

## SECTION X: CLAIMS MANAGEMENT

### X.1 Amerigroup's Claims Management System Capabilities

***X.1 Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide.***

***Identify any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10.***

***Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide.***

***If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.***

As an experienced and trusted partner to DHH since 2011, Amerigroup Louisiana (Amerigroup) recognizes the critical value that accurate claims and encounter data bring to effective management of clinical and health care services information, and the systems, processes, and staffing necessary to maintain high standards.

Amerigroup's Management Information System (MIS) is already configured to support Louisiana operations. Our MIS is compliant with DHH claims management requirements outlined in Section 17 of the RFP, and we will continue to meet or exceed DHH expectations with no limitations.

Amerigroup understands that the State's current Medicaid Management Information System (MMIS) contract expires at the end of 2014, and that after an anticipated extension, a reprocurement will be completed. Amerigroup will continue to comply with transactional requirements if DHH contracts with a new Fiscal Intermediary during the Contract term.

**Amerigroup's MIS is already configured to meet DHH requirements for claims processing and encounter data submission, allowing us to continue to meet DHH expectations with no limitations. **

### Systems Capabilities and Limitations—Section 17.8 Encounter Data

As an operational MCO in Louisiana, ***Amerigroup already has systems and processes in operation to submit timely and accurate encounter files to the State's Fiscal Intermediary in accordance with DHH requirements and the Prepaid Systems Companion Guide, Version 4.3.*** We are in full compliance with DHH performance indicators on timeliness, financial reconciliation, and remediation of repairable errors, and we will continue our high level of performance if selected as an MCO under the new Contract.

Amerigroup understands and supports the need for accurate and timely submission of encounters to DHH. To determine the effectiveness of Louisiana's Medicaid Program, DHH relies on encounter data, such as utilization, claim denial tracking, provider trends, verification of reported MCO metrics, financial tracking to Per Member Per Month contracts, rate setting, federal reporting requirements, attested Electronic Health Record patient volume verification, responses to Freedom of Information and legislative requests for information, Office of the Inspector General (OIG) and the Medicaid Fraud Control Unit (MFCU) support, and informing Medicaid policies. An appreciation of how DHH uses encounter data drives our support of DHH.

Amerigroup will continue to meet all of the requirements in Section 17.8 of the RFP with no limitations or disparities. Amerigroup is compliant with version 4.3 of the Systems Companion Guide. DHH recently released the Bayou Health Prepaid Plan Systems Companion, Version 4.4 (August, 2014), we have reviewed the new release and determined that we meet the revised requirements.

Amerigroup maintains a national Encounter Management Department that combines dedicated staffing, a robust encounter management system (EMS), and a tightly managed submission schedule to meet DHH encounter data requirements. The EMS is a critical component of our MIS and is highly customizable to meet State-specific encounter requirements. Controls allow employees to closely monitor completeness, accuracy, and timeliness during the creation of each encounter data file. The Encounters Management team dedicates a full-time business analyst, trained specifically on Louisiana encounters, to manage the submission process. The business analyst partners with technical resources and functional departments to meet all encounters reporting obligations. The Encounter Data Quality Coordinator will work closely with the national Encounter Management Department, health plan leadership, and DHH to identify, resolve, and monitor encounter submissions and quality.

### Encounter Submission Files

Amerigroup currently submits a single HIPAA-compliant ANSI X12N 5010 837P (which includes professional, DME, and transportation services), a single 837I, and a single NCPDP encounter file in the provider-to-payer-to-payer Coordination of Benefits (COB) Model to the DHH Fiscal Intermediary. Files contain all encounter data, according to DHH requirements, regardless of source of claim or type of provider. Amerigroup submits line-level encounters for all encounters except for inpatient encounters, which are submitted at a document level.

Amerigroup currently submits weekly encounter files to DHH that combine claims that we process with claims from our subcontractors. 

Amerigroup contracts with most of our providers on a fee-for-service basis, which inherently drives claims submission and results in encounter data. For those few capitated provider arrangements, we require submission of encounter data as zero-pay claims at the same level of detail required of our non-capitated providers. For all providers, we account for submission compliance through records audits and data trending analysis. In addition, the submission of

encounter data is a contractual requirement in our standard provider contracts. We collaborate with Provider Services to address any provider compliance issues, developing corrective action plans for providers failing to consistently submit complete encounter data.

Amerigroup uses subcontractors for services such as pharmacy, vision, Durable Medical Equipment (DME), and transportation. We contractually require our subcontractors to submit data to us on a schedule that enables us to incorporate it into our encounter submission files and meet the State-specified schedule. Moreover, contractual language holds subcontractors accountable for submission of encounter data, along with penalties for non-compliance. We receive subcontractor encounter data, load it into our EMS, edit the data, and incorporate it into our overall claims history data for submission as encounters.

Amerigroup will submit encounters to DHH for all services providers deliver to our members, including services not covered by Medicaid that Amerigroup will reimburse providers for as part of our provider incentive programs discussed in our response to Section Z, Value Added to Providers.

Amerigroup will continue to meet specific DHH requirements for complete encounter data:

- **Processor Control Number**—We have a unique Process Control Number and include it in all 837 transactions, along with a Bank Identification Number.

- **Encounter Data Submission**—We submit our encounter data weekly. All encounters for claims adjudicated (paid, including \$0.00 paid, or denied) the previous month are submitted by the 25<sup>th</sup> calendar day of the month.
- **Prior Authorization Requests Data**—Amerigroup provides DHH a weekly file of the encounter data on all prior authorization requests. The file includes the data elements as defined in Section 17.8.5 of the RFP and is transmitted in the format specified in the Systems Companion Guide.
- **Encounter Data**—Amerigroup includes encounter data for all levels of provided health care services. We collect encounter data from our subcontractors and include the data in our overall encounters submission.
- **Conversion of Paper Claims**—Amerigroup converts all claims received as paper to electronic claims data prior to claims adjudication. All claims, regardless of submission method, are available to the encounter data process.
- **Capitation Arrangements**—Amerigroup supports capitated reimbursement arrangements with providers. We contractually require capitated providers to submit encounter data at a level of detail equivalent to fee-for-service claims.
- **Adherence to Federal and/or DHH Payment Rules**—We will continue to follow all federal and DHH payment rules, as defined in the RFP, DHH provider billing manuals, and the System Companion Guide, in the treatment of certain data elements, including units of service, so that we can deliver accurate and complete encounter data submissions.
- **Settled and Adjusted Claims**—Encounter data Amerigroup submits to DHH include settled (paid and denied), voids, and adjusted claims.
- **Record Rejection by the Fiscal Intermediary**—If the DHH Fiscal Intermediary finds it appropriate to return encounter records to Amerigroup, we act quickly to research and resolve all encounter data issues and include the corrected record in a subsequent encounter submission.
- **Repairable Denials**—We have employees and processes to address the repairable denials for resubmission according to DHH requirements and time frames.
- **Attestation**—Amerigroup’s Director of Finance attests to the truthfulness, accuracy, and completeness of encounter data we submit to DHH.
- **Adjustment to Encounters**—Amerigroup adjusts encounters when we discover the data are incorrect or no longer valid or require other changes to the original claim. If DHH discovers errors or a conflict, Amerigroup adjusts or voids the encounter. Amerigroup works in collaboration with DHH to identify solutions to prevent or minimize the reason(s) for the error where possible.

### **Limitations or Disparities—RFP Sections 17.2, 17.8, and 17.10**

Amerigroup will continue to meet all of the requirements in Sections 17.2, 17.8, and 17.10 with no limitations or disparities.

### **System Capabilities and Limitations—Section 17.10 Pharmacy Claims Processing**

Amerigroup will continue to meet all of the requirements in Section 17.10 of the RFP with no limitations or disparities. Amerigroup is compliant with the NCPDP Guide in the Bayou Health Prepaid Plan Systems Companion, Version 4.3 (April 2014). DHH recently released the Bayou Health Prepaid Plan Systems Companion, Version 4.4 (August 2014), we have reviewed the new release and determined that we meet the revised requirements.

As an operational MCO in Louisiana, Amerigroup already has a Pharmacy Benefits Manager (PBM) that meets requirements of DHH and the Bayou Health Prepaid Systems Companion Guide, Version 4.3 (April, 2014). For the new Contract period, Amerigroup intends to subcontract with Express Scripts, Inc. (Express Scripts) as our PBM. Amerigroup will manage all functions of our pharmacy program and maintain full accountability and oversight while continuing to meet Contract requirements.

### System Requirements and Pharmacy Encounters Claims Submission

Amerigroup submits pharmacy encounters in the HIPAA-compliant claim-level detail NCPDP D.0 format, including all DHH-required data. Amerigroup currently submits a single HIPAA NCPDP encounter file that contains all pharmacy encounter data according to DHH requirements, including designation of 340B claims.

We receive daily encounter data from the PBM and edit the transactions to verify the encounter is correct. If the encounter data do not conform to DHH standards, we work with the PBM to achieve compliance. By following this verification process, we submit only accurate, compliant encounters to DHH.

The PBM edits pharmacy claims for eligibility, benefit limitations, prescriber eligibility, and prospective/concurrent utilization. Through the prospective drug utilization review (ProDUR), our PBM performs program edit checks on a real-time basis, before the prescription is dispensed, to confirm appropriate utilization, member safety, and prescribing in compliance with State- and nationally recognized guidelines. Prescription reviews are based on combinations of DUR edits to alert the pharmacist to potential conflicts or the need for prior authorization. The PBM checks all prescriptions for member eligibility and plan design features and compares them to a history of prescriptions filled by the same pharmacy and other network pharmacies. The PBM identifies drug conflicts online when the prescription is entered, enabling the pharmacist to review the member's history and contact the prescriber or member to make necessary adjustments prior to dispensing.

The PBM conducts automated updates to the National Drug Code and maintains historical pricing schedules. The drug file is updated every week (seven days or fewer). The drug files for both retail and specialty drugs, including price, are updated daily, Monday to Friday, based on the frequency of updates from both FirstDataBank and MediSpan by our PBM.

Our MIS maintains historical encounter submission information for all encounters, including pharmacy, for a minimum of six years.

### Pharmacy Rebates

Amerigroup will continue to submit all drug encounters, as specified in RFP Section 17.10.3, to DHH in support of DHH's participation in the federal supplemental pharmacy rebates program.

### Disputed Encounters

Amerigroup will implement a process to research and resolve the weekly file of disputed pharmacy encounters from DHH within the times frames specified in RFP Section 17.10.4.2. Once resolved by our pharmacy rebate team, we will resubmit the encounters and send a response file to DHH containing the corrected, resubmitted encounters. If we are unable to resolve the disputed encounters we will provide a detailed explanation of why the encounters could not be corrected.

### PBM Oversight

Amerigroup will submit the oversight plan for the PBM's performance prior to implementing our new PBM for DHH approval.

## Amerigroup's Ability to Meet DHH Requirements in RFP Section 17

Amerigroup will continue to meet all of the requirements in Section 17 of the RFP.

## X.2 Process for Submitting all Claims Timely and Accurately

*X.2 Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately.*

As an operational MCO in Louisiana, Amerigroup has systems and processes in place to submit timely and accurate encounter files to the State's Fiscal Intermediary in accordance with DHH requirements. In the past 12 months, Amerigroup has submitted more than three million HIPAA-compliant encounter records to DHH. We fully comply with DHH performance indicators for timeliness, financial reconciliation, and remediation of repairable errors. We will continue our commitment under the new Bayou Health Contract.

In the last 12 months, Amerigroup has submitted more than 3 million HIPAA-compliant encounters to DHH. 🌸

Amerigroup's ability to submit timely and accurate encounters begins with our ability to process claims. In the sections below, we first discuss our ability to accept and adjudicate claims and then discuss our process for delivering encounters to the State.

### Accepting and Adjudicating Claims

Amerigroup Louisiana adjudicates claims in a timely, accurate, and provider-friendly manner—our results demonstrate our success. In the last 12 months, we processed more than 1.6 million claims in an average of 4.5 days per claim. Our automated claims adjudication process delivers faster and more consistent claims processing and payment. Automated routines apply a series of standard and State-specific edits, and we edit claims data using industry-recognized products, such as code review and code-bundling software. In the last 12 months, we automatically adjudicated 86.4 percent of Louisiana claims.

Amerigroup is committed to prompt payment of incoming claims, regularly exceeding DHH standards for timeliness. During the last 12 months, our timeliness measurements have exceeded standards:

- 99.73 percent of clean claims processed in 15 business days or less (the standard is 90 percent)
- 99.88 percent of clean claims processed in 30 calendar days or less (the standard is 99 percent)

To give our providers maximum flexibility, Amerigroup accepts claims on paper or electronically. We offer providers the following free-of-charge options to submit electronic claims:

- One of our three nationally-recognized clearinghouses
- Availity, a multi-payer portal, to submit either an 837 file or data-enter a claim online (Direct Data Entry)

Amerigroup encourages adoption of electronic claims submission and promotes its availability in the provider manual, on the provider website, and in provider trainings. During the last 12 months, Amerigroup averaged an EDI claim submission rate of 91.7 percent.

Amerigroup's Average EDI Claim Submission over the past 12 months is 91.7 percent. 🌸

However, we recognize that not all providers are prepared to submit claims electronically. We convert paper claims we receive to electronic format for auto adjudication within 48 hours of receipt. All claims, regardless of entry source, pass through the same edits and adjudication processes to deliver consistency.

Regardless of whether the claims are received in electronic or paper format, we verify that the number of claims we received equals the number of claims loaded into the core operations system.

## Claim Adjudication

Our MIS applies a series of edits and validations to all claims throughout the claims processing cycle including the following:

- Front-end edits to validate content and apply Louisiana-specific rules and industry-standard coding edits
- Compliance checks of the transaction
- Validations against member and provider data, authorizations, and member benefits, among others
- Enhanced claims editing using National Correct Coding Initiative (NCCI) standards
- Upon receipt, we process claims files through our HIPAA compliance checker to validate the data contents and format for compliance with the HIPAA standardized code sets

Next, we apply a variety of automated pre-processing edits designed to validate the quality of the data submitted. These edits verify that the data are relevant, complete, and contextually appropriate. We apply value-added edits to comply with Louisiana-specific rules and regulations. Claims passing all of these edits are forwarded to the adjudication engine for processing. This attention to pre-processing edits significantly enhances the efficiency by which we process claims. Incomplete claims are rejected within five days so providers can correct and resubmit them.

During the adjudication process, we apply hundreds of industry-standard system edits to verify member eligibility, checking provider status, validating that authorization requirements are met, verifying that the services are covered, and checking for duplicate claims. We edit against standard code sets, including HCPCS, ICD-9, CPT, revenue, CDT/ADA, and NDC codes. In addition, we maintain and use HCPCS Level II and Category II CPT codes, allowing both Amerigroup and DHH to evaluate performance measures.

## Claim Accuracy

Amerigroup currently conducts a monthly Louisiana claims accuracy review of a random sample of adjudicated claims. In July 2014, results of the review documented claims processing accuracy at 99.61 percent and claims financial accuracy at 99.9 percent.

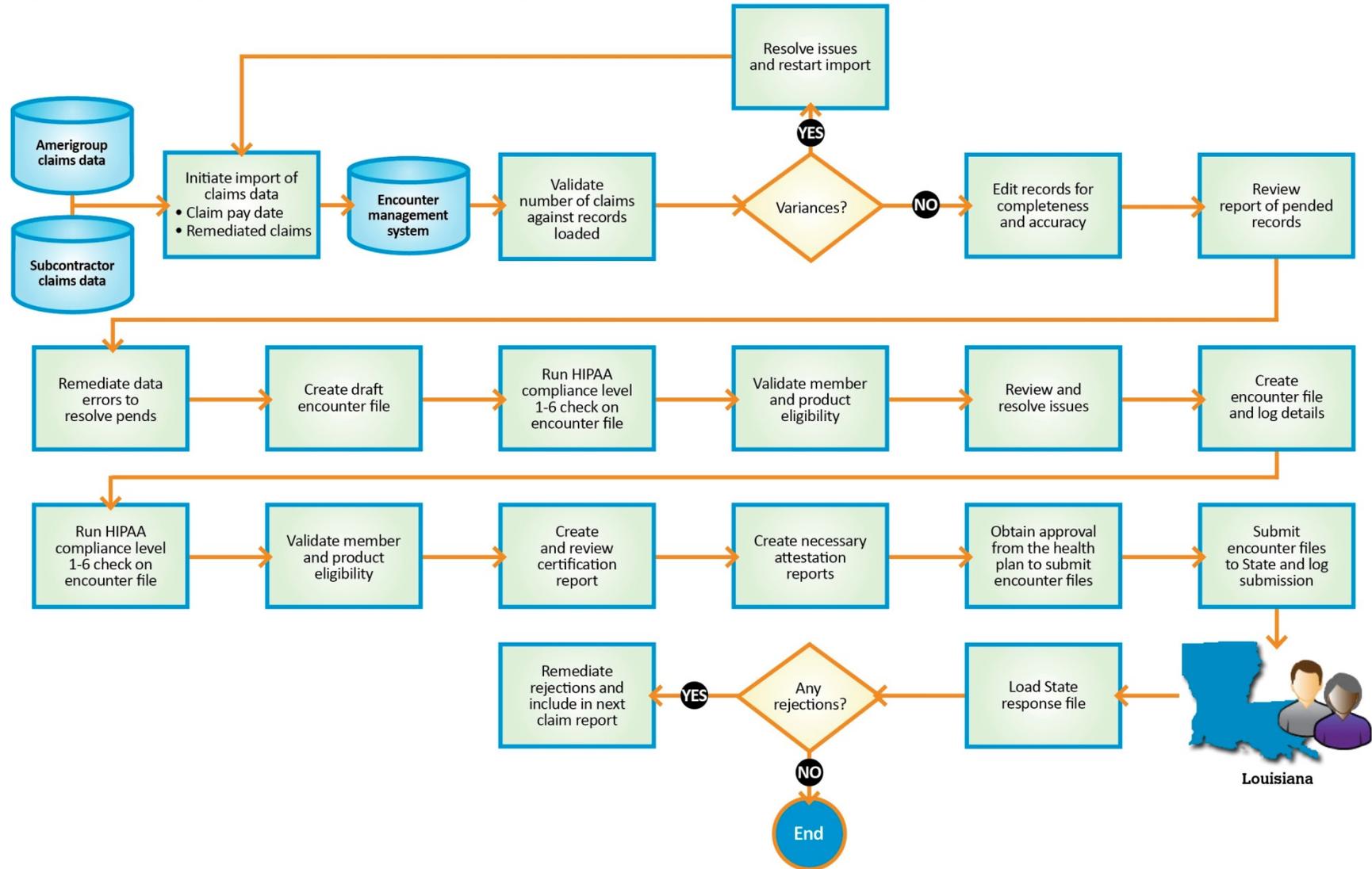
## Amerigroup's Encounter Process

The dedicated staffing in the national Encounters Management Team, in conjunction with the Encounter Management System and a tightly managed submission schedule, assures that we meet the accuracy, timeliness, and completeness of encounter data specified in the RFP requirements. The Encounters Management team includes a full-time business analyst trained specifically on Louisiana encounters. This Business Analyst partners with technical resources and functional departments to meet all encounters reporting obligations.

Amerigroup currently meets DHH requirements as specified in the RFP and in the Bayou Health Prepaid Systems Companion Guide (version 4.3). We submit encounter data each week using Secure File Transfer Protocol (SFTP). We currently submit our pharmacy encounters in NCPDP format every Wednesday and our 837 files on Thursdays. During implementation, we will confirm with the Fiscal Intermediary that this schedule is acceptable.

Figure X.2-1 details the flow of the encounter process after the claim adjudication process.

Figure X.2-1. Amerigroup's Encounter Process is Designed to Deliver Timely, Accurate, and Complete Encounters to DHH



## Encounter Submission Timeliness

We will continue to meet or exceed the DHH requirements related to timely submission of encounter data. Amerigroup has submitted encounter data on time to DHH's Fiscal Intermediary since we submitted our first encounter file on April 5, 2012. We will maintain this high level of performance under the new Bayou Health Contract.

## Adherence to HIPAA and Use of Industry Standard Codes

Our systems currently conform to the standard transaction and code sets as documented in the HIPAA implementation and Louisiana Systems Companion Guides. Our HIPAA gateway verifies that the electronic files we receive are compliant with standard HIPAA transaction standards and code sets. We generate HIPAA-compliant files for transmission to DHH, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Model transaction for Professional (including professional, DME, and Transportation) and Institutional claims, and NCPDP D.0 for pharmacy claims.

## Encounter Data Completeness

Amerigroup currently submits a single 837P, a single 837I, and a single NCPDP encounter file to the DHH Fiscal Intermediary that contains all encounter data, according to DHH requirements, regardless of source of the claim or type of provider. We collect encounter data from our subcontractors and include it in our overall encounters submission. The encounter information we submit to DHH includes settled, adjusted, and voided claims. We have the staff and processes to address the repairable denials for resubmission according to DHH requirements and time frames.

## Encounter Data Accuracy

We use automated routines to extract data for transmission to DHH. Our EMS edits and processes all encounter records against DHH requirements. Business rules evaluate each claim or service line to verify the presence and validity of all required data elements. Without affecting the remaining records, we pend any claims that fail an edit. Records failing established edits are flagged by our Encounter Management System for our Encounters Management team to review and correct. Our system compiles encounter records that pass all edits into a HIPAA-compliant format prior to submission to DHH.

Prior to releasing the encounter files, the encounters team conducts an independent validation and reviews a random selection of records in each file for accuracy and completeness. Once it passes the validation review, we transmit the encounter file to the DHH Fiscal Intermediary. Amerigroup's Director of Finance attests to the truthfulness, accuracy, and completeness of encounter data submissions.

We understand the Fiscal Intermediary will continue to apply edits to the encounter submission to identify valid and invalid encounter records. If the DHH Fiscal Intermediary returns records to us for research and resolution, we act quickly to research and resolve encounter data issues. We currently comply with the requirement of correcting 90 percent of repairable errors in 30 calendar days and 99 percent of repairable errors in 60 calendar days or within a negotiated time frame approved by DHH.

Amerigroup makes an adjustment to an encounter when we discover the data is incorrect or no longer valid or there are other changes to the original claim. If DHH discovers errors or a conflict, Amerigroup adjusts or voids the encounter. Amerigroup will continue to collaborate with DHH to identify solutions to prevent or minimize the reason(s) for the error where possible.

## Encounter Data Submission Tracking

The encounter management team closely tracks, trends, and monitors the entire encounter process life cycle, from the creation of an encounter submission through the acceptance of encounter data by the

State's Fiscal Intermediary. Our system maintains comprehensive information on each encounter record in a submission batch that enables us to not only closely monitor the submission and revision process, but also to track trends over time that may identify issues or opportunities for improvement.

There are several checkpoints during the weekly process to create an encounter data submission. At each checkpoint, the encounter management team uses a series of internal reconciliation and certification reports to manage, monitor, and validate the integrity of the encounter data submission. If there are problems with individual encounter records, they are remediated prior to submission or pended and included in a future submission.

Amerigroup's process includes multiple checkpoints to confirm that we create and deliver complete and accurate encounter data to DHH. 

Daily encounter aging reports allow the team to remediate encounter records that were pended during the encounter submission process; employees work with operational departments to resolve issues. Remediated encounter records are included in the next weekly encounter data submission.

After loading each encounter response file from the DHH Fiscal Intermediary, the encounter management team reviews all rejections and works with necessary departments and subcontractors to remediate errors.

The encounter management team aggregates rejected encounters to identify trends, perform root cause analysis, and make changes to operational and system processes to increase the number of accepted encounter records. If analysis identifies a pattern of deficiencies for specific providers or subcontractors, we work with the appropriate business function to identify and resolve issues.

## Encounter Data to Payments Reconciliation

We create internal reconciliation and certification reports for each file to allow the encounter analyst to identify inconsistencies and shortfalls in the claim counts and dollars.

The Reconciliation Report displays the total claims and dollars available for submission for the reporting period and compares these totals to the total claims and dollars imported into the Encounter Management System. This report identifies any claims available for the reporting period not imported for encounter submission.

The Certification Report is a detailed report displaying the number of claims and dollars:

- For claims in the encounter processing system
- Submitted on the encounter files
- Held due to incomplete/inaccurate data to be reviewed and remediated for submission at a later date
- Excluded from submission based on State guidelines (for example, claims denied as duplicates); variations in numbers of claims or number of dollars are reviewed and analyzed, and necessary corrections are made to ensure encounter file accuracy; when necessary, program changes are made to enhance encounter processing and reporting

We recognize the need for strict controls regarding the receipt of information to make certain the data processed and maintained by our systems are valid and complete from inception. Clean data in our systems is the first step to delivering complete and accurate data to DHH. All incoming data are processed according to well-documented procedures and quality control processes. Receipt and processing status of all incoming electronic data files is logged and monitored to confirm complete processing of all transmissions. Systematic edits are applied to all data, regardless of source, to determine if the data are accurate, complete, and valid with respect to format and presence.

## X.3 Ability to Provide and Store Encounter Data

*X.3 Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide.*

After careful review of the RFP, specifically Section 17.8. Encounter Data and the Systems Companion Guide (August 2014; Version 4.4), ***we are confident in our ability to continue to meet and exceed the requirements to provide and store encounter data with our existing MIS, policies, and procedures.***

### Providing Encounter Data

Amerigroup has in place the infrastructure, experience, and past performance necessary to meet all encounter data gathering and reporting requirements in the RFP. With our extensive knowledge and experience with the 837I, 837P, and NCPDP, as well as the detailed information provided in the DHH Systems Companion Guide, Amerigroup is confident that we will be able to continue to submit accurate and complete encounter data to DHH under the Bayou Health Contract.

### Storing Encounter Data

Amerigroup retains encounter data submissions for a minimum of six years in our encounter management system. Storage of and access to historical encounter data in a manner that supports on-going processing, as well as reporting and auditing, are critical to effective operations. Amerigroup has policies and procedures in place that exceed DHH's requirements for historical data maintenance and access. Amerigroup's Encounter Management System serves as the system of record for information on encounters.

We store all electronic data and documents for no less than six years in our live systems. Amerigroup retains or archives all records that are part of our designated record set in accordance with State and federal laws and regulations. Our designated record set includes enrollment, payment, claims adjudication, and case or medical management records concerning a member, and other records used to make a treatment or payment decision about a member.

**Amerigroup will not require further system upgrades or enhancements for the continued support of the Bayou Health Program.** 

The business owners who create or handle paper records that are part of the designated record set are responsible for filing, maintaining, and retrieving the documents. According to our documented procedures, we archive paper documents according to a defined schedule and store them in an off-site storage facility. Our core operations system maintains an audit history of data updates, including time and source of change, and audit trail information for

no less than 10 years, online for no less than six years, and then available from archive. Archived audit trail information is available within DHH's 48-hour turnaround requirement. ***Our current systems and record retention processes support the requirements outlined in the RFP***, including all electronic information being available online for seven years and archived for 10 years. Services with an once-in-a-lifetime indicator are not archived or purged. We also prevent data from being archived until all tasks or proceedings are completed.

## X.4 Methodology for Meeting Claims Payment Accuracy Standards

*X.4 Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response:*

- *The process for auditing a sample of claims as described in Section 17.5 Sampling of Paid Claims;*
- *Documentation of the results of these audits; and*

*The processes for implementing any necessary corrective actions resulting from the audit.*

Amerigroup’s claims processing practices are based on comprehensive policies and procedures that guide our professional audit staff as they monitor and audit claims to verify timeliness, accuracy, and integrity and evaluate claims processing for financial, payment, and statistical accuracy. We maintain an internal audit function independent of claims management. In the paragraphs below, we describe our process for sampling paid claims in accordance with the requirements in Section 17.5 of the RFP and our claims auditing process to verify claims payment accuracy.

### Sampling of Paid Claims

Amerigroup currently meets federal and DHH requirements for a monthly member sample process to verify delivery of services. Amerigroup considers this sampling process to be a valuable tool for verifying claim payment accuracy and identifying possible fraud and/or abuse.

The sampling of paid claims requires that we send an explanation of benefits notice to a sampling of members with one or more claims paid the previous month. The Louisiana Member Verification of Services process, also known as REOMB (Recipient Explanation of Medical Benefits), requests that members who receive the notice report to the MCO if the paid services listed on the notice were not received. The notice is delivered by mail.

In satisfying this requirement, Amerigroup identifies the population of members from which the random sample will be chosen. The overall population is identified as those members who have had one or more paid claim for services within 45 days (based on the Date of Payment) of the date the sample is developed. The sample is also stratified to include proportionate representation of provider types. A claim with only hospital, lab, or pathology services is not included in the sample. Claims with specified “sensitive services,” identified by diagnosis codes and/or procedure codes as defined by DHH, are also excluded from the sample population due to member confidentiality concerns. We apply a random process to the final sample to select members for the monthly sample. The selected sample is at least two percent of the monthly paid claim volume.

We produce letters for the selected sample population. The letter meets the 6<sup>th</sup> grade reading level, as required by DHH, and contains a description of the services rendered, the name of the rendering provider, the date of service of the claim, and the amount paid. The letter asks the member to call the member call center if the member denies knowledge that the services were rendered. It also explains that no further action is needed on the member’s part if the member agrees that the services listed were provided.

To maintain a high level of claims payment accuracy, Amerigroup:

- Sends EOBs to a sample of members.
- Conducts an end-to-end audit of 51 Louisiana claims each week.
- Performs additional audits for specific situations. 🌸

If a member identifies services listed that were not delivered, Amerigroup will, within three days of notification by the member, refer the information to the Medicaid Special Investigation Unit (MSIU), as well as to DHH. Amerigroup will review the identified issues to determine if changes need to be addressed in a wider scope.

Amerigroup will report the number of letters sent, the number of letters sent back or member calls with issues, the total number of claims included in the sample, and the number of members/claims referred to DHH for further review.

## Additional Claim Payment Accuracy Processes

In addition to the sampling of paid claims discussed above, Amerigroup's claims processing practices guide our professional audit staff in monitoring and auditing claims to verify timeliness, accuracy, and integrity and to evaluate the financial, payment, and statistical accuracy of our claims processing system. In July 2014, the Claims Processing Accuracy Rate was 99.61 percent; the Financial Accuracy rate was 99.90 percent. Our claims auditing function is independent of claims management and reports directly to the Staff Vice President of Business Solutions. To measure our overall performance on claims accurately, we audit a random sample of 51 Louisiana claims each week. In addition, we perform specialized audits, including the following:

In July 2014, Louisiana  
Claim Process Accuracy was  
**99.9 percent.** 

- **High-dollar audits**—Daily pre-payment audits of all high-dollar claims where the payment amount or the denied claims amount is over specific dollar thresholds
- **Individual focus audits**—Weekly audits on claims from each claims analyst and daily audits of claims during the new-hire training period to determine processing accuracy
- **Focus audits**—Targeted audits on specific claim types, or surrounding processes, to measure performance and remediate claims issues
- **Post-implementation audits on new markets/expansions**—Targeted audits on new or expanded markets to ensure accuracy

Our audit process includes a thorough end-to-end review (from receipt to final disposition) to verify our compliance with all federal, State, and internal requirements and any specifics in the provider contracts. If errors are found, the audit is not closed until the claim is corrected and the correction is validated by the auditor. We work to determine root cause of errors so we can prevent future instances.

## Documentation of Audit Results

We record all audit results, including error sourcing, and attribute testing results in our Auditing Tool, with the exception of some focus audits that may be performed externally. The Auditing Tool allows us to produce internal and external reports and ad hoc requests. Monthly dashboards present current, quarterly, and year-to-date performance to share with executive leadership and all internal areas involved in the claims process. We track error data over time to identify trends and ensure consistent performance. We conduct trend analyses by market as well as by broad and sub-error category.

To maintain the quality of the audit data, auditors present all identified errors to leadership for review. If there is a disagreement between the source department and auditor(s), we follow a formal escalation process. We also have a separate group of senior auditors who “audit the auditors.” In addition, we evaluate all auditors quarterly based on key claim processes in a Measurement System Analysis. In this process, auditors review selected claims, and results are compared against the expert. This process identifies learning opportunities for our auditors and sharing of knowledge.

Amerigroup employs both immediate error mitigation and root cause analysis to prevent future occurrences. When possible, we correct identified errors prior to closing the audit. Each error is assigned to a source department that has responsibility for remediating the issue. Auditors work with the source departments to correct each identified audit issue.

We will continue to provide our results to DHH on a monthly basis by submitting the required Claims Payment Accuracy Report.

### **Additional Resources to Improve Claims Quality**

Our national Claims Quality Steering Committee includes senior leadership from operational areas and meets monthly to review audit errors, discuss the root causes, and create action plans to address deficiencies. Based on our audit findings, we develop policy changes or edits to our claims processing system to mitigate future problems and improve our claims payment accuracy. All corrective actions identified by the Steering Committee are logged and tracked through completion in the action item log.

We maintain a dedicated national Quality Process Improvement team that works on large projects to improve claims payment accuracy, increase auto adjudication rates, and bring efficiencies to our internal processes. This team follows an established project methodology through five phases: initiation, planning, execution, control, and close. It also employs Six Sigma methodology when warranted.

Monthly Quality Framework meetings provide an opportunity to review manual claims audit data and create action plans to prevent future errors. Led by Regional Operations Experts, the meetings bring together the Director of Performance Enhancement, Process Improvement Business Analysts, and Claims Quality Managers. All actions initiated through these meetings are tracked by the Quality Process Improvement team.

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