

## SECTION H: PROVIDER MANAGEMENT

### H.1 Monitoring and Ensuring Adherence to Appointment and Wait Time Requirements

*H.1 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.*

Easy, extended access to care positively impacts member satisfaction. We believe when members are able to choose providers with convenient appointments, the likelihood of positive health outcomes and adherence to treatment plans and follow-up is increased.

As required by our current contract with the State, our participating provider agreement requires our providers to abide by all DHH appointment standards, including those specified in Sections 7.1.1, 7.2 and 7.5 of the RFP. We educate all providers on access standards through orientations, on-going training, our provider manual (incorporated by reference as part of the participating provider agreement), and frequent reminders in newsletters and fax blasts.

Amerigroup Louisiana (Amerigroup) deliberately scrutinizes our network to identify providers who do not meet availability standards. We are steadfastly committed to delivering member access and choice, and we take specific measures to identify providers who do not meet standards through:

- **Appointment availability audits**—Amerigroup conducts an annual audit of a random, statistically valid sampling of PCPs to assess appointment availability and after-hours coverage.
- **Member input and feedback**—Amerigroup's member Health Education Advisory Committee, focus groups, and one-on-one member interactions afford us information on the adequacy and availability of network providers. We also review member grievances and the results of our annual member satisfaction survey to monitor provider adherence to access and availability standards.
- **Employee feedback**—our provider relations representatives, nurse case managers, quality management employees, and as representatives relay information on the access and availability of network providers.
- **Network Strategy Workgroup recommendations**—this cross-functional workgroup provides valuable insight and feedback to make sure our network is accessible and available to members.
- **Provider utilization analyses**—each quarter, we generate a report on network providers who did not submit a claim in the previous six months; this could indicate Amerigroup members may have trouble getting appointments.

Amerigroup's Chief Medical Officer and Provider Relations staff promptly reach out to providers we identify as non-compliant. Using face-to-face and telephone contact, they re-engage providers and reinforce contractual obligations for availability.

#### Appointment Availability Audits

We are steadfastly committed to enabling member access and choice, and we take specific measures to proactively identify providers who may not be abiding by their duty to see Medicaid patients.

## Targeted Surveys

Amerigroup works with a contracted vendor to conduct annual telephone calls to a random, statistically valid sample of our network provider sites to:

- Monitor compliance with contractual requirements for access and availability
- Evaluate after-hours access compliance for PCPs (lack of after-hours access often results in members visiting emergency departments for non-emergent conditions)
- Auditors call providers to ask about appointment availability and wait times for the following types of care needs:
  - Urgent visits—associated with presentation of medical signs that require immediate attention but are not life threatening
  - Non-urgent sick visits—associated with presentation of symptoms that do not require immediate attention
  - Routine or preventive care visits—typically include wellness/preventive care appointments, such as annual gynecological examinations or pediatric and adult immunization visits
  - Medically necessary or routine specialist visits
  - Lab referrals or X-rays—urgent and regular appointments
  - Initial prenatal visits

The following are some examples of the questions by care category the auditors ask. The provider is asked to tell the auditor how each request would be handled and the earliest availability for each appointment type:

- Urgent visit: “My child is 2 ½ years old. She had a head cold a couple of days ago, and now her nose is stuffed up. She has a fever of 103 degrees and is screaming and pulling at her right ear. She is staying awake at night and keeping me up. Tylenol is not helping. She has no other health problems.”
- Non-urgent sick visit: “I have lower back pain. The ache has persisted over the last week. Over-the-counter medications like Motrin are not helping. I have no history of back injuries; however, I want to be checked out.”
- Routine/preventive care visit: “I am a current patient and would like to schedule a routine well-woman visit.”

Amerigroup depends on its primary care providers to offer members appropriate telephonic access to their PCP. 

All results are compiled and used to analyze next steps and corrective action plans, where necessary.

## After Hours Compliance Audits for Primary Care Providers

In accordance with Bayou Health program requirements, Amerigroup Louisiana defines the expectation for after-hours access to care as evening and Saturday appointments: two hours at least one day per week after 5 p.m., and four hours or more on Saturdays.

We verify provider after-hours availability during the initial credentialing process. Annually thereafter, we conduct after-hours compliance audits of random, statistically valid samplings of PCPs. We do this through survey calls placed with providers after normal business hours to verify availability.

To further improve member options for access to care or medical advice during nontraditional office hours, we also deliver the following enhancements:

- We contract with Urgent Care Centers and other walk-in or after-hours clinics in each service area so members have access to care during extended evening and weekend hours.
- We offer telemedicine capabilities, especially in rural or underserved areas.
- Our Amerigroup On Call program provides a level of service beyond that of a typical nurse advice line, 24 hours a day, seven days a week. Members speak with nurses to receive triage services, self-care advice, and assistance with referrals to network providers, including scheduling telephonic consultations with physicians.

Amerigroup On Call enhances access to physicians after hours through telephonic consultation. 

## Compliance Audits for Delegated Vendors

We continuously monitor our subcontractors to verify compliance with Amerigroup standards and requirements, State and federal laws and regulations, DHH requirements, and applicable NCQA standards. Amerigroup understands that we have full legal responsibility for all activities under the Contract, including those performed by subcontractors (such as wait times for transportation pick up).

Amerigroup's Louisiana-based Quality Management Committee (QMC) provides oversight and review of delegated services to verify compliance.

We monitor our delegated subcontractors' performance through reports that are specific to the types of services they provide, such as transportation access and service quality indicator reports and vision services utilization reports.

Our local Louisiana leaders oversee delegated subcontractor performance, regularly review their performance reports, and monitor grievances and appeals from our members. Through these performance reports, we are able to quickly identify and address access issues as soon as they arise.

## Use of Member Feedback

We continually monitor and act on information obtained through our Provider Relations, Medical Management, Quality Management, and Member Services departments. Our Member Services Representatives or Case Managers also help members arrange for care with other network providers when needed.

## Grievance Data

Another avenue to monitor provider compliance is member grievance reporting. Our Member Services Representatives review, log, and categorize grievances by cause, disposition, and type. This includes grievances regarding access to care. Our Quality Management employees review member grievances trends regarding access, over time, to identify on-going patterns of noncompliance.

## Satisfaction Surveys

Annually, Amerigroup assesses member satisfaction through the Consumer Assessment of Health Plans Survey<sup>®</sup> (CAHPS) administered by an independent third-party vendor. It gathers data on member satisfaction with access, availability, and quality of services. We assess year-over-year improvements in survey results and compare our performance to that of the industry overall. The results provide us with valuable benchmark information and point us to those areas where we can focus for improvement.

Table H.1-1. 2013 Selected Amerigroup Louisiana CAHPS Results by Age Group

Age Group and Survey Question	2013 Percent Responded Always or Usually
<b>Adult Medicaid</b>	
Getting care as soon as needed	80.71
Getting appointment as soon as needed	81.25
Easy to get care believed necessary	80.47
Easy to get appointment with specialist	72.73
<b>Child with chronic conditions (general population)</b>	
Getting care for child as soon as needed	91.67
Getting appointment for child as soon as needed	91.76
Easy to get care believed necessary for child	91.10
<b>Child with chronic conditions</b>	
Getting care for child as soon as needed, when it was needed right away	92.77
Getting check-up/routine appointment as soon as needed	94.78
Easy to get care, tests, or treatment	90.91
Getting appointment with specialist as soon as needed	85.84

### Member Turnover

Amerigroup also monitors PCPs for the total number of members assigned to panels and member turnover rates (that is, when a member requests a new PCP). Results are referred to the Amerigroup Quality Management Committee and/or the Credentialing Committee if a significant issue arises.

### Use of Provider Profile Reports

Another avenue to monitor adherence to Contract requirements for access and availability is the reports generated as part of our provider profiling process (detailed in Section H.4 of our response). The reports indicate:

- Rates of group and individual provider compliance with HEDIS® quality measures by patient and care category compared to peer, state, and NCQA percentiles
- Individual members with missed opportunities for preventive care so PCPs and their staff can outreach to schedule appointments for needed or missed services

If reports show high utilization of emergency departments, we work with the provider to analyze whether access can be improved by expanding office hours, directing members to Amerigroup On Call when the office is closed, or increasing outreach to those with high-risk conditions.

If reports show on-going low member utilization of preventive care opportunities with a particular practice or provider, we perform further research to determine whether an appointment availability problem exists. If confirmed, we implement corrective actions and monitor the provider to verify improvement.

## Our Record of Compliance in Louisiana

Amerigroup maintains a strong record of provider adherence to appointment availability and wait time standards, and we continually seek opportunities to improve. As many of these same doctors, facilities, and hospitals also participate on the other Louisiana-contracted MCO networks, we anticipate the combined efforts of our health plan and the other MCOs will continue to improve compliance in the coming year.

Table H.1-2 below presents the results of our last two annual audits for Louisiana. We randomly audited more than 2,300 network providers over two years to achieve a statistically valid sample.

*Table H.1-2. 2013 Amerigroup Louisiana Compliance with Appointment and Wait Time Standards*

Compliance Area	2013 Percent Compliance of Provider Sample Group
Emergent care appointments	99
Symptomatic acute (sick) care appointments	99
Urgent care appointments	92
Routine care appointments	97
High-risk prenatal appointments	87
First trimester prenatal appointments	97
Second trimester prenatal appointments	87
Wait time at appointments	79
Notify member at specified wait time	99
Hospital discharge follow-up appointment	99

## How We Address Noncompliance

We work closely with our network providers to help them improve appointment wait times, HEDIS scores, care quality, compliance with Contract requirements, and member satisfaction.

We take immediate action if a member contacts Amerigroup about appointment access difficulties for a specific provider. When this occurs, a local Amerigroup representative contacts the provider to obtain an appointment for the member. If the provider cannot see the individual, the representative identifies an available practice within the area and secures an appointment to assure the member of timely care. Subsequently, the Provider Relations staff investigates the access issue and develops an action plan with the provider to bring the practice into compliance.

When we identify a pattern of access problems with a certain provider or practice location—through after-hours access audits, member satisfaction survey reviews, complaints from members, or discovering quality issues through audits or other ways—we quickly respond. Amerigroup sends a written notice to the non-compliant provider and:

- Provider Relations employees investigate the access issue and develop an action plan with the provider to bring the practice into compliance.
- Provider Relations employees contact the provider by telephone or hold on-site meetings to discuss the plan, re-educate the provider about the standards, formalize a compliance action plan, and obtain agreement for follow-up reassessment.

- Provider Relations employees monitor and evaluate the implemented action plan to make sure the provider completes the critical tasks according to schedule and issues do not recur.
- We conduct a follow-up audit three months after resolution.
- If the provider does not achieve compliance or if noncompliance recurs, we refer him or her to the Medical Advisory Committee for guidance. This committee may impose sanctions, such as limiting the provider's panel size.
- Finally, if the provider does not correct his/her deficiencies after our continued improvement efforts, sanctions may ultimately lead to termination of active network status.

Ultimately, we remove providers who do not meet access standards from the network if they do not take action to meet the access and after-hours requirements in their contracts and as outlined in our provider manual.

## H.2 The Provider Grievance and Appeal Process

*H.2 Describe your provider grievance and appeal process.*

### Grievances

We maintain robust, effective procedures for our provider grievance process, from receipt and tracking methods, to escalation processes and resolution timeframe requirements, to follow-up responsibilities. We include instructions for filing complaints and grievances in our Provider Manual. Amerigroup will distribute our policies and procedures to DHH and network providers in accordance with this RFP and Contract requirements.

As outlined in the RFP, Addendum 8, DHH defines the following:

- Provider grievance – a formal expression of dissatisfaction with general policies or actions of the MCO, filed in accordance with procedures established by the MCO
- Provider appeal – a request for the reconsideration and reversal of the MCO’s decision on a specific action or transaction, such as a denial of a claim, termination of a contract, or recoupment of payment

The failure by a provider to complete the precertification request in a timely manner constitutes a denial and is considered an action by the plan.

### Receiving and Managing Grievances

Providers can contact us regarding a grievance using any method they choose: phone call, email, through our provider self-service website, in writing, or in-person by visiting our local health plan offices. They are also permitted to bundle service inquiries, grievances, and complaints. No matter the method by which the grievance is received, our Louisiana-based Provider Relations team is ultimately responsible for researching and resolving each grievance in a timely manner.

Amerigroup’s unique blend of local, on-the-ground account management, telephone and web-based services options, and a cross-functional team of experts provides an unsurpassed level of service to our provider customers. 

Louisiana-dedicated employees comprise the Amerigroup Louisiana Internal Resolution Unit (IRU)—a group of Amerigroup associates who help research and resolve grievances in an expedited manner (whether inquiries originate from calls to our provider call center or from other sources, such as feedback gleaned by a local representative’s visit to a provider office). IRU staff assists the local Provider Relations team by performing research and helping to outreach with provider follow-up. This team is managed by a key staff leader dedicated to overseeing the receipt and timely processing of provider grievances.

### Our Grievance Workflow

We use an internal program to document receipt of grievances and track them to resolution, maintaining timely follow-up and response. While we strive to resolve a provider grievance on first contact, there are three sequential levels of grievances in our defined process and tracking system that represent escalation where necessary:

- **Level I** grievances follow our initial inquiry receipt process, documentation, and resolution on first contact.
- **Level II** grievances occur when the provider is not satisfied with the resolution from the initial Level I grievance, and decides to submit a formal written complaint; internal escalation occurs to facilitate resolution.

- **Level III** grievances occur when the provider decides to escalate the grievance/complaint after dissatisfaction with the resolution/decision at Level II.

We resolve Level I grievances and communicate to the submitter within 20 business days of receipt by Amerigroup. If the complaint is initiated through DHH offices, an initial response regarding status is provided to DHH within 24 hours. If the grievance is not resolved within the 20 business days, Amerigroup will document the reasons and communicate them to the provider. All Level I grievances must be completely resolved within 90 calendar days.

The provider has 30 days after communication of the Level I resolution to escalate to a Level II grievance. We resolve Level II grievances within 30 calendar days of receipt and communicate via formal letter to the complainant, including those from DHH, within five calendar days of resolution. If the Level II grievance is not resolved within the 30 days, Amerigroup documents reasons and communicate them to the provider.

The provider has 15 business days after communication of the Level II resolution to escalate to a Level III grievance. We complete resolutions at this level within 10 calendar days and formally communicate with the provider within 15 calendar days of receiving the Level III complaint.

After all internal levels of grievance are exhausted, either party may request binding arbitration, except to the extent the parties have agreed in their Amerigroup provider agreement to use an alternate means of binding dispute resolution. The parties will select an arbitrator with expertise in the health care field in accordance with the rules of the American Arbitration Association. The arbitrator will conduct a hearing and issue a final ruling. Amerigroup and the other party or parties will pay equally any arbitration fees and expenses within 30 calendar days of receipt of the bill, or in a timeframe otherwise required under the arbitration rules. Each party will be responsible for his or her own attorney's fees related to the arbitration.

## Provider Appeals Process

### Technology-assisted Efficiencies

Amerigroup uses PEGA, an industry-awarded workflow management system from Pegasystems, Inc. This tool documents, routes, and tracks appeals from receipt to resolution, including written follow-up notifications to close out and communicate appeal status to the requesting provider. It reduces many of the manual and human processes that go along with managing appeals, thereby reducing errors, and increases timeliness and efficiency. The application interfaces with our other systems, providing real-time access to member and provider information, including membership, eligibility, service, and claim payment details.

Our Quality Management (QM) staff and Provider Relations leadership continually review the outstanding appeals and their status within this system to confirm timely resolution. We also review appeals for trending information that may help us identify additional needs for provider education or process improvement.

### Appeals Workflow

Providers have only one level of appeal—either an appeal based on an administrative denial or an appeal based on medical necessity.

### Administrative Denial of Services

An administrative denial of services is based on reasons other than medical necessity. Providers are never penalized for filing appeals, but must file within 30 days from the date on the Amerigroup notice of adverse action by mailing letters and supporting documentation to Amerigroup.

Upon receipt, we determine:

- The nature of the appeal
- Whether additional information is required
- The appropriate subject matter expert (SME) who reviews the appeal and confirms resolution

We conduct an internal review and communicate results in writing to the provider within 30 calendar days. If Amerigroup upholds the previous decision, we mail a determination letter to the provider. If Amerigroup overturns the decision, we reprocess the claim or notify the requestor of the action that needs to be taken.

### **Medical Necessity Denial of Services**

Any decision by Amerigroup to deny a service or authorize a service in an amount, duration, or scope less than a provider requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition, including to the health plan Chief Medical Officer, Behavioral Health Medical Director, or a board-certified consultant.

A provider must file an appeal for denial of services for medical necessity reasons within 30 days from the date on the Amerigroup notice of adverse action by mailing letters and supporting documentation to Amerigroup.

When a medical necessity denial of services occurs, our medical management team:

- Faxes a notice of denial to the requesting provider
- Mails a notice of proposed action to the requesting provider, the member's PCP and/or attending physician, and the member (this includes instructions to request a peer-to-peer discussion, and copies of member and provider appeal rights and instructions)
- Strives to obtain the necessary information to provide additional support for decisions based on established medical necessity criteria

And our Appeals Department:

- Endeavors to obtain the necessary information to provide additional support for decisions based on established medical necessity criteria

In the event there is insufficient information to render an approval of services, we manage the case as a medical necessity decision and forward it to our Chief Medical Officer (or appropriate practitioner) for final determination.

### **Peer-to-Peer Discussions to Help Providers**

The provider can contact Amerigroup to request a peer-to-peer discussion regarding our decision. These discussions must be scheduled within five business days from the provider's receipt of our faxed notice of denial. If the provider has an urgent need or expedited request that requires a conversation with the Chief Medical Officer, we will connect the provider to a peer within the same business day. If the request is outside of the appropriate timeframe, we instruct the provider to follow the appeals process as outlined in the notice of proposed action letter.

Following the peer-to-peer discussion:

- If the Chief Medical Officer upholds the original denial decision, the provider is notified and instructed on the next appropriate steps, as well as any applicable appeal rights.
- If the Chief Medical Officer reverses the original denial decision, the provider is notified and we complete the reconsideration notice of proposed action approval letter.

## Collaborating with Providers to Reduce Appeal Occurrences

When our local Provider Relations or Quality Management teams become aware of potential or actual issues that may cause provider dissatisfaction, confusion, or rework, we proactively design solutions.

We work to streamline processes and reduce administrative burden for Louisiana providers. 🌸

For example:

- Glenwood Regional Medical Center, West Monroe, LA: In 2013, our Louisiana health plan Quality Appeals staff noticed an increasing trend related to this facility's volume of service denials and appeals. Leadership for QM, medical management and our Chief Medical Officer evaluated the trended volume and determined further outreach to Glenwood was required. A meeting was scheduled with key stakeholders, including Glenwood's Chief Executive Officer, Chief of Operations, and Managed Care and Utilization Management leadership. Amerigroup's Chief Medical Officer and Medical Management Manager attended the meeting to facilitate next steps. The collaborative meeting allowed the teams to identify areas of improvement, including hospital billing; hospital prior authorization practices; and a need for additional training on managed Medicaid, medical necessity criteria, and authorization requirements. Subsequently, Amerigroup's Chief Medical Officer, Manager of Utilization Management, and Inpatient medical management nurse were deployed for two days on-site to work side-by-side with the facility Medical Director, Director of Case Management, and individual employees to educate them on prior authorization requirements, licensed Medical Necessity Criteria, integrated rounding, medical necessity appeals, and claims billing processes. As a result of this collaboration and investment, the facility was able to recoup previously denied claims dollars and now experience a decreased medical necessity denial pattern.
- In July 2012, DHH amended the Amerigroup contract to remove the state fair hearing process from provider appeal escalation options. Our Louisiana Quality Appeals staff observed many providers in the state, including the Division of Administrative Law, still needed clarity or were confused about the appeals process and whether state fair hearings applied. Our Quality Appeals leadership requested a meeting with DHH through our Contract Compliance Coordinator. Our Contract Compliance Coordinator worked with DHH to compel and coordinate a conference call which took place on October 19 with DHH and Amerigroup. Our health plan was tasked with providing clarity to Amendment 2, as well as further education on appeal rights and responsibilities to our providers statewide.

We take our involvement and responsibility to Louisiana seriously, and we strive to go the extra mile to find solutions for challenges to public health and the provider community.

## H.3 Accepting and Managing Provider Inquiries Outside the Grievance and Appeals Process

***H.3 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.***

In addition to the formal process for provider grievances and appeals outlined in Section H.2 of our proposal, Amerigroup offers many avenues for a provider to reach us so that we can accommodate all preferences and technology comfort levels. Our claims dispute process is also managed outside the formal grievance and appeals process and is described in the section below.

### The Amerigroup Provider Service and Experience Model

Our provider service and experience model engages providers locally to foster a mutually beneficial relationship and encourages feedback at multiple touch points. It includes:

- Minimum contact standards for our Louisiana-based Provider Relations representatives and their assigned territory practices/providers
- Regional, open-forum information-sharing meetings
- Provider focus groups
- An enhanced call center and research function to support our local service model and expedite inquiry/complaint resolution

***Hope’s Children and Family Care Clinic provides health care services in a rural community to patients from newborn through adulthood. Access to care is improved through our joint efforts with Amerigroup. We endorse Amerigroup Louisiana as a true partner and applaud their on-going efforts to support our patients and their needs. 🌿***

— Patricia Hope Monk, Owner  
Marksville, LA, July 2014

TESTIMONIAL

Success at achieving accountable, caring, and trusting relationships drives our overall approach to working with providers, and it all begins with hiring talented staff. ***Our 11 Louisiana-based Provider Relations representatives have 150 years of combined health care experience that allows them an exceptional understanding of provider office functions and challenges. These representatives proactively visit an average of 240 providers, in-person, each month, to deliver on-going service, education, and opportunities for feedback.***

### Identifying and Resolving Provider Issues

The Amerigroup multi-faceted approach to provider relations combines the resources of our national organization with a high-touch local presence that emphasizes collaboration between our Louisiana health plan staff and participating providers. Each team member takes time to prepare for the visit to gain full understanding of that provider’s status with Amerigroup, including review of claims payment details, demographic information, quality reports, subcontractor feedback, and myriad other reports and information to position the representative to best serve the provider.

## In-person Provider Visits

During in-person visits, our provider relations team members not only review our information with the provider's office, but we also intently listen to concerns the provider may have so we can design an

Louisiana-based Provider Relations representatives average 240 in-person provider visits monthly to deliver on-going service, education, and opportunities for feedback. 🌸

avenue for resolution. Some of that resolution occurs instantaneously through the representative providing immediate clarity around topics like billing protocols, authorization entry, and more. Other issue resolutions may take more time as they involve more focused research.

*Our goal is to visit all providers at least annually but many more frequently as determined by a tiered schema based on member panel size.* For example, Tier 1 providers are visited monthly.

Provider Relations representatives educate these providers on

administrative or program changes, our quality programs, and other topics as requested by the provider.

**Tier 1 providers are our 100 largest network PCP group practices (by member panel size). They represent 70 percent of the Amerigroup Louisiana member population.**

This enhanced support increases provider satisfaction and gives us an opportunity to engage with the provider on initiatives to drive quality outcomes. Provider visits serve as an effective communication vehicle—we benefit from this regular interaction with our providers and use this feedback to continuously improve our operations and service.

### Resolving Issues Identified Through In-person Visits

When our representatives meet with providers, they document their meetings and any issues in Salesforce, a web-based application that allows the representatives and the local leadership to track, trend, and deliver timely resolution of the remaining provider concerns. Timely and accurate response to our providers is essential to building collaborative relationships with them, so our local Provider Relations representatives are supported by our provider call center and a Louisiana-dedicated Internal Resolution Unit (IRU)—a group of Amerigroup employees who research and resolve questions and claims or contractual disputes in an expedited manner, whether those inquiries originate from calls to provider call center or from other sources like feedback gleaned by a local representative's visit to a provider office. These experienced and specifically trained employees are also empowered to adjust claims when necessary. When an IRU employee partners to resolve a provider inquiry, he or she is also responsible to ensure the loop of communication and follow-up is closed with the provider and the Provider Relations representative involved.

**REAL SOLUTIONS**  
*mean*  
**REAL RESULTS**

A "Tier 1" provider is defined as a provider with a large Amerigroup member panel. Tier 1 providers are visited at least once a month. 🌸

### Addressing Provider Requests for Information and Other Questions

For complaints, requests for information, inquiries (for example, credentialing status, member eligibility, authorizations) or help with our website or general procedures, providers may call our provider call center or local offices, send a letter or email, contact us through our provider self-service website, or work with their local Provider Relations representative.

## The Amerigroup Provider Call Center

The majority of issues handled outside the grievance and appeals process are received through our dedicated provider call center. Complementing our local Provider Relations team, our provider call center offers convenient access to specifically trained, seasoned representatives who address questions through a single point of contact. Providers who telephone the call center are offered a menu of both automated and live-agent services.

Today, there are more than 500 provider call center representatives available, at a minimum, from 7:00 a.m. to 7:00 p.m. Central time. Our call center clinical staff members are available twenty-four hours a day, seven days a week (24/7) to respond to prior authorization requests. We also have a website technical support team available Monday through Friday from 7:00 a.m. to 7:00 p.m. Central time to help providers with any web-related issues.

Our powerful customer service platform enables front-line call center employees to respond efficiently and effectively by integrating information from multiple back-end systems onto a single-screen view. The **integrated desktop** rapidly accesses and displays all data related to the member's benefits, assigned Primary Care Provider (PCP), service utilization and claims history, enrollment, authorizations, and other health insurance coverage and is tailored to specific Bayou Health programs and service areas.

The Center for Customer-Driven Quality awarded our call center the prestigious Benchmark Portal certification, distinguishing it as a Certified Center of Excellence that meets or surpasses rigorous standards of efficiency and effectiveness. The certification is based on best-practice metrics drawn from the world's largest database of call center information, maintained by researchers from Benchmark Portal.



Our service stats speak for themselves. From July 2013 through July 2014, specific to provider calls regarding Bayou Health programs:

- 99,068 calls were received
- 0.5 percent of calls were abandoned
- 94 percent of calls where the caller requested to speak to a live agent were answered within 30 seconds
- 31 percent of callers chose to use our helpful IVR menu options and information instead of speaking to a live agent

## Call Center Staffing and Training

We staff our call center with representatives who possess strong customer service skills and exemplify our steadfast commitment to quality service. We use a workload balancing application, Impact 360 Workforce Management, to:

- Predict provider call volumes and arrival patterns
- Schedule staff at the most opportune times to meet forecasted needs
- Allow for real-time monitoring to quickly and efficiently allocate staff to meet demand

Our training curriculum builds the skills necessary to deliver knowledgeable assistance to providers. New provider call center representatives participate in a comprehensive 45-day training program. Much of the training includes areas specific to DHH and the Bayou Health program such as:

- Overview and history of the Bayou Health program and our partnership
- Enrollment eligibility
- Plan design and benefits
- Covered services
- Program requirements

Additional training covers specific provider call center functions and general information about credentialing and re-credentialing. Call center representatives learn how to access and view key information about claims in the Claims Processing Application group. All trainees monitor live calls and engage in role-playing exercises. Each provider call center representative's success in the training program is measured by comparing their pre-training testing scores with the results of their post-training evaluation.

### After-hours Procedures and Services

Providers can better serve our members when they have ready access to information. We are accessible to our providers through a variety of mechanisms. Providers may inquire through our call center clinical team, our Interactive Voice Response (IVR) system, or our provider website—all available 24/7—to verify eligibility and request authorizations. The IVR is a call pick-up system that offers self-service options and collects information to route the call quickly. During business hours, providers with questions can also opt out of the IVR and connect directly with a live agent.

## Managing Claim Disputes

Like provider inquiries or complaints, the claim dispute process is also managed outside the formal grievance and appeals process outlined in Section H.2 of this proposal.

A claim dispute, defined by Addendum #8 as a provider's request to seek payment or adjustment of payment for a specific claim, can be lodged by:

- Written correspondence through U.S. mail
- Written correspondence through our secure, online claims portal
- Calling our provider call center

To be considered timely, claim disputes must be submitted to Amerigroup within six months of the date printed on our Explanation of Payment. Claim disputes follow a three-level process flow.

**First-level disputes.** Upon receipt of the dispute, we mail an acknowledgment letter to the provider that outlines the dispute process. Within 30 days of the dispute receipt date, the provider receives a mailed, written response explaining the Amerigroup decision on the dispute. If a payment adjustment is made to the disputed claim, a check to the provider follows the written response.

**Second-level disputes.** Upon receipt of the second-level dispute, we mail an acknowledgment letter to the provider that outlines the dispute process. Within 30 days of receipt of the Amerigroup first-level dispute decision letter, a provider can file a second-level of dispute if he or she disagrees with the first-level decision. This level of dispute can be filed through any of the three original filing methods outlined above. Within 30 days of the second-level dispute receipt date, the provider receives a mailed, written

response explaining the Amerigroup decision on the dispute. If a payment adjustment is made to the disputed claim, a check to the provider follows the written response.

**Third-level disputes.** If the provider is dissatisfied with the Amerigroup decision or payment after following the first two levels of dispute, he or she must follow the State of Louisiana process to seek third-party arbitration.

Using the information registered in all levels of the dispute process, we work to perform root-cause and trending analysis to minimize future disputes.

### On-going Commitment to Quality Improvement

Amerigroup continually enforces the philosophy that providers are our customers too. We dedicate significant resources toward increasing provider satisfaction, education, and engagement. Our national Provider Relations leadership team and the Provider Relations leadership team based in Louisiana spend time weekly reviewing and analyzing trending information, survey feedback, and feedback received during provider focus groups conducted across the country to determine other opportunities for improving our relationships with our provider network. *We understand provider success is our success— only by working together can we positively influence member outcomes.*

We welcome the opportunity to partner with DHH to share this information and receive recommendations for future enhancements, as we know the DHH also receives important, local information we can use to further serve the State's health care community.

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## H.4 Practice and Methodology for Provider Profiling

*H.4 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.*

- *Submit sample quality profile reports used by you, or proposed for future use (identify which).*
- *Describe the rationale for selecting the performance measures presented in the sample profile reports.*
- *Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.*

### REAL SOLUTIONS mean REAL RESULTS

We collaborate with providers using meaningful and reliable data to identify opportunities for improving access to quality care for members. 

Amerigroup uses provider profiling to focus network providers on delivering care resulting in **sustainable gains to achieve quality metrics**, supporting DHH's mission to protect and promote health for Louisiana citizens. Our investment in Health Care Economics resources, including provider profiling tools, demonstrates our commitment to fostering productive provider relationships and improving quality of care while being responsible stewards of State health care resources.

### Current Provider Profile Reports

In our experience, robust provider profiling and evaluation do not easily lend themselves to use of a single tool or approach.

Therefore, Amerigroup continually develops solutions and methodologies to fully examine all aspects of patient care and their relationship to quality. Our profile tools are described below. **Sample reports are included as Attachment H.4-1.**

### HEDIS® Data Sharing Scorecards

Amerigroup Quality Management (QM) nurses visit our network PCPs with panels of 50 or more members in-person, at least yearly (part of our Provider Operational Development strategy teams). The QM nurses share HEDIS Data Sharing scorecards that capture group and individual provider rates of compliance with HEDIS measures by member population (such as screenings for children, tests for people diagnosed with diabetes, prenatal/postpartum visits, or immunizations). This report also compares those performances against State compliance targets, peer providers in the State, and NCQA percentiles. The goal is to increase the number of members who complete appointments for needed care, thereby increasing the number of providers who meet quality measures.

To promote improvement, the report then lists all panel members whose quality goal was not achieved. Provider offices can use this information to contact those patients and refine practice behaviors to promote improved overall scores. **This report fosters increased quality of care as measured by HEDIS.**

Currently, the printed report is shared with the provider and can be left behind after the discussion. In 2015, this report will be available for PCPs on our provider self-service website.

## Potential Missed Care Opportunity Report

Each month, the Potential Missed Care Opportunity Report is issued through our provider self-service website to the Amerigroup network's top 100 provider groups (based on assigned membership) who

**Our user-friendly Gaps in Care report reminds providers to outreach to Amerigroup members who have gaps in their care such as missed screenings or office visits.**

cover approximately 70 percent of our total membership statewide. All other network providers receive this report by mail, email, or in-person when an Amerigroup QM nurse visits.

The report identifies members with gaps in care, such as missed tests, screenings, or visits; it is a reminder to outreach to Amerigroup members. The user-friendly data set is presented in Excel<sup>®</sup> format, allowing providers to sort and pivot the information in ways that work best for the practice. The report file contains six

tabs that include a group and individual provider summary and information on Amerigroup members.

The assigned QM nurse from our POD strategy team reviews the report with practice clinical staff to develop plans of action for outreach to the identified members. *We find that increased results are often achieved when clinical staff from the health plan engages providers' clinical staff at provider's offices.*

In 2015, the report will be made available to all Louisiana providers through our provider self-service website. We have provided a sample Potential Missed Care Opportunity Report as Attachment H.4-1c at the end of this Section.

## Advanced Medical Home Reports

We also deliver an array of reports through our secure provider self-service website that equip Medical Homes with information to better manage their assigned members' care. We deliver data on daily census, weekly summary of emergency department visits, and missed care opportunities (that is, members who are overdue for well-care visits or periodic appointments), and lists of high-risk members.

*This year, Amerigroup implemented additional online technology—Member 360<sup>°sm</sup>. To advance providers' access to member health information and further support the development of Patient-Centered Medical Homes, Member 360<sup>°sm</sup> combines member data and information from various sources into a single record to deliver a holistic picture of the individual's utilization, care management services, and gaps in care. It includes information, such as member health risk assessments, care plans, longitudinal health records, and clinical data. Through the provider-facing Member 360<sup>°sm</sup> tools, providers can see their members' records via the Amerigroup self-service website, giving them simple, easy-to-access data and information to help engage members in their own health and well-being. The integrated data is displayed to make it easy for the provider to act, assuring their patients of the services they need. This view enables any provider who treats our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve quality of care. The physician view will enable them to understand, from a population health perspective, how members are doing and more importantly, get information to help them achieve better results.*

Our platform supports providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, providers can search Amerigroup patients with diabetes to see their most recent HbA1c results. The tool takes the providers to the next level by delivering much more than data; it gives them information that is synthesized and displayed in a succinct view to create obvious, actionable items.

## Rationale for Selecting Performance Measures in Profile Reports

Amerigroup selected our quality performance measures to promote credibility and consistency in educating our network providers about the care they deliver, while focusing on those with the most significant impact across all our members.

To assess provider effectiveness meeting quality targets, Amerigroup selected performance metrics based on the HEDIS Data Sharing scorecard report:

- **Widest impact for our members.** We selected a mix of adult and child measures, as well as those that reflect the greatest disease prevalence in our covered Medicaid populations to focus on those measures that affect the greatest number of our members.
- **Historically low-performing results.** We included measures with the greatest opportunity for improvement within our health plan, promoting our own accountability in positively impacting our under-performing quality metrics.
- **Ease of reporting.** We selected measures we can report using administrative data only, enabling us to deliver periodic, consistent data to providers without the burden of on-going record reviews.

As Amerigroup advances our provider collaboration and quality outcomes strategies, we remain actively engaged in looking at next generation provider profiling technology that allows us to deliver additional utilization, quality and cost information to our providers. 🌸

Our Quality Management leadership evaluates our performance measures periodically to assess their continued significance. We look forward to working with DHH to advance quality outcomes for the Bayou Health population and using our tools to help DHH achieve improvement in its priority measures.

## Future Quality Profile Reports

In 2015, Amerigroup will deploy a more dynamic approach to profiling and evaluating our provider network. We are constructing tools and processes to create an innovative approach that balances predictive accuracy, clinical relevance, and practical criteria to drive improvement in overall quality and member health.

The aforementioned HEDIS Data Sharing and Potential Missed Care Opportunity reports will remain in use through the beginning of 2015. Early next year, we will migrate our provider reporting suite and roll out the Symmetry Episode Treatment Groups<sup>®</sup> (ETG) and the Provider Care Management Solutions (PCMS) programs.

## Symmetry Episode Treatment Groups

The ETG program allows Amerigroup to enable network providers to *review their resource utilization and expenditures for treatment of different medical conditions against their peers* in the same community. The ETG methodology uses member enrollment, along with medical and pharmacy claims data, to assign members to unique episodes of care. This assignment facilitates provider-to-peer comparisons. ETGs will be released quarterly. Our intent is to distribute the reports, then review them with providers as needed to determine whether there are actions that can improve performance.

## Provider Care Management Solutions

The Provider Care Management Solutions (PCMS) program is a web-based application that will be available to network providers on demand at any time. Using alerts, dashboards, and reports, PCMS gives provider practices the tools they need to manage their Amerigroup members' health. It will help providers stratify their Amerigroup member panel based on risk and prevalence of chronic conditions. It will also

offer actionable clinical insights, including care-gap messaging and preemptive flagging of patients with high risk for readmission. Its functionality will enable provider- and member-level drill-down capabilities into quality performance metrics and identification of cost-of-care savings opportunities, such as emergency department avoidance.

As seen in Attachment H.4-1, the home page of the application provides a high-level summary of the provider's practice. This will include:

- Number of current and new members attributed to the provider for the month
- Readmission Hot Spotters: current and previous months  
Hot Spotters are high-risk members who will benefit from increased care coordination activities.
- Chronic Hot Spotters: current and previous months
- Inpatient Authorizations: current and previous day
- Care Opportunities: current and previous months
- Care Opportunities by condition: due in 60 days, 30 days, and past due

Each screen will be designed to enhance the information presented on the home page. Providers will be able to download PCMS-related reports in Excel format for further monitoring and review of the data.

Amerigroup will involve as many providers as possible in the programs listed above because member outcomes will only improve through their awareness and involvement. For the programs we will introduce in 2015, our approach will be to expose the majority of our provider network to the data sources so they can self-manage the results. However, we will focus our work more intently on the provider groups that represent approximately eighty percent of our membership base.

## Collaborating with Providers to Improve Quality Scores

This year, Amerigroup improved the way we work directly with providers to initiate collegial dialogue about quality and performance, including results of the profile reports described below. We formed **Provider Operational Development (POD) strategy teams** consisting of Louisiana-based quality management nurses, Provider Relations representatives, and other local clinical team members, such as pharmacists who work together to:

- Analyze profile data
- Use data to identify and work with providers who are practice outliers as well as high performers
- Educate all Primary Care Providers (PCPs) and high-volume specialists about practice patterns relative to their peers, best practices, and performance against quality measures and targets

This strategy strengthens our relationships with providers and fully aligns our provider education—and incentives—with DHH goals. Our Quality Management Department promptly investigates any issues indicating potential inappropriate utilization or quality of care concerns, and takes corrective actions as indicated.

Complementing the POD strategy teams, our Chief Medical Officer plays a leadership role in meeting directly with PCPs and specialists to improve provider practice patterns. We seek to maintain visibility throughout the community and cultivate productive, trusting long-term provider relationships that contribute to overall improvements.

We also talk to the highest-performing providers to gather information on practice management protocols for measures where they achieved strong results, then share them with lower-performing provider offices

as appropriate. When we visit providers to share best practices, we see marked improvement in quality scores, including rising to the next quartile level.

In addition to monitoring quality of care through the profiling activities and reports described in this section, we have also developed innovative provider incentive programs that place a more focused emphasis on specific DHH priorities. ***Our focus on quality and DHH priorities are also tied to our provider incentive programs outlined in this proposal in Section Z.*** Amerigroup recognizes provider engagement significantly impacts member behavior. Our incentive programs are designed to maximize provider motivation to influence positive member response. Moreover, there is synergy between provider and member incentives because they are aligned to facilitate continuity and meet the objectives of this procurement. For example, the standards for the provider and member incentives for Maternal-Infant health metrics provide motivation for outcomes for many of the same measurement standards, such as rewards for completion of prenatal and postpartum visits.

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## H.5 Training Providers on Billing Requirements

***H.5 Describe how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and on-going education and training for current and new providers. Identify the key requirements that will be addressed.***

Our provider education and training program is built on our experience with Louisiana’s Medicaid provider community and augmented by the vast experience of our affiliate Medicaid health plans in 18 other states. Serving the medical community in Louisiana, and participating in the initial launch of the Bayou Health program, we have learned what types of training work best with different providers and what information they value most.

Specific to billing requirements, we educate providers through:

- In-person and live webinars
- Online tutorials
- Our Provider Manual
- Newsletters and fax blast updates

**99 percent**  
of our claims received in the  
last year were paid without  
adjustment. 

### Regular contact with our Provider Relations Representatives

Our 11 Louisiana-based Provider Relations Representatives offer 150 years of combined health care experience, affording them exceptional understanding of provider office functions and challenges. They receive and review claims trending reports for their assigned providers and present individualized coaching on billing requirements to facilitate prompt payment.

***To demonstrate the success of our educational efforts on billing requirements, 99 percent of Louisiana claims received in the last year were paid without adjustment.***

### Initial Education and Training—Billing

For new providers joining our network, Table H.5-1 outlines our initial training topics on billing. A newly contracted provider completes initial training within 30 days of going on active status with our network. Qualified Amerigroup Provider Relations Representatives and leadership team members conduct the training. We post all materials from training sessions to our provider website.

*Table H.5-1. Billing-related Topics Covered in Initial Training*

Topic	Provider Education
Eligibility Verification	<ul style="list-style-type: none"> <li>• Enrollment and eligibility for the program</li> <li>• How to verify member eligibility</li> </ul>
Covered Services and Cost-sharing	<ul style="list-style-type: none"> <li>• Covered services</li> <li>• Prohibition against member cost-sharing</li> </ul>
Claims Submission Guidelines and Processes	<ul style="list-style-type: none"> <li>• Claims submission requirements and time frames</li> <li>• Clean claim requirements</li> <li>• Electronic claims submission process</li> <li>• Electronic Funds Transfer (EFT) setup</li> </ul>
Provider Payment Guidelines and Processes	<ul style="list-style-type: none"> <li>• Reimbursement policies (policies are available on our provider website)</li> <li>• Payment cycles (Amerigroup runs twice weekly payment cycles)</li> </ul>

Topic	Provider Education
	<ul style="list-style-type: none"> <li>• Explanation of Payment (EOP) and Remittance Advice (RA) generation, content and time frames (providers are given their choice of remittance options, including RAs in HIPAA-compliant 835, PDF, and HTML formats, as well as hard copy; and checks or EFT for payment)</li> <li>• Interest payments</li> </ul>
Prior Authorization and Referrals	<ul style="list-style-type: none"> <li>• Services requiring prior authorization and referral</li> <li>• Prior authorization and referral submission requirements and time frames (Amerigroup provides real-time authorizations for telephonic and online requests from providers)</li> <li>• Use of evidence-based and nationally accepted clinical criteria</li> <li>• Decision time frames</li> <li>• Demonstration of the look-up tool on our provider self-service website</li> </ul>
Grievances, Appeals, and Claims Disputes	<ul style="list-style-type: none"> <li>• Provider complaint, grievance and appeal, and claims dispute processes and time frames (phone, web, and mail submissions)</li> </ul>
Provider Website	<ul style="list-style-type: none"> <li>• How to access our self-service tools</li> <li>• How our site interacts with Availity.com, a multi-payer portal</li> <li>• A demonstration of each site's and tool's functionalities</li> </ul>
Third Party Liability (TPL)	<ul style="list-style-type: none"> <li>• Overview of TPL and reporting</li> </ul>
Fraud and Abuse	<ul style="list-style-type: none"> <li>• Prohibitions against fraud and abuse</li> <li>• Reporting and compliance</li> <li>• How to contact our Office of Business Ethics with concerns or questions</li> </ul>

### Customized Training for Specific Provider Types

We tailor our training to meet the needs of specific types of providers. For instance, we provide hospitals with a separate, comprehensive orientation session that includes policies, procedures, and formal agreements for communications between our Medical Management team and the hospital. We conduct on-going Joint Operating Committee meetings with them to provide further education and address any operational issues.

Amerigroup is prepared to educate new and current providers on changes in the program, including new services like personal care service (PCS) and hospice. We will work personally with them, explaining billing and authorization guidelines (prompt and accurate payment is often vital to the continued operations of small PCS providers). We will closely track cycles of claims payments to these critical providers. While the claims may well be within DHH standards for cycle time, we follow-up internally as necessary to promote more rapid payment. This helps avoid disruption of services, and in particular, disruption of important relationships between members and provider staff that can be critical to avoiding acute inpatient hospitalizations or nursing facility admissions.

## Our Provider Website

To simplify practice management, our provider website also supplements live training by allowing providers to review billing and claims payment information, including but not limited to:

- Important billing news and administrative updates
- Claims submission and status
- Prior authorization requirements and requests status

***In our most recent Louisiana provider satisfaction survey, 77 percent of respondents said they use our provider website.***

*Figure H.5-1. The Amerigroup Website Features Easy-to-Navigate Self-service Tools for Providers*



Table H.5-2 presents our website self-service functionality.

*Table H.5-2. Additional Amerigroup Provider Self-Service Website Functionality*

Functionality	Description
<i>Before login</i>	
New User Registration	Allows network and out-of-network providers to register for access to our site
Login Assistance	<ul style="list-style-type: none"> <li>• Recover user name</li> <li>• Reset password</li> <li>• Recover account activation code</li> </ul>
Application Request	Allows providers interested in joining the Amerigroup network to submit a request for more information
<i>After login</i>	
Eligibility Tool	Allows user to verify a patient’s enrollment status and assigned PCP
Panel Listing Tool	Allows user to see panel listings for a provider, group, or

Functionality	Description
	independent practice association over a specified date range
Claims Tools	<ul style="list-style-type: none"> <li>• Claims submission</li> <li>• Claims status look-up</li> <li>• McKesson's Clear Claim Connection to verify code combinations</li> <li>• Instructions to submit claims using Electronic Data Interchange (EDI)</li> <li>• Notification receipts for 837 batch uploads via the site's Message Center</li> </ul>
Account Management Tools	<p>Allows user to manage:</p> <ul style="list-style-type: none"> <li>• Demographic information (practice info, profile information, updated rosters)</li> <li>• Provider accounts (add new TINs, manage TINs)</li> <li>• User profile information (user name, password, contact info)</li> </ul>
Delegated Administration Tools	<p>Permits delegated administration, enabling a practice (TIN) administrator to assign/revoke user rights; features include:</p> <ul style="list-style-type: none"> <li>• Managing user roles</li> <li>• Activating accounts</li> <li>• Adding and activating new TINs</li> </ul>
Help and Reference Library	<p>Repository of forms and documents available for download:</p> <ul style="list-style-type: none"> <li>• Provider handbook and quick reference card</li> <li>• Medical and office support forms</li> <li>• Claims forms</li> <li>• Links to our State and vendor partner websites</li> </ul>
Provider Announcements	On-going Amerigroup and DHH news and bulletins, including those relating to billing
<i>Both Before and After Login</i>	
Health Plan Contact Information	Local office and toll-free provider call center phone numbers and email addresses
Prior Authorization Tools	<p>The authorization/precertification tools allow:</p> <ul style="list-style-type: none"> <li>• Determination of service precertification or notification requirements</li> <li>• Submission of authorization requests</li> <li>• View of authorization status</li> <li>• Download of special authorization request documents</li> </ul>
Clinical Policy Guidelines	Assists in providing quality care by reducing inappropriate use of medical resources
Reimbursement Policies	Allows access to Amerigroup reimbursement policies, including information on EDI and electronic funds transfer (EFT); helps providers submit accurate claims by outlining the basis for reimbursement if the service is covered by a member's benefit plan
Online Tutorials and User Guides	Flash tutorials and downloadable user guides to assist users with the site's functionality; upcoming training opportunities and tutorials on other topics, such as cultural competency

## Billing is a Way We Make it Easy to Do Business with Us

We receive, on average, more than 125,000 electronic claims from Louisiana providers each month. *Amerigroup is committed to continuous investment in technology to support providers with easy-to-use billing and payment options that reduce administrative burden and cycle time.* For example:

- We have *reduced the number of services requiring prior authorization* to streamline the process for provider office staff.
- In addition to supporting EDI and EFT, *we implemented Availity web technology* for our Louisiana providers in May 2014. Instead of logging in to multiple payer systems, providers can now use a single sign-on process through Availity.com to file claims; and access member eligibility, claims status, and payment information for Amerigroup and multiple other payers in one place. Availity links directly to our provider website for access to our other online tools and vice versa. As an alternative, providers can still call our Interactive Voice Response (IVR) system or contact their assigned Provider Relations Representatives by phone or email with questions about claims or payments.

**Provider Website Improves Efficiency**  
In May 2014, Amerigroup Louisiana rolled out new online technology to further reduce administrative burden for providers. We conducted significant training on use of Availity.com, a multi-payer portal that supports all online claims submission, claims status, and eligibility verification. 🌸

## Initial Training on Other Non-Billing Requirements

*Upon Contract renewal, we will develop a multi-channel training schedule that affords existing providers opportunities to learn about changes and enhancements to the Bayou Health program and receive refresher training where needed.*

At initial training, we provide copies of our Provider Manual, prior authorization quick reference guide, and member benefit collaterals. We also include a session to address specific provider questions. We use in-person and live web seminars, and online tutorials to cover a host of valuable topics, including:

- Overview of the program: DHH populations/eligibility, covered services and value-added benefits, Medicaid policies and procedures, and key contact information
- Provider responsibilities: cultural competency and assisting members with special needs; appointment access, after-hours availability and wait time standards; reporting communicable disease; preventive health service standards; grievances, appeals, and claims dispute processes; medical record standards and reviews, and other policies or procedures; working with our pharmacy benefits administrator; and emergency service responsibilities
- Amerigroup programs: provider incentive programs and Patient-Centered Medical Homes
- Amerigroup services: our role and responsibilities; Quality, Chronic Care, and Case Management programs and referral processes; behavioral health services and our whole-person treatment model; electronic service records; language and interpreter services; and telemedicine and Amerigroup On Call programs
- Member services: enrollment process; rights and responsibilities; PCP selection, assignment and change processes; ID cards; advance medical directives; compliance with State Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and immunization schedules; and grievance and appeals processes

## Monitoring Providers on Appropriate Billing Practices

In addition to educating our participating providers, the Amerigroup national Medicaid Special Investigations Unit (MSIU) deploys significant resources to identify irregular claims on a prepayment basis. However, even the best algorithms cannot always identify aberrant practices before claims are paid. Consequently, we also use a program to identify aberrant patterns after claims are paid. ***The data-mining tools used by our billing integrity and claims analytics teams identify providers whose billing/utilization practices are markedly different from their peers either globally or for specific services.*** Additional detail about this team's monitoring practices are described in Section V, Program Integrity, of our proposal.

Upon identification, we promptly send these providers educational materials that describe the aberrant behavior and include proper coding references, and also offer telephonic or in-person education. If those patterns continue, we request clinical records to verify that the coding not only represents the services performed, but also services that were clinically appropriate. Providers who exhibit high error rates on post-payment review will receive further education and may be subject to pre-payment review going forward.

At all phases of intervention, we give providers opportunities to dispute determinations, including a chance to discuss a determination with a Certified Professional Coder and/or our Chief Medical Officer, as appropriate.

### Maximizing Provider Participation

All contracted providers must complete our initial orientation. We offer training via various modes and venues to maximize participation. In addition, we offer multiple dates at convenient times and locations for each training session. We also serve food to encourage attendance. We take attendance at every training session and track individual provider participation. ***When a provider does not attend a scheduled initial training session, our Provider Relations staff contacts him or her and reschedules training, offering the option of a one-on-one or webinar.***

### Training Evaluation

At the conclusion of each training session, we ask participants to complete surveys to assess their satisfaction with the presenters, training materials, content, and effectiveness. Attendee responses let us know where we can improve our training and services in the future.

Using data analytics, Amerigroup discovered this provider billed for identical services, same patients, and same dates of service using separate and distinct tax identification numbers. The duplication of services was not immediately detected by the claims processing system due to the provider using different identification numbers. Amerigroup determined the provider was overpaid \$27,421.81.

♣ **How Detected**—Proactive advanced data analytics.

♣ **Actions Taken**—Referred the allegations to Department of Health and Hospitals (DHH) and the Louisiana Medicaid Fraud Control Unit (MFCU). Using system offsets on future claims, Amerigroup recouped the funds from all duplicate claims. Notifications were made to the other MCOs to review their claims data for this scheme.

♣ **Customer**—Louisiana Department of Health and Hospitals; Medicaid Program Integrity.

HOSPITAL

## On-going Training

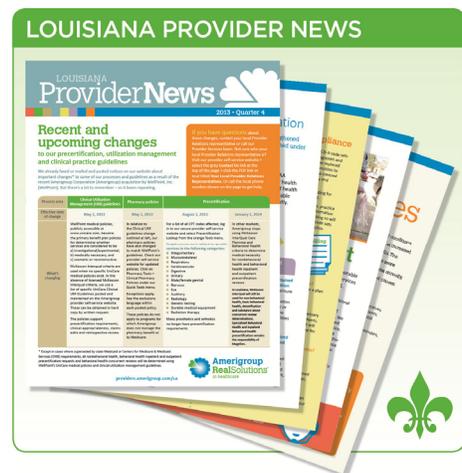
We tailor our on-going training programs to meet the unique needs of the local provider community. For example, we periodically hold statewide workshops/seminars to afford our health plan staff opportunities to communicate program updates, industry trends, and enhancements to our products and services. We offer group training sessions quarterly as refreshers and opportunities for providers to train new office staff. In addition, we conduct individual training any time throughout the year when we identify a need or upon request from a provider.

**Amerigroup “Lunch Bunches” offer staff the opportunity to communicate program updates, industry trends and enhancements to our products and services.** 🌸

Certain high-volume providers also receive training via monthly, quarterly, and annual education office visits from Provider Relations Representatives. The team conducts random audits of these visits to determine whether the on-site training met our objectives. We incorporate this feedback to improve the provider education program and the performance of our Provider Relations staff.

## Effective Provider Communication Strategies

- Keeping in touch:** We also use communications media, including blast faxes, provider newsletters, and our website to disseminate educational information to address specific needs and help keep providers up-to-date on current health information, changes to the program, and member incentives. Provider newsletters are conveniently available on our website. Quarterly Reimbursement Policy Bulletins also provide brief summaries of our policies.
- On-demand training for new technology and program changes:** When we implement new tools and technology or there is a program change, our local and national Provider Relations resources collaborate to create and deliver new training materials, a training schedule, and strategy to help keep all network providers in the loop. For example, as proposed in Section Q of this RFP, Amerigroup intends to use a new pharmacy benefits administrator, beginning in 2015, to improve program costs and efficiencies for Louisiana members and providers. We will partner with DHH and Express Scripts to develop multi-channel training to inform providers in advance of program and process changes.



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