care, and treatment plans within two (2) business days of receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS and DJJ. Requests are made as follows: • For a Georgia Families 360° member transitioned from another CMO or from private insurance, a request is sent to the prior CMO or other insurer. • For a Georgia Families 360° member transitioned from fee-for-service Medicaid, Amerigroup coordinates with DCH to send requests to the member's prior service providers. • Complex Care Coordination: Georgia Families 360° Program – GA • Amerigroup Transitional Healthcare Assessment Centers • Std. IV.3 – GAHIN AMG Activity 5-19-2014 • Std. IV.3 – E-form DFCS • Std. IV.3 – E-form DJJ

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
	• Std. IV.3 – TOC GF 360° • Std. IV.3 – TOC State Process Std. IV.3 – Continuity of Care – Transition of Care for FC-GA • Std. IV.3 – Health Care Outcomes FC – GA (#1) States it was put into effect on January 1, 2014 • Std. IV.3 -- CAID PCK Handbook AA Addendum (p. 5 if printed; p. 12 if in PDF view) • Std. IV.3 - Amerigroup FC TOC Form - DFCS Accepted DJJ edits 11-21-2013
Findings: AMERIGROUP had a process in place to request information regarding Georgia Families 360° member needs, current medical necessity determinations, authorized care, and treatment plans once the eligibility file was received; however, these requests were not being processed within two business days of receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS and DJJ.	
Recommendation: AMERIGROUP needs to improve the timeliness of the processing of treatment requests for Georgia Families 360° members.	
3. CMO Responsibilities: Addendum 4.5.7.2 (b) The CMO ensures the Comprehensive Child and Family Assessment (CCFA) medical assessments are completed within ten (10) calendar days of receipt of the FC member's eligibility file from DCH or written notification from DFCS whichever comes first for a member newly entering or re-entering FC as a FC member.	Amerigroup ensures the Comprehensive Child and Family Assessment (CCFA) medical assessments are completed within ten (10) calendar days of receipt of the FC member's eligibility file from DCH or written notification from DFCS whichever comes first for a member newly entering or re-entering FC as a FC member. • Std. IV.4 – Final Draft DFCS Enrollment Flow • Std. IV.4 – Provider Manual (p.66 if printed; p. 68 if on PDF view) • Std. IV.4 – Care Coordination of Medical and Trauma Assessments Initial and Ongoing (#1) • Std. IV.4 – Copy of Compliance Overview May 2014 • Std. IV.4 – Barriers to Success
Findings: AMERIGROUP was not able to demonstrate timely completion of the CCFA medical assessment. HSAG's understanding from AMERGROUP staff members is that AMERIGROUP was not completing CCFA medical assessments.	
Recommendation: The contract requirements associated with these assessments should be revised as AMERGROUP is currently not meeting this contract requirement.	

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
4. CMO Responsibilities: Addenda 4.5.7.2 (b); 4.5.7.4 The CMO ensures the outcomes of the medical assessments are sent appropriately as follows: ◆ Outcomes are sent to the DCH-contracted CCFA provider preparing the final CCFA report within 20 calendar days of the CMO's receipt of the eligibility file from DCH or written notification from the Division of Family and Children Services (DFCS), whichever occurred first. ◆ Outcomes are sent to the DJJP member's residential placement provider within 15 calendar days of the CMO's receipt of the eligibility file from DCH or written notification from DJJ, whichever occurred first.	Amerigroup ensures the outcomes of the medical assessments are sent appropriately as follows: • Outcomes are sent to the DCH-contracted CCFA provider preparing the final CCFA report within 20 calendar days of Amerigroup's receipt of the eligibility file from DCH or written notification from the Division of Family and Children Services (DFCS), whichever occurred first. • Outcomes are sent to the DJJP member's residential placement provider within 15 calendar days of Amerigroup's receipt of the eligibility file from DCH or written notification from DJJ, whichever occurred first. • Std. IV.5 – Provider manual (p.66 if printed; p. 68 if on PDF view) • Std. IV.5 – Intake Compliance Overview May 2014 • Std. IV.5 – What are Transitional Healthcare Assessment Centers (Draft) • Std. IV.5 – Intake Compliance Team Procedure (item 11) • Std. IV.5 – Care Coordination of Medical and Trauma Assessments initial and ongoing (#1 & #3) • Std. IV.5 – Barriers to Success
Findings: AMERIGROUP is responsible for completing the EPSDT component of the Comprehensive Child and Family Assessment (CCFA) medical assessments, and the remainder of the components are completed or compiled by the agency contracted to complete the CCFA. As contractually written, AMERIGROUP is required to complete the CCFAs; however, staff members reported that CCFA medical assessments were not being completed by AMERIGROUP because it was unable to hold the providers to a standard since they were identified and contracted by the Division of Family and Children Services (DFCS). AMERIGROUP staff reported that members joining the plan were scheduled for medical assessments. However, the CMO staff reported continued challenges in completing these assessments. Staff members reported that they were unable to contact the member at the location provided on the eligibility file sent from the State. Members have missed appointments due to transportation issues, and staff members were unable to contact the DFCS case worker to provide transportation support.	
Recommendation: The contract requirements associated with these assessments should be revised to reflect the required process and responsible agencies as AMERGROUP is currently not meeting this contract requirement.	
5. CMO Responsibilities: Addendum 4.5.7.2 (b); 4.5.7.4	Amerigroup ensures that the CCFA medical assessment's initial medical

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
The CMO ensures that the CCFA medical assessment's initial medical evaluation addresses all age-relevant components of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule, including: ◆ Age-appropriate development ◆ Vision screenings ◆ Hearing screenings ◆ Dental screenings	evaluation addresses all age-relevant components of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule, including: • Age-appropriate development • Vision screenings • Hearing screenings • Dental screenings • Std. IV.6 – Provider manual (p. 55 if printed; p. 57 if on PDF view) • Std. IV.6 - What are Transitional Healthcare Assessment Centers (Drafts) • Std. IV.6 – Examples of EPSDT Health Check Exam for GF 360° Member • Std. IV.6 – EPSDT Core Policy Barriers to Success: Amerigroup Barriers Encountered with Implementation of Georgia Families 360° program:
Findings: AMERIGROUP is responsible for completing the EPSDT component of the Comprehensive Child and Family Assessment (CCFA) medical assessments, and the remainder of the components are completed or compiled by the agency contracted to complete the CCFA. As contractually written, AMERIGROUP was required to complete the CCFAs; however, staff members reported that CCFA medical assessments were not being completed by AMERIGROUP because it was unable to hold the providers to a standard since they were identified and contracted by the Division of Family and Children Services. AMERIGROUP staff reported that members were identified on the eligibility file from the State and the CMO scheduled the member's medical, dental, and trauma assessment. However, continued communication issues with DFCS case managers, member eligibility, accuracy of the member's current PCP, accuracy of the member's current placement, and accuracy of the member's current DFCS case manager made it challenging for the CMO to ensure completion of these assessments.	
Recommendation: The contract requirements associated with these assessments should be revised to reflect the required process and responsible agencies as AMERGROUP is currently not meeting this contract requirement.	
6. CMO Responsibilities: Addenda 4.5.7.2 (e) (i); 4.5.7.2 (f) The CMO ensures that the trauma assessments are initiated within ten (10) calendar days of written notification from DFCS for the following populations:	Amerigroup ensures that the trauma assessments are initiated within ten (10) calendar days of written notification from DFCS for the following populations: • New or re-entering FC members. • Members who have been in FC for a period of 12 or more months and

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
◆ New or re-entering FC members. ◆ Members who have been in FC for a period of 12 or more months and whose completed CCFA is more than 12 months old. ◆ AA members in the event of abuse or neglect as reported by a provider, adoptive parent, or other.	whose completed CCFA is more than 12 months old. • AA members in the event of abuse or neglect as reported by a provider, adoptive parent, or other. • Std. IV.7 – Intake Compliance Team Procedure (#3a) Draft 2 dated May 19, 2014 • Std. IV.7 – Provider manual (p.67-68 if printed; p. 69-70 on PDF view) • Std. IV.7 – Care Coordination of Medical and Trauma Assessments Initial and Ongoing (p. 4) • Barriers to Success: Amerigroup Barriers Encountered with Implementation of Georgia Families 360° program: • What are Transitional Healthcare Assessment Centers
Findings: According to AMERIGROUP's Care Coordination of Medical and Trauma Assessment Initial and Ongoing Assessments policy, page 3, contracted providers conducting trauma assessments for FC members are to complete this assessment within 15 calendar days of the notification to AMERIGROUP of the youth remaining in care beyond the preliminary placement hearing.	
Recommendation: The CMO should revise its policies and procedures to meet the 10-day contract requirement for ensuring trauma assessment completion.	
7. **CMO Responsibilities:** Addendum 4.5.7.2 (g) The CMO coordinates and ensures that the FC and AA members receive any care specified within the trauma and medical assessments in accordance with the following timeliness requirements. The following care is provided within 30 days of the need being identified: ◆ Dental treatment. ◆ An audiological assessment and treatment or prescribed corrective devices. ◆ A developmental assessment.	Amerigroup coordinates and ensures that the FC and AA members receive any care specified within the trauma and medical assessments in accordance with the following timeliness requirements. The following care is provided within 30 days of the need being identified: • Dental treatment. • An audiological assessment and treatment or prescribed corrective devices. • A developmental assessment. • Std. IV.8 – Care Coordination of Medical and Trauma Assessment Initial and Ongoing (#7) • Std. IV.8 – Provider Manual (p. 69 if printed; p. 71 on PDF view)
Findings: AMERIGROUP's policies reflected the coordination of care for services identified in the trauma assessment within 30 days after the need was identified.	
Recommendation: None.	

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
8. CMO Responsibilities: Addendum 4.5.7.3 The CMO ensures that providers refer FC members ages three (3) years and younger who are exposed to substantiated maltreatment to the Children 1st program for developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA).	Amerigroup ensures that providers refer FC members ages three (3) years and younger who are exposed to substantiated maltreatment to the Children 1st program for developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA). • Std. IV.9 – THAC (Draft) • Std. IV.9 – Provider Manual (p.23, 38 if printed; p. 25 and 40 on PDF view) • Std. IV.9 – Intake Compliance Team Procedure (#2) Draft 2 dated May 19, 2014
Findings: AMERIGROUP had a procedure for ensuring providers refer FC members ages 3 years and younger who are exposed to substantiated maltreatment to the Children 1st program.	
Recommendation: None.	
9. CMO Responsibilities: Addendum 4.5.7.5 The CMO provides a health risk screening within 30 days of receipt of the eligibility file from DCH. The health risk screening is independent of the assessments conducted for the CCFA. A new health risk screening is completed as necessary based on a change in the Georgia Families 360° member's medical or behavioral health as identified by providers. The CMO assesses the need to complete a new health risk screening each time a Georgia Families 360° member moves to a new placement.	Amerigroup provides a health risk screening within 30 days of receipt of the eligibility file from DCH. The health risk screening is independent of the assessments conducted for the CCFA. A new health risk screening is completed as necessary based on a change in the Georgia Families 360° member's medical or behavioral health as identified by providers. Amerigroup assesses the need to complete a new health risk screening each time a Georgia Families 360° member moves to a new placement. • Std. IV.10 – Provider Manual (p.66 if printed; p. 68 on PDF view) • Std. IV.10 – Care Coordination of Medical and Trauma Assessment Initial and Ongoing (HRS, 9) • Std. IV.10 --Initial Health Risk Screening - Pediatric ENG FINAL FOR WEB
Findings: AMERIGROUP's policies and procedures outline the process to complete a health risk screening for new members and for each new placement within 30 days from receipt of the eligibility file. During the transition months, AMERIGROUP did not meet the 30-day timeline.	
Recommendation: AMERIGROUP should continue efforts to ensure that a health risk screening is completed within 30 days for new members and for members in a new placement.	
10. Health Care Service Plan for Georgia Families 360° Members: Addenda 4.11.8.7; 4.11.8.8; 4.11.8.9	Amerigroup develops a health care service plan for Georgia Families 360° members within 30 calendar days of member enrollment. Amerigroup:

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
The CMO develops a health care service plan for Georgia Families 360° members within 30 calendar days of member enrollment. The CMO: ◆ Documents the involvement of the Georgia Families 360° member's PCP, dentist, behavioral health providers, specialists, or other providers in the development of the health care service plan and provide evidence of such documentation to DCH, DFCS and DJJ. ◆ Regularly reviews and updates the health care service plan. ◆ Includes a safety and contingency crisis plan with the health care service plan for Georgia Families 360° members with a severe emotional disturbance.	• Documents the involvement of the Georgia Families 360° member's PCP, dentist, behavioral health providers, specialists, or other providers in the development of the health care service plan and provides evidence of such documentation to DCH, DFCS and DJJ. • Regularly reviews and updates the health care service plan. • Includes a safety and contingency crisis plan with the health care service plan for Georgia Families 360° members with a severe emotional disturbance. • Std. IV.11 – Care Coordination Services and Level of Care Identification (Draft) Std. IV.11 – Care Coordination of Medical and Trauma Assessment Initial and Ongoing (#9)
Findings: AMERIGROUP had a process outlined to develop a health care services plan for members within 30 days of member enrollment; however, during the early months of enrollment and transition, AMERIGROUP did not meet the time frame of 30 days for completion. HSAG observed during file review that the health risk screenings were not consistently documented. In several cases, questions were skipped, and it was unclear in the documentation what was and was not completed.	
Recommendation: AMERIGROUP should continue to work toward meeting the 30-day requirement for completing a health risk assessment for members within 30 days of enrollment. In addition, AMERIGROUP should implement a monitoring oversight process to ensure that HRAs are being completed and fully documented.	
11. Care Coordination Team for Georgia Families 360° Members: Addenda 4.11.8.10; 4.11.8.11(a), (b), (c), (d) The CMO assigns each Georgia Families 360° member an interdisciplinary care coordination team to provide the care coordination services identified in the health care service plan. The care coordination team's responsibilities include but are not limited to: ◆ Ensuring access to primary care, dental care, specialty care, and support services by locating providers and scheduling and obtaining appointments as necessary. ◆ Expediting the scheduling of appointments for medical assessments used to determine residential placements as requested by DFCS and DJJ.	Amerigroup assigns each Georgia Families 360° member an interdisciplinary care coordination team to provide the care coordination services identified in the health care service plan. The care coordination team's responsibilities include but are not limited to: • Ensuring access to primary care, dental care, specialty care, and support services by locating providers and scheduling and obtaining appointments as necessary. • Expediting the scheduling of appointments for medical assessments used to determine residential placements as requested by DFCS and DJJ. • Assisting with coordinating non-emergent transportation for Georgia Families 360° members as needed for provider appointments and

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
◆ Assisting with coordinating non-emergent transportation for Georgia Families 360° members as needed for provider appointments and other health care services. ◆ Documenting efforts to fulfill the above responsibilities. Documentation should include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with providers, or arranging referrals to community-based resources.	other health care services. • Documenting efforts to fulfill the above responsibilities. Documentation should include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with providers, or arranging referrals to community-based resources. • Std. IV.12 – Care Coordination of Medical and Trauma Assessment Initial and Ongoing • Std. IV.12 – Barrier to Success • Std. IV.12 – GAGA CAID PC MHB ENG with AA Addendum (p. 1 if printed; p. 62 if viewed on PDF)
Findings: AMERGROUP hired staff member resources to serve the Georgia Families 360° population as an interdisciplinary team. Case review showed evidence of AMERGROUP staff assisting members with coordination of services.	
Recommendation: None.	
12. Care Coordination Team for Georgia Families 360° Members: Addendum 4.11.8.11(h) The CMO assigns a nurse care manager (NCM) to assist Georgia Families 360° members identified through the health assessment as members with special health care needs (MSHCN). The NCM helps MSHCN members obtain medically necessary care and health-related services, and coordinates clinical care needs with holistic consideration.	Amerigroup has assigned a nurse care manager (NCM) to assist Georgia Families 360° members identified through the health assessment as members with special health care needs (MSHCN). The NCM helps MSHCN members obtain medically necessary care and health-related services, and coordinates clinical care needs with holistic consideration. • Std. IV.13 – Care Coordination of Medical and Trauma Assessment Initial and Ongoing (3) • Std. IV.13 – Case Management and Care Coordination for Members with Special Health Care Needs – GA • Std. IV.13 – Continuity of Care – Transition of Care for FC - GA
Findings: AMERIGROUP used indicators provided by DCH on the eligibility file to identify members with special health care needs. In addition, information was collected through the HRA. Identified needs were incorporated into a care plan.	
Recommendation: None.	
13. Selection of a Primary Care Provider: Addenda 4.1.2.1.3; 4.1.2.1.5 The CMO:	Amerigroup auto-assigns a PCP to the Georgia Families 360° member within two (2) business days of receipt of notification of the member's enrollment in Amerigroup if the legal guardian/member does not voluntarily select a PCP

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
◆ Auto-assigns a PCP to the Georgia Families 360° member within two (2) business days of receipt of notification of the member's enrollment in the CMO if the legal guardian/member does not voluntarily select a PCP upon enrollment.	upon enrollment. • Std. IV.16 – PCP Assignment (Enrollment) • Std. IV.16 – Provider Manual (p. 19 if printed; p. 21 on PDF view)
Findings: AMERIGROUP staff members described the CMO's process as assigning a PCP to Georgia Families 360° members using the eligibility file within two days; however, the CMO's policy did not include the time frame for ensuring the assignment was made within two days.	
Recommendation: AMERIGROUP should revise its policy and procedure to include the provision that the PCP is assigned within two days of enrollment.	
14. Access to the Primary Care Provider Following a Change in Placement: Addenda 4.1.2.1.6; 4.1.2.1.7 The CMO: ◆ Must assess the Georgia Families 360° member's access to the PCP within one (1) business day following receipt of notification of a change in the member's out-of-home placement or residential placement. If the PCP no longer meets the geographic access standards, the CMO: Shall reassign a PCP within three (3) business days of receipt of above notification if the member/legal guardian did not voluntarily select a new PCP within two (2) business days of the relocation.	Amerigroup assesses the Georgia Families 360° member's access to the PCP within one (1) business day following receipt of notification of a change in the member's out-of-home placement or residential placement. If the PCP no longer meets the geographic access standards, Amerigroup reassigns a PCP within three (3) business days of receipt of above notification if the member/legal guardian did not voluntarily select a new PCP within two (2) business days of the relocation. • Std. IV.17 – PCP Assignment (Enrollment) • Std. IV.17 – Provider Manual (p. 19 if printed; p. 21 on PDF view) • Std. IV.17 – GAGA CAID PC MHB ENG with AA Addendum (p. 4 if printed; p. 11 on PDF view) • Std. IV.17- GAMKT-0662-13 Step by Step FCDJJAA Flier (#2)
Findings: AMERIGROUP provided policies and procedures that outlined the process for member access to a PCP when there was a change in foster placement. AMERIGROUP assessed the member's PCP location within one business day after receipt of notification of the member's change in foster care placement. If the PCP no longer met the geographic standard, a new PCP was assigned within three business days if a PCP was not selected by the member/legal guardian within two business days.	
Recommendation: None.	
15. Selection of a Dental Provider: Addenda 4.1.3.1; 4.1.3.2, 4.1.3.3 The CMO: ◆ Auto-assigns a dental provider to the Georgia Families 360°/AA member within five (5) business days of receipt of notification of the member's enrollment in the CMO if the legal guardian/member does not voluntarily	Georgia Families 360°/AA member within five (5) business days of receipt of notification of the member's enrollment in Amerigroup if the legal guardian/member does not voluntarily select a dental provider upon enrollment. • Std. IV.18 – Scion Dental Provider Manual GF 360° (p.20 if printed; p. 22 on PDF view)

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
select a dental provider upon enrollment.	• Std. IV.18 – Scion Dental Provider AA Assignment (P&P) • Std. IV.18 – Scion Dental PCD Assignment Letter
Findings: AMERIGROUP provided CS-3000.220.10/ Amerigroup GA Primary Care Dentist Selection: Adoption Assistance policy for review with this element. This policy, the intellectual property of Scion Dental, represented the work that Scion Dental completes for AMERIGROUP. This policy described the auto-assignment of a PCD; however, the policy did not provide a time frame for this auto-assignment. AMERIGROUP also provided Scion Dental's provider manual as a representing document for auto-assignment of members. The provider manual clearly identified that a member will be auto-assigned a PCD, if the member had not identified one, when Scion Dental was notified of the member's eligibility for dental benefits. AMERIGROUP did not provide a corporate policy or supporting documentation that Scion Dental was to complete, or be accountable for, the auto assignment of a PCD within five business days of notice of CMO enrollment.	
Recommendation: AMERIGROUP/Scion must develop a policy and procedure that represents the required time frames for provision of services and PCD assignment for the Georgia Families 360° program.	
16. Access to the Dental Provider Following a Change in Placement: Addenda 4.1.3.4; 4.1.3.5 The CMO: ◆ Must assess the FC/DJJP member's access to the dental provider within two (2) business days following receipt of notification of a change in the FC member's out-of-home placement or the DJJP's member's residential placement. If the dental provider no longer meets the geographic access standards, the CMO: Shall reassign a new dental provider within five (5) business days of receipt of above notification if the member/member's legal guardian did not select a new dental provider within two (2) business days of the relocation.	Amerigroup assesses the FC/DJJP member's access to the dental provider within two (2) business days following receipt of notification of a change in the FC member's out-of-home placement or the DJJP's member's residential placement. If the dental provider no longer meets the geographic access standards, Amerigroup reassigns a new dental provider within five (5) business days of receipt of above notification if the member/member's legal guardian did not select a new dental provider within two (2) business days of the relocation. • Std. IV.19 – Scion Dental Provider Manual GF 360 (p. 20 if printed; p. 22 in PDF view) • Std. IV.19 – Scion Dental PCD Assignment (P&P)
Findings: AMERIGROUP provided CS-3010.220.10/ Amerigroup GA Primary Care Dentist Selection: Juvenile Justice and Foster Care Population policy for review with this element. This policy, the intellectual property of Scion Dental, represented the work that Scion Dental completes for AMERIGROUP. This policy described Scion Dental's processes for members' self-selecting a PCD; auto-assigning a PCD; notifying providers and members of an auto-assignment; reassessing the PCD assignment when there was a change in the member's living status; increasing access to care; and reassigning a PCD after provider termination from the network, and notifying the member of this change. During business hours, Scion Dental ran a "custom algorithm" against the database to identify members who did not have a PCD. The algorithm also identified geo-access codes and assigned members to a PCD where the codes match. The policy did	

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
not provide time frames other than for the daily monitoring during business hours.	
Recommendation: AMERIGROUP/Scion must develop a policy and procedure that represents the required time frames for provision of services and PCD assignment for the Georgia Families 360° program.	
17. Employing system of care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies that also serve Georgia Families 360° members.	Amerigroup employs system of care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies that also serve Georgia Families 360° members. • Std. IV.21(c) – Continuity of Care Transition of Care for FC-GA (Example of incorporation into policy) • Std. IV.21(c) – SOC Training DBHDD 11-15-2013 • Std. IV.21(c) – SOC AGP Attendee List • Std. IV.21(c) – SOC Primer
Findings: AMERIGROUP demonstrated strong linkages established with many agencies including State partner agencies, psychiatric and residential treatment services, and community organizations such as CHRIS Kids and Together Georgia. These linkages helped support the transition of children into AMERIGROUP.	
Recommendation: None.	
18. Discharge Planning Specific to FC and DJJP Members: Addendum 4.11.4.4.3; 4.11.4.4.4 The CMO supports DFCS and DJJ, participating in transitional roundtables initiated by DFCS or DJJ as appropriate in planning for: ◆ The FC member exiting foster care: Planning will begin one (1) year prior to the FC member's 18th birthday or one (1) year prior to the FC member planning to exit FC if the member elects to continue FC service past his or her 18th birthday. ◆ The DJJP member returning home: Planning will begin upon the DJJP member's enrollment in the CMO.	Amerigroup supports DFCS and DJJ, participating in transitional roundtables initiated by DFCS or DJJ as appropriate in planning for: • The FC member exiting foster care: Planning will begin one (1) year prior to the FC member's 18th birthday or one (1) year prior to the FC member planning to exit FC if the member elects to continue FC service past his or her 18th birthday. The DJJP member returning home: Planning will begin upon the DJJP member's enrollment in the CMO. • Std. IV.29 - Care Coordination Team - Members Transitioning Out of Foster Care and DJJ Workflow • Std. IV.29 - Provider Manual (p. 127 if printed; p. 129 on PDF view)
Findings: AMERIGROUP provided policies and procedures that outlined the process for FC and Department of Juvenile Justice Program (DJJP) member discharge planning. The CMO's policy was to work with DFCS and DJJ to transition members out of the Georgia Families 360° program starting one year prior to the member's 18th birthday.	

Standard IV—Coordination and Continuity of Care	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
Recommendation: None.	

Standard V—Coverage and Authorization of Services		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	
1. CMO Responsibilities: Addendum 4.8.17.10 The CMO ensures continuity of care for an FCAAP or DJJP member receiving services authorized in all treatment plans by their prior CMO, private insurer, or through fee-for-service Medicaid. The CMO authorizes the FCAAP or DJJP member to continue with his or her providers and current services, including those that are out of network, previously authorized for a period of at least 30 days or until the health care service plan is completed.	• Std. V. Second Medical Opinion • Std.V. Second Opinion • Other – Member Manual pg. 10-12 • Other-Provider Manual pg. 22-34 • Std. V. 2014 UM Program Description pg. 12-19 • Std. V. Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process Core Process • Std. V. Pre-Certification of Requested Services Core Process • Std. V. Continued Stay Review-GA • Std. V. Approval and Application of Medical Necessity Criteria-GA	☒ Met ☐ Not Met ☐ N/A
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO had no prior authorization (PA) requirements for 90 days, allowing for open access for initial onboarding of the populations. Going forward, at minimum, 30 days will be afforded to members for continuity of care.		
Required Actions: None.		
2. CMO Responsibilities: Addendum 4.11.8.11 (i) The CMO ensures continuity of care for Georgia Families 360° members identified as MSHCN receiving services authorized in a treatment plan by their prior health plan. The CMO works with the MSHCN's current PCP and specialists to provide services to meet the MSHCN's ongoing needs.	Amerigroup ensures continuity of care for Georgia Families 360° members identified as MSHCN receiving services authorized in a treatment plan by their prior health plan. Amerigroup works with the MSHCN's current PCP and specialists to provide services to meet the MSHCN's ongoing needs. • Std. V.6 – Care Coordination of Medical and Trauma Assessments Initial and Ongoing • Std. V.6 – Case Management and Care Coordination for Members with Special Healthcare Needs – GA • Std. V.6 - GAGA CAID Provider Manual (p. 129 on PDF view; p. 127 if printed out)	
Findings: The written documentation and staff interviews demonstrated compliance with this element. The CMO will outreach to nonparticipating providers for		

Standard V—Coverage and Authorization of Services	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
contracting opportunities. Additionally, case management will honor treatment plans from a UM perspective. Interviews with staff members revealed that AMERIGROUP also uses eligibility file indicators to identify members with special health care needs.	
Recommendation: None.	
3. Prior Authorization and Pre-Certification Requirements for Georgia Families 360° Members: Addendum 4.11.2.7(a) The CMO allows a prescriber to request prior authorization as a condition of coverage or payment for a prescription drug under the following provisions: ◆ A determination to approve or deny the prior authorization request is made within 24 hours of the request. ◆ If the prescription is not filled when it is presented to the pharmacist due to a prior authorization requirement, the CMO allows the pharmacist to dispense a 72-hour emergency supply of the prescribed medication. The CMO reimburses the pharmacy for the temporary supply of medication and contracted dispensing fee.	Amerigroup allows a prescriber to request prior authorization as a condition of coverage or payment for a prescription drug under required provisions: • Std.V.28 – Pharmacy Prior Authorization (# 1, 12) • Std.V.28 - GAGA CAID PC MHB ENG with AA Addendum (p. 5 if printed; p. 66 of PDF view))
Findings: The written policy and staff interviews demonstrated compliance with the element. The CMO had no PA requirements for 90 days, allowing for open access. The CMO had proactively identified members receiving medications that would have a step therapy (ST) requirement and entered prior authorizations for those drugs through 2015. Additional work was in progress to analyze for the appropriate utilization of behavioral health drugs and for identification of possible member drug safety issues.	
Recommendation: None.	
4. Outpatient Psychotherapy Sessions for Georgia Families 360° Members: Addendum 4.11.2.7 (c) The CMO does not require prior authorization for the first ten (10) individual or group outpatient psychotherapy sessions provided by a contracted behavioral health provider per 12-month rolling period. Such sessions may include the initial evaluation. Additional visits are reviewed and approved based on a medical necessity review conducted by the CMO.	Amerigroup does not require prior authorization for the first ten (10) individual or group outpatient psychotherapy sessions provided by a contracted behavioral health provider per 12-month rolling period. Such sessions may include the initial evaluation. Additional visits are reviewed and approved based on a medical necessity review conducted by the CMO. • Std.V.29– 2014 BH CORE Blast (Provider Alert) • Std. V.29 – GAGA CAID Provider Manual (p.37 if printed; p. 39 on PDF view) • Std.V.29 – AGP Written Response to Standard V (29) Requirement.
Findings: The written policy and staff interviews demonstrated compliance with the element. The CMO did not require prior authorization for these specific	

Standard V—Coverage and Authorization of Services	
Requirements and References	**Evidence/Documentation as Submitted by the CMO**
psychotherapy services.	
Recommendation: None.	

Appendix G. **Case Management File Review Tools**

Following this page are the Case Management File Review Tools HSAG used to evaluate AMERIGROUP's cases.

Case Management File Review Tools—AMERIGROUP

Case Identifier: Case 1
Diagnosis: Necrotizing fasciitis, glaucoma, gastroparesis, and diabetes
Synopsis: 41-year-old African American female with history of diabetes admitted to hospital for debridement of wound to left upper leg and IV antibiotics.

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I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member was referred for physical health case management by the inpatient review nurse on 1/28/2014 after admission to Dekalb Medical Center for wound to upper left leg. Member was transferred to inpatient rehabilitation center on 1/31/2014 for wound care and continued administration of IV antibiotics.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Physical health case management – level of complexity group 3.

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- Member was enrolled in case management on 1/31/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)

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- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:

- High-cost condition, chronic condition, and high-risk condition.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Assessment was completed telephonically with member on 1/31/2014 after she was transported to the inpatient rehabilitation center. The member is a 41-y/o African American female member who was admitted to the hospital on 1/10/2014 for debridement of wound on upper left leg and administration of IV antibiotics. Member reported that she currently lives in Section 8 housing with her five children and her partner who is unable to complete wound care for the member. Member reported that this is why she had to go to an inpatient rehabilitation facility for continued wound care and IV antibiotics. Member reported that she was diagnosed with gestational diabetes during pregnancy, and there was no cessation of the diabetes after she gave birth. Member reported she is currently prescribed Lantus and Metformin but reported that she does not take her Metformin because of side effects (nausea). Member reported that she has not been testing her blood glucose levels for the past several months but shared that she does have a glucometer. Member also reported that she was diagnosed with glaucoma (2010) and gastroparesis (2011); member rated her health as good. Reported no cultural or linguistic needs, shared that her current housing placement is stable, and safe and she gets help from family and friends. Reported that her only social concern at this time is financial, shared that she did apply for Supplemental Security Income (SSI), was denied, and is currently working with a lawyer to appeal the decision. Member reported that she sees her PCP regularly, with her last visit being 4 to 6 months ago, reports that she has a primary care dentist (PCD) and last saw him on 1/2/2013, and had her eyes checked 12/2013. Member reported that she wanted to change PCPs because she wants to get a PCP that is closer to her home. Member identified her partner JW as an alternate contact.
- PHQ-9 completed with member – no issues with depression identified by member.
- CAGE completed – no alcohol or other drug (AoD) issues identified by member.

Recommendations:

- None.

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6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- Member identified no cultural or linguistic needs or concerns.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- The member reported that she was seeing her PCP every 4 to 6 months; predictive modeling identified that this is an underutilization of her PCP.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Member family support is documented in the note; family was not part of the process for this assessment as member was inpatient in a rehabilitation center and the assessment was completed on the telephone.

Recommendations:

- Work to include member's family in the assessment process to ensure that all member needs are being addressed.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No noted discussion with the member's PCP or rehabilitation provider.

Recommendations:

- Include the member's providers in the assessment process to determine member's level of engagement in her own health care process, current doctor's treatment orders/treatment recommendations, and provider-identified gaps in the member's care.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan was completed on 1/31/2014. The goals for the treatment plan are:
    1. Coordinate care between all providers.
    2. Make attempts to follow case management guidelines.
    3. Independently manage her care.
    4. Comply with treatment plan.

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5. Stabilization post discharge for wound management.

Recommendations:

- Individualization of the care plan and inclusion of the member in the care planning process. Goals need to be individualized based on reported member needs; measurable, realistic, and reachable by target dates. Ensure the care plan has a start date, review date(s), and/or date of update(s) on the care plan.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- Staff reported that the care plan is considered member-centered when the member agrees with the care plan goals. During the file review there was no noted member, caregiver/family, or provider inclusion in the development of the care plan.

Recommendations:

- Inclusion of the member, the member's family/caregiver, and the member's providers or specialist in the development of the care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- Identified care gaps are: not up-to-date with immunizations – influenza (flu), pneumococcal (pneumonia), and diphtheria, tetanus, and pertussis (DTaP), not taking prescribed diabetes medications, not checking her blood glucose levels, and not seeing her PCP regularly. This information was collected from predictive modeling but does not reflect a formalized review of multiple data sources to identify the member's care gaps, such as the member's control of diabetes.

Recommendations:

- The CMO should incorporate a formal process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 1/31/2014: CM contacted the member who was in rehab; member reported that she would be in rehab for about 2 more weeks and would need wound care at home and would need home health care. Case manager gave member information for new PCP and let her know that the referral for social worker (SW) and Emdeon was completed.
- 2/3/2014: SW called the member, who stated that she was unable to talk at that time as nurse was doing wound care.

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- 2/10/2014: CM called, no answer; unable to leave message.
- 2/10/2014: CM called the member and member reported that she was going to be released on 2/14/2014 and she would need a wound vacuum-assisted closure (VAC) and wound care. The dressing would need to be changed every two days. Member reported that she was changed to Levemir insulin at bedtime and she was prescribed Dilaudid for pain and this medication was increased due to her pain level. The member reported that she did not have support during the day and would need support and care during the day (home health care but not custodial care). The CM provided the member with information on how to spot signs of infection and reminded the member to listen to training about wound care; her medications (how, how much, and when to take them); and her diet. The CM reported to the member that the inpatient discharge nurse would work with the discharge team from the facility to create the discharge plan.
- 2/10/2014: SW completed a psychosocial assessment, and the member reported that she is working on her SSI but has not heard from her lawyer. Member reported that she is unemployed currently and she needs home health care. Member reported that her sister passed away from the same condition and she is worried about not being able to get care in the home. The SW completed the special needs assessment on 2/10/2014. Member also had a diabetes assessment.
- 2/10/2014: SW called Emdeon for the member concerning her SSI application; the referral was received on 2/5/2014. Emdeon staff told SW that the member did not have an attorney and her application was not in appeal status. Emdeon would need to assist the member with completing a new SSI application.
- 2/14/2014: CM called the member and told the member to obtain a list of all the medications she needs to take when she leaves the rehabilitative facility. Member is to call the new doctor for her PCP linkage and she is to pick up her medications. Member was advised of wound care and infection. Home health care was arranged and member reported that she understood all her instructions.
- 2/19/2014: CM attempted to contact; no success.
- 2/25/2014: CM was told that member was readmitted on 2/22/2014 for issues with the wound. Member reported that on 2/20/2014 the home health nurse reported to the member that wound VAC was broken and the nurse did not know what to do. Member went back to the ER on 2/21/2014. Member reported that she did not follow through on getting her glucose monitor or her medications. Member did have scheduled follow-up appointment with her PCP but did not make the appointment due to being in the hospital. The member stated that she did not call the case manager because she lost the telephone number and had no time. Due to the member not following through with glucose monitor, the nurse called Nipro for TRUEresult testing machine and ordered the member's glucose monitoring supplies. Home health issues sent over to quality of care to identify breakdown in the system.
- Face-to-face visit on 2/26/2014: CM went to the hospital to see the member, spoke to the staff nurse about discharge planning, identified patient training on wound care. New PCP appointment was made for March 5, 2014, by the member.
- 2/28/2014: CM called member at home. On 2/27/2014 member was sent home and Health Force was the new home health agency. CM identified that member had received the DME as it was ordered and she had all her needed medical equipment.
- 3/03/2014: CM attempted to contact member to follow up; no contact left message.
- 3/07/2014: CM contacted member who reported that she did see Dr. Moody and reported that Dr. Lee's office does not take AMERIGROUP so she could not go to her appointment for the wound follow-up on 3/10/2014.
- 3/21/2014: CM attempted to contact member, unsuccessful.
- 4/3/2014: CM called Health Force home care to get an update on the member. Health Force nurse reported that she requested an extension for extended

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home visits and had faxed the request to the CMO on 4/1/2014. CM could not find authorization for extension of home health care services. CM had the Health Force nurse refax the request. CM approved and faxed to Health Force home care on 4/10/2014.

- 4/10/2014: CM attempted to contact member, left message.
- 4/17/2014: CM attempted to contact member, left message.
- 4/22/2014: CM attempted to contact member, left message.
- 4/30/2014: CM attempted to contact member, left message and sent letter.
- 5/12/2014: CM attempted to contact member, male answered, stated that the member went to her MD of Friday and the MD stated to keep using the wound VAC; left message for member.
- 5/15/2014: CM spoke with member who reported that she needs a sliding scale for her insulin injections, endocrinology referral made, wound check. Member declined to change PCPs; member hung up, called her back and she would not answer.
- 5/19/2014: CM attempted to contact member, left message about diabetic health fair and surgeon appointment.
- 5/21/2014: Spoke with member about health fair, talked to her about the bonus for getting the blood work and her eye exam.
- 5/29/2014: CM attempted to contact member on 5/27/2014, left message.
- 5/30/2014: CM attempted to contact member, left message.
- 6/9/2014: CM called member who stated that she is doing well, wound has healed but she does have some pain and she is taking Tylenol for the pain. Blood sugar is 160 to 210 and has stopped drinking Kool-Aid. CM did some education about diet and diabetic care.
- 6/27/2014: Called member, reported that she is doing well, blood sugar is still 198 – 210; member reports that she is working on it. Member has had no ER visits or inpatient stays since the second discharge and she is picking up her medications. Working to get lab work done to transition her into disease management.
- 7/1/2014: CM followed up with member to reminder her about the health fair.
- 7/15/2014: CM called member to follow up with her care and wound issues. Member weight now 135 down from 178 due to edema. Expressed possible need for BH support, recommended therapists, and telephone went dead. CM tried to call member back member, did not answer.
- 7/21/2014: CM attempted to contact member, left message.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 3/7/2014: CM spoke with the nurse and was told that member had come to her appointment.
- 3/7/2014: CM called Dr. Lee's office and worked out that member would be able to go to the wound care clinic. Member called on 3/7/2014 concerning keeping that appointment.
- 3/10/2014: CM followed up with wound care office and the appointment was with the physician assistant (PA).

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- 3/10/2014: CM called the member concerning her care, and member reported no issues. CM spoke with the home health nurse who reported that member was doing well and the wound was healing. Agreed to call back in 2–3 days.
- 3/18/2014: CM called and spoke to the member about the wound and treatment.
- 3/18/2014: CM reviewed and approved wound equipment.
- 4/17/2014: Called PCP office and spoke with assistant to get the office notes and labs from the office.
- 5/6/2014: Called home health nurse, left message.
- 5/7/2014: CM received return call from Health Force; HF reported that the member was doing well and the MD needs to change the orders for the wound VAC to get it discontinued.
- 5/13/2014: CM received return call from the home health nurse, reports member is testing her blood sugar and taking neutral protamine Hagedorn (NPH) insulin and Lantus and asked the nurse to conduct the medication reconciliation with the member.
- 5/13/2014: CM attempted to contact PCP, left message for PCP.
- 5/13/2014: CM called MD office about use of wound VAC and getting the member seen sooner than June 23, 2014.
- 5/13/2014: CM received call from PCP office, CM requested labs and office notes.
- 5/15/2014: CM called surgeon about the wound care and management of diabetes, surgeon reported that no changes to member's current care would be made at this time.
- 5/30/2014: CM called the surgeon about wound care, stopping the wound VAC, and writing a discharge order so Kinetic Concepts, Inc. (KCI) can pick up the DME wound VAC. Called KCI on 5/30/2014 concerning the change.
- 7/21/2014: PCP called CM, expressed need to obtain needed labs. Asked for support with compliance of this member.

Recommendations:

- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- No contact made with member's family.

Recommendations:

- Include the member's family in the care process if the member gives permission for the CMO to speak with the family.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- Case manager made referral on 1/31/2014 to social work case manager and referral to Emdeon for SSI application support.
- Case manager gave recommendations for BH therapists on 7/15/2014.

Recommendations:

Case Management Evaluation Guide

- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- Case conference on May 15, 2014 – member's case was presented to the panel – will provide the CMO a note stating that the recommendations were to follow up with surgeon for wound care and link the member to patient-centered medical home (Absolute Care).

Recommendations:

- None.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- 1/10/2014: ER visit with hospitalization for wound to left upper thigh with diagnosis of necrotizing fasciitis, member required wound debridement and IV antibiotics during hospitalization.
- 1/31/2014: Member transferred to rehabilitation center for continued wound care and IV antibiotics.
- 2/22/2014: ER visit for increase swelling, redness, and pain to wound site on left upper leg, member admitted to hospital.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- No discharge orders identified in the member's case file for the 2 hospitalizations and 1 inpatient rehabilitation stay. Case manager documented that she talked to the nursing staff during the member's second hospitalization, but no formal discharge orders where obtained.

Recommendations:

- Obtain discharge orders for all inpatient stays.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- Two of the five goals on the member's care plan address the member's need for coordination of care and transition needs: coordinate care between all providers and stabilization post discharge for wound management.

Case Management Evaluation Guide
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ The case manager reached out to the member on multiple occasions to ensure that the member received the necessary DME for her diabetes and wound care. Case manager ordered the member's DME after member reported that she had not completed the task on multiple occasions.
Recommendations: ◆ None.

Case Identifier: Case 2
Diagnosis: Post traumatic stress disorder (PTSD) by report, stage 3 liver disease, gastroesophageal reflux disease (GERD), and scoliosis
Synopsis: 32-year-old Caucasian female identified through CI3 predictive modeling due to history of anxiety and depression.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- This member was identified through the CI3 predictive model due to history of anxiety and depression, member also has hypertension (HTN), stage 3 kidney disease, chronic tonsillitis, congenital heart problems, and chronic back pain.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Behavioral Health – level 3

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- Member was enrolled in case management on 3/21/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:

- Chronic conditions.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- Assessment completed telephonically on 3/21/2014. Member is a 32 y/o Caucasian female, lives with her two children (2 and 9 y/o), reported that she was functioning at a high level and then she had knee surgery and nasal issues. Member reported that she was placed on opiates and developed kidney problems. Member reported no cultural or linguistic needs – primary language is English, and no identified religious issues. Member reports her health as poor at this time, member reported that she does have a PCD and a PCP but would like to get into the case management program due to her PCP issues. Member reports that she would like to move and she is looking for a new PCP and would like connection to services. Member reported that she is taking medication for HTN and depression, also takes over-the-counter (OTC) medication for pain. Member reports that she does not use tobacco products and has no special needs at this time. Member did report mild hearing loss with no impairment of functionality. Member reported that she has support from her family, boyfriend, and children. She has no nutritional or DME needs. Member reported that she is having difficulty with transportation and financial stability.

Recommendations:

- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- The member reported that she had no cultural or linguistic needs.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No issues identified with member over- or underutilization of resources.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

Case Management Evaluation Guide

- No inclusion of the member's family/support system noted in the assessment.

Recommendations:

- Inclusion of the family members and support system in the assessment process when approved by member.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No inclusion of the member's providers noted in the assessment.

Recommendations:

- Inclusion of the member's providers in the assessment to ensure clear identification of member diagnosis and treatment regimen.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan goals are:
    1. Resolving additional service needs.
    2. Assisting with PCP.
    3. Comply with treatment plan.
    4. Coordination of care between all disciplines.

Recommendations:

- Individualization of the care plan and inclusion of the member in the care planning process. Goals need to be individualized based on reported member needs, measurable, realistic, and reachable by target dates. Ensure the care plan has a start date, review date(s), and/or date of update(s) on the care plan.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- Staff reported that the care plan is considered member-centered when the member agrees with the care plan goals. During the file review there was no noted member, caregiver/family, or provider inclusion in the development of the care plan.

Recommendations:

- Inclusion of the member, the member's family/caregiver, and the member's providers or specialist in the development of the care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers,

Case Management Evaluation Guide

specialists, or CMO staff members and the care the member actually receives.)

Observations:

- Care gap for member was identified as not being up-to-date with her immunizations – influenza. This information was collected from predictive modeling but does not reflect a formalized review of multiple data sources to identify the member's care gaps.

Recommendations:

- The CMO should incorporate a formal process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 3/21/2014: Original assessment note, member diagnosed with PTSD by record, stage 3 liver disease, GERD, scoliosis, chronic tonsillitis. Two surgeries 12/18/2013 and 1/7/2014: member has psychiatric appointment 4/14/2014. Barriers are financial and transportation. Member reported that she wants pain management and new PCP medication reconciliation completed.
- 3/31/2014: Member called CM to discuss current care. Reported a marked increase in back pain, reported that she was seen by another provider and told she has an extra vertebra.
- 3/31/2014: CM called member to provide referral information for pain management providers.
- 4/2/2014: Member called CM with name of new PCP, discussed linking with another psychiatrist. PHQ-9 completed, score was 23 – this indicates that she needs to follow up with the psychiatrists.
- 4/4/2014: CM attempted to contact member about PCP linkage, left message.
- 5/2/2014: CM attempted to contact member, left message
- 6/2/2014: CM contacted member who reports PCP contacted but reports that she is moving back to old home town and she would like to be linked with her old PCP.
- 7/2/2014: CM called member to talk about the x-ray results and her need to see the cardiologist. Member reported that she needs a stress test and an ultrasound.
- 7/17/2014: CM followed up with member concerning the ultrasound and the stress test; BH CM is going to transition member to physical case management due to health issues.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

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Observations:

- During case file review no documentation presented that the care plan was provided to the member's providers or discussed with the providers.
- Case manager had one documented contact with the member's PCP - 6/2/2014. PCP contacted about issues with magnetic resonance imaging (MRI) and getting it completed.

Recommendations:

- Communicate member's care plan and member's reported health needs with providers to ensure continuity of care and that member's needs are being met.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- No contact with the member's family or support system was noted in the case file review

Recommendations:

- Facilitate contact with member's family or support system after obtaining member consent to contact.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- No referral needs noted for this member. Member was provided contact information for self-referral to a new PCP and pain management services.
- It was noted that the CM discussed the member's follow-through with PCP linkage. However, there was no documentation noted that the CM followed up with the member to ensure follow-through with linkage to pain management services.

Recommendations:

- Follow-up with member and inquire about member follow-through with information provided for all services – PCP and specialty.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- 7/2/2014: Case presented to case conference round – recommendation was made to transfer member to physical health case management due to current physical needs.

Recommendations:

- None.

Case Management Evaluation Guide

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- Member had no identified ER visits.
- Member had outpatient knee surgery on 12/18/2013.
- Member had a tonsillectomy with hospital stay on 1/7/2014.
- Hospitalization for kidney failure 1/22/2014 to 1/24/2014.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- Member was brought into behavioral case management after the identified visits and had no hospitalizations after entering case management.

Recommendations:

- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- The care plan identified the member's request for support in changing PCPs due to her reported move.

Recommendations:

- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- Case manager was monitoring the member's need for an MRI and issues with the completion of this service. Case manager was also working with the member to ensure linkage to a new PCP and then linkage with the member's previous PCP after member moved a second time.

Recommendations:

- None.

Case Identifier: Case 3
Diagnosis: Eczema
Synopsis: 7-month-old male with 5 ER visits in a 3-month period.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:
- Referred through CI3 for 5 ER visits for contact dermatitis in a 3-month period.

Recommendations:
- None.

2. What level of case management or program type is the member enrolled in?

Observations:
- ER case management – group 0.

Recommendations:
- None.

3. When was the member enrolled in the CMO's case management program?

Observations:
- 3/24/2014.

Recommendations:
- None.

4. Was the member identified as having any of the following special needs?
- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:
- Chronic condition.

Case Management Evaluation Guide

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- 7-month-old child referred through CI3 system due to multiple ER visits. Child had 5 ER visits in a 3-month period but also had 9 PCP visits. Mother reported that she had talked to her child's PCP but the mother went to the ER after she spoke with the PCP. Mother reported that the issues were emergent and she thought that they could not wait. Family's primary language is Spanish, no cultural needs noted. Mother reported that the child has a PCP but there is no current appointment scheduled. Mother reported that the child is eating normally – formula and Gerber baby food. Mother reported that child has hit all developmental goals and the child is normal. Mother reported that she is the primary caregiver for the child as the father of the child is not involved. Mother reported that she is currently receiving food stamps and has stable housing at this time.

Recommendations:
- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- Family's primary language is Spanish; an interpreter was used to communicate with the mother of the child. No cultural needs identified.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- Documentation reviewed, noted overutilization of ER service for child's medical condition.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- Documentation reviewed, noted discussion with the mother to complete the assessment for the member.

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

Case Management Evaluation Guide

- No communication with the PCP during the assessment process was noted in the documentation.

Recommendations:

- Inclusion of the member's PCP during the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan goal—To have a medical home to decrease inappropriate ER usage and reduce ER visits.

Recommendations:

- Goals need to be individualized based on reported member needs, measurable, realistic, and reachable by target dates. Ensure the care plan has a start date, review date(s), and/or date of update(s) on the care plan.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- Member has overutilization of the ER due to mother's belief that the child's itching is an emergent problem. Member is a minor and all care is directed by the mother. AMERIGROUP's goal is to decrease ER utilization.

Recommendations:

- Address the caregiver's concerns in the care plan to accurately reflect the catalyst for continued ER usage.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- Care gaps identified through predictive modeling are overutilization of ER use, non-adherent to appointments, medications, and not accessing the PCP.

Recommendations:

- The CMO should incorporate a formal process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

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Observations:

- 3/24/2014: CM completed assessment, sent the baby's name to Wellstar Blue Bell alert via SharePoint for identification when member is seen in the ER. Encouraged mother to visit the CMO's Web site for information concerning ER visits.
- 4/23/2014: CM contacted mother who reported that the child is doing well and has been going to the PCP and the dermatologist. Mother discussed follow-up with allergist with PCP, reported that PCP told her that the child is too young to be tested for allergies. CM told mother that she was going to call the PCP and discuss the care plan with the PCP.
- 4/23/2014: CM followed up with mother after talking with the PCP. CM to follow up in 30 days.
- 5/21/2014: CM reviewed member case and found no ER visits in the last 30 days, contacted mother who reported that the child had been seen for his 9-month well-baby appointment and she saw the dermatologist who recommended changing the child to a formula that was non-dairy. CM provided mother with information about Women, Infants, and Children (WIC) for support in getting the formula.
- 6/16/2014: CM contacted mother who reported that the child was still having issues with allergies; CM discussed transitioning the member out of the program.
- 7/11/2014: CM reviewed member file, identified that child had 2 more ER visits with no PCP follow-up. CM attempted to contact mother, left message.
- 7/14/2014: Mother attempted to contact CM, left message. CM called mother back same day and left message, CM received another message from the mother. CM was able to contact the mother and the mother reported that the child had a fever and vomiting and this is why she went to the ER with the child. Mother reported that the PCP was not helping and she wanted to change PCPs. Mother reported that she was concerned because the child is scratching himself. CM set up follow-up call for 30 days to find out about well-care visit.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 4/23/2014: CM called PCP (Susan Lomax) who reported that the mother is non-adherent with prescribed medications and that she had provided the mother with a referral to the dermatologist who reported that the child might have a mild allergy to dairy and told the mother to stop giving the child dairy, which the mother refused to do.
- 7/11/2014: CM attempted to contact PCP about recent ER visits, left message.
- 7/21/2014: CM called PCP to verify the child has a well-baby appointment scheduled, left message.
- 7/21/2014: CM received call from allergy doctor concerning member's case.

Recommendations:

- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?

Case Management Evaluation Guide

(Insert case manager contact with caregiver/family.)

Observations:

- 3/24/2014: CM completed assessment, sent the baby's name to Wellstar Blue Bell alert via SharePoint for identification when member is seen in the ER. Encouraged mother to visit the CMO's Web site for information concerning ER visits.
- 4/23/2014: CM contacted mother who reported that the child is doing well and has being going to the PCP and the dermatologist. Mother discussed follow-up with allergist with PCP, reported that PCP told her that the child is too young to be tested for allergies. CM told mother that she was going to call the PCP and discuss the care plan with the PCP.
- 4/23/2014: CM followed up with mother after talking with the PCP. CM to follow up in 30 days.
- 5/21/2014: CM reviewed member case and found no ER visits in the last 30 days, contacted mother who reported that the child had been seen for his 9-month well-baby appointment and she saw the dermatologist who recommended changing the child to a formula that was non-dairy. CM provided mother with information about WIC for support in getting the formula.
- 6/16/2014: CM contacted mother who reported that the child was still having issues with allergies; CM discussed transitioning the member out of the program.
- 7/11/2014: CM reviewed member file, identified that child had 2 more ER visits with no PCP follow-up. CM attempted to contact mother, left message.
- 7/14/2014: Mother attempted to contact CM, left message, CM called mother back same day and left message, CM received another message from the mother. CM was able to contact the mother and the mother reported that the child had a fever and vomiting and this is why she went to the ER with the child. Mother reported that the PCP was not helping and she wanted to change PCPs. Mother reported that she was concerned because the child is scratching himself. CM set up follow-up call for 30 days to find out about well-care visit.

Recommendations:

- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- CM provided mother with information on WIC; no follow-up by the CM was noted in the documentation.

Recommendations:

- Follow-up with caregiver to ensure linkage to community resources.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

Case Management Evaluation Guide

- 7/21/2014: CM had case conference with medical director who recommended that the CM wait 30 days to find out about the mother's follow-through with the child's well-baby visit.

Recommendations:

- None.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- 12/3, 12/5, 12/9/2013; 1/6, 1/14/2014—all ER visits for contact dermatitis.
- Two more ER visits were identified by the case manager; no dates identified in the documentation reviewed.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- Member had no inpatient hospitalizations.

Recommendations:

- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- Target goal was to decrease member ER usage, interventions completed by the CM worked to help the mother transition from ER utilization to PCP utilization for non-emergent medical issues.

Recommendations:

- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- CM followed up with member's mother concerning ER and PCP utilization to ensure that member was utilizing the PCP for all non-emergent needs.

Recommendations:

- None.

Case Identifier: Case 4—Georgia Families 360°
Diagnosis: PTSD, Attention Deficit Hyperactivity Disorder (ADHD), and Generalized Anxiety Disorder (GAD)
Synopsis: Member was placed into foster care system on September 26, 2013

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Members in the Georgia Families 360° program are automatically referred for case management services when they enter the foster care system. Member went into the foster care system on September 26, 2013.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Care Coordination – level 1

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 03/03/2014 – became eligible with The Georgia Families 360°/AMERIGROUP.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:
- Member was placed in foster care system.

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- Staff reported during the case file review that members in the Georgia Families 360° program who are stratified as a level one (1) do not have a full assessment completed. Instead, an initial pediatric screening is completed; if greater member needs are identified during the screening, a full assessment is completed.
- The initial pediatric screening for this member was initiated on 7/14/2014, with addition information collected by the CM on 7/17/2014.
- Member has identified diagnosis of PTSD and ADHD by report, and no assessment was completed due to member's stratification as a level one.
- Member was enrolled in case management and considered open on 03/03/2014. No contact was made with this member's caregivers/foster parents until 07/14/2014. This is approximately a 5-month lag and well outside of the 90-day transition period.

Recommendations:
- Completion of a full assessment for all members to ensure that the members' needs are being identified and addressed. Contact with members within the 30-day guideline for case management program.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- Covered in the pediatric screening, during contact with foster parents, Division of Family and Children Services (DFCS).

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- Not identified in the pediatric screening.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- Pediatric screening information is collected from the DFCS case manager and the member's foster parent.

Case Management Evaluation Guide

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- The pediatric screening is not discussed with the PCP.

Recommendations:
- None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- Care plan was developed on 7/14/2014. The goal is to maintain medical, dental, and medication management appointments and care coordination.
- Concern that this a maintenance goal that may not adequately address the member's needs based on current diagnosis.
- Care plan not completed until 7/14/2014; at this point member had been enrolled in case management for over 90 days without a care plan.

Recommendations:
- Completion of care plan that clearly addresses member's needs.
- Care plan completed within the 30-day guideline for case management program.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- Information for member was collected from the DFCS case manager for the child.

Recommendations:
- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- None identified.

Recommendations:

Case Management Evaluation Guide

- None.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 7/3/2014: Care coordinator (CC) reached out to the foster parent to discuss the program and the contact information and to discuss the placement of the child. Foster mother reported that the child is doing well and noted a past history of killing animals and being physically aggressive, past physical abuse by father and possibly mother's boyfriend. Child was reading at kindergarten level; foster mother reports that he is doing better. Currently has weekly visits with mother and sisters, suggestion is to start family therapy. Currently prescribed Intuniv, Risperidone and Trazodone. CM used the psychotropic med tool to complete the medication reconciliation with the foster mother.7/3/2014: Care coordination check list used to identify scope of care child needs.
- 7/10/2014: CC contacted foster parent to discuss marketing event and schedule face-to-face visit.
- 7/17/2014: CC had face-to-face visit with the child; DFCS, and foster parent were in attendance. Foster mother reported that child is doing well in the home and school.

Recommendations:

- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 7/3/2014: CC attempted to contact therapist, left message
- 7/9/2014: CC attempted to contact therapist to discuss member progress.
- 7/9/2014: CC contacted identified PCD for confirmation that member is a patient with the dentist. 7/14/2014: CC contact with psychiatrist to confirm diagnosis, medications, and that he is a client there.
- 7/14/2014: CC contact with psychiatrist to confirm diagnosis, medications, and that he is a client there.

Recommendations:

- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

Case Management Evaluation Guide

- 7/3/2014: CC sent e-mail to DFCS to discuss PCP.
- Member was enrolled in case management for four months prior to case manager having contact with the DFCS case manager.

Recommendations:

- Greater inclusion of DFCS case manager in the member's enrollment/transition into the case management program.
- Communication with the DFCS case manager to include outreach at the time of member's enrollment/transition into case management.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- No referral needs identified at this time.

Recommendations:

- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- 7/21/2014: CMO's psychiatrist feedback on member's current medications "ok."
- Psychiatrist's review of the member's medications was completed for continued authorization for payment.

Recommendations:

- Utilization of a multidisciplinary group to review the member's case to include the DFCS case manager, the member's foster parent(s), and the member's PCP.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- No ER or hospitalizations identified for the member.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

Case Management Evaluation Guide

- No hospitalizations for this member.

Recommendations:

- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- At this time, the CC is working to ensure all of the member's needs are being met and the foster parent understands the role of the CC.

Recommendations:

- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- CC had first contact with member's foster parent on 7/3/2014. CC is currently working to establish that the member is assigned to a PCP, a PCD, and has all services in place.

Recommendations:

- None.

Case Identifier: Case 5—Georgia Families 360°
Diagnosis: ADHD
Synopsis: 10-year-old male, entered the foster care system on 1/21/2014. Member is currently taking Vyvanse for his ADHD.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member referred for case management after entering foster care system on January 21, 2014. Care management not initiated until start of Georgia Families 360° on 3/3/2014.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Care Coordination – level 1

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 3/3/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:
- Foster care.

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- Care Coordinator (CC) initiated the pediatric screening on 3/12/2014, with reported updates on 3/13/2014, and 3/26/2014. CC updated the pediatric screening again on 7/2/2014.
- Extended period of time between initial outreach calls and finalization of the pediatric screening.
- No assessment completed for this member.

Recommendations:
- Completion of a full assessment for all members to ensure that member's needs are being identified and addressed. Make contact with members within the 30-day guideline for case management program.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- No cultural or linguistic need identified during the pediatric screening or during the conversation with the foster parent.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- No issues with under- or overutilization identified during case file review.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- No comprehensive assessment completed for this member.

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Case Management Evaluation Guide

Observations:
- No comprehensive assessment completed for this member.

Recommendations:
- None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- Care plan completed 7/9/2014. Current goal: Mental health counseling services and care coordination and health prevention.

Recommendations:
- AMERIGROUP should develop a care plan for all members in the Georgia Families 360° program and attempt timely development of the care plan following the initial assessment.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- Staff reported that care plan is to be sent to the DFCS case manager for the member.
- There was no documented participation of the member, the foster parent(s), or PCP in the development of the care plan.

Recommendations:
- Inclusion of the member, foster parent(s), PCP, and DFCS case manager in the development of the care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- No care gaps identified for this member.

Recommendations:
- None.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?

Case Management Evaluation Guide

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- 3/21/2014: CC had multiple contacts: DFCS, foster care parent, dentist, PCP, and behavioral health provider (did the initial family health assessment).
- 3/26/2014: CC completed checklist for scope of services.
- 7/9/2014: CC attempted to contact member's Court Appointed Special Advocate (CASA) worker.
- 7/9/2014: CC completed referral for individual counseling and 2nd Chances due to his father's death in April 2014.
- 7/21/2014: CC requested psychological evaluation.
- After 3/26/2014, case manager had no contact with DFCS, the foster parent, the PCP, or any of the member's providers.

Recommendations:

- Continued engagement after initial contact with member; ensure that member is being contacted at least every 30 days to ensure all needs are addressed and being met.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- No communication with the member's PCP, foster parent, or DFCS case manager noted in the file review after the initial contact on 3/21/2014, prior to the development of the care plan.

Recommendations:

- Include the member's PCP, DFCS case manager, and foster parent in the assessment.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- No communication with the member's foster parent noted after the 3/21/2014 outreach by the CC.

Recommendations:

- Outreach to the DFCS case worker responsible for the member.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- CC made multiple referrals for this member – 1. Referral for individual counseling, 2. Referral for 2nd Chances, 3. Referral for psychological evaluation.

Recommendations:

- Timely identification of referral needs and completion of referral process.

Case Management Evaluation Guide

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Based on the documentation reviewed, the member's case was not reviewed with a multidisciplinary team.

Recommendations:
- The case manager should use a multidisciplinary team to manage the member's care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- Member had no identified ER visits or hospitalizations.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- No inpatient admissions identified for this member.

Recommendations:
- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:
- CC is currently working on coordinating the member's care with DFCS.

Recommendations:
- None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:
- CC is currently working on coordinating the member's care with DFCS.
- Member was first contacted on 3/21/2014 and then again on 3/26/2014; after March 26, member was not contacted again until 7/9/2014.

Recommendations:

Case Management Evaluation Guide
◆ Continued follow-up with member that includes contact with member at least every 30 days.

Case Identifier: Case 6—Georgia Families 360° - Adoption
Diagnosis: No current physical or mental health diagnosis.
Synopsis: 12-year-old member living with adoptive family, member is linked to a PCP and a PCD

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member has a 90-day opt-out. These members were not contacted due to opt-out process. AMERIGROUP care coordinator (CC) started outreach after the member's adoptive parents identified that they would want to remain in the AMERIGROUP program. Member grouped by CI3 information and this member was grouped as a group 0 (score was 1.03).

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Case management – group 0

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 3/3/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy

Case Management Evaluation Guide

- Infant/toddler with risk for developmental delays

Observations:

- Georgia Families 360° - Adoption

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- The pediatric screener was done 7/3/2014, attempted to contact the member's caregiver multiple times, sent letter and updated on 7/14/2014. This form provides demographic, current care, physical issues, behavioral issues/concerns, and current health status; immunizations are up-to-date.
- Adoptive mom identified needs to increase social skills – member was having adjustment concerns after going to middle school, mom given information on the Boys and Girls Club and therapists in her area.

Recommendations:

- Completion of a full assessment for all members to ensure that member's needs are being identified and addressed. Contact with members within the 30-day guideline for case management program.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- Cultural and linguist needs identified during initial health risk screening (HRS) and discussed with mom.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No issues with over- or underutilization of services identified for this member.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Pediatric screening completed with adoptive mother.

Recommendations:

- None.

Case Management Evaluation Guide

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- No comprehensive assessment was completed for this member.

Recommendations:

- A care plan should be developed for all adoptive assistance members.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- Care plan completed on 7/3/2014. The member's goals are:
  1. Continued health maintenance—member will maintain preventive measures to maintain health.
  2. Dental care—educate mother on well-child checks, maintain dental check-ups.
- Member was considered enrolled in case management for over 90 days prior to the completion of the care plan.

Recommendations:

- Completion of the care plan within the 30-day guideline for case management program.

11. Does the care plan reflect participation of any of the following?

- The member
- The member's caregiver/family
- Providers and specialists

Observations:

- The PCP and PCD were utilized for the development of the care plan.
- The member's adoptive mother was contacted.

Recommendations:

- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- No care gaps identified for this member.

Recommendations:

- None.

Case Management Evaluation Guide

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- Monitoring for a level 0 care plan developed within the first 30 days; if there are any changes, the care plan is updated. If no issues arise the care plan is reviewed annually. The parent was told by CM to call AMERIGROUP if the member had any needs or concerns.
- No rounding on a level 0.
- 7/3/2014: Adoptive mother called CM back, reported that member is in need of a dental appointment; reported no other assistance needs at this time.
- 7/14/2014: CC called mother, left message.
- 7/14/2014: CC e-mailed mom dental information for appointment.
- 7/14/2014: CM reviewed claims, Medicaid is secondary insurance.
- Member was considered enrolled in the case management program on 3/3/2014; however, no outreach attempts were made by the case manager until member had been in the case management program for over 90 days.

Recommendations:

- Initiate contact with member within the 30-day guideline for case management program.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:

- 7/3/2014: CM left message with PCP to obtain medical information.
- 7/14/2014: CM called dentist office, left message.
- 7/14/2014: CC received call from member's dentist, office staff members reported that they would not be sending dental care information to AMERIGROUP because there was no release of information for the CMO.

Recommendations:

- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:

- CC has continued ongoing telephone and e-mail contact with member's adoptive mother.

Recommendations:

Case Management Evaluation Guide

- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- CC provided adoptive mom with information on the Boys and Girls Club and therapists in her area. No follow-up noted during file review and would anticipate follow-up at next scheduled call.

Recommendations:

- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:

- Member's case has not been presented in a multidisciplinary team setting.

Recommendations:

- The case manager should use a multidisciplinary team to manage the member's care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- Member has had no ER, urgent care, or inpatient visits during the identified time frame.

Recommendations:

- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- N/A.

Recommendations:

- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

Case Management Evaluation Guide
◆ The care plan identifies the member's need to maintain health and dental visits.
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ CC continues to monitor the member's case.
Recommendations: ◆ None.

Case Identifier: Case 7—Georgia Families 360° - adoption
Diagnosis: None identified.
Synopsis: Member is in foster care but opted out of receiving active care coordination.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- Member's adoptive parent opted out of the program on 3/13/2014; however, member is in the foster care system. Member has the right to opt out but will still be assigned a care coordinator. Member's services will be monitored by the assigned care coordinator.

Recommendations:

- None.

2. What level of case management or program type is the member enrolled in?

Observations:

- Member is enrolled in case management due to current status in foster care.

Recommendations:

- None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- 03/03/2014.

Recommendations:

- None.

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:
- Foster care.

Recommendations:
- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:
- No assessment or screening completed for this member.

Recommendations:
- None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:
- No assessment or screening completed for this member. The member's adoptive mother opted member out of the case management program.

Recommendations:
- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:
- No assessment or screening completed for this member.

Recommendations:
- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:
- No assessment or screening completed for this member.

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- No assessment or screening completed for this member.

Recommendations:

Case Management Evaluation Guide

- None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- No care plan developed for this member.

Recommendations:
- None.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- No care plan developed for this member.

Recommendations:
- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- No care plan developed for this member.

Recommendations:
- None.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:
- Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.

Recommendations:
- None.

Case Management Evaluation Guide

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:
- Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.

Recommendations:
- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:
- Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.

Recommendations:
- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.

Recommendations:
- None.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant

Case Management Evaluation Guide
information.
Observations: ◆ Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.
Recommendations: ◆ None.
19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?
Observations: ◆ Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.
Recommendations: ◆ None.
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations: ◆ Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.
Recommendations: ◆ None.
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations: ◆ Member is in the Georgia Families 360° program and was adopted. Member's adoptive parents opted out of case management.
Recommendations: ◆ None.

Case Identifier: Case 8—Georgia Families 360° - Adoption
Diagnosis: No current diagnosis.
Synopsis: 11-year-old African American female, lives with adoptive parents and her biological sibling who was adopted by the same couple.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:
- Member was referred for case management because she is part of the Georgia Families 360° - Adoption program.

Recommendations:
- None.

2. What level of case management or program type is the member enrolled in?

Observations:
- Adoption care coordination – group 0.

Recommendations:
- None.

3. When was the member enrolled in the CMO's case management program?

Observations:
- 3/3/2014.

Recommendations:
- None.

4. Was the member identified as having any of the following special needs?
- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age
- High-risk pregnancy
- Infant/toddler with risk for developmental delays

Observations:

Case Management Evaluation Guide

- Adopted from the foster care system.

Recommendations:

- None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- 11-y/o African American female, no other health insurance, resides with her adoptive parents and her biological sibling, she is currently in the fifth grade, her health is reported as good, and she has no current diagnosis; she is not on any medication and last dental visit was on 5/5/2014.
- Developmental health risk screening done on 7/7/2014: Member is seeing the dentist every 6 months; there are no reported BH issues, currently no medical conditions reported and member is not on medication.
- Health risk screening sent to adoptive father on 7/1/2014.
- Member has had a developmental screening and cardiac screening by the pediatrician.
- Member was considered enrolled in case management on 3/3/2014. No outreach was attempted prior to the health risk screening being sent to the foster family on 7/1/2014.

Recommendations:

- Completion of a full assessment for all members to ensure that member's needs are being identified and addressed. Contact with members within the 30-day guideline for case management program.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- No cultural or linguistic needs identified by adoptive father.

Recommendations:

- None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- No over- or underutilization of services noted.

Recommendations:

- None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- Member's adoptive father reported that he completed the health risk screening.

Case Management Evaluation Guide

Recommendations:
- None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:
- CC has contacted the member's PCP and PCD for dental and medical records.

Recommendations:
- None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?
(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:
- Care plan completed on 7/7/2014 – Maintaining preventive measures for overall health, access to community linkage resources.
- Member was considered to be enrolled in case management on 3/3/2014. However, member's care plan was not completed until 7/7/2014.

Recommendations:
- Completion of care plan within the 30-day guideline for case management program.

11. Does the care plan reflect participation of any of the following?
- The member
- The member's caregiver/family
- Providers and specialists

Observations:
- Care plan completed with member's adoptive father.

Recommendations:
- None.

12. Does the care plan reflect care gap analysis, identification, and interventions?
(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:
- No care gaps identified.

Recommendations:
- None.

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IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?
(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:
- 7/1/2014: CC sent e-mail to parent that contained the health risk screen (HRS) and the transition of care form that lists services available to member, provided information to the parent concerning the Boys and Girls Club, the Girl Scouts and a safe link telephone.
- 7/7/2014: CC contacted adoptive father, started the care coordination process. Father reported that he had e-mailed the HRS to the CC on 7/1/2014. CC let parent know that the document was not obtained; he said father said he was going to resend the document to the CC.
- 7/14/2014: CC called adoptive father regarding the HRS and father requested information about braces for the child. HRS not received at this time.

Recommendations:
- None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?
(Insert case manager contact with providers.)

Observations:
- 7/9/2014: CM called dentist to request dental records.
- 7/9/2014: CM contacted PCP to request medical records.
- 7/10/2014: Confirmed with PCD receipt of dental records.

Recommendations:
- None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?
(Insert case manager contact with caregiver/family.)

Observations:
- Care plan was discussed with the adoptive father.

Recommendations:
- None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:
- CC provided the adoptive father with information concerning the Boys and Girls Club, the Girl Scouts and a safe link telephone. No follow-up attempts

Case Management Evaluation Guide

concerning this information noted.

Recommendations:
- None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?
- Grand rounds
- Care team meetings
- Case conferencing
- Member rounds
- Multidisciplinary work pods/groups

Observations:
- Case has not been discussed in a multidisciplinary team meeting at this time.

Recommendations:
- The case manager should use a multidisciplinary team to manage the member's care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:
- No ER or hospitalizations noted for this member.

Recommendations:
- None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:
- N/A.

Recommendations:
- None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:
- CC is working with the adoptive parents to coordinate the member's dental and physical care.
- Member was enrolled in case management on 3/3/2014; no outreach was attempted until 7/1/2014,

Recommendations:
- Complete outreach to member and foster parent(s) within the 30 day-guideline for case management program.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

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Observations:

- CC continues to contact the adoptive parents concerning the member's needs.
- Member was enrolled in case management on 3/3/2014; no outreach was attempted until 7/1/2014. There was no documentation noted for continued follow-up with this member after enrollment in case management.

Recommendations:

- Timely outreach to the member and foster parent(s) to ensure member's needs are addressed and covered.

Appendix H. **Disease Management File Review Tools**

Following this page are the completed Disease Management File Review Tools HSAG used to evaluate AMERIGROUP's cases.

Disease Management File Review Tools—AMERIGROUP

Case Identifier: Case 1
Diagnosis: Hypertension
Synopsis: 37-year-old female with hypertension, depression, and obesity.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Hypertension (HTN).

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Member was identified from CI3, the CMO's predictive modeling software. This member was identified for gaps in care related to HTN. Case was opened on 1/21/2014.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed on 1/21/2014.
- The disease management assessment assesses for race/ethnicity and member communication preferences. Member is Black. Written language preference: English. Approval to send updates to the member and provider.
- No tobacco. No substance use.
- Member is obese. Member requested information on reaching a healthier weight.
- Member rated her health as average.

Disease Management

- No ER visits.
- Has a primary care provider (PCP).
- Member able to take medications as needed. No issues with getting meds filled. No side effects noted.
- Member does not have any issues completing her activities of daily living (ADLs).
- Member identified transportation needs.
- Has family/caregiver to assist her.
- Cardiac assessment completed. Member cannot state blood pressure at the last visit. The care management notes show a blood pressure reading of 160/104 from 7/22/2014. The blood pressure pulls from the Healthcare Effectiveness Data and Information Set (HEDIS®)[G-1] data mart. The system does not allow for multiple blood pressure readings, the blood pressure from the HEDIS data mart overwrites any data populated from the assessment.
- High cholesterol.
- Assessment of knowledge of HTN. Case manager indicated there is a deficit. No history of heart attack. No stroke. Symptoms of headache, pulsating, blurred vision, and nausea. No swelling in ankles or feet. Some symptoms of shortness of breath with stairs and walking. Diet – member states she had a poor diet. Doctor said to watch salt intake. Previous treatment in the past for depression. Some recent symptoms of feeling depressed, loss of interest. Feeling anxious and overwhelmed last four weeks. Not suicidal or homicidal.
- Depression, HTN, and obesity. Sinus and arthritis. Member notes health issues have a significant impact on mood.
- Member indicated that her request for a blood pressure cuff was denied.
- Member's stratification level is a level 2, which indicates monthly outreach.

Note that accompanies the assessment – Some economic stressors; unable to find a job.

Recommendations:

- While the care management system populates a blood pressure reading from the HEDIS data mart, any reading provided from the assessment or on subsequent interactions with the member is overwritten from the system. The CMO should explore ways to allow for multiple blood pressure readings to be obtained with a date so they can be reviewed over time. In addition, the case manager should investigate the reason for the denial of the member's request for a blood pressure cuff and assist the member in obtaining this equipment.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed on 1/21/2014.
- Goal for member to verbalize understanding of importance of coordination with provider related to changes in blood pressure.
- Goal: Diet and nutrition education. Member to verbalize understanding of diet, low sodium diet (Dietary Approaches to Stop Hypertension [DASH]).

[G-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Disease Management

Diet and nutrition education through AMERITIPS.
- Care plan updated 2/19/2014.
- Care plan updated 4/7/2014 – get member blood pressure monitor.

Recommendations:
- The care plan should include goals for needs identified during the assessment. For this member the initial care plan did not include a goal of obtaining a blood pressure monitor, which was identified as a need during the assessment in January 2014. The goal was not added until April 2014.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:
- Clinical practice guidelines were built into the system. The disease management program used the Adult Hypertension Clinical Practice Guideline – Joint National Committee and Treatment of High Blood Pressure.

Recommendations:
- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:
- The disease case manager accessed and sent AMERITIPS specific to hypertension.

Recommendations:
- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:
- The CMO does not use a toolkit for members with hypertension.

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- The member did not meet any of the care plan goals. The CMO lost contact with the member.

Recommendations:
- The CMO should continue to work on patient engagement.

Disease Management

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- There was no self-care or self-management plan documented. The CMO lost contact with the member.

Recommendations:

- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- 1/24/2014: Member was enrolled in active disease management.
- 2/10/2014: Member called requesting a blood pressure cuff.
- 2/19/2014: Member was moved from active disease management to passive due to inability to contact the member.
- 4/7/2014: Member called the CMO and the disease case manager completed a follow-up assessment. The member indicated that she wanted to resume disease management with goals to lose weight and maintain control of blood pressure. The member also indicated a need for assistance with transportation. The member acknowledged she had a blood pressure cuff.
- 7/10/2014: Member disenrolled from the CMO.
- No documentation of blood pressure over the course of contact.

Recommendations:

- The disease case manager should be discussing the member's blood pressure during each contact.
- Address gaps in contact with members. If disease case manager is unable to contact member telephonically, outreach needs to be completed by written communication.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- 1/21/2014 – Introduction letter sent to the PCP. The disease case manager verified the fax number. The systems does not allow for view of the letter within the Clinical Care Advance system.

Recommendations:

- The CMO should explore options for maintaining written communication with the member and provider within the Clinical Care Advance system.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Disease Management

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- The clinical tools options within Clinical Care Advance will load labs and blood pressure monitoring results; however, the HEDIS readings will overwrite anything that is in the system.
- The case documentation did not include any specific goals around weight loss, and there was no evidence that the member obtained a blood pressure cuff.

Recommendations:

- The CMO should explore ways to engage the member into the care planning process to establish goals that may increase engagement in the disease management program.

Case Identifier: Case 2
Diagnosis: Diabetes
Synopsis: 42-year-old female with history of gestational diabetes.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- Diabetes.

Recommendations:

- None.

2. How was the member identified or referred for disease management services?

Observations:

- Member was in passive diabetes disease management in December 2013.
- Member was identified 3/7/2014 through HEDIS outreach campaign for the State of Georgia. Members identified as having gaps for HEDIS were outreached for active disease management to help assist in getting services completed. Member showed an active alert for a hemoglobin A1c test greater than 9.0. In addition, the member did not have evidence of retinal eye exam or monitoring for nephropathy.

Recommendations:

- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:

- An assessment was completed on 3/18/2014.
- Initial health risk assessment completed.
- Member was identified as overweight and was open to achieving a healthier weight.
- Member reported her health as good.
- Member's last visit with her primary care provider (PCP) was 4–6 months ago.
- Member indicated she is on medication but refused to divulge the medications she was taking and if she was taking medications other than those prescribed by her provider.

Disease Management

- Member has a history of gestational diabetes 1 year ago. Member denies medications at this time for diabetes. Last A1c over 1 year ago. Member reported that she only had gestational diabetes.

Assessment note –Member denies need for care management. Per CMO's pharmacy data, member is on Metformin and glipizide and claims for diabetes mellitus. Hemoglobin A1c results in April of 9.5.

3/20/2014: Member called stating she has been diagnosed with Type II diabetes and hypertension and wants to give case manager names of medications.
3/20/2014: Case manager called the member back and could not reach her. No additional contact with this member.

Recommendations:

- The CMO should work on strategies to improve member engagement in disease management.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- A care plan was not created for this member. There was no additional contact with this member after a message left with the member on 3/20/2014. Per the case manager, the outreach campaign was targeted to address the HEDIS gaps and get the member in for services.

Recommendations:

- The lack of follow-up by the disease case manager to engage this member in active disease management was a missed opportunity.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- The disease case manager was unable to engage the member in active disease management.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- The disease case manager was unable to engage the member in active disease management.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Disease Management

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:
- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:
- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:
- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:
- Not applicable, the disease case manager was unable to engage the member in active disease management.

Disease Management

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- Not applicable, the disease case manager was unable to engage the member in active disease management.

Recommendations:

- None.

Case Identifier: Case 3
Diagnosis: Asthma
Synopsis: 8-year-old male

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Asthma.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Identified for disease management on 3/12/2014. Identified from the CI3, predictive model.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed on 3/28/2014.
- Member is Hispanic and member's mother requires a translator. Assessment noted that member prefers English but the disease case manager noted that this could have been filled in as the default in error.
- Parent wants healthier weight information. Parent indicated that the doctor wants the member to be outside and exercise and walk. Good overall health status.
- Member has been in the emergency room five times in the last six months.
- Member has seen the primary care provider in the last month.
- Member has medications, inhaler, and nebulizer.
- Member is a child and parents assist.
- Member stratified at a level 2 – with monthly contact recommended.

Disease Management

- Parent indicated known symptoms of asthma attacks include cold, phlegm. Triggers are humidity and pollen.
- Member has a peak flow meter.
- Problems breathing two times per month. Difficulty at night.
- Emergency plan is to give the member medication and take to ER.
- Member has an asthma action plan to use inhaler. Has a controller medication.

3/28/2014 – completed with language interpreter and member's mother.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed on 3/28/2014.
- Goal to eliminate asthma attacks and decrease inpatient and ER visits.
- Asthma control.
- Care plan introduction for the member and letter to the provider sent on 4/4/2014.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Yes. Assessment and care plan based on asthma clinical practice guidelines.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- CMO used AMERITIPS and telephonic conversation.

Recommendations:

- None.

Disease Management

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- 4/7/2014 – sent asthma AMERITIP – A Healthy Lifestyle for You and Your Child.

Recommendations:

- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- Unknown. No additional contact with the member after the second contact.

Recommendations:

- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- 4/7/2014: Mother had questions about insurance and CMO referred her to State Medicaid office.
- Attempts to reach member in April and May. Mom busy.
- 5/9/2014: Trying to Reach Letter sent to member.
- 5/13/2014: Call attempts through translator.
- 5/13/2014: Member moved to passive disease management.

Recommendations:

- The CMO should implement strategies to improve member engagement.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- Member moved to passive disease management after second contact.

Recommendations:

- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- The case manager sent a disease management introduction letter to the primary care provider.

Disease Management

Recommendations:

- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- No. Member was moved from active disease management to passive disease management after the second contact.

Recommendations:

- None.

Case Identifier: Case 4
Diagnosis: Hypertension
Synopsis: 59-year-old female with hypertension.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Hypertension (HTN).

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Identified through CI3.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed on 5/7/2014.
- Member is Black and has an English preference.
- No tobacco.
- Member agreeable for healthier weight. Body mass index calculated as obese.
- Member reports fair health.
- Member last saw her primary care provider in the last 2–3 months.
- Member takes blood pressure medications, iron medication, as well as medications for cancer.
- Denies substance use.
- Member does not have high cholesterol.
- No knowledge deficit noted.

Disease Management

- Some swelling in the feet/ankles.
- Member uses a cane to ambulate.
- Member has had a hysterectomy and mastectomy for breast cancer approximately 6 years ago.
- At the time of the assessment, the member indicated her blood pressure is unknown. Member does not know her last blood pressure reading in the doctor's office.

Assessment note – member identified her goal as weight loss. Denies asthma and indicates she has an inhaler for bronchitis. No ER or inpatient admissions. Compliant with medications.

The member's blood pressure is unknown, and it is unclear if the blood pressure is controlled. The disease case manager did not assess whether the member had a blood pressure cuff.

Recommendations:

- The disease case manager should ensure that members in the hypertension disease management program have a blood pressure cuff.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan developed on 5/7/2014.
- Self-care management goal of diet/nutrition.

Recommendations:

- While the care plan included the member's goal of weight loss, it did not include a goal of blood pressure control.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- The case notes did not evidence the use of hypertension guidelines.

Recommendations:

- The disease case manager should use hypertension guidelines.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Education provided to the member includes AMERIGROUP Web site information and verbal education.
- For this case, no AMERITIPS sent to the member.

Disease Management

Recommendations:
- The disease case manager should provide active management of members.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:
- No.

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Not documented.

Recommendations:
- The disease case manager should provide active management of the member.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- No further contact with the member since enrollment into active disease management.
- The disease case manager noted that since the member is in the process for bariatric services and being evaluated for surgery that the member will be required to attend support groups, receive education, etc.
- Next contact noted for member in August 2014.

Recommendations:
- The disease case manager should consider developing a plan of self-care with the member.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- The disease case manager does not appear to be actively managing the member since the member is being evaluated for gastric bypass.

Recommendations:
- The disease case manager should work with the member to incorporate plans for gastric bypass into the care plan and develop a mechanism to monitor the member's disease.

Disease Management

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- 5/9/2014 – a letter was sent to the primary care provider.
- There was no discussion with the member about coordinating care with the bariatric center.

Recommendations:

- The disease case manager may have discussed with the member coordination with the bariatric center.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- There was no measure of member health outcomes documented or a plan to obtain health outcomes.

Recommendations:

- The disease case manager should establish a measurement of health outcomes for the member including weight loss and blood pressure.

Case Identifier: Case 5
Diagnosis: Hypertension
Synopsis: 53-year-old female

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Hypertension (HTN).

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- CI3 identified member for disease management on 3/7/2014.
- Member enrolled into disease management on 5/7/2014.

Recommendations:
- The disease case manager should attempt timely enrollment of the member into disease management after identification.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- Assessment completed on 5/7/2014.
- Member reported that she is Black. Prefers English.
- No tobacco.
- Member noted as overweight but member was not interested in losing weight.
- Member rates her health as good.
- Member is taking medication.
- Denies alcohol or drug use.
- Level 1 stratification – quarterly contact.
- Blood pressure managed by PCP. 7/22/2014 reading of 151/82. System will not allow the member self-reported reading.

Disease Management

- No high cholesterol.
- History of hypertension, overweight, and Crohn's disease.

Note – Previous history of diabetes but had not had the diagnosis for 3–4 years. Member indicated that she used to take oral medication and insulin. Has had a partial hysterectomy. Disease case manager noted the member needs a Pap test and mammogram and member indicates she has an appointment to see someone.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan created on 5/7/2014.
- Hypertension – disease process care plan.
- Hypertension – exercise.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Assessment and care plan goals based on hypertension guidelines.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Member was sent a member handbook and provided verbal education.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- No.

Disease Management

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Member's goals all remained opened. No contact with the member since enrollment into disease management.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- There was no evidence of a self-care plan.

Recommendations:
- The disease case manager may consider helping the member to develop a plan of self-care.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- There was no contact with the member following the assessment.

Recommendations:
- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:
- Member has not yet seen a PCP; therefore, no letter has been sent.

Recommendations:
- None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:
- No.

Recommendations:
- None.

Disease Management

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- There was no contact with the member beyond the initial enrollment into disease management.

Recommendations:

- None.

Case Identifier: Case 6
Diagnosis: Asthma
Synopsis: 6-year-old male

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Asthma.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- CI3 identification – 5/20/2014

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- 5/21/2014: Assessment completed with the member's mother.
- Member is Hispanic or of Latino origin. Translation is required. Spanish is preferred written language, but assessment notes that English is spoken well.
- Mother indicates that doctor wants healthier weight for member who is obese.
- Health noted as good.
- Member in the ER 3–4 times in the last six months. Member has had nose bleeds for one week and getting worse.
- Member uses an inhaler 2 x a day. Nebulizer every 4 hours if agitated or experiences shortness of breath.
- Disease management stratification - Level 2
- Member has a nebulizer that is 6 years old. Member does not have a peak flow meter.
- Member has asthma symptoms at night approximately 2–3 times a month.
- Member has an asthma action plan – use of inhalers and nebulizer and then ER if not better.

Disease Management

- Controller medications, rescue inhaler, corticosteroid.
- Member has symptoms of headaches, nose bleeds.
- Member has a diagnosis of attention deficit hyperactivity disorder.

Assessment note: Member is seeing a neurologist for headaches and has feet pain at night.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan created on 5/21/2014.
- Referral to dietician and nutritional plan.
- Goals to lose weight and improve asthma.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Assessment and care plan goals are tied to clinical guidelines.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Telephonic.

Recommendations:

- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- No.

Disease Management

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Unable to assess. Limited contact with member.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- A self-care plan was not noted.

Recommendations:
- The disease case manager may consider helping the member develop a plan of self-care.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?
(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:
- 6/23/2014: Follow-up assessment and note with member's father. The member's father indicated that he did not like the current ear, nose, and throat (ENT) provider and the disease case manager helped the father locate a new one and schedule an appointment for 8/13/2014.
- Father indicated that the member is in soccer and eating habits have changed.
- Plan for call after ENT appointment in August.

Recommendations:
- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:
- No coordination with providers noted.

Recommendations:
- The disease case manager should coordinate care with the member's primary care provider.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:
- No.

Disease Management

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- Member relatively new to disease management; however, there was no measure of health outcomes noted in the present or future.

Recommendations:

- The disease case manager may consider establishing measures of member health outcomes.

Case Identifier: Case 7
Diagnosis: Diabetes
Synopsis: 42-year-old female with diabetes, hypertension, and depression.

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Diabetes.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Identified based on HEDIS gaps on 5/27/2014.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- 5/30/2014: Assessment completed.
- Member self-reported as Black.
- Body mass index calculation shows member is obese. Member is interested in a healthy weight.
- Member has been in the emergency room 1–2 times in the last six months.
- Member connected with primary care provider and seen last month. Next visit scheduled for 6/2014.
- Member takes medications.
- Member identified a need for assistance with food.
- Disease management stratification - Level 2.
- Diagnosis of diabetes for 20 years with a diagnosis at age of 23.
- Member indicates she has never had an eye exam.

Disease Management

- Last hemoglobin A1c over 10 within the last 6 months.
- Member indicates she has limited transportation and does not always have access to healthy food.
- Member has a glucometer and tested her blood sugar in the last 24 hours. Reading under 150.
- Member was in the ER for elevated blood sugar.
- Member indicates that she attended a diabetic event in Georgia and heard about cholesterol based on the event.
- Treated for mental health, has feelings of depression, loss of interest, and feeling overwhelmed.
- Member has a history of depression, hypertension, Type II diabetes, chronic back pain, anxiety.
- Member indicates her health status has some impact on satisfaction in life.

Assessment note: Disease case manager identified that the member has been to the ER for pain. No psychiatric visits were noted for the member in claims history and no active behavioral health referral.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- Care plan created - 5/30/2014.
- Goals for exercise/activity.
- Referred to provider for activity plan.
- Self-care management.
- Obesity care plan.

Recommendations:

- The case manager should consider addressing the behavioral health concerns with a referral to behavioral health. In addition, the case manager should address the lack of an eye exam and explore whether the member had a flu shot due to her diagnosis.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Assessment and care plan goals integrate some of the practice guidelines; however, in this case neither the lack of an eye exam nor exploration of a flu shot was addressed.

Recommendations:

- The case manager should consider all guidelines when developing the care plan.

Disease Management

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:
- Member education includes Obesity AMERITIP, Nutrition AMERITIP, Making a Change series. Depression AMERITIP. Diabetes AMERITIP.

Recommendations:
- None.

7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:
- No.

Recommendations:
- None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:
- Member met education goals.

Recommendations:
- None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:
- Yes. A goal was developed for self-care plan. Making a Change series used to support self-management.

Recommendations:
- None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Disease Management

Observations:

- 7/10/2014: Follow-up assessment. Evidence of the disease case manager reviewing with the member, the same items included in the notes and care plan. Care plan updated based on this contact.
- Last contact with member 7/10/2014.

Recommendations:

- None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- No.

Recommendations:

- The disease case manager should collaborate and coordinate care with the member's providers.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- No.

Recommendations:

- None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**

Observations:

- Some evidence of goal completion; however, little evidence of monitoring of labs, utilization history, etc.

Recommendations:

- The disease case manager should establish a mechanism to establish measures of member health outcomes.

Case Identifier: Case 8
Diagnosis: Asthma
Synopsis: 10-year-old female

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:
- Asthma.

Recommendations:
- None.

2. How was the member identified or referred for disease management services?

Observations:
- Member identified for disease management on 5/20/2014 from CI3, the CMO's predictive modeling software.

Recommendations:
- None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?
(Insert assessment findings.)

Observations:
- 5/30/2014: Assessment completed with member's mother.
- Mother self-report member is Black. Language preference is English.
- Mother indicated that she would be interested in a healthier weight for member.
- Member has been in the ER 3–4 times in the last six months.
- Mother indicates member's health as fair.
- Member has seen the primary care provider (PCP) in the last 2–3 months.
- Member is taking medication (Singulair), albuterol (as needed).
- Member's asthma symptoms include shortness of breath, tightness in the chest, feeling like someone is sitting on her chest.
- Member knows how to use her inhalers.
- Triggers – Smoke, change in weather, pollen, exercise, strong odors, dust pollen.

Disease Management

- Member has a working nebulizer and a peak flow meter.
- Member experiences shortness of breath approximately 23 times per week.
- Has an asthma action plan - sit down, let adult know, use inhaler and then use nebulizer, then medical attention.
- Member has controller medication and rescue inhaler. Using rescue inhaler 2–3 times per week.
- Asthma keeps member from most activity.
- Mother indicates that when asthma is not relieved with home nebulizer, providers give her breathing treatments, steroids, and antibiotics.
- Mother indicates that asthma has a significant impact on member.
- Disease management stratification - Level 1

Assessment note: Has not seen a pulmonary specialist, and asthma managed by PCP. Member knows triggers, action plan, how to use inhaler, etc. No needs at this time.
Disease case manager noted that member has primary insurance through Tricare. Secondary is Medicaid, and member should have been referred to an outside source.

Recommendations:

- None.

4. Was a care plan created for the member?
(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- 5/30/2014: Self-care management.

Recommendations:

- None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- Integrated into assessment questions and care plan.

Recommendations:

- None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- Verbal education on 5/30/2014.

Disease Management
Recommendations: ◆ None.
7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)
Observations: ◆ No.
Recommendations: ◆ None.
8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?
Observations: ◆ Mother already very knowledgeable about member's condition including triggers, medications, and actions.
Recommendations: ◆ None.
IV. Monitoring
9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)
Observations: ◆ Self-management plan developed.
Recommendations: ◆ None.
10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)
Observations: ◆ Follow-up scheduled for 8/29/2014. Unable to assess monitoring.
Recommendations: ◆ None.
11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?
Observations: ◆ No coordination noted with PCP.
Recommendations: ◆ The disease case manager should coordinate with the member's PCP.

Disease Management
12. Was the member transitioned from disease management to case management due to member deterioration?
Observations: ◆ No.
Recommendations: ◆ None.
V. Measureable Outcomes
13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)**?**
Observations: ◆ Follow-up scheduled for 8/29/2014. Unable to assess.
Recommendations: ◆ None.