

SECTION L: CUSTOMER SERVICE

L.1 Provide a narrative with details regarding your member services line including:

- o Training of customer service staff (both initial and ongoing);*
- o Process for routing calls to appropriate persons, including escalation; the type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);*
- o Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;*
- o Monitoring process for ensuring the quality and accuracy of information provided to members;*
- o Monitoring process for ensuring adherence to performance standards;*
- o How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g. Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and*
- o After hours procedures.*

Responsive and Efficient Customer Service Empowers Members and Facilitates Access to Care

Amerigroup offers centralized member call center service through our state-of-the-art Member Call Center. The call center delivers personalized services to members that are efficient and cost effective by leveraging advanced technologies for economies of scale. In 2010, we answered more than 2.2 million Live Agent member calls across all of our health plans with a call abandonment rate of only 3 percent.

We serve members through our Call Center Representatives located in our call centers in Tampa, FL, Nashville, TN, and Virginia Beach, VA. Our telephony technology gives us the ability to flow calls among our three call centers as necessary, creating one virtual call center. Such capability allows us to be nimble in responding to spikes in call volume – such as during implementation phases – or business interruption due to a natural disaster at any one location. For instance, in the event of a natural disaster or overflow of calls, we can route the calls to different sites to serve members. We believe this design offers the best value to our members and our customers.

Our organization provides **comprehensive, personalized customer service** with Call Center Representatives successfully handling on average 16,500 calls from members, physicians, and other providers in addition to 5,000 self-service voice portal calls on a daily basis.

Members who call the toll-free member hotline are able to select assistance from a menu of options that direct calls to Call Center Representatives or points of self-service, depending upon the members' needs. Our Member Call Center offers:

- A single point of contact for members to simplify service
- Clinical assistance through the *Nurse HelpLine*, an added value to Louisiana members

We provide 24 hours a day, seven days a week access to our *Nurse Helpline*.

- 24 hour a day, seven days a week (24/7) automated self-service for enrollment status, changing address and phone number, selecting and changing PCP, requesting an ID card and ordering member handbook/provider directory
- Telephone menus in both English and Spanish
- Staff, including bilingual Call Center Representatives, specifically trained to serve members



Nurse HelpLine. As an added value benefit, with DHH approval we will provide 24/7 access to our *Nurse HelpLine*. While callers with emergent needs are directed to hang up and dial 911, callers with an immediate but non-emergent need are connected with our *Nurse HelpLine*. A Nurse HelpLine registered nurse, guided by sophisticated decision tree software, assesses the caller's needs and provides recommendations for seeking treatment, which may include self-care, an appointment with the caller's PCP, immediate referral to the emergency room, or on-demand access to a physician – all based on the nature and severity of the symptoms. We promote our *Nurse HelpLine* through mail and telephone outreach campaigns and we also use a variety of methods to communicate the services of the Nurse HelpLine to our members and parents/guardians, including:

- Telephonic outreach by Service Coordinators/Social Workers
- Member handbook
- Member mailings through newsletters and letters
- Reminders including refrigerator magnets
- Automated communication messages for callers using our toll-free telephone number

E-Inquiries Enhance Member Convenience. Recognizing the ever-increasing role of the computer in our daily lives, Amerigroup also allows members to ask questions via our secure member portal and web site at www.myamerigroup.com. Immediately upon the successful submission, the member receives confirmation of their request. Responses are provided within two business days of receipt.

Beneficiary Rights Ombudsman Serves Concerned Members. Amerigroup also maintains a 24/7 Beneficiary Rights Ombudsman line that can be used by members and prospective members to report comments, concerns, or complaints in all states where Amerigroup operates health plans. Amerigroup has appointed a Beneficiary Rights Ombudsman who is responsible for accepting, recording, remedying, and responding to reports.

REAL SOLUTIONS *mean*
REAL RESULTS

**Continuously Driving Service
Improvements**

As a testament to service, Amerigroup was recently awarded the prestigious Benchmark Portal certification, distinguishing it as a "Certified Center of Excellence," having met or surpassed rigorous standards of efficiency and effectiveness. The certification is based upon best-practice metrics drawn from the world's largest database of call center information, maintained by researchers from Benchmark Portal and the Center for Customer-Driven Quality at Purdue University.

Amerigroup Provides Comprehensive Initial and Ongoing Training of Customer Service Staff

Amerigroup offers an extensive 43-day training process that includes program curriculum on Louisiana CCN. As we do today for all of our members across 11 states, Amerigroup will maintain a well-trained, experienced staff to serve Louisiana members. Call Center Representatives I are required to have two years of experience in customer service and/or call center environment. Call Center Representatives II are required to have four years of customer service and/or call center experience. We strive to provide the highest quality of service to every member and maintain a comprehensive training program that equips our Call Center Representatives with the appropriate knowledge and tools to achieve that goal.

As an indicator of the effectiveness of our training process, **our 2010 member services average quality audit score was 96.5 percent.** The quality audits, conducted by Quality Assurance Analysts on a regular basis, evaluate Representatives' performance on multiple areas related to program knowledge and a service-oriented approach to call handling. In addition to a one-day orientation for all new hires, in which Representatives are oriented to the organization, HIPAA privacy compliance requirements, and customer and membership base, Representatives participate in an extensive 18-day training before they begin answering live calls from members.

The full training continues for a total of 43 days and is divided into segments when a Representative will learn certain processes and then apply those for a short period of time. They then go back into the classroom and learn additional skills that build on what was learned in the first section. The full 43-day training is divided into classroom, monitoring, on the job training (OJT), then more classroom, performance monitoring, and OJT, as detailed in Table L-1. Learning the information in small segments and then applying it before moving on has shown the best results.

This training is conducted in a controlled environment with supervision and coaching, followed by an evaluation period. Our training curriculum, developed with our Organizational Development experts, builds the skills necessary to deliver knowledgeable, accessible and respectful assistance and services to members of all cultures and abilities. During training, we simulate calls so that Representatives can hone their skills in providing members with the appropriate Louisiana CCN program information and benefits.

Table L-1. Comprehensive Staff Training Offered to Maintain Skills

Topic	Training Description
Systems Training	We introduce Call Center Representative to the computer-based programs used to assist our members. All Representatives undergo extensive training on our core operations system. Training includes instruction on verifying member enrollment, changing a PCP, and accurately recording all member transactions in the contact log.
Call Monitoring	Representatives participate in call monitoring, a controlled classroom exercise in which Representatives listen to live calls and see the systems in use. Representatives discuss each call and learn techniques to address member’s needs.
On-the-Job Training	Call Center Representative remain in the controlled classroom setting and handle live calls under close supervision from an experienced staff member. We provide an assessment exam after each training session to assess the Representative’s understanding of our process and procedures. For example, when we train our Representatives to perform a PCP change for a member, the Representative must successfully pass the assessment to verify that he or she can perform the change according to state-specific and internal standards. Once the Representative successfully masters all required skills, we integrate them into the Call Center work team. We continue monitoring activities using call evaluation software. We use audio recordings and video screen shots as Representatives work through member calls.
Ongoing Training	After Call Center Representative receive their initial 90-day training and begin taking member calls, they benefit from ongoing training initiatives to verify their skills remain fresh and they are continually engaged in personal development. For example, when we introduce a new product or system, we make certain that each Representative has a full understanding of the product through one-on-one and/or classroom training.

Cultural Competency is an Essential Element to Effective Member Engagement. Recognizing and being sensitive to the cultural needs of diverse populations demands that cultural competency be a strength of our Call Center Representatives and Amerigroup’s cultural competency training plan fully supports this effort. All employees must complete this training – and must pass an exam at the end of the course – to demonstrate their understanding that the provision of services to people of all cultures, races, ethnic backgrounds, abilities and religions must be completed in a manner that **recognizes, values, affirms and respects the worth and protects and preserves the dignity of each member.** Our training curriculum includes definitions, benefits of cultural competency, government regulations, values, language resources and variations in social comfort factors. Amerigroup policies and procedures fully support all 14 federal culturally and linguistically appropriate guidelines regarding cultural issues, languages and readability.

Customized Service for Louisiana CCN Members. Amerigroup Louisiana members will be served primarily by a designated team of Call Center Representatives who will be **trained specifically on the Louisiana CCN program.** Callers to the toll-free number choose from a menu to access self-service options or to talk directly with a Call Center Representative.

- **Designated and Specially Trained Representatives.** The member call center identifies a Louisiana CCN member via automatic number identification which identifies the area code from which the person is calling or by members verifying their address in our Voice Portal. If the area code is a Louisiana area code OR if the caller authenticates in our Voice Portal, the Automated Call Distribution system, will route the call to a Representative who has received training on Louisiana CCN program. If the member is calling from a number with an area code outside of Louisiana OR if they do not authenticate in the Voice Portal, they are routed to a Representative who handles inquiries for all states. Additionally, our Representatives

receive daily announcements, via our knowledge management system, regarding changes to programs, requirements, or processes. If the changes are determined to be of a complex nature, then we make a determination to enhance those announcements with supervisor reinforcement via team meetings, computer-based training modules, or actual classroom training.

Efficient Routing Technology Allows for Timely Member Response

We ensure timely and accurate responses to member inquiries and will meet DHH performance standards by using call routing technology that recognizes the area code of the caller and routes members to a Call Center Representative using Voice Portal prompts, available in both English and Spanish. Voice Portal technology enables us to quickly identify a caller's need and rapidly direct him or her to the most appropriate resources, including the Behavioral Health Hotline and the *Nurse HelpLine*. Members reach a Representative with a minimum of prompts. Based on the member's selection, our automated call distribution (ACD) system routes the call to a Representative who is most appropriate; for example, one with particular expertise in EPSDT benefits. The Representative then assists the member with the member's question or concern.

Voice Portal Options (English and Spanish)

- Check eligibility status
- Request a new ID card
- Order a member handbook or provider directory

Powerful Integrated Desktop Efficiently Accesses Member Data. Amerigroup recently implemented a powerful new customer service system that helps our Representatives to more efficiently handle member inquiries and requests. This new customer service system integrates information from multiple back-end systems onto a single screen view for our Call Center Representatives. **The integrated desktop speedily accesses and displays data related to benefits, service utilization, enrollment, authorizations, and other health insurance coverage, tailored to the members' programs and Geographic Service Areas.** When a member calls in, for example to request a new ID card, inquire about a benefit or add a new baby to the plan, the integrated desktop eliminates the need for our Representatives to spend time flipping between screens – while the member is waiting – in search of information during the service call.

Powerful desktop technology *reduces* average member call time by 30 seconds.

The integrated desktop displays necessary information for our Representatives in an organized and simplified fashion, according to the business rules of the specific market and product. These pre-programmed rules guide our Representatives to enhanced efficiency in servicing our member's requests, while the integrated desktop system captures detailed call documentation. When a Representative is unable to resolve an inquiry during the first call, the issue is immediately routed to the appropriate business area for resolution – with issue status available to all viewers.

Since we've begun using this system in February 2010, call handling times have consistently been reduced, on average by 30 seconds. Significantly, our new system's efficiency and ability to both access and process data across multiple back-end systems has reduced the average call time for a member to add a new baby to the plan from eight minutes to three minutes—an impressive five minute reduction.

While Amerigroup never rushes callers or places a maximum time limit on member calls, the system optimizes the use of the time we do spend to promote single-call resolution.

Handling Calls from Members with Limited English Proficiency and Persons Who Are Hearing Impaired

Services for members with limited English proficiency. Amerigroup Call Center Representatives (Representatives) include employees who reflect the cultural and linguistic backgrounds of our members. All other interpretive services are provided by professional over-the-phone interpreters (OPI) service vendors, the TDD line for the hearing impaired or locally contracted interpreter service vendors. The cost of providing these services is paid by Amerigroup.

When a member who does not speak either English or Spanish calls Amerigroup, the Representative places the member on “hold” and calls the appropriate OPI services vendor. Generally, within an estimated 45 seconds, an interpreter, member and Representative are connected in a three-way conversation.

Services for Members with Hearing and/or Language Disabilities. A separate toll-free number provides Telecommunication Devices for the Deaf/Teletypewriter Technology (TDD/TTY) access for members with hearing loss and/or language disabilities via AT&T Relay Services. The member calls the TDD line and the TDD Operator places a call to Amerigroup. The TDD Operator communicates the member’s message to a Call Center Representative. The Representative then replies to the member through the TDD Operator.

Callers with hearing disabilities can also communicate with Amerigroup using technology that allows them to conduct video relay conversations through **a qualified sign language interpreter.**



The member actually sees the Amerigroup representative and a sign language interpreter on his or her television screen and is able to visualize their facial expressions, a subtle but important factor in connecting with members.

To further assist members and potential members in understanding the requirements and benefits of their Plan and to meet their customer service needs, Amerigroup will also provide:

- Written member communications in English, Spanish and Vietnamese:
- The member handbook available on tape or in large print or Braille for members who are vision impaired
- A provider directory with a listing of the languages spoken by Primary Care Providers (PCPs) and OB/GYN providers
- The member handbook with information to members regarding ways to access various linguistic services
- Written materials to prospective and current members in a manner and format that are designed to be easily understood

Monitoring Process for Ensuring the Quality and Accuracy of Information Provided to Members

Amerigroup monitors and evaluates the quality of service and accuracy of information delivered to customers through the use of call monitoring and documentation reviews of Call Center Representatives. All callers will hear a message informing them that their calls may be monitored for quality control purposes. Call monitoring may include, but is not limited to, the following:

- Silent monitoring
- Recorded calls
- Side-by-side monitoring

Quality Assurance (QA) Analysts primarily perform call monitoring randomly throughout the month. Quality evaluation results for associates completing new hire training are utilized as coaching opportunities during the first two months on the phones. The quality audit evaluates Representatives performance on multiple areas related to program knowledge and a services-oriented approach to call handling. Aggregate and individual performance information is tabulated and available monthly for the call center management team. **Our 2010 member services average quality audit scores was 96.5 percent.**

Using Member Satisfaction Data to Drive Service Improvements. Amerigroup recognizes the importance of listening to our members and their families as part of a quality member services program. To this end, we regularly complete member satisfaction studies across our health plans, gathering feedback on such areas as:

- Satisfaction with Member Services
- Staff courteousness
- Ease of accessing care
- Satisfaction with the number of providers available
- Amerigroup's ability to provide physicians who work well with members and their families

The data gathered from these surveys become an integral component of our Member Services continuous quality improvement program. The results provide us with valuable benchmark information and point us to those areas that we can focus on for improvement. We will continue to reach out to our members for their feedback and use the information they provide to further improve our programs.

Monitoring Process for Ensuring Adherence to Performance Standards

Managing Performance Standards. Amerigroup utilizes multiple call status reports, at a variety of frequencies -- ranging from every 15 minutes to quarterly -- that detail our compliance with performance standards. Our reports show trends for call volume, average speed of answer and abandonment rate. We evaluate existing processes for our call center and make necessary adjustments to meet all service levels and requirements to improve the quality of service offered by our Representatives.

We maintain operating protocols that promote consistent achievement of our service standards, including real-time monitoring of our call handling performance. Our Workforce Management team conducts real-time monitoring of the call center's telephony metrics using a variety of technology tools and custom reports. When call volume increases beyond the capacity of our scheduled Representatives, we expand the call answering queue to include designated back-up Representatives who may be located in any of our three call centers. This approach enables us to optimize staff efficiency while capably meeting all performance standards. Additionally, our workload balancing application helps to ensure that our scheduled staff can meet the forecasted needs.

Interacting with Other Customer Service Resources to Connect Members to Additional Resources

In addition to providing information about Amerigroup benefits and resources, our Call Center Representatives are equipped to provide referrals to other health and social service agencies that are commonly accessed by members in their local communities. If a member calls requesting information for services outside of the Amerigroup Louisiana benefit plan, our Louisiana CCN-trained Representatives have the ability to reference a listing of community-based service organizations and other state, parish, and city agencies and will provide the phone number to members as requested. The listing of these agencies and service organizations, developed in coordination with DHH, is also provided in the member handbook. Amerigroup is willing to collaborate with DHH regarding options for assuring the Call Center successfully connects members to resources in their community.

After Hours Procedures

Amerigroup recognizes the importance of being available to members after normal business hours. Call Center Representatives play a critical role in linking our members to appropriate health care and covered services and are available from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday. In addition, we also assist members 24 hours a day, seven days a week (24/7) including holidays via our *Nurse HelpLine* service and our self-service Voice Portal (VP) system. Members can access our voice-controlled automated system available in English and Spanish.



Our *Nurse HelpLine* staff provides medical and behavioral health advice based upon approved protocols to guide callers to the most appropriate after-hours health service (such as emergency room or urgent care center) or to recommend self-care at home for non-urgent conditions. They can also provide answers to caller's medical or behavioral health questions. Additionally, callers may leave a message in our voice mailbox. All members who leave a message will receive a return call from a Call Center Representative by the close of the next business day.

Innovative Solution

Amerigroup On Call. Amerigroup offers members a suite of programs, as shown in Figure L-1, including access to our 24/7 *Nurse HelpLine*, to ensure member access to care for many non-emergency medical issues. Amerigroup On Call is a comprehensive strategy for delivering non-emergent care in alternate settings. The foundation of the program is an innovative urgent care services network, including PCPs who have extended hours, urgent care centers, limited services clinics and physician telephonic consults which broaden member access to ER alternatives, especially after hours.

Figure L-1. Components of Amerigroup On Call



In our Maryland pilot, during its first year of operation the Amerigroup On Call program achieved a **27 percent reduction in Emergency Room (ER) visits by facilitating timely access to alternatives.**

With the addition of Teladoc, our *Nurse HelpLine* extends the referral options available to members with on-demand access to a physician when a nurse determines that a Member’s health issue can be treated by Teladoc. Teladoc physicians are board-certified, U.S.-based physicians who are licensed in the states in which they operate. During the call, the physician conducts a brief assessment and provides recommendations and guidance, including issuing prescriptions such as antibiotics when indicated.

Members may also access web-based self-service tools after hours, for example, search for providers, request a new ID card or view a member handbook. Members may use the website to obtain eligibility, benefit and PCP information; health and condition-specific educational materials; and information on local health promotion events. The site provides easy access to an array of relevant information. Also, our website technical support team is available to assist members with any issues communicated via our website.

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L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.

The member call center uses various reporting measures to ensure telephone statistics meet national benchmarks, individual state Medicaid contract requirements and Amerigroup’s internal guidelines. The Automated Call Distribution and Service Level reports are downloaded on a daily, weekly, monthly and quarterly basis from Avaya CMS and the contact management system. Results are distributed daily, weekly, monthly and quarterly to NCC management, including supervisor and above. They are also provided to the Quality Improvement Committee (QIC) and Senior Managers.

The Member Hotline Status Report for the December 2010 through February 2011 quarter, for our Medicaid and CHIP managed care contract with the largest enrollment is provided below. This report, along with the additional three quarters requested is provided as Attachment L.2.a.

Table L-2. Member Hotline Performance Measures December 2010 through February 2011

Total Number of Calls Received	Month 1 36,312	Month 2 34,192	Month 3 31,432	Quarter Total 101,936	MCO Performance
Answered Calls	34,686	33,905	31,188	99,779	97.88%
Calls Answered by 4th Ring Performance Standard: 99%	34,362	33,905	31,188	99,455	99.68%
Busy Signal Call Rate Performance Standard 1% or less	1	7	1	9	0.01%
Answered Calls by Live Person Performance Standard: 80% within 30 seconds	31,277	30,200	27,944	89,421	89.62%
Number of Abandoned Calls Performance Standard: 7% or less	1,626	287	244	2,157	2.12%
Average Hold Time Performance Standard: 2 minutes or less	13.7 seconds	15.7 seconds	14.8 seconds	15 seconds	0:00:15

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Member Hotline Status Report

MCO	Amerigroup Texas, Inc.
Subcontractor: (if applicable)	
Quarter	2
Fiscal Year	2011

	Month 1	Month 2	Month 3	Quarter Total	MCO Performance
Total Number of Calls Received	36312	34192	31432	101936	
Answered Calls	34686	33905	31188	99779	97.88%
Calls Answered by 4th ring Performance Standard: 99%	34362	33905	31188	99455	99.68%
Busy Signal Call Rate Performance Standard: 1% or less	1	7	1	9	0.01%
Answered Calls by Live Person Performance Standard: 80% within 30 seconds	31277	30200	27944	89421	89.62%
Number of Abandoned Calls Performance Standard: 7% or less	1626	287	244	2157	2.12%
Average Hold Time Performance Standard: 2 minutes or less	13.71250649	15.67515116	14.81807105	15	0:00:15

Member Hotline Status Report

MCO	Amerigroup Texas, Inc.
Subcontractor: (if applicable)	
Quarter	1
Fiscal Year	2011

Total Number of Calls Received	Month 1	Month 2	Month 3	Quarter Total	MCO Performance
	42545	32119	27853	102517	
Answered Calls	41748	31393	26923	100064	97.61%
Calls Answered by 4th ring Performance Standard: 99%	41135	31393	26923	99451	99.39%
Busy Signal Call Rate Performance Standard: 1% or less	0	1	2	3	0.00%
Answered Calls by Live Person Performance Standard: 80% within 30 seconds	37773	27083	24527	89383	89.33%
Number of Abandoned Calls Performance Standard: 7% or less	797	726	930	2453	2.39%
Average Hold Time Performance Standard: 2 minutes or less	13.34372904	18.19058389	13.10344315	15	0:00:15

Member Hotline Status Report

MCO	Amerigroup Texas, Inc.
Subcontractor: (if applicable)	
Quarter	4
Fiscal Year	2010

Total Number of Calls Received	Month 1	Month 2	Month 3	Quarter Total	MCO Performance
		37077	30908	33023	
<u>Answered Calls</u>	36166	30254	32211	98631	97.65%
<u>Calls Answered by 4th ring</u> <u>Performance Standard: 99%</u>	36166	30254	32211	98631	100.00%
<u>Busy Signal Call Rate</u> <u>Performance Standard: 1% or less</u>	516	63	28	607	0.60%
<u>Answered Calls by Live Person</u> <u>Performance Standard: 80% within 30 seconds</u>	33070	28031	28525	89626	90.87%
<u>Number of Abandoned Calls</u> <u>Performance Standard: 7% or less</u>	911	654	812	2377	2.35%
<u>Average Hold Time</u> <u>Performance Standard: 2 minutes or less</u>	12.37916828	9.631354532	17.36931483	13	0:00:13

Member Hotline Status Report

MCO	Amerigroup Texas, Inc.
Subcontractor: (if applicable)	
Quarter	3
Fiscal Year	2010

Total Number of Calls Received	Month 1	Month 2	Month 3	Quarter Total	MCO Performance
		41306	34442	31160	106908
Answered Calls	40663	33851	30375	104889	98.11%
Calls Answered by 4th ring Performance Standard: 99%	40663	33851	30375	104889	100.00%
Busy Signal Call Rate Performance Standard: 1% or less	546	70	661	1277	1.19%
Answered Calls by Live Person Performance Standard: 80% within 30 seconds	38024	31043	27774	96841	92.33%
Number of Abandoned Calls Performance Standard: 7% or less	643	591	785	2019	1.89%
Average Hold Time Performance Standard: 2 minutes or less	7.712318324	11.11600839	11.37520988	10	0:00:10

L.3 Describe the procedures a Member Services representative will follow to respond to the following situations:

- o A member has received a bill for payment of covered services from a network provider or out-of-network provider;*
- o A member is unable to reach her PCP after normal business hours;*
- o A member is having difficulty scheduling an appointment for preventive care with her PCP; and*
- o A member becomes ill while traveling outside of the GSA.*

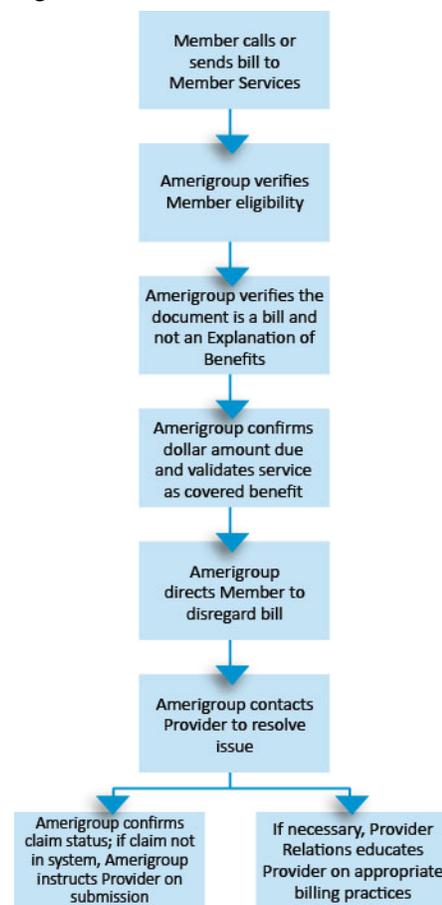
Responding to a Member Who Has Received a Bill for Payment of Covered Services from a Provider

Any member who receives a bill for payment for services from a network or out-of-network provider should call or send the bill to Member Services for assistance. If the member calls the member call center, the Call Center Representative confirms the member’s identity in accordance with privacy regulations and verifies eligibility on the date(s) of service.

Next, the Representative instructs the caller to look at the document and verify that the document is in fact a bill rather than an Explanation of Benefits and, if a bill, confirm if there is a dollar amount due. If so, the Representative validates if the service is a covered benefit. If the service is a covered benefit, the Representative reassures the member that Amerigroup will resolve the matter and verifies that they are not legally bound to pay the bill.

The Representative then contacts the source of the bill, usually a provider’s office or an agency and educates them about acceptable billing practices. If, after checking the system, the Representative confirms that Amerigroup has already received the claim and it is being processed, he or she will communicate the claim status and suggest that the provider check further status updates through our online tools or through the Voice Portal. If it appears that the provider has not yet submitted the claim to Amerigroup, he or she will instruct the provider to send it for adjudication. Our Provider Relations Representatives continue to educate providers on prohibited practices and continuously monitor their activity.

Figure L-2. Scenario One Flowchart

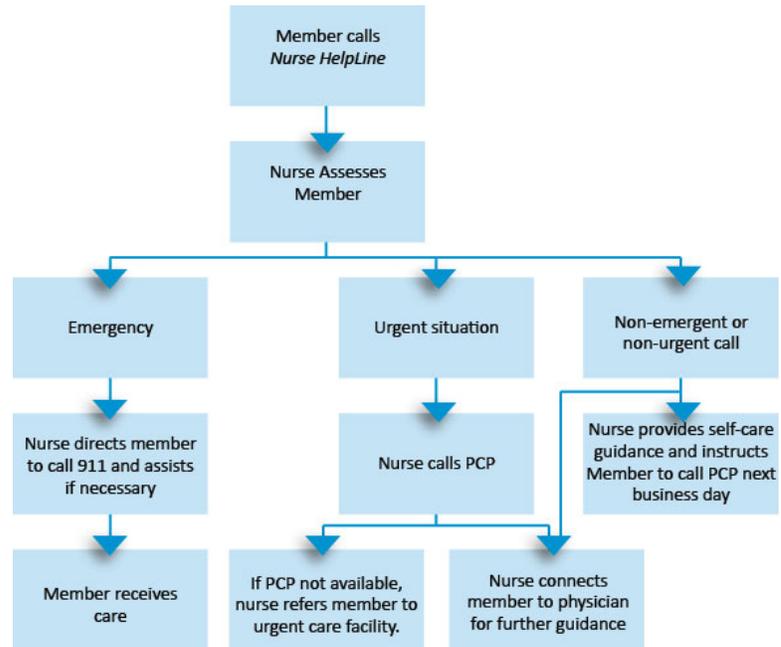


Responding to a Member Who Is Unable to Reach Her PCP after Normal Business Hours

If a member is unable to reach a PCP after normal business hours, our *Nurse HelpLine* is available 24/7 to assist. Our member handbook instructs members who cannot reach their PCP after hours to call the toll-free *Nurse HelpLine*. Upon calling the Member Call Center and selecting the *Nurse HelpLine* option, the member is connected with a Registered Nurse.

The nurse, using structured online clinical tools, briefly performs an assessment (including the presenting problem, symptoms and history). With that information, he or she applies evidence-based criteria to determine the most appropriate next steps. In an emergency, the nurse directs the member to call 911 or assists the member if he or she is unable to dial the number. If the situation is urgent, the nurse calls the PCP’s office for assistance. If the PCP is not available, the nurse directs the member to an urgent care facility and assists the caller in locating one nearby. For calls that are not emergent or urgent, the nurse assists the caller with self-care options and instructs the member to call their PCP the next business day. For calls that are not an emergency, the nurse may also connect a member directly to a physician for guidance. The nurse then documents the call.

Figure L-3. Scenario Two Flowchart

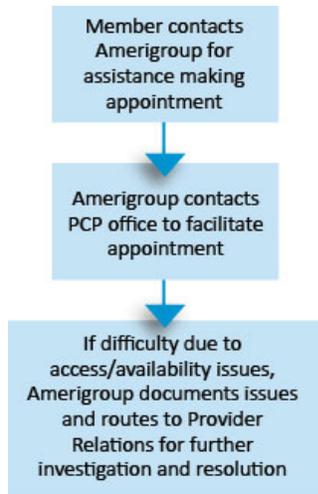


Amerigroup PCPs must provide coverage 24/7 to assist members with urgent needs after-hours. If the member indicates to the *Nurse HelpLine* that he or she first called their PCP but did not receive a return call from their PCP within 30 minutes, the nurse documents the details of the complaint and forwards it to Amerigroup Quality Management (QM) for follow up. After logging the complaint, the QM staff will route the call to Provider Relations to investigate and, if necessary, educate the provider’s office about the need to provide 24/7 coverage. Continually, our Quality Management staff tracks trends; reporting to the Provider Relations Representative all providers with three or more complaints. As part of our quality and monitoring process, we incorporate provider complaint data into our re-credentialing process.

Responding to a Member Who Is Having Difficulty Scheduling a Preventive Care Appointment

Prompt access to preventive care is vital to improving overall health care quality. In keeping with the DHH commitment to establishing a patient centered medical home, Amerigroup will use the welcome call to verify a PCP assignment has been made and encourage all members to make an appointment with their PCP before care is needed for an illness or condition.

Figure L-4. Scenario Three Flowchart



Amerigroup maintains and monitors appointment standards to promote the availability of preventive health services within six weeks of requests for adults and in accordance with the American Academy of Pediatrics periodicity schedule for children. Further, Amerigroup will comply with the requirements for coverage of preventive health services as reflected in the Patient Protection and Affordable Care Act.

A member who is having difficulty scheduling an appointment for any reason is encouraged to contact the member call center, as directed by our member handbook. Our Call Center Representatives work with each caller to identify and address the causes. If the member simply needs help making the appointment, the Representative will call the PCP office, with the member on the line, to facilitate scheduling an appointment. If the difficulty lies in appointment access or availability, in addition to facilitating an appointment, the Representative documents the issue and electronically routes it to the Provider Relations team for investigation and resolution. As with the other scenarios, cases in which the provider is not meeting his or her contractual obligations

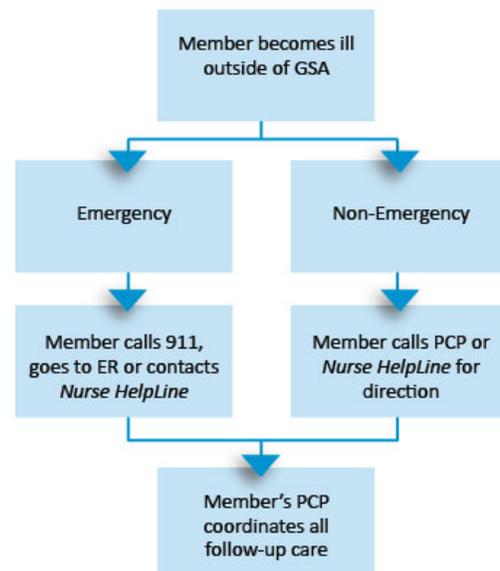
will be resolved by the Provider Relations team.

Responding to a Member Who Becomes Ill While Traveling Outside of the GSA

Amerigroup’s member handbook includes clear instructions for members who become ill while outside of the Geographical Service Area (GSA). If a member needs emergency care, he or she may go directly to the nearest hospital emergency room or call 911. If the need is not emergent, members call their PCP, who is available 24/7 and provides direction for members with urgent health care needs. The PCP will listen to the member’s description of his or her symptoms and determine what care the member needs while they are out of the area.

Members may also call our *Nurse HelpLine* 24/7, and a nurse will assess the caller’s symptoms and assist in determining the most appropriate course of action, including referral to an emergency room, urgent care facility or self-care, until the individual returns home. In all

Figure L-5. Scenario Four Flowchart



cases, the member's PCP coordinates all follow-up care once they are back in the GSA.

When a member has such an emergency, there is no need for the member or provider to contact us before receiving or providing treatment. While we will not deny claims based on failure to receive notification of ER services, we encourage the member or provider to contact us within 24 hours of treatment so we can begin service management and facilitate authorizations for ongoing care or transfers to network providers. When a provider outside the Geographical Service Area (GSA) requests authorization, we help the provider apply for a Provider Identification number, as appropriate. After the member has received the necessary care, the Case Manager contacts the member and notifies the participating PCP of the care provided and the need for any ongoing or follow-up treatment or services.

L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Culturally and Linguistically Appropriate Services

We design services to meet the cultural, linguistic, and special needs of our membership. As a result, we retain existing members and help potential members feel valued, understood, and appreciated.

Amerigroup recognizes that Louisiana residents represent a wide array of cultural backgrounds. With a growing Hispanic/Latino community and established Vietnamese community, we know that proactively embracing and honoring these differences is vital to successfully serving members' health care needs. Additionally, providing access to persons with special needs - such as our video relay line for the hearing impaired - is essential to our goal of providing comprehensive customer service to our members. Paramount to everything we do is respecting the privacy and dignity of the member.

Cultural Competency. At Amerigroup, cultural competency is a leadership principle and an integral part of our tradition. Our cultural competency practices are based on the 14 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the U.S. Department of Health and Human Services' Office of Minority Health. Amerigroup policies and procedures fully support the national CLAS standards. Per the requirements in RFP Section 12.2.1, we will include a Cultural Competency Plan with our Marketing and Member Education Plan and submit to DHH within thirty (30) days of contract award.

Amerigroup will do the following to ensure that linguistically-proficient and culturally-relevant services are available to our members:

- Recruit a culturally diverse workforce including local, corporate, and call center staff, who reflect the diversity of our membership
- Conduct introductory and ongoing cultural competency training for every Amerigroup employee
- Contract a culturally competent provider network that communicates effectively across cultures
- Provide language-assistance services
- Employ Marketing, Community Relations, and Call Center Representatives who are culturally sensitive, knowledgeable about the linguistic needs of the population, and able to assist as needed
- Create Member Advisory Groups which include member and community representatives and provide feedback on how well we are addressing member needs and cultural competency issues
- Produce linguistically appropriate and culturally sensitive member communication materials in English, Spanish, and Vietnamese
- Conduct ongoing organizational assessments of culturally- and linguistically-appropriate capabilities as part of our Quality Management Program

Budget commitments are made annually in the following areas to support CLAS standards:

- Cultural competency training for all Employees
- Salary differential for bilingual Call Center Representatives
- IVR and phone menu prompt/message translation and recording in Spanish
- Bilingual call management at our member call center
- Redundancy in contract interpreter services to ensure 24/7 availability
- Clinically-certified contract interpreters at higher than standard translation rate
- Spanish-language website that mirrors complete English content
- All member materials printed in English, Spanish and Vietnamese

We ensure cultural competency practices are incorporated into our service delivery processes. These include: relevant questions asked during initial and comprehensive member assessments, development of cultural supports in the member's plan of care, recruiting qualified multicultural practitioners, and partnering with local community-based organizations and cultural groups to provide additional support for our members.

All Amerigroup employees participate in our Cultural Competency computer-based training (CBT) course. This training defines cultural competency and presents examples of it in action. The curriculum includes: definitions, benefits of cultural competency, government regulations, values, language resources, and variations in social comfort factors. We also require all newly-hired employees to participate in diversity training during their orientation.

Workforce Diversity. Amerigroup is committed to making it easier for our members to access and receive health care services. This commitment is evidenced by our pride in the diversity among our employees throughout Amerigroup departments. For example, in Amerigroup Texas, our largest health plan, 68 percent of our associates (and 49 percent of our managers) represent minority populations. These rates far exceed the national averages of 30 percent for overall diversity in the workplace and 15 percent for diversity in management. Women represent 84 percent of our workforce and 69 percent of our Texas management team. We expect the diversity of our employees to only increase as we expand to include the new the Louisiana CCN program.

L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English Proficiency and members who are hearing impaired, including the provision of interpreter services.

Providing Services in an Appropriate Manner for Members with Limited English Proficiency and for those who are Hearing Impaired

AMERIGROUP INNOVATIONS

Innovations in Customer Service: Listening to our Members

Problem In states new to managed care, Medicaid managed care programs may create confusion and concern for consumers who are unaccustomed to the benefits of managed care model.

Amerigroup Solution Amerigroup brings extensive experience serving members enrolled in public health programs – including best practices gleaned from our work in rural and frontier areas across the country. We strive to provide age and culturally appropriate information, such as:

- *Listening to Deaf Members.* Members with hearing disabilities can communicate with Amerigroup through a video relay tool. The member actually sees the Amerigroup representative and a sign language interpreter on his or her television screen.
- *Listening to Members with Language Barriers.* Access to health care services can only be optimized if members can comfortably and effectively communicate with their health plan. This is especially a challenge in New York where our membership represents over 30 different languages.

Benefits Amerigroup offers a local approach to the State. We fully understand that each market is different and develop customized approaches to meet the needs of our members.

According to the 2010 Census data, 8 percent of people at least five years old living in Louisiana spoke a language other than English at home. Of those, 35 percent spoke Spanish and 65 percent spoke some other language; 32 percent reported that they did not speak English "very well."

The quality of the patient-provider interaction has a profound impact on members' ability to communicate symptoms to their provider and to adhere to recommended treatment. We expect our providers to demonstrate cultural awareness and to have appropriate skills, such as the ability to understand another's values. Our network strategy and performance measures are designed to incorporate NCQA Standards, most notably: "The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary."

Amerigroup consistently works to recruit and retain providers who can best meet the cultural, ethnic, and linguistic needs and preferences of members and to

communicate the availability of these providers to members in all our plans. We have learned that many health care professionals are committed to providing culturally-competent care, but lack the awareness, knowledge, or skills to do so. Through our provider training, we furnish information that providers and their staff can use to remove cultural barriers between the provider and the member. We make every effort to ensure that our providers are not only culturally sensitive but also reflect the culture and languages of our members. We ensure that we have a network of providers who are sensitive to ethnicity, language, culture, and age through the following strategies:

- Identifying all member and user populations by ethnicity and income level
- Completing geo-access provider and practitioner reports related to cultural competency and comparing results to the population profile
- Recruiting and retaining providers to meet the identified cultural needs
- Developing ongoing cultural competency

Interpreter Services

If a member with Limited English Proficiency or one who is Hearing Impaired requires interpreter services for an appointment with a provider, an Amerigroup Case Manager will arrange for a locally contracted interpreter to accompany the member to his/her appointment.

The member always has the right to refuse the interpreter service. If they do so, Amerigroup documents that decision in the member's file. A family member, especially a minor child, is not to be used as an interpreter in assessments, therapy or other medical situations in which impartiality and confidentiality are critical unless specifically requested by the member. Even if the member refuses such services, Amerigroup will recommend that a professional interpreter sit in at the appointment to help ensure accurate interpretation.

Handling Calls from Members with Limited English Proficiency and Persons who are Hearing Impaired

Services for members with limited English proficiency. Amerigroup Call Center Representatives (Representatives) include employees who reflect the cultural and linguistic backgrounds of our members. All other interpretive services are provided by professional over-the-phone interpreters (OPI) service vendors, the TDD line for the hearing impaired or locally contracted interpreter service vendors.

Services for Members with hearing and/or language disabilities. A separate toll-free number provides Telecommunication Devices for the Deaf/Teletypewriter Technology (TDD/TTY) access for members with hearing loss and/or language disabilities via AT&T Relay Services. The member calls the TDD line and the TDD Operator places a call to Amerigroup. The TDD Operator communicates the member's message to a Call Center Representative. The Representative then replies to the member through the TDD Operator.

Callers with hearing disabilities can also communicate with Amerigroup using technology that allows them to conduct video relay conversations through a **qualified sign language interpreter.**

SERVICES FOR MEMBERS WITH LIMITED ENGLISH PROFICIENCY

In 2010, more than 87 percent of calls from members who prefer Spanish were handled by in-house staff, demonstrating the strength of our bilingual capabilities. Additionally, we are currently piloting a process where Amerigroup Representatives fluent in Vietnamese primarily handle Vietnamese calls. In addition to handling Spanish and Vietnamese calls with in-house Amerigroup Representatives, we arrange for translation services for calls in more than 170 other languages for members with Limited English Proficiency. We train all our Representatives to offer interpretation services when necessary and to educate members and their parents/guardians about the availability of such services. Interpreters are available to join calls 24/7, and the translation staff is versed in health care terminology.



The member actually sees the Amerigroup representative and a sign language interpreter on his or her television screen and is able to visualize their facial expressions, a subtle but important factor in connecting with members.

Amerigroup is continuously identifying communication needs and developing solutions to meet those needs. Our provider directory includes languages spoken for each PCP. As indicated above, we are contracting with a vendor to provide video conferencing for the hearing impaired with a qualified sign language interpreter. Additionally, we recently identified a need to provide greater access to Vietnamese-speaking Call Center Representatives. As a result, we are currently piloting a process where Amerigroup Representatives fluent in Vietnamese primarily handle Vietnamese calls.

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SECTION M: EMERGENCY MANAGEMENT PLAN

M.1 Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:

- o Employee training;*
- o Identified essential business functions and key employees within your organization necessary to carry them out;*
- o Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;*
- o Communication with staff and suppliers when normal systems are unavailable;*
- o Specifically address your plans to ensure continuity of services to providers and members; and*
- o How your plan will be tested.*

Emergency Response Continuity of Operations Plan

With the goal to swiftly and seamlessly respond to an emergency with minimal impact on all constituencies, Amerigroup maintains a detailed emergency response continuity of operations plan, also referred to as our Business Continuity and Disaster Recovery (BC-DR) Plan. It specifies the policies,

REAL SOLUTIONS *mean* REAL RESULTS

The BC-DR Plan represents a detailed blueprint of our preparation for and planned response to any emergency, including a pandemic or natural disaster.

procedures and tools that Amerigroup uses to assure successful continuity and recovery of business processes for all Amerigroup health plans and the corporate offices. The breadth and depth of our operations across the country, complemented by a strategic partnership for alternate work area recovery sites, promote resiliency and vigilance in our response to temporary interruption of any business operations.

Our BC-DR Plan covers all Amerigroup locations, both corporate and individual health plans, and identifies key individuals and business functions as well as systems. As a part of our implementation, Amerigroup Louisiana will be incorporated into our BC-DR plan to ensure continued Louisiana operations.

Our BC-DR is comprehensive and covers both systems and operational recovery. **Our BC-DR plan is “scenario neutral” meaning it works for any situation that disrupts normal operations, from minor incidents to major disasters, including pandemics and hurricanes. Our plan is designed to comprehensively recover our operations regardless of the disaster.**

Strong Leadership and Corporate Support

The BC-DR Plan designates a Recovery Leadership Team (RLT), which consists of department leadership or senior technical leads for departments that perform essential business functions, including representation from the local health plan when affected. The primary focus of this team is to resume normal business operations in the event of an interruption. Upon notification of an event, the local RLT works in concert with the corporate Incident Management Team (IMT) to evaluate the scope and level

of the incident and identify appropriate actions. The IMT Lead facilitates communication among all team members. Each team member is guided by a specific checklist that details the steps to take within each respective department or function, including details for initiating continuity, recovery and resumption activities. The process also incorporates a post-incident debriefing to assess the operating status and identify lessons learned that may drive revision of our plan.

Our BC-DR Plan includes all corporate functions and services provided to each plan, such as claims and call centers, as well as plans for local operations, and will include Amerigroup Louisiana. A Business Continuity Steering Committee oversees all business continuity and contingency planning. The Steering Committee reflects representation from our corporate leadership in the following departments: Technology Services (TS), Human Resources, Infrastructure Services, Corporate Services Administration, Service Operations (such as National Customer Care), Health Care Management Services, and health plans. The BC-DR Plan is reviewed and approved by this committee at least annually and updated as necessary. The Steering Committee reviews and approves the plan as updates are incorporated. Supporting the Steering Committee is a designated Incident Management Team Lead (IMTL), a senior staff member who is the executor of local decisions.

Incident Management – Identification and Assessment

Our Incident Management Plan (IMP) is a guide for continuity efforts of our critical functions. The IMP covers assumptions, roles and responsibilities, and other elements required to ensure continuity of each of our critical business functions after an unplanned business interruption.

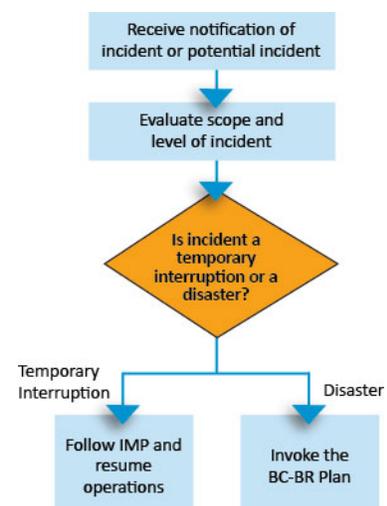
The IMP guides our response efforts through a series of detailed checklists to enable the response team to assess the impact of the situation and determine if a disaster declaration is required and if the BC-DR must be invoked, as shown in Figure M-1. Temporary interruptions in normal operations include events like unplanned system outages, power outages, weather related office closures/delays and facility evacuations.

We initiate the plan when we receive notification that an event

has occurred, or potentially will occur. Once an event occurs, the Incident Management Team evaluates the scope and level of the event and determines appropriate actions for initiating the plan. The scope and level determine whether or not the recovery facility is activated and to what degree the teams will be deployed.

Communication is critical when an incident occurs and we must be able to contact key members of the team. The IMP lists multiple telephone numbers for key executives and other Amerigroup employees. Contact information for command centers and recovery sites are also included. In the event of an incident, an incident hotline relays important information and keeps employees abreast of developments or changes. Our Emergency Notification System (ENS) allows us to distribute broadcast text messages and emails and converts text message to speech so we can send messages to home phone numbers.

Figure M-1. Incident Management



DHH Review

We will provide our contingency plan, the IMP, to DHH for approval within 30 days from the date the Contract is signed.

Our BC-DR Plan is proprietary and available for on-site review by DHH. If review of the BC-DR is desired, we will work with DHH to determine the best approach for review, which could include DHH review within Amerigroup facilities, via WebEx, or other options.

**REAL SOLUTIONS *mean*
REAL RESULTS**

Our BC-DR is comprehensive and covers both systems and operational recovery. Our BC-DR plan is “scenario neutral” and addresses any situation that disrupts normal operations, from minor incidents to major disasters.

Prepared for Action – Pandemic, Natural Disaster and More

We have mapped pandemic and natural disaster scenarios against our scenario neutral BC-DR plan and confirmed its ability to recover operations in the event of these types of disruptions. These plans provide an organized and consolidated approach to managing the incident by reducing confusion and exposure to error.

Pandemic Preparedness and Response

Amerigroup maintains a Pandemic Preparedness Plan that addresses the unique nature of a pandemic. This plan works in conjunction with our IMP and BC-DR and addresses specific tasks related to preparing for and responding to a pandemic.

Our primary concerns are the health and safety of Amerigroup employees and the continuity of service to our members. In our plan, we assume that the occurrence of a pandemic would create an exceptionally difficult situation and would require us to effectively handle unprecedented demand from our members, potentially with a significantly reduced workforce. Our provider network would also be strained with tremendous demand from the general population.

In our Pandemic Preparedness Plan, we have identified specific procedures in the BC-DR to address the occurrence of a pandemic within the defined scenario of workforce unavailability. Tasks and activities address:

- Employee health
- Continuity of care for members, including adjustments in business practices
- Internal and external communications with DHH, employees, members, providers and the community
- Remote access to systems so employees can work from home

Natural Disaster Recovery and Response

Because of the vulnerability of several of our health plans to hurricanes, we maintain a Hurricane Response Plan to address this specific type of natural disaster. This plan works in conjunction with our IMP and BC-DR and addresses specific tasks related to hurricane preparedness and post-incident response. Specific tasks and activities related to the recovery of systems and operations are contained within the BC-DR plan.

The Hurricane Response Plan lists the department, employee and tasks associated with:

- Preparation for hurricane season
- Start of hurricane season on June 1
- A hurricane **watch** has been issued by the National Hurricane Center
- A hurricane **warning** has been issued by the National Hurricane Center
- Post hurricane response

Amerigroup Florida successfully executed its Business Continuity and Disaster Recovery plan three times during the summer and fall of 2004 after a series of hurricanes struck the state. In September 2008, our hurricane response was tested again when Hurricane Ike struck Texas. Lessons learned from each incident result in changes to our plan that will enhance our response to future incidents. A more detailed discussion of our response to Hurricane Ike is presented at the end of our response to M.1.

After each incident, we perform a detailed review of all aspects of our response and recovery efforts.

In our response to M.2, we provide additional details about specific activities we will perform in the event that a major hurricane disrupts, or threatens to disrupt, Louisiana operations.

Employee Training

All employees are informed about how the incident hotline is used in the event of an emergency and how email alerts are used to keep employees informed before, during and after an incident. With impending incidents, notices are sent out through email reminding employees of the hotline number and the protocols for office closure and other related items. Incident emails are not limited to the area of impact: All Amerigroup employees receive notice when an office is closed, which helps them make informed decisions as they conduct business and handle things while the impacted office is closed.

The BC-DR Plan designates a point of contact for each functional area and health plan. Within the health plan, the Plan Compliance Officer is designated as a back-up. We assess and identify essential personnel to be designated as the point of contact and they are then trained in their responsibilities in the event of an emergency. We train each designee on the specific components of the BC-DR Plan and their specific role and responsibilities, including:

- Relationship between business continuity and technology recovery
- Plan leadership – roles and responsibilities of major plan participants
- Plan tasks and activities – including technology for access and update of the plan
- Communications – how, when and with whom we communicate

Our Director of Service Continuity leads training activities. The Director is a DRII Certified Business Continuity Professional and is fully dedicated to our BC-DR efforts. Refresher training is provided as necessary.

While employee training is performed, the best training associated with our BC-DR plan is obtained during annual tests of business continuity and technology. These tests require that employees involved

with the test scenario perform the tasks associated with their role in the plan. This not only exercises the plan and keeps employees trained, but it also provides opportunity to improve the response. Following each test, we perform a critical review, identify enhancements and improvements and implement them.

Essential Business Functions and Key Employees

Our BC-DR Plan covers all Amerigroup locations, both corporate and health plan. It identifies key individuals, business functions, and command center strategies.

The knowledge, tools, processes and singular MIS platform that all support Amerigroup allows for swift and effective continuity of services in response to emergencies.

Amerigroup and especially its health plans benefit from common tools, processes, and systems. This enables operations to transition seamlessly in the event of an emergency, not only between call center instances, but also between our health plans. Employees from an affected plan are able to effectively continue their function from an alternate Amerigroup health plan, if necessary, and employees from alternate health plans are able to assist with functions to support an affected health plan.

The BC-DR Plan Recovery Leadership Team consists of department leadership or senior technical leads for departments that perform essential business functions and includes representation from the local health plan when affected. The primary focus of this team is to resume normal business operations in the event of an interruption. Essential business functions are identified within each Plan as well as all Corporate departments.

Examples of essential business functions include:

- Health Plan
 - Case Management
 - Concurrent Review
 - Complaints Processing
 - Appeals/Denials Processing
 - Provider Relations
- Corporate
 - Inbound Member Call (clinical and non-clinical)
 - Inbound Provider Call (clinical and non-clinical)
 - Authorizations
 - Outbound Calling
 - Nurse HelpLine
 - Disease Management
 - Behavioral Health

The BC-DR Plan identifies key staff within each essential business function as well as designees within each health plan for the recovery team. Each essential business function and health plan designates a primary and at least one alternate recovery team representative. Extensive contact information for key employees is contained within the plan. The IMT Lead is responsible for engaging our corporate President/Chief Executive Officer and Chief Operating Officer as quickly as possible.

Command Center

The plan specifies where and how incident management team members assemble. A primary and three alternate command centers are designated. Depending on the nature and geographic impact of the incident (local versus regional), the command center and audio conferencing enable us to create a virtual command center that links all key staff and team members.

Contingency Plans – Essential Business Functions

Continuing services throughout an occurrence is our priority in an emergency. Whether it is a short-term incident, such as inclement weather, or a longer term emergency, including a pandemic or natural disaster, we use established protocols to guide business continuity and data recovery. Further, we leverage SunGard's LDRPS online information availability tool, as our repository and maintenance tool for the BC-DR Plan. LDRPS is hosted by SunGard on secure systems in a secure data center facility, with replication to an alternate, geographically separate, secure facility and systems. Therefore, the BC-DR Plan information is accessible at all times via the internet without reliance on our Technology Services infrastructure.

Regardless of the nature of the emergency, our redundant operations will minimize disruption for Louisiana members, providers and DHH. Each work site has a recommended recovery location. We can quickly and seamlessly re-route member and provider calls to an unaffected work site because we maintain redundant operations for key functions, including care management, the call center, and claims offices. Our telecommunications and networking technology enables transparent transition among remote sites. For example, should a local or regional incident affect the availability of our call center in Nashville, calls will be routed to Virginia Beach, Virginia or Tampa, Florida. Should an event restrict access to the Louisiana administrative office, all employees will be prepared to work from home or a remote Work Recovery Area.

Technology Tools Supporting Home-Based Work

Especially in the event of a pandemic, we rely on **remote systems access for staff to facilitate continuing operations.** We maintain technology tools that enable employees to access necessary systems remotely. Through the use of our Citrix Access Gateway, employees can utilize critical applications from any location that provides Internet access. The availability of almost 200 Citrix servers allows fast, efficient remote access to all critical applications.

Contracted Work Area Recovery Sites

If a local alternate Amerigroup work site is unavailable and telecommuting is not effective, we maintain a contract with SunGard to enable **use of Work Area Recovery sites that are geographically or regionally close to our offices.** Should employees from a local office be unable to access their office or our network, SunGard Work Recovery Areas provide temporary work space with access to all Amerigroup systems.

Technology – Recovery of Major Systems

We strive to optimize the availability of our systems and the reliability of data, especially in disaster recovery planning. We are prepared to keep our mission-critical applications and tools available even in the event of a disaster declaration. Amerigroup maintains a state-of-the-art data center at our Corporate facilities in Virginia Beach, Virginia, and we follow detailed protocols to facilitate data backup and recovery. To protect our most critical operations, we manage a geographically separate backup data center.

Amerigroup has defined the Recovery Time Objective for our mission-critical applications to less than 24 hours. Additionally, we have taken steps to minimize the Recovery Point Objective (RPO) and thus

Near real-time data replication provides us with a Recovery Point Objective of 15 minutes or less.

minimize the data loss associated with an outage. For the most vital of our mission-critical applications, those that serve as the system of record for our member, provider, claims, and authorization data, we have invested in a solution where the application is staged in our secondary geographically distributed data center for failover within one to two hours. We perform near real-time data replication. The replication for these solutions provides us with a RPO of 15 minutes or less. We apply this optimal recovery solution for our core operations system, care management system, our medical

criteria, and our workforce management application, among others.

New applications are assessed as they come online in support of our business to determine the appropriate Recovery Time Objective (RTO). We continually reevaluate each application's RTO to assess its ongoing appropriateness. Through such ongoing assessment, we identify additional applications as mission-critical and work through the associated redundancy and replication planning.

We contract with AT&T for our internal disaster recovery hot site, which is located in an AT&T Internet Data Center (IDC) in Dallas, Texas. The Dallas AT&T IDC provides a secure, reliable environment for the Amerigroup internal disaster recovery hot site. It also provides a very scalable environment, with tremendous capacity for additional space, power, HVAC, UPS, and all other critical infrastructure components, as our requirements increase over time.

We also maintain daily backups with an offsite tape rotation. For the core operations system, Amerigroup has invested in complete redundancy for all tiers of the application thus providing a High Availability (HA) instance in addition to the production and disaster recovery instances. This HA solution is located in our primary data center in Virginia Beach, Virginia, and in the event of a non-disaster issue with our core operations system we are able to switch to this HA solution.

Communication with Staff and Suppliers

In the event of a planned or unplanned system outage, our primary means of communication with employees is using email through our Service Desk. We also have broadcast voicemail capabilities that support companywide communication. We maintain redundant data centers to minimize the risk of a complete email outage, however, should one occur, **we have a back-up notification system** that enables us to communicate using email, voicemail, SMS texting, or text to speech.

Our plan designates employees who are responsible for communicating as necessary and appropriate with our suppliers and customers.

Ensuring Continuity of Services to Providers and Members

A primary focus of our BC-DR plan, and our response to any disaster, is our ability to provide continuity of services to our members and providers. Tasks and activities define specific actions required to ensure that members continue to receive covered services and providers can continue to effectively service their members.

Continuity of Services to Members

There are several elements to ensure that members continue to receive covered services in the event of a disaster.

Ensuring access to Amerigroup:

- **Member Call Center.** Our call center telephony technology allows us to load balance calls among call centers to handle additional volume. Call center hours will be extended as necessary to support our members
- **Member Website.** Alerts and information are placed on our member website so that members understand what they can do in advance of the disaster and how to receive care in the aftermath of a disruption
- **Nurse HelpLine.** Our *Nurse HelpLine* can assist displaced members with immediate, but non-emergent needs and provide recommendations for seeking treatment, which may include self-care, an appointment with the an out of network provider, or immediate referral to the emergency room, based on the nature and severity of the symptoms

Ensuring access to providers:

- **Provider Network.** As necessary, members will be allowed to use non-network providers for care
- **Service Authorization.** As necessary, requirements for service authorizations will be waived to ensure member access to care
- **Member Website/Portal.** Alerts and information are placed on our member website so that members understand what they can do in advance of the disaster and how to receive care in the aftermath of a disruption

Ensuring continuity of care:

- **Case Management.** Case Managers or our outbound call unit call our highest risk Medicaid members to make sure they have an evacuation plan, in advance of the storm. If necessary, Amerigroup will relocate members to a safer environment such as skilled nursing facilities. In addition, we help members locate housing after the storms when their housing is lost or damaged
- **Transition of Care.** Our plan includes task and activities to ensure appropriate transition of care for our hospitalized members in the event of a disaster

Continuity of Services to Providers

Our plan identifies a number of steps to ensure that providers have continued access to Amerigroup:

- **Provider Call Center.** Our call center telephony technology allows us to load balance calls among call centers to handle additional volume. Call center hours will be extended as necessary to support our providers.
- **Provider Website/Portal.** Alerts and information are placed on our provider website so that providers understand what they can do in advance of the disaster and how to manage members' care in the aftermath of a disruption. Providers also have access to the Electronic Service Record and Personal Disaster Plan where granted by members.

Amerigroup will require facilities, Durable Medical Equipment (DME), and Home Health providers to have a continuity of operations plan in place to try to mitigate the disruption to delivery of care in the event of a disaster.

AMERIGROUP INNOVATIONS

eHealth: Personal Health Record with Personal Disaster Plan

Problem Many Medicaid enrollees don't have the information and resources they need to understand their health or manage their condition

Amerigroup Solution Amerigroup seeks to empower our members to make responsible decisions about their health and well-being. One way we do this is by offering Personal Health Records, including an integrated and critical Personal Disaster Plan.

We are working with partners like Microsoft to implement new technologies and extend capabilities to allow members to store health information from multiple sources in a single online location. These Personal Health Records are automatically organized and always available. Members can choose to share this data with caregivers, family members and medical professionals, making it a vital part of a personal preparedness plan in case of emergency or relocation.

Benefits Support and enhance member/provider communication by giving members information to share with their provider when they visit, increasing their ability to knowledgeably consider treatment options and plans.

Amerigroup seeks to empower our members to make responsible decisions about their health and well-being. One way we do this is by offering Personal Health Records, including an integrated and critical Personal Disaster Plan.

Amerigroup will offer Louisiana CCN members an Electronic Service Record (ESR) that will give access to a comprehensive summary of their care plan, health metrics fed by multiple data sources, and provider contact info to enhance member engagement in managing their chronic conditions and accessing and coordinating needed services to support their independence in the community.

The ESR also includes a Personal Disaster Plan (PDP) for members, where they can provide information about required supports and services (such as, wheelchair battery charger, medications, personal care attendant and feeding tube) that would need to be sustained

during a disaster like a hurricane. This service supports DHH's goal of improving member understanding of service coordination.

In addition to incorporating the historic elements of an Electronic Health Record (EHR), Amerigroup's ESR encompasses information necessary to prospectively identify a member's ongoing health care needs. The record includes items such as:

- Contact information for the member and the member’s support system (such as family or friends who should be contacted in an emergency or a point of contact where the member may go in the event of a disaster)
- Information on ongoing treatment needs, such as dialysis services or oxygen
- Transportation requirements (in the event of a disaster)
- Potential housing needs (in the event of a disaster)
- Other special needs

Recognizing this program’s value to members in the Louisiana CCN program, we are planning a multi-pronged campaign to advance members’ participation. The campaign will include:

- Identification of the capability on the on-hold message to incoming callers that encourages members to ask the Customer Care Representative (CCR) about the capability
- CCRs will promote the capability during live calls and educate the member on its use
- Automated outbound calls to give members an overview of the service and prompting them to create a service record or to learn more about ESRs and the Personal Disaster Plan
- Louisiana CCN Service Coordinators to prepare them to include it on their introductory overview of the Covered Services and benefits

Providers may access their member’s Personal Disaster Plans if they have been completed by the members, and if the member permits access by the Provider.

Testing our Contingency Plans

To monitor readiness, we test the BC-DR Plan at least annually, assessing our technology recovery capabilities as well as our business continuity preparedness. Tests are performed on both the technology components and the business continuity aspects of our plan.

Technology

As dictated by the BC-DR Plan, the TS Department schedules and conducts backup and recovery tests and exercises no less than once each year to demonstrate readiness and ensure the success and viability of the BC-DR Plan. The TS Department establishes simulated disaster or recovery scenarios and activates the procedures in the Plan. This includes testing and restoration of our applications at our Dallas, Texas facility and verifying the ability of alternate locations to assume business operations for a health plan that is experiencing a disaster. Amerigroup has also tested recovery at SunGard Work Area Recovery sites. Upon testing completion, a full report is developed that summarizes the response and specifies lessons learned, including vulnerabilities that must be corrected.

The most recent Technology test was in October 2010. Another technology disaster recovery exercise is scheduled for September 2011. After each test, results are carefully reviewed, opportunities for improvement are identified and the plan is modified accordingly.

Business Continuity

Our business continuity plans are also tested at least annually using a combination of tabletop exercises and testing of our Work Area Recovery Sites. Tabletop exercises are structured to simulate an incident that escalates to disruption. Designated Employees participate in the simulation and discuss the steps to be taken in accordance with the BC-DR Plan. In Work Area Recovery Site testing, employees simulate an incident which requires them to either telework, or relocate to a SunGard Work Area Recovery site where they test access to all Amerigroup systems.

We executed a claims work area recovery exercise in May 2011 and have an exercise with a health plan scheduled for October 2011.

After tests, detailed summary reports are produced to highlight our performance with respect to the BC-DR Plan.

Our Plan in Action

Our redundant operations and systems capabilities and geographically dispersed employees enable us to rapidly transition calls from one facility to a designated back-up facility. Employees at the back-up facilities have access to the same data and tools to assist callers in the affected market. This process has been triggered numerous times and has proven to be successful in easing the impact of a local or regional incident or emergency on members and providers. In early June 2011, we kept our call center open 24/7 for members of a health plan that may have been impacted by wild fires in their area.

Our decisive and multi-faceted response to actual incidents and emergencies best illustrate the strength of our planning.

Inclement Weather

The most common reason for initiation of recovery protocols is inclement weather. Whether an office is closed due to snow or closes early because of tornadoes in the area, we activate the plan, rerouting calls and functional responsibilities according to the Plan. Key employees are also enabled to work from home, so unless they are personally affected by the disaster, they are able to continue working with our members and providers. We regularly handle such temporary business disruptions with little impact on members or providers.

Hurricane Ike

In September of 2008, as Hurricane Ike bore down on the Texas coast, we initiated planning for the anticipated disruption of our operations in Houston. Following our Hurricane Response Plan, we mapped out the strategy for maintaining operations expecting that many members, providers, and employees would be affected by the storm. In planning before the storm, among a long list of tasks, we established telecommunications re-routing to the designated back-up facility, located in Dallas-Fort Worth, to maintain continuity of services for members and additionally re-routed all email for key employees to email servers in Virginia.

Once the storm subsided, our entire Texas team burst into action, although many were directly affected by the storm themselves. With extensive support from our Dallas-Fort Worth, Corpus Christi, San Antonio, and call center employees, we reached out to every member to ascertain if they needed assistance, particularly critical for our aged, blind and disabled members with ongoing needs, such as

oxygen or dialysis. Our Case Management team contacted special needs members to assess how they were affected by the hurricane and what immediate needs they had. Not only were our local technology systems (phones, e-mail, and network connectivity) brought back online once power was restored, more importantly, **our dedicated team maintained our member and provider wellbeing as their primary focus, going above and beyond to promote continuity of care and service.**

M.2 Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.

- You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.*
- Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.*

Amerigroup understands the devastating nature of a hurricane on employees, members, providers, and the ability to sustain business operations. Our comprehensive BC-DR plan, and associated policies, procedures and resources, position us to adapt quickly in the event of a hurricane, or other disaster, to recover operations and provide continuity of care to members.

We have responded successfully to actual disasters in a number of our health plans over the past several years. Each incident has validated the ability of Amerigroup to continue and recover business operations effectively and identified opportunities to strengthen our ability to respond in the event of a disaster.

We understand that Hurricanes Gustav, Katrina and others served to illuminate the the vulnerabilities of Louisiana. This was especially true in Baton Rouge following Gustav where the city was essentially shut down for several days, 34 parishes were declared disaster areas and 1.5 million people were without power. During implementation, **we will develop a BC-DR plan specific to Amerigroup Louisiana**, as part of our comprehensive BC-DR, that will address the tasks and resources required to recover operations. We will work closely with DHH to ensure that all concerns are addressed in development of the plan.

Activating the Plan

As soon as the impending hurricane is identified, we will activate our Hurricane Response Plan. We will initiate tasks to address continuity of business operations, continued services to members and providers, and responsiveness to DHH. Since many Amerigroup Louisiana members are likely to be personally impacted by the mandatory evacuation order, we will leverage resources across Amerigroup to respond to this crisis.

As documented in our Hurricane Response Plan, a number of tasks are performed as soon as a hurricane watch is announced by the National Hurricane Center. At this time, we will:

- Closely monitor the progress of the storm and evaluate the potential areas of impact
- Distribute copies of the Hurricane Response Plan and Incident Management Plan to the Recovery Leadership Team, comprised of department leadership and senior technical

leads for departments that perform essential business functions, including the Louisiana health plan

- Begin daily meetings of the RLT to discuss specific tasks and verify individual responsibilities
- Communicate status updates to Amerigroup Louisiana employees, other affected Amerigroup employees and Amerigroup and DHH leadership
- Contact the local emergency management office to discuss procedures for allowing key staff to return to work in a storm-damaged area
- Determine external communication requirements and contact information
- Fill fuel tanks in fleet vehicles and generators
- Establish and publish the management communication plan

At the time when the actual hurricane warning is issued, additional components of the plan are activated. At this time we will:

- Discuss the timing of rerouting call center traffic to a location not impacted by the storm. Reroute incoming telephone calls according to timing decision
- Update the incident hotline status information
- Email communication to potentially affected health plan employees
- Complete external notifications
- Determine if SunGard should be placed on alert for potential work area recovery
- Contact home delivery providers to ensure that they schedule deliveries prior to the hurricane
- Review technology backups and schedule additional backups if necessary

Throughout the incident, employees are directed according to the tasks in the Hurricane Response Plan, BC-RP and the Incident Management Plan.

Technology – Continued Operations

Technology recovery is very straightforward since our primary data center is in Virginia Beach, VA, which means we do not have to worry about its ability to continue normal operations during a land falling hurricane in Louisiana. We do, however, house local servers in many of our health plans supporting local area network functions and place email mailboxes locally for day-to-day operations. In the event of an impending disaster, **we proactively relocate the email mailboxes of essential Plan personnel to our Virginia Beach data center**, enabling uninterrupted access by these employees. Since the servers at the Louisiana health plan are managed from Virginia Beach, the email mailboxes can be relocated without involvement of local employees. Once these tasks and any rerouting of local phones are completed, disaster response and recovery plan tasks will focus on business operations, rather than technology recovery.

Louisiana Health Plan Facility

If the storm is expected to impact the building housing the Louisiana health plan, tasks will be executed to protect vital physical files within the building and determine the location of an alternate work site that is in an unaffected area.

The health and safety of our employees is a priority for Amerigroup. Even if the health plan building is not in danger, we will have employees impacted by the storm. We will provide regular communication with our employees, via email and our incident hotline to keep them apprised of the situation and provide necessary assistance.

The following sections describe the steps we will take to ensure that we remain responsive to DHH, our members, the provider network, and to the community throughout the course of the disaster. Tasks and activities executed are presented as “before the hurricane” and “after the hurricane”.

Responsiveness to DHH

As soon as the approaching hurricane is announced, Amerigroup will initiate and maintain close communication with DHH to ensure all parties remain informed. Communications will include a description of the impact of the incident on operations, regular and frequent updates on activities to support members and providers and other tasks associated with the plan.

Amerigroup employees working with DHH and the Louisiana operations are located not only at the health plan in Louisiana, but also at our corporate offices. Because of this structure, Amerigroup is able to provide DHH with a point of contact during the incident who is personally unaffected by the incident and who understands Louisiana operations and already has a relationship with DHH.

Before the Hurricane Strikes

Since DHH staff may also be impacted by the approaching hurricane and subject to evacuation, we will provide alternative methods for DHH employees to contact Amerigroup leadership, including home and cell phone numbers of multiple employees, since our ability to contact them may be compromised.

We will continue to keep DHH apprised of work performed to prepare for the approaching hurricane.

After the Hurricane Strikes

After the hurricane strikes, the tasks and activities in the BC-DR plan are centered around assessing the impact of the storm on our facilities, workforce, members, providers and the overall community. We will notify DHH as we document the extent of the impact and implement contingency plans.

Responsiveness to Members

Amerigroup is committed to serving all of our members, especially in the event of a disaster. With 30,000 members, as presented in the scenario, some of them with high risk health problems, we will leverage resources across Amerigroup to help our members prepare for the hurricane and deal with its aftermath. The Electronic Service Record and Personal Disaster Plan available to our members on the member portal are supported by technology that can easily address the needs of the 30,000 members impacted by the hurricane in the described scenario. Tasks and activities that will be executed are categorized below into “before the hurricane” and “after the hurricane”.

Before the Hurricane Strikes

With a major hurricane 72 hours from making landfall, tasks and activities related to members focuses on helping members to be prepared to evacuate or remain in their homes, depending on their location.

To help prepare our members, Amerigroup will use alerts on our member website and proactive telephone calls to disseminate important information to our members and to collect critical information from our members. We will:

- Advise evacuating members to:
 - Complete the Personal Disaster Plan
 - Gather identification papers, including ID Card, in a waterproof container
 - Gather prescriptions and other necessary medications
 - Notify a friend or family member, in addition to Amerigroup, where they are going
- Advise members and caregivers who plan to remain in their home to develop a back up plan in case they must evacuate, to complete the PDP, and to have the following supplies on hand:
 - 2 weeks worth of non-perishable food and bottled water
 - 1 month worth of medications and incontinence supplies
 - Flashlights, batteries, a battery powered radio and other emergency essentials
 - Non-cordless phone, if they have a Plain Old Telephone Service (POTS) line

Member Call Center Representatives and Case Managers will educate members about their options for obtaining extra supplies and double delivery processes prior to the event

Using our case management and disease management programs, Case Managers will also proactively call our highest risk Medicaid members to make sure they have an evacuation plan, whenever possible. As necessary, we can also mine claims data to identify members with certain diagnoses and or procedures to identify additional members for targeted outreach. This will especially apply to members that are dependent upon electricity to meet their medical needs (for example, refrigerating insulin supplies or delivering oxygen) or are especially sensitive to prolonged heat. If necessary, Amerigroup will relocate members to a safer environment such as a skilled nursing. We will leverage our outbound team to make targeted outreach calls to these members. Our outbound team uses predictive dialing technology to streamline calls and we are able to augment our team to reach potentially affected members as efficiently as possible.

After the Hurricane Strikes

In the aftermath of a major hurricane, our member population is likely to be dispersed not only across the state, but to neighboring states. Our goal is to ensure continuity of care until such time as the member's living situation stabilizes. In order to ascertain the location of our members, we will rely heavily on the members contacting us through our member call center. Current location information can be stored on the member's PDP, if they have one, or attached to a member's record in notes.

Providing displaced members with access to care is challenging, and it is a top priority for Amerigroup. Case Managers and Member Call Center Representatives will undertake several steps to assist members needing to access care while temporarily outside of the Amerigroup GSA and prior to their returning home.

Authorized employees will access a member's Personal Disaster Recovery Plan to identify members who planned to evacuate outside the GSA. For members who have not completed a Personal Disaster Plan, the Member Call Center Representatives will ascertain a member's location during member calls. We will assist members in locating providers, whether within the GSA or outside the GSA. Additionally, Amerigroup will work to ensure all evacuated members obtain needed care through the following means:

- **Our Nurse Helpline** will assist displaced members with immediate, but non-emergent needs and provide recommendations for seeking treatment, which may include self-care, an appointment with the an out of network provider, or immediate referral to the emergency room, based on the nature and severity of the symptoms
- **Specialized Call Center** will be dedicated to managing the transfer of stabilized members back to in-network hospitals and operates 24 hours a day, seven days a week (24/7)
- **Member Call Center Representatives and Case Managers** will educate members about their options for obtaining extra supplies and double delivery processes
- **Case Managers** call our highest risk Medicaid members to ensure that they are receiving care. In addition, we will direct members to resources that can help them locate housing when their housing is lost or damaged
- **Expanding Access to Providers** by allowing the use of non-network providers and/or waiving the requirement for service authorizations (and making the necessary adjustments to claims processing edits)

Amerigroup Louisiana will also leverage our established relationships with providers, community-based organizations and advocacy groups to provide dislocated members with information on how to contact Amerigroup Louisiana.

If the circumstance arises that a member permanently relocates outside of the Amerigroup GSA, our Representatives will work with DHH staff, as necessary, to determine the appropriate timing for the disenrollment process. Our Care Managers will work closely with the member and his/her new coverage entity to ensure clinical care is appropriately transitioned.

Responsiveness to Providers

Our providers are critical to our ability to provide continuation of service to our members in the event of a disaster. We will rely heavily on our provider website/portal and our provider call center to disseminate information to our providers.

Before the Hurricane Strikes

After notification of the approaching hurricane, we will execute BC-DR plan tasks and activities to help assess the potential impact of the incident on major providers such as hospitals and emergency facilities. Depending on the size and scope of facilities in danger, we will contact providers to:

- Document where the current members at the facility will be located and pass information to Case Managers
- Obtain an alternate or cell phone number for the Hospital Administrator or key facility staff
- Verify that each facility is prepared and has supplies on hand during and after the storm, such as generator, non-perishable food, and water

Depending on the projected impact on major facilities, alternative care facilities will be identified.

We will contact home health providers to ensure they can serve our members before and after the storm and relay the information to Case Management.

Using our website, our provider call center, and, as necessary, outbound calls to providers, we will:

- Ask providers to be prepared for members needing extra supplies and provide double delivery processes prior and post event
- Request that DME suppliers provide members with new, charged batteries for devices such as respirators, oxygen systems and hearing aids, to allow for operation during a power failure
- Encourage all providers to verify member eligibility through our web site or to call our call center rather than require a member have their ID Card

After the Hurricane Strikes

After the hurricane, our focus shifts to assessment of the hurricane's impact on our provider community, and, therefore, the ability of our members to receive care.

Our provider call center and provider website/portal will play vital roles in communicating information to our providers, enabling them to:

- Inform us of their ability to service members post-hurricane
- Learn about modifications to policies and procedures such as, waived service authorizations
- Verify member eligibility in the absence of an ID card
- Assist members in finding out-of-area providers

Responsiveness to the Community

Amerigroup’s view is that communities are not just where you are, they are part of who you are. We understand the challenges communities face in the aftermath of natural disasters. That’s why the Amerigroup Foundation developed the **Disaster Response Team – a group of passionate employees ready to serve when disaster strikes**. These dedicated volunteers travel to damaged communities across the country and help provide shelter, administration and food to members who have disabilities or special needs.

The Disaster Response Team works in conjunction with the American Red Cross in its temporary shelters to serve those who need it most. Amerigroup has been in contact with the Louisiana Voluntary Organizations Active in Disasters (LAVOAD) about providing emergency response in Louisiana as a result of the recent devastating flooding.

AMERIGROUP INNOVATIONS

Innovations in Commitment to the Communities We Serve: A Culture of Commitment to Improving Lives

Problem When Amerigroup began nearly 15 years ago, we focused on getting out into the community to serve a vulnerable population whose health care needs had previously been overlooked. The focus, by necessity for a growing health care company, was one community at a time, one member at a time.

Amerigroup Solution Amerigroup now serves approximately 2 million members nationwide. With that growth and success comes a tremendous responsibility. Last year, we were proud to be named the winner of the Best Overall Corporate Social Responsibility Program for companies under 25,000 employees by PRNews magazine.

“Amerigroup Community Volunteers” – An Award-Winning, Rewarding Volunteer Program. Since our founding, Amerigroup’s community – and member-based focus has not changed. In a recent companywide survey, more than 90 percent of Amerigroup employees expressed a personal connection to the mission of the company. For Amerigroup, everything returns to the company’s employees and the genuine desire – in fact, passion – to serve those who need a little help.

Benefits Helping the vulnerable among us to lead healthier lives through proactive care – and some irreplaceable personal relationships as well. The truth is, solutions to our nation’s health care challenges begin when we put our care and our passion to work, one unique individual at a time.

Six members of our Disaster Response Team recently returned home after a weeklong volunteer effort assisting residents in flood ravaged Kentucky. The Disaster Response Team assisted families reeling from one of the worst floods to hit the region in decades. Amerigroup volunteers were on the ground providing comfort and support from recovering personal belongings to finding temporary housing, tearing down drywall, assisting with paperwork, and connecting individuals with the appropriate agencies.

Amerigroup Community Volunteers

Since our founding in 1994, Amerigroup’s community- and member-based focus has not changed. In a recent companywide survey, more than 90 percent of Amerigroup employees expressed a personal connection to the mission of the company. For Amerigroup, everything returns to the company’s employees and the passion to serve those who need a little help.

Amerigroup was named 2010 Overall Leader in Corporate Social Responsibility (CSR) Practices by PR News for its companywide volunteer and campaign initiatives. The award was presented at PR News’ annual CSR & Legal Awards

luncheon, Feb. 24, 2010 at the National Press Club in Washington, D.C., which recognizes corporations and their partners for outstanding CSR campaigns in 30 different categories.

The mission of our Amerigroup Community Volunteers program is to actively engage employees in improving the communities in which the members whom we serve live by providing the time, energy, expertise and resources needed to have a measurable impact. Just as Amerigroup strives to be innovative in its care for members, our employees also seek out unique ways to assist the communities where we serve. *In fact, over the last two years, Amerigroup employees contributed an average of more than 7,600 volunteer hours annually in our communities. For 2011, we are trending toward more than 12,000 volunteer hours.* With our formal Amerigroup Community Volunteers initiative, we have expanded our efforts with greater opportunities for our employees to be involved in the company and their communities. More detail on our volunteer efforts is provided in our response to question F.7.

Call Center Continuity

Reliable, continued operation of our call center is a critical component of our plan for continuing to provide support to our members and our providers after the hurricane.

We serve providers and members through our Call Center Representatives located in our call centers in Tampa, Nashville and Virginia Beach. As a national organization, our call center is not currently in Baton Rouge as the example specifies. In fact, should any of the areas in which Amerigroup's call centers are located ever be impacted by a disaster such as the hurricane in this scenario, Amerigroup will flow calls among our three call centers as necessary. Such capability also allows us to be nimble in responding to unexpected spikes in call volume – such as during implementation phases – or business interruption due to a natural disaster at any one location.

Our telephony technology gives us the ability to flow calls among our three call centers as necessary, creating one virtual call center.

For instance, in the event of a natural disaster or overflow of calls, we can route the calls to different sites and leverage our cross-trained Call Center Representatives and redundant operations to continue serving members. Call center hours will be extended, as necessary, to meet call demand before, during and after a disaster. We believe this design offers the best value to our members and our customers.

Before the Hurricane Strikes

If our call center were located in Baton Rouge, an area expected to be impacted by the approaching hurricane, our BC-DR plan would outline the tasks and activities to ensure our continued ability to respond to calls from our members and providers. As with our Louisiana Health Plan employees, the safety and security of our Baton Rouge call center employees would be of utmost importance to Amerigroup.

In this situation, we would:

- Monitor the progress of the storm and the vulnerability of the call center to service disruption
- Fill fuel tanks in fleet vehicles and generators
- Prepare a timeline for rerouting calls to another call center. Reroute incoming telephone calls according to timing decision

- Alert Call Center Representatives across the Amerigroup organization to the situation in Louisiana to prepare them to service members and providers

After the Hurricane Strikes

After the hurricane, calls will continue to be routed to another location until power is restored to the local facility and it is back online. Our BC-DR plan documents tasks and activities associated with recovering operations of the affected call center. We would:

- Determine the impact on the call center facility, including the building, telephone lines, heating/cooling and power. Depending on the time required to restore facility operations, call center operations could move to a contracted Work Area Recovery site
- Evaluate the impact on the call center workforce. Even if the facility is undamaged, employees affected by the hurricane may be unable to return to work for several days, several weeks, or not at all. Our telephony technology will allow us to return volume gradually to the affected call center as the facility and staffing allow

The Plan in Action

Our decisive and multi-faceted response to actual incidents and emergencies best illustrate the strength of our planning and commitment to our members and community, as shown in Figure M-2.

Figure M-2. Illustrating the Effectiveness of our Plan

AMERIGROUP REAL STORY

Amerigroup’s Business Continuity and Recovery Plan Proven Effective

All too often, Florida is affected by hurricanes. Amerigroup is prepared to continue operations and maintain continuity of care for members during natural disasters. We will continue to ensure that our Contact Centers in Virginia Beach, Virginia, and Nashville, Tennessee, are able to handle all Florida-related phone calls, claims and care services if operations in Florida are disrupted. Our ability to seamlessly maintain operations, ensuring members are safe and continue to receive care, was evident during the 2004 hurricanes in Florida and in 2008, when Hurricane Ike affected our members in Texas.

2004 Hurricanes

Amerigroup Florida successfully executed its Business Continuity and Recovery Plan (BCRP) three times during the summer and fall of 2004, after a series of hurricanes struck the state. With a fully redundant Contact Center in Virginia Beach, all Florida-related phone calls were handled when local Florida operations were evacuated. Access to care was not interrupted despite the multiple hurricanes. Members and providers were still able to access health plan services as a result of thorough preparation in anticipation of inclement weather. Health plan and corporate support staff identified members who were at-risk due to their special needs, such as requiring monitors but having no electricity. Once these members were identified, we reached out to them to offer assistance and ensure members with special needs continued to receive services:

- Prescription drug benefits were extended in case members lost their medication or were not able to access pharmacies during the storms
- Amerigroup Case Managers needed to evacuate our Florida offices, but due to concern for our seniors and members with disabilities in the Long-Term Care program they contacted member by phone or visited them in person
- In some instances, Amerigroup relocated members to a safer environment such as skilled nursing facilities.



After the hurricanes, Amerigroup Associates participated in a series of outreach efforts to support our members and the communities hit hardest by the storms. We delivered food and water to numerous relief centers and reached out to our members and Associates living in the affected areas. Amerigroup Case Managers were able to account for all members in active case management and in Long-Term Care after the storms passed.

2008 – Hurricane Ike

In September of 2008, as Hurricane Ike approached the Texas coast, we initiated planning for the anticipated disruption of our operations in Houston. Following our Hurricane Response Plan, we mapped out the strategy for maintaining operations expecting that many members, providers and Associates would



be affected by the storm. In planning before the storm, we, among a long list of tasks, established telecommunications re-routing to the designated back-up facility, located in Dallas-Fort Worth, to maintain continuity of services for members and re-routed all e-mail for key Associates to e-mail servers in Virginia.

Once the storm subsided, our entire Texas team initiated our action plan, although many were directly affected by the storm themselves. With extensive support from our Dallas-Fort Worth, Corpus Christi and San Antonio staff, we reached out to every member to ascertain if they needed assistance, particularly critical for members with ongoing needs, such as oxygen or dialysis. Our Case Management team contacted special needs members to assess how they were affected by the hurricane and what immediate needs they had. Not only were our technology systems brought back online as quickly as possible, more importantly, our dedicated team maintained our member and provider well-being as their primary focus, going above and beyond to promote continuity of care and service.

SECTION N: GRIEVANCES AND APPEALS

N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:

- o Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*
- o Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and*
- o Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.*

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

Amerigroup has oriented our grievance and appeals processes described in this section to support the goal of member advocacy. We recognize that managed care programs will be new for many Louisiana Medicaid recipients, and our members may be unfamiliar with the process for accessing health care services. We will make every effort to educate and orient members through new member materials, access to a convenient toll-free member call center and ongoing member communications. However, we understand that members who are dissatisfied or wish to file a grievance or an appeal may require extra support throughout the process.

Amerigroup has a highly structured grievance resolution and appeal process, in accordance with all applicable contracts and federal and state laws and regulations that afford several levels of recourse to our members for addressing their issues in a professional, respectful and timely manner. Both grievances and appeals are investigated and resolved by the Quality Management Department at the health plan.

Amerigroup has a record of resolving complaints, grievances and appeals in timeframes below state limits in the states where we operate today. For example, in Texas – our largest health plan – Amerigroup's average time for resolving member complaints for the 12 months ending April, 2011, was 16.2 days from date of receipt to date of notification of disposition. For the same period, the average time for resolving member appeals was 14.5 days.

Grievance System and Process

As directed by DHH, Amerigroup defines a grievance as an expression of dissatisfaction about any matter other than an action. This may include dissatisfaction related to the quality of care of services rendered or available, rudeness of a provider or employee or the failure to respect the member's rights.

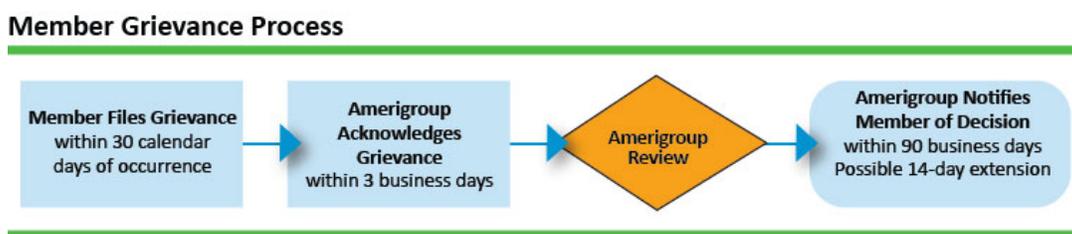
Members can file a grievance either orally or in writing to Amerigroup within 30 calendar days of the occurrence of the matter that is the subject of the grievance. A provider may file a grievance on behalf

of a member, as well as advocate and advise on behalf of the member, with the member’s written consent.

Upon receipt, Amerigroup will acknowledge receipt of a grievance within three business days. We are committed to resolving non-expedited grievances for Louisiana members within 90 calendar days of receipt, including the documentation, investigation, analysis and communication of final results and decisions to members and providers, as appropriate. This timeframe may be extended up to 14 calendar days if the member requests an extension or Amerigroup shows, to DHH’s satisfaction, that there is a need for additional information and how the delay is in the best interest of the member. If there is an extension, Amerigroup will notify the member in writing.

Figure N-1 illustrates the grievance process.

Figure N-1. Grievance Process



Appeals System and Process

Amerigroup defines an appeal as a request for a review of an action, as is consistent with DHH requirements. An action is:

- Denial or limited authorization of a requested service including the type or level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure of Amerigroup to act within the required timeframes

A member may file an appeal within 30 days of an Amerigroup Notice of Action (NOA). A provider may file an appeal on behalf of a member, as well as advocate and advise on behalf of the member, with the member’s written consent. Amerigroup will not take punitive action against a provider who supports a member appeal. Amerigroup will consider the member, representative or estate representative of a deceased member as parties to the appeal.

An appeal may be filed in writing or orally; oral requests for a standard appeal must be followed by a written request. Amerigroup will acknowledge the appeal within three business days. Before and during the appeals process, Amerigroup will allow the member and/or the authorized member representative to examine the members’ case files, including medical records and any other relevant documents and records and to present evidence, and allegations of fact or law, in person as well as in writing.

Upon receipt, Amerigroup will acknowledge an appeal within three business days. Amerigroup will resolve the appeal and provide notice of the resolution within 30 calendar days of receipt of the appeal.

This timeframe may be extended up to 14 calendar days pursuant to State guidelines. Using State-approved templates, we will send an appeal resolution letter without delay to a member and member representative. The written notice will include a description of the actions taken, the reason for the action, the member’s right to request a State Fair Hearing, the process for filing a fair hearing and other information as required by DHH.

Expedited Appeals

Members may request an expedited appeal if the turnaround time for a standard appeal could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function. A provider may file a request for expedited appeal on behalf of a member, as well as advocate and advise on behalf of the member, with the member’s written consent.

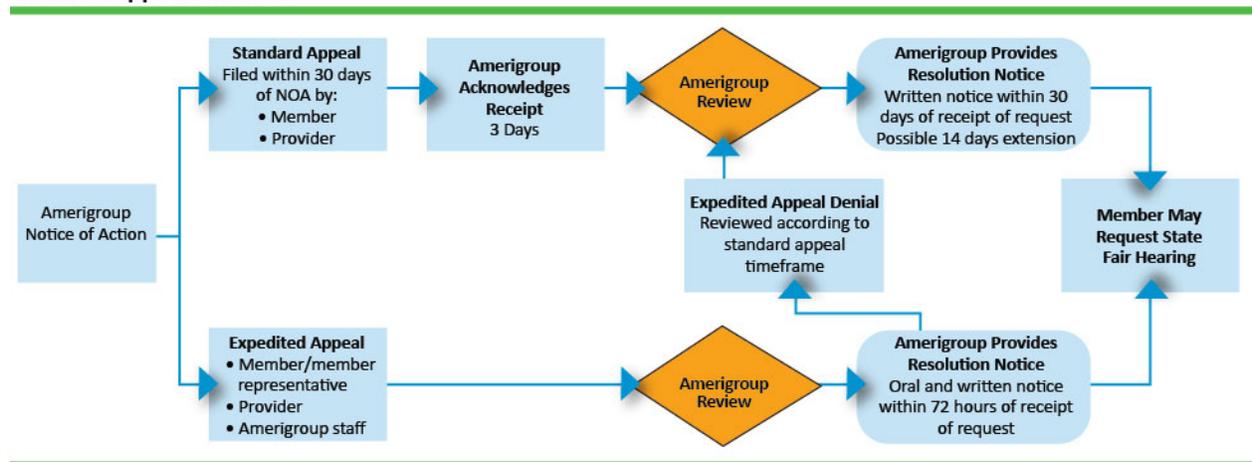
The expedited appeal may also be made by Amerigroup staff when they determine, based on a request from a member, that one of the above conditions is met; by providers making requests on behalf of members; and by members or their representatives. No punitive action will be taken against a provider who requests an expedited resolution. Expedited appeals may be requested either orally or in writing.

Amerigroup will resolve expedited appeals and provide notice, as expeditiously as the member’s health condition requires, within State-established timeframes not to exceed 72 hours after we receive the appeal, unless this timeframe is extended according to DHH guidelines. We will provide written notice of the disposition of the appeal to the member and/or the authorized member representative and make reasonable attempts to provide oral notice as well. Should a request for expedited resolution be denied, we will transfer the appeal to our standard appeals process and provide written and oral notice to the member within two calendar days of the request. If a member does not agree with the decision, he or she may request a State Fair Hearing.

Figure N-2 illustrates the appeals process, including expedited appeals.

Figure N-2. Appeals Process

Member Appeals Process



Amerigroup's Process for Determining if an Expedited Process is Necessary

Amerigroup has defined policies and procedures for managing requests for expedited appeals. Upon receipt of a request for an expedited appeal, the following takes place:

- The request is logged in our information system. If the request is received in writing, it is also scanned into our document management system.
- An Appeals Nurse researches the information and documents the issue in a case file. If additional information is needed, the Nurse will contact the requesting provider or member.
- The Medical Director, or designee, is presented the case within 24 hours of receipt of the appeal identifying that this is an Expedited Appeal.
- The Appeals Nurse ensures that the Medical Director, or designee, who is reviewing the expedited appeal, is not the same physician who was involved in the initial adverse determination and is not subordinate to the physician who made the initial adverse determination.
- The Medical Director, or designee, makes a determination to approve or deny the request for expedited reconsideration within 72 hours of Amerigroup's receipt of the request.
- If the member requests an extension or Amerigroup shows, to DHH's satisfaction, that there is a need for additional information and how the delay is in the best interest of the member, the timeframe will be extended for up to 14 calendar days. If there is an extension, Amerigroup will notify the member in writing.

Notices

All notices will be in writing and include the elements contained within Section 13.6.2 of the RFP. They will be generated and mailed within the timeframes contained with in Section 13.6.3 of the RFP.

Notices will meet the language and format requirements of 42 CFR §438 and Section 12 the RFP to ensure ease of understanding in accordance with Section 13.6.1 of the RFP. Notices will also be National Committee for Quality Assurance (NCQA) compliant.

Amerigroup has all written materials available in prevalent languages as required and will translate materials upon request. Amerigroup will provide interpretation services for all written member materials in any language at no charge. Members can request this interpretation by simply calling Amerigroup. We also offer materials in additional formats at no charge to the member, including large print, audio recording and Braille, to accommodate those with visual or hearing impairments, disabilities or special needs.

Assisting Members in Filing a Grievance or Appeal

Amerigroup educates members as well as providers and subcontractors regarding grievance, appeal and Fair Hearing procedures, including clear and concise instructions, and timeframes through various media. All materials will be subject to review and approval by DHH. As is consistent with our practices in 11 other states, providers and subcontractors will be notified of all appropriate information at the time they enter a contract with Amerigroup. Other points of notification will include:

- Member handbook and provider manual and updates

- Member and provider web sites
- Individual notification to members and providers, such as with adverse decision
- Member and provider newsletters
- Forms for filing a grievance or appeal

Amerigroup will provide forms for filing a grievance or appeal upon request. They will also be posted to our web site.

In all cases, we support the member throughout these processes. Our Member Call Center Representatives are trained to assist members in the grievance and appeal process, and in completing forms. Interpreter and TTY/TTD assistance is also provided. The Quality Management (QM) Leader will be responsible for investigating and leading the resolution of Amerigroup member grievances, serving as a liaison between the member and health plan. The QM Leader will have a thorough understanding of the Louisiana health care environment, including the unique challenges facing the financially vulnerable, elderly and people with disabilities. As appropriate, the QM Leader will interact with members, their caregivers, or advocates throughout the grievance and appeals process, ensuring that members understand their rights and the decisions made. In our experience, designating a specially trained staff member to work closely and advocate on the member's behalf throughout this process results in greater member satisfaction and prompt resolution of grievances and appeals. In all cases, the QM Leader facilitates the process, coordinating language assistance if needed and making sure all materials are in the member's primary language. As necessary or appropriate, the QM Leader will engage the State Ombudsman to facilitate the process.

Ensuring Individuals Making Decisions Have Appropriate Expertise and Were Not Involved in Previous Reviews

All grievances and appeals will be investigated and resolved by the Quality Management Department in our Louisiana health plan.

For each case reviewed, the **name of the individual who conducted the review is logged in our system, ensuring that any subsequent reviews are not by the same individual.**

Furthermore, we will use health care professionals with clinical expertise in treating the member's condition or disease should the case involve a:

- Appeal of a denial that is based on lack of medical necessity
- Grievance about the denial of expedited resolution of an appeal
- Grievance or appeal involving clinical issues

The Medical Director identifies appropriate options based upon the clinical condition involved in the appeal. Options include utilizing other Amerigroup Medical Directors with similar credentials or experience treating the same problems as those in the appeal; utilizing a network practitioner with similar credentials or experience treating the same problems as those in the appeal; or utilizing a contracted external independent review organization.

Timely Review and Response to Member Inquiries, Grievances and Appeals

Our grievance and appeal procedures will be supported by our information system, whose tracking and reporting capabilities together with clearly delineated policies and procedures, including all appropriate timelines, help us ensure a timely review and response to member inquiries.

All actions are noted in our transaction system, and the system automatically generates a NOA letter to the provider and the member notifying them of the denial or reduction of requested services. The NOA will provide the member with information about how to file an appeal or request a fair hearing. The NOA is a formal communication in which we inform the member and/or representative of the decision, the reasons for the action, and the options available to the member to pursue additional review. All notices of action will be developed in accordance with State guidelines and reviewed by DHH prior to use.

Our Member Call Center Representatives review, log and categorize complaints by cause, disposition and type. The Representatives are trained to distinguish between appeals and grievances, to document the issues well, and to log and track all inquiries, grievances and appeals in our transaction processing system. Letters are generated acknowledging receipt of a verbal grievance or standard appeal within three business days. Written requests are scanned into the system and tracked, and an acknowledgement letter is generated and mailed to the member. We house information on inquiries, grievances and appeals in our comprehensive database documenting the status and final disposition of each appeal. We monitor the length of time and resolution for each grievance or appeal, including tracking the acknowledgement and resolution letters, notes, nature of complaint and turnaround times. In addition, our Quality Management team will oversee the resolution process and identify opportunities for improvement.

Coordinating with the State for Member Appealed Grievances

Amerigroup will make every effort to resolve the appeal in a fair and equitable manner, recognizing that on occasion an adverse decision may be rendered. In those cases, a member has the right to request a State Fair Hearing. Members may request a State Fair Hearing after they have exhausted our appeals process within 30 calendar days of the written notice of our appeals determination. Parties to the State Fair Hearing include Amerigroup, the member and his or her representative or the representative of the deceased member's estate. If a member or authorized representative requests a Fair Hearing, Amerigroup will promptly provide the all necessary information and support documentation on the appeal investigation and findings. The Amerigroup Medical Director will serve as the State's contact for Fair Hearings. Amerigroup agrees to be bound by the decision of the State Fair Hearing Officer.

We actively participate in the State Fair Hearing process, providing medical records and other documentation at our expense. We also present evidence at Fair Hearings and if necessary, we arrange non-emergency transportation for those members who wish to attend but do not have transportation. For certain member appeals, we continue to provide benefits to our members according to DHH regulations.

Should Amerigroup or the State Fair Hearing process reverse a decision to deny, limit or delay services not furnished while an appeal is pending, we will authorize the disputed services promptly, and as expeditiously as the member's health condition requires. Should Amerigroup or the State Fair Hearing

process reverse a decision to deny services and the member received the disputed services while the appeal was pending, we will pay for the services.

Using Data from the Grievance System to Improve Operational Performance

Amerigroup's Quality Management Manager tracks all grievances and appeals to identify quality improvement opportunities. This is built into our annual work plan and on a quarterly basis, we analyze grievances and appeals data. The Louisiana Quality Management Committee reviews all reports on a quarterly basis.

Information from member grievances, as well as provider complaints, is used throughout Amerigroup to improve the services we provide to members, providers and our state customers. This includes those filed formally, or through informal methods such as member forums or ongoing provider training sessions. Below are some examples of how Amerigroup has used this valuable information.

- **Improve Clinical Performance.** Amerigroup regularly monitors a long list of statistical clinical indicators and incorporates the results into our clinical quality improvement process. We collect data from multiple sources, including complaint/grievance reports, medical records, claims and encounter data, member and provider surveys, utilization review, peer review and provider site visits.
- **Identify and Resolve Quality of Care Issues.** Amerigroup reviews member grievance data to identify, investigate and resolve quality of care issues. Once the QM Department has identified a case or situation that raises quality of care concerns the Department obtains the appropriate medical chart(s) and any other pertinent information for review from the provider. The Medical Director, after reviewing all available information, makes an initial determination as to the presence of a significant quality issue. Quality of care issues are resolved within 60 calendar days of receipt of requested supporting information. The investigation is expedited based on the clinical severity of the quality of care concern/issue.
- **Improve the Quality of Re-Credentialing.** Amerigroup captures and assesses member grievances and appeals from our member surveys and our databases during the re-credentialing process. In addition, information from quality reviews and provider profiling results from our Quality Assurance Performance Improvement (QAPI) program and Peer Review Subcommittee activities; information from licensing and accreditation agencies, as well as appropriate primary and secondary verifications from the credentialing process; and utilization management data extracted from our data bases is also used in re-credentialing.
- **Best Serve the Needs of Members.** We use information from member grievances, both formal and informal, to improve the service we provide. One recent example came from our New York health plan and began with a member named Ingrid. Ingrid, is a longtime deaf Amerigroup member, who described to one of our Member Services Representative how many individuals in the local deaf community were using a new technology to communicate by telephone. The technology allows deaf and hard-of-hearing callers to conduct video relay conversations through a qualified sign language interpreter. Ingrid introduced our Member Service staff to the technology, and Amerigroup promptly secured the technology and trained our staff to use it. Members with hearing disabilities can now communicate with Amerigroup through this video relay tool. The member actually sees the Amerigroup representative and a sign language interpreter on his or her television screen, visualizing their facial expressions, a subtle but important factor in connecting with members.

- **Improve our Response Time to Members.** Amerigroup recently implemented a powerful new customer service system that helps our employees to more efficiently handle member inquiries and requests — with some very positive results to date. This new customer service system integrates information from multiple back-end systems onto a single screen view for our Member Services Representatives. When a member calls in, for example to request a new ID card, inquire about a benefit or add a new baby to the plan, the integrated desktop eliminates the need for our associates to spend time flipping between screens – while the member is waiting – in search of information during the service call. When an employee is unable to resolve an inquiry during the first call, the issue is immediately routed to the appropriate business area for resolution – with issue status available to all viewers. Since we began using this system in February 2010, call handling times have consistently been reduced:
 - Average call handle time has been reduced by 42 seconds. This amounted to a 13 percent reduction for non-clinical calls and a 15 percent reduction for clinical calls
 - Average call handle time to register a new baby has dropped from 10 minutes to 2 minutes
 - Average call handle time to complete a request for clinical authorization has been reduced by 16 percent

- **Improve Business Performance.** Amerigroup strives to achieve improved business performance through utilization of process improvement techniques, underscoring our dedication to pursuit of operational excellence in our customer interactions as well as a more streamlined and cost effective operation. We have a team staffed with senior level clinical and non-clinical industry experts dedicated to leading business improvement initiatives across the company. We are trained in a full array of business improvement tools that include Six Sigma and Improvement through Process Mapping. We have a disciplined approach that works with the subject matter expert business function owners to document current processes, identify improvement opportunities, develop future processes, ensure correct measurement and reporting of process output and measure customer satisfaction.

Examples of current projects include reengineering of our authorization processes to improve the efficiency of our response to providers requesting services, assure consistency of our interactions with our providers, improve our reporting and analytics of our authorization trends and assuring that emerging best practices are implemented. Another current project is the retooling of our Provider Lifecycle. This includes evaluation of all provider touch points from contracting and ongoing relationship with Amerigroup. It also includes the capturing and maintenance of all data and processing of information including credentialing, reporting, production of directories and maintenance of our provider network.

SECTION O: FRAUD & ABUSE

O.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.

Amerigroup has built a robust Program Integrity operation to ensure that every available health care dollar is spent where it was intended – to protect the health and safety of our members while safeguarding the financial stability of the Medicaid program. Our efforts **prevented or recovered more than \$87.1 million in 2010, with more than \$97.1 million** projected in 2011. We take seriously our role as a **responsible steward of Louisiana’s public funds** with a vested interest in lowering the overall cost of health care and providing quality health care services for Louisiana’s Medicaid members. We believe that our program brings to Louisiana an industry-leading plan that will assist the State in meeting its Program Integrity goals.

Our Comprehensive Approach to Program Integrity Ensures Appropriate Use of Louisiana Health Care Resources

Each year in the United States, health care fraud results in the loss of billions of dollars and unnecessary or unsafe procedures. At Amerigroup, we continue to successfully reduce fraud, abuse and waste in the markets we serve by staying true to our value proposition to deliver quality health care and save taxpayer dollars. We have built a system of processes and controls to prevent and mitigate potential issues.

Table O-1: Categorizing Fraud, Abuse and Waste

FRAUD	Intentionally, or knowingly and willingly attempting to execute a scheme to falsely obtain money or other benefit from any health care program.	ABUSE	Practices inconsistent with sound fiscal, business or medical practices resulting in unnecessary services or costs or potential harm to patient	WASTE	<p><u>Provider-driven:</u> Inappropriate and/or inefficient use of resources</p> <p><u>Amerigroup-driven:</u> Claims payment errors and complex contractual requirements</p>
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Our detailed Fraud, Abuse and Waste Plan is included as Attachment O.1.a. Our plan reflects rigorous best practices deployed across the 11 states in which we operate. Our plan includes the specific requirements of the State, as well as those of each state in which we operate, exceeding DHH requirements. The Louisiana Fraud, Abuse and Waste Plan will be updated annually and submitted to DHH for review and approval. This plan details our goals, objectives and planned activities for the coming year along with written policies and procedures and standards of conduct.

As detailed in the Attachment and described herein, Amerigroup's Plan centers on:

- Extensive prevention and detection protocols
- Investigation practices that include collaboration with DHH's Program Integrity Unit
- Assistance and Cooperation with the Louisiana Office of Attorney General and the United States Attorneys' Offices in the prosecution of Medicaid fraud in Louisiana

Strong Leadership

Amerigroup brings substantial resources to DHH to assure compliance with our Fraud, Abuse and Waste Plan. As the designated "Fraud Officer," our Louisiana Chief Executive Officer CEO, C. Brian Shipp, is ultimately responsible for combating fraud, abuse and waste by ensuring employees cooperate fully with state and federal investigations. The Fraud Officer, as defined in the plan, may delegate this responsibility to the Corporate Investigations Department (CID) Associate Vice President Kathy Runkle. As such, she is responsible for implementing and overseeing the Fraud, Abuse and Waste Plan, to include reporting potential issues to DHH.

Because we are dedicated exclusively to serving members enrolled in publicly funded programs, **Amerigroup maintains a solid program integrity infrastructure**, including the CID that is designed to meet the specific needs of publicly funded health programs. As a recognized industry leader, our team is often asked by our state customers to provide recommendations for strengthening state Program Integrity efforts. For example, because we collegially engage other MCOs in identifying cases of fraud and abuse, states have approached us for guidance on establishing similar partnerships in their own states. Our team regularly speaks at industry conferences about best practices, recognizing that when the industry does well at rooting out fraud and abuse, our state customers, and the members we serve, all benefit.

Extensive Prevention and Detection Protocols

Recognizing that Louisiana is best served when we avoid payment of fraudulent or abusive claims, Amerigroup's **front-end prevention methodology** includes protection against potentially fraudulent or abusive provider billing patterns. Amerigroup deploys McKesson ClaimCheck software for prepayment audits on submitted claims. ClaimCheck[®] automatically and comprehensively audits codes before claims are paid. The system identifies the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesiology procedures identified by CPT[®]-4 and HCPCS codes. The tool's sophisticated clinical logic is based on clinical practice and reimbursement standards, along with the knowledge and judgment of medical experts. The system incorporates clinical coding sources including CPT-4, HCPCS and ICD-9-CM, AMA and CMS guidelines as well as industry standards, medical policy, literature and academic affiliations.

Coding Validation Initiatives

Amerigroup conducts statistical analysis to identify those providers whose billing patterns are outside the norm of their geographic peers through our Coding Validation Initiatives (CVI) program. The program was launched in 2008 with a focus on Evaluation and Management codes and was recently expanded to identify providers who submit claims in a manner that bypasses the edits provided by Amerigroup’s system-based code editing software—resulting in a paid claim when the claim should have been denied. In addition to identifying the inappropriate use of codes, CVI also targets providers who are potentially over-utilizing procedures or billing inappropriate units of measure, thereby creating increased medical costs for services that might not have been medically necessary or supported by documentation.

The CVI program **goal is to change the identified provider’s aberrant billing behavior** through education on the appropriate billing of the applicable codes then monitoring the affected provider’s billing patterns to verify if a behavior change has occurred. If not, our coding specialists – nurses, physicians and certified coders – conduct a post-payment medical record review of the provider’s claims in which we assess overall claims for accuracy, appropriateness for the code billed and standard documentation rules. Depending on the outcome of these reviews, **corrective action could include provider education and monitoring or placement on pre-payment review for a period of time until documentation supports the codes billed.** This allows Amerigroup to make the determination prior to payment of the claim as to whether the CPT code billed was appropriately documented and/or was medically necessary.

Encouraging Reporting through Multiple Avenues

We maintain a confidential Corporate Compliance Hotline for employees, members and providers to report suspicions of fraud and abuse.

Referrals originate from many sources, both internally and externally, and we encourage reporting from multiple avenues. Referrals come from members, providers, employees, law enforcement agencies and professional organizations. Amerigroup also enables reporting through confidential email, a toll-free telephone number or a link through the company website. Amerigroup policies include provisions for protecting confidentiality of reporting, including untraceable confidential voice mail and email.

REAL SOLUTIONS *mean* REAL RESULTS

To date, Amerigroup has avoided more than
\$6.5 MILLION
in inappropriate payments through our
Coding Validation Initiative.

REAL SOLUTIONS *mean* REAL RESULTS

Added Benefits through CVI

In Texas, we implemented a prepayment review process for hospital claims, meeting specific criteria for well-baby and sick-baby reviews.

In New Mexico, we implemented a program to minimize the potential for provider steerage that utilizes a validation process for durable medical equipment (DME), home health and personal care attendants. By implementing this process, the health plan identified a number of cases where the changes that were requested by providers were not in line with the member’s request. Amerigroup also implemented a new assessment process focused on removing variability and subjectivity when evaluating home services. By adding a consistent scoring methodology, the health plan will begin to see a reduction in higher level services that are not necessary.

In Maryland, we implemented a hospital audit program to help identify any possible fraud, waste or abuse. This initiative resulted in the recovery of \$5.8 million.

Investigations and Collaboration with DHH

Amerigroup's CID leads all investigative efforts for any potentially fraudulent or abusive claim or issue, regardless of how it was identified. If the CID investigator determines that fraud or abuse likely occurred, the case will be referred to DHH.

The CID, which reports directly to the Chief Risk Management Officer, is comprised of a multi-disciplinary team of investigative staff, including nurses, retired law enforcement officers, health care investigators, auditors and programmers. Many of our employees maintain professional certifications from organizations such as the Association of Certified Fraud Examiners, National Health Care Anti-Fraud Association, the Association of Certified Fraud Specialists and America's Health Insurance Plan's Health Care Anti-Fraud Associate Program. The investigative staff research and monitor fraud detection resources.

REAL SOLUTIONS *mean* REAL RESULTS

Amerigroup Referral Nets State Customer Significant Savings

Several years ago Amerigroup referred a small case of approximately \$700 to one of our state customers for further investigation. That state recently convicted the DME company owners of health care fraud after billing the State and others over \$2.3 million for Medicaid claims.

Investigations

When CID identifies a potential fraud or abuse issue or receives a referral, the lead is entered in the CID database. CID performs an initial assessment to establish predication and the need for additional investigation. Investigations are prioritized and completed in a timely manner. The investigations are in-depth and can include contract and credentialing reviews, licensure validation, data analysis, medical record audits, and interviews with members, providers, and office staff, onsite office visits, internet research or collaboration with other managed care organizations.

The results of these investigations are shared with the Fraud Officer, Chief Risk Management Officer and other senior-level executives. The Fraud Officer and CID meet regularly to discuss matters of potential fraud, abuse and waste.

Technology Tools

Augmenting referrals from across the Amerigroup organization, Amerigroup's CID undertakes continual data mining to identify potential cases. Amerigroup utilizes EDIWatch Intelligent Investigator™, a fraud detection tool designed specifically for health care investigators, investigation management and support staff. EDIWatch Intelligent Investigator™ is a retrospective, rules-based data analysis system optimized for the purposes of health care fraud detection. EDIWatch Intelligent Investigator™ applies thousands of statistics, rules and trends against paid claims data. These rules cover all general categories of potential health care fraud and abuse, including provider, member, facility, dental and pharmacy. EDIWatch Intelligent Investigator™ maintains claims data for three years, and identifies instances where values fall outside or in excess of norms. The aberrant providers identified through EDI Watch become leads for the CID investigators.

Collaboration with DHH

Amerigroup understands that to be successful in the fight against fraud, abuse and waste, we must partner with DHH. **When the evidence supports the allegation of fraud or abuse, CID will report the case, within three business days to DHH's Program Integrity Unit for further handling and deliver timely reports highlighting activities and results.** Additionally, the designated CID lead for Louisiana,

who has more than 10 years of related experience, will cultivate productive relationships with DHH, its Program Integrity Unit and law enforcement. Cases in which we identify suspected fraud will be referred to DHH for investigation, and we will aid the State as necessary in their investigations. We take seriously our role as a sentinel for the State and will diligently pursue all suspected cases, regardless of size.

To foster ongoing collaboration, **our team will meet on a quarterly basis with DHH** and we will support DHH efforts to comply with the federal Recovery Audit Contractor (RAC) Program. **We will also work with DHH’s Medicaid Surveillance and Utilization Review Department and their designated vendor**, to complement our internal data mining activities. In most states in which we operate, we also participate in regional task forces aimed at reducing health care fraud, including FBI-sponsored task forces in many states. Task force activities differ state by state and may include educational activities, case and scheme sharing, and networking with other MCOs on identifying issues and ways to reduce fraud, abuse and waste. We look forward to engaging in similar activities in Louisiana. This collaboration optimizes the State’s efforts, minimizes redundancy and expands the State’s efforts to reduce increased costs associated with fraud and abuse.

**REAL SOLUTIONS *mean*
REAL RESULTS****Provider Convicted of Health Care Fraud**

Amerigroup was recognized by the U.S. Attorney’s Office for providing assistance in a fraud case in Washington, D.C. Dr. Ehigiator O. Akhigbe billed for services not rendered and inappropriately modified members’ medical records. Akhigbe was sentenced to 53 months in federal prison, fined and ordered to pay Amerigroup \$133,418 in restitution based upon CID’s investigation, referral and testimony. U.S. Attorney Ronald C. Machen Jr., FBI assistant director Shawn Henry and D.C. Inspector General Charles J. Willoughby extended their appreciation to Amerigroup’s internal fraud investigators for first detecting and reporting Akhigbe’s conduct.

Assistance and Cooperation with State and Federal Authorities in the Prosecution of Medicaid Fraud

Amerigroup understands that Louisiana’s Medicaid Program Integrity Division (PID) operates under a Memorandum of Understanding with the Louisiana Attorney General’s Medicaid Fraud Control Unit which sets the process for investigations and referrals for potential fraud cases. We are prepared to work with the Medicaid PID, the Louisiana Office of Attorney General and the United States Attorneys’ Offices in the prosecution of Medicaid fraud in Louisiana.

With a full understanding of the impact of fraud, abuse and waste on our organization, our members and our state partners, we will continue our corporate wide efforts. We will build upon our experience and proven processes by exploring additional innovative tools and methods to increase our efficiency in detecting and preventing fraud, abuse and waste.

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CORPORATE INVESTIGATIONS DEPARTMENT

FRAUD, WASTE, AND ABUSE PLAN

STATE of LOUISIANA

As of 5/13/2011

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FRAUD, WASTE AND ABUSE PLAN IMPLEMENTATION

The initial Corporate Investigation Department (CID) Fraud, Waste and Abuse Plan were implemented in 2004. The Fraud, Waste and Abuse Plan is considered a “living” document and the CID will continue to evaluate, on an ongoing basis, their organizational, operational, training and staffing requirements to keep up with the current changes in the industry and ever changing fraud schemes. This re-evaluation will also allow the CID to ensure that their operations conform to the strictest statutory and contractual obligations.

When the Fraud, Waste and Abuse Plan is amended, the changes will be reflected in the written plan and notification will be issued to appropriate regulatory authorities at least on an annual basis. If contractual requirements dictate notification more frequently than on an annual basis, such will be noted in the addendum to this plan.

CID shall maintain up-to-date and accurate records on their fraud, waste and abuse prevention and detection plan, which shall at minimum, include those necessary to prepare the reports as required in each contract as detailed in the addendum.

MISSION STATEMENT

We will perform investigations of known or suspected fraudulent activities by providers, members, or associates and improve the awareness, prevention, detection, and prosecution of fraud, waste, and abuse. We will operate to protect the Company's assets, integrity and reputation, and support compliance with laws and regulations governing the prevention and reporting of fraudulent activity.

We will improve the healthcare delivery system through effective detection, prevention, investigation, and prosecution of fraud by developing a comprehensive and creative fraud, waste, and abuse program with integrity, passion, excellence, and innovation.

We will achieve this through the efforts of dedicated personnel, the implementation of technology and a partnership with Regulators, Providers, Law Enforcement, Plan Members and Amerigroup Associates – all with a common goal and focus on improving the quality and affordability of the healthcare system.

We will do this in a culture where members of our team are recognized for the value they bring, and where exceptional effort results in exceptional outcomes.

DEFINITION OF FRAUD, WASTE, AND ABUSE

Black's Law Dictionary defines Fraud as, "an intentional perversion of truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him or to surrender a legal right" More simply, fraud is intentionally misrepresenting a material fact that is actually relied upon by another.

The four (4) major elements of fraud are:

- A false statement
- Of material matter
- Which is willfully made
- With an intent to deceive

Operationally, Amerigroup defines fraud as "a material and intentional misrepresentation for the purposes of obtaining a benefit otherwise not entitled."

Abuse is defined as "an activity not consistent with generally accepted business, medical, or fiscal standard practices."

Waste results in the expenditure of resources in excess of need. Waste can simply be the result of sloppy, careless, or inefficient billing or treatment. This carelessness results in unnecessary costs being incurred by the Medicaid system. Unlike fraud, waste does not involve intent to deceive or misrepresent.

The above definitions are included as overall guidance when assessing fraud, abuse, and waste and should be used in the absence of a state specific definition. If applicable, the State specific definition is included in the addendum to this plan.

Amerigroup Corporation
FRAUD, WASTE, AND ABUSE PLAN

AMERIGROUP CORPORATION OVERVIEW

Amerigroup Corporation, headquartered in Virginia Beach, Virginia, improves healthcare access and quality for low-income Americans by developing innovative managed health services for the public sector. At present, Amerigroup serves more than 1.9 million members in Florida, Georgia, Maryland, New York, New Jersey, New Mexico, Nevada, Ohio, Tennessee, Texas, and Virginia. Amerigroup refers to each of these locations as a Plan.

Plan Operations, such as claims and customer service are managed from Corporate Headquarters.

Amerigroup Corporation
FRAUD, WASTE, AND ABUSE PLAN

FRAUD OFFICER

The Chief Executive Officer (CEO) of each Plan is the designated Fraud Officer, unless otherwise elected, responsible for all reporting of fraud, waste, and abuse to the Amerigroup Corporate Compliance Officer, as well as to appropriate state agencies.

The Fraud Officer is also responsible for ensuring that employees cooperate fully with state and federal fraud, waste, and abuse investigations, as needed. The Fraud Officer may delegate reporting of fraud, waste, and abuse to the Corporate Compliance Officer, the Assistant Corporate Compliance Officer, or Corporate Investigations Department (CID) Management.

Periodic meetings are held between the Fraud Officer and the CID to discuss matters of potential fraud, waste, and abuse. All provider cases where the evidence supports the allegation of fraud, waste, and abuse are referred to the Fraud Officer and to the Corporate Compliance Committee, if appropriate.

The contact information for the Fraud Officer can be found in the addendum to this contract.

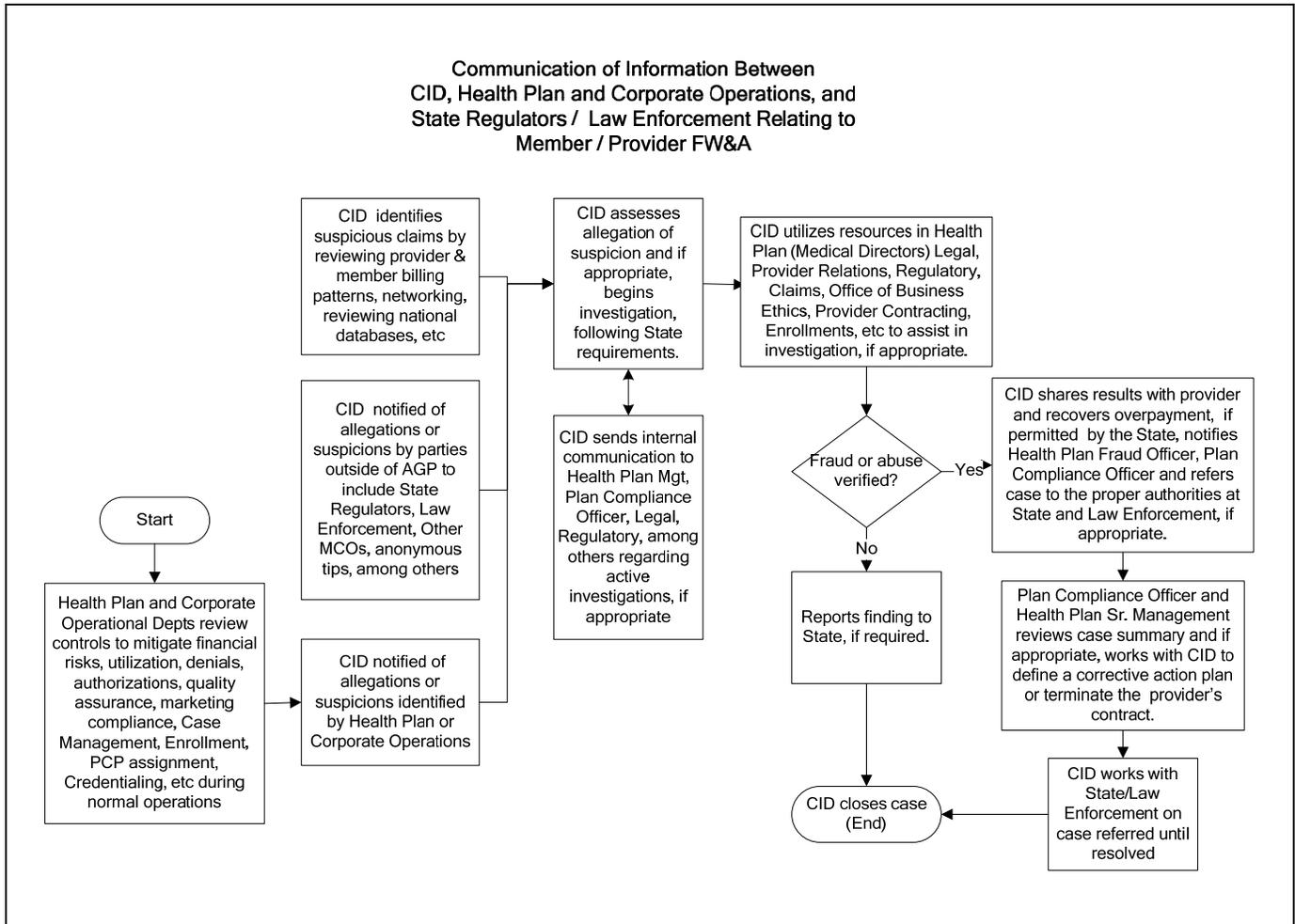
CORPORATE INVESTIGATIONS DEPARTMENT (CID)

The CID was developed by Amerigroup to establish controls, develop a coordinated and consistent approach to fraud, waste and abuse efforts, and to ensure compliance with mandated regulatory requirements.

The CID is an internal proprietary function, fully dedicated to the detection, prevention, investigation and prosecution of fraud, waste and abuse. The unit is physically separate from the Claims and Operations Departments within secured space consisting of offices, cubicles and file cabinets.

Although CID is independent of the Health Plan and Corporate Operations, they have strong reporting relationships relative to communication. The Health Plans and Corporate Operational Departments have processes to review utilization, controls to mitigate financial risks, quality assurance, and compliance, among many others. The Health Plans and Corporate Operational Departments are tasked with ongoing review of compliance with Medical Necessity Determination guidelines as well as review of items such as denial patterns to ensure that the processes used are in compliance with state contractual and regulatory requirements as well as to ensure that there are no unnecessary barriers to access to care for Health Plan members. Therefore, these relationships are necessary in order to effectively detect, prevent, investigate, and report fraud, waste, and abuse.

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If and when necessary, external resources, such as surveillance, expert document review, and testimony, will be retained.

Reporting

CID Management is responsible for the Department, and reports to Dennis Kinzig, Chief Risk Management Officer.

Budget

The CID maintains a distinct budget within the overall Risk Management and Audit Department.

Policy Decisions

CID Management collaborates with the Chief Risk Management Officer and the Fraud Officers to make policy decisions. When applicable, decisions are coordinated with Plan Management, Counsel, Regulatory Services, and Senior Management.

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STAFFING & RESOURCE RATIONALE

The Amerigroup CID has formed its staffing philosophy based on the various skill sets that may be utilized during healthcare fraud investigations. Amerigroup has partnered with its Human Resources (HR) Department to create detailed job descriptions, adequate staffing levels, and competitive compensation packages particular to diverse nature and complexity of being at the forefront in battling healthcare fraud.

At the center of the staffing and resource rationale, Amerigroup must position itself not only for the present, but also for the future. There are numerous aspects involved with detection, investigation and resolution of any suspected or potentially fraudulent healthcare activity or scheme, and the more diverse the unit is, the more capable and proficient it becomes in its ability to conclude investigations successfully.

Awareness amongst Amerigroup associates is the Company's first line of defense, and the CID requires its staff to be proficient in presenting, educating and training Amerigroup employees and business partners. CID associates are preferred to possess excellent communication skills with the ability to utilize the technological presentation platforms available through software applications.

Data mining and manipulation are vital to the CID, thus it is considered greatly beneficial if all team members are comfortable with navigating within claims systems and data, proficient to highly skilled with Excel and Access, adept with internet and intranet usage, and knowledgeable with the use of sampling, statistics and extrapolation. This is considered a key element within the CID. The CID has hired a dedicated Data Analysis Manager who has the ability to craft and pull specialized targeted queries. This full time position enhances the unit's ability to be proactive in detecting aberrant billing patterns, schemes, or front end logic avoidance billing techniques.

Amerigroup highly values the unique skill sets and investigative techniques of law enforcement, and has centered a portion of its core investigative ability and strategy on personnel with those qualifications. The field experience and interaction within federal and state agencies that prior law enforcement have allows the Amerigroup CID to maximize its networking and liaison across the broad spectrum of agencies that may be affiliated with any healthcare related investigation. Additionally, the previous interaction within the legal system allows the CID to posture cases for criminal as well as civil charges.

Medical knowledge is absolutely vital to the success of the unit. Currently the CID has two Registered Nurses and several Certified Professional Coders (CPCs). Within the framework of Amerigroup, there are several RNs, Pharmacists and Doctors, who can be utilized. Having a full time, dedicated team member has greatly impacted the efficiency of the unit, and additionally allows for all team members to work directly with a medical

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expert. In addition, CID utilizes the Medical Directors with each Plan to assist in provider meetings, medical terminology, and medical necessity issues. We also contract with other medical experts, when necessary.

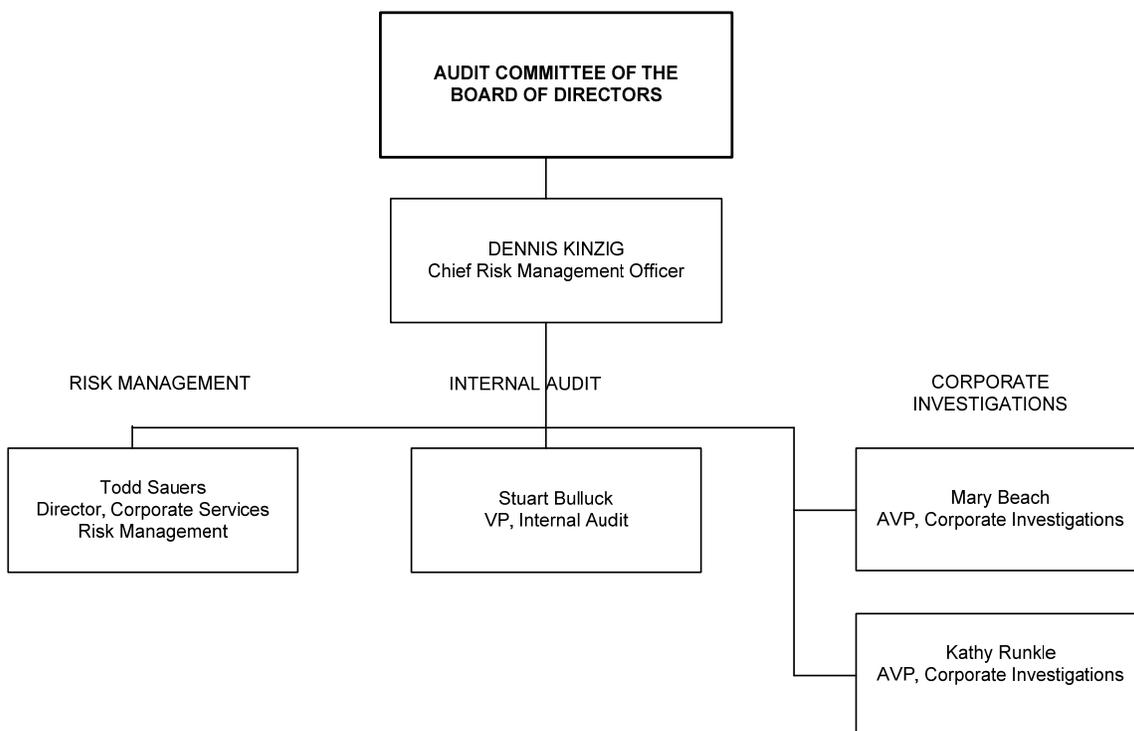
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Each Health Plan will have a Lead Investigator assigned to be the primary contact with the Fraud Officer, Health Plan and Operational associates, State Regulators, and Law Enforcements in that market. All other CID staff will also be utilized to prevent, detect and investigate fraud, waste, and abuse in each market, in addition to resources throughout the Health Plan and Corporation to include Legal, Regulatory, Information Technology, Claims, Quality Assurance, Medical Management, Credentialing, Enrollment, Cost Containment, Medical Directors, etc.

Staffing levels are assessed and established based on numerous factors including, but not limited to:

- Total Member Population
- Claims Processed
- # of Suspect Cases and/or Claims
- Perceived Vulnerability
- Investigator Caseload & Case Clearance Rates

CID resources for each market will also be allocated based upon the above criteria. Staffing levels will be re-evaluated periodically in order to maintain effectiveness. The following are the current organizational charts relative to the CID, including their reporting relationship within Amerigroup.



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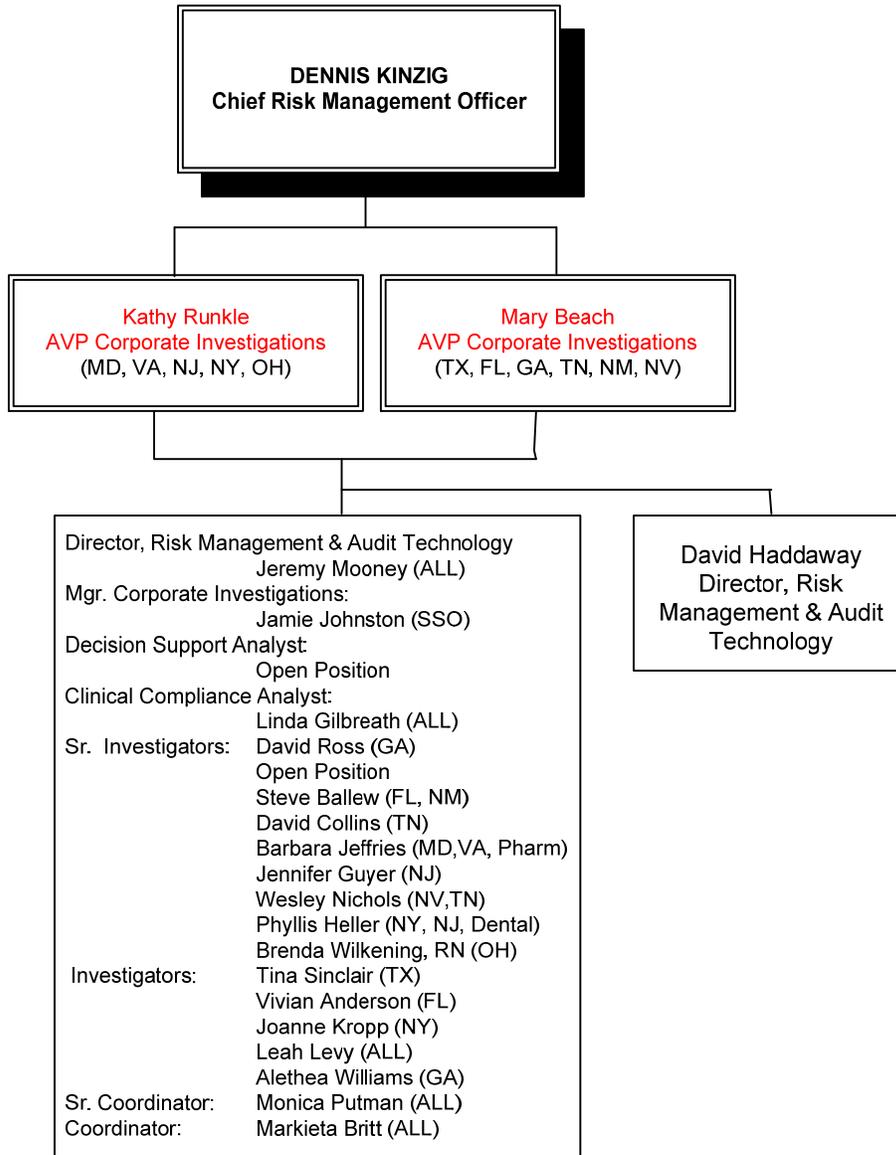


Exhibit 1 includes a summary of staff qualifications and **Exhibit 2** includes the job descriptions.

EDUCATION & EXPERIENCE REQUIREMENT

In accordance with applicable regulatory requirements pursuant to education and experience, as well as CID management philosophy, the CID has established the following minimum qualifications for investigative positions in the CID:

- A Bachelor's degree; or
- Minimum of 4 years experience in Criminal Justice, Business, Insurance, Medical Insurance Claims, or other investigative field required; and
- Minimum 2 years experience conducting full scale insurance investigations and interacting with state, federal and local law enforcement agencies.
- Law enforcement experience preferred.
- Clinical experience a plus.

Certification and Licensure:

- Accredited Health Care Fraud Examiner (AHFI) preferred.
- Certified Fraud Examiner (CFE) Preferred

DETECTION & INVESTIGATION OVERVIEW

Referrals originate from many sources, both internally and externally. They are received through the mail, via the telephone, in person, email, internet, intranet, or from the compliance hotline. They will come from enrollees, providers, employees, law enforcement agencies and professional organizations. The CID independently identifies cases through the media, data analysis, the use of appropriate software and databases, and other intelligence gathering techniques.

Members and providers can report suspicions of fraud, waste, and abuse through Amerigroup's toll free number, the Corporate Compliance Hotline, or the fraud, waste, and abuse reporting links on Amerigroup's website. Newsletters will periodically remind members and providers of the mechanisms to report suspicions of fraud, waste, and abuse.

CLAIMS TO BE REFERRED

Claims that have definite indicators of fraud, abuse, or waste should be referred to the CID for investigation. Claims to be referred should include:

- Claims containing red flag indicators, or other objective evidence of fraud, regardless of the number of indicators;
- Any claim that involves a direct contact with or by an informant must be referred immediately to the CID;
- Information obtained as the result of contact by or through third party sources such as police reports, regulatory inquiries may justify a CID referral;
- All claims in which there has been a law enforcement contact regarding the possibility of fraud should be referred to the CID;
- Cases involving employees, contractors, or vendors should be referred to the CID.

REFERRAL TIMING

To ensure a prompt investigation, all suspect claims must be forwarded to the CID within 24 hours upon the recognition of indicators and suspicion of possible fraud. Information sent to CID will include all pertinent provider/member information, claims detail, areas of concern, etc.

Any additional claim documentation received by the Claims Department should be forwarded immediately to the CID for evaluation and possible use in the investigation.

All referrals will be entered into the CIMS (Corporate Investigations Management System) database, receive an initial assessment, and be prioritized within 30 days of

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receipt or otherwise specified by state regulations. Investigations will be completed in a timely manner; however, the actual time frame for an investigation will vary based upon circumstances of the case, the magnitude of the issues, and CID's priorities.

REFERRAL METHODS

Hotline

A voice-mail box has been established to permit users to leave information on a confidential hotline. This number can be accessed both within each Plan, and external to the office.

Within Each Plan

In Virginia Beach

Dial "3RISK" (37475) from within the Virginia Beach offices

In Other Plan Offices

Dial 33633 from each Plan office, or

External Calls

Dial 757-518-3633 from outside the office.

Callers who wish to remain anonymous can call the External Compliance Hotline at 1-877-660-7890 or through the external reporting website:

<http://amerigroup.silentwhistle.com>

Members are also encouraged to call the Amerigroup toll free number to report allegations of fraud, abuse & waste.

1-800-600-4441

E-mail:

In addition to the hotline, CID has established an e-mail account dedicated to referrals within the organization. All Amerigroup associates can reach CID by selecting "Corporate Investigations" from the global address book within the e-mail system, Outlook.

External to Outlook, suspicions of fraud, waste, and abuse can be emailed directly to CID at corpinvest@amerigroupcorp.com.

Online:

Suspicions of fraud, waste, and abuse can also be referred to CID through Amerigroup's website www.amerigroupcorp.com. There are fraud, waste, and abuse links in the member and provider portals to report details regarding a potential issue. This information is then forwarded directly to the CID email inbox which is monitored daily.

TRACKING SYSTEM

CID tracks cases through a Corporate Investigations Management System (C.I.M.S.) C.I.M.S. is a Microsoft Access based proprietary database that allows for effective tracking and reporting of case information. C.I.M.S. is secured in a private electronic folder, in which only CID and Risk Management staff have access.

The system has several main components which include, but are not limited to:

- Main Case Information
- Additional Related Case Lists
- Subject Information
- Complainant Information
- Financial Data
- Criminal Referral Information
- Regulatory Referral
- Extensive Reporting Features

Within each of these sections, data is tracked to include the date of referral to CID, the date information was submitted to the state (if applicable), the date the case was cleared, jurisdiction, demographic information on the subject, provider status, allegations and much more.

A new feature is the ability to link case notes and investigation reports to the database. This allows the investigator to update notes within the CIMS database, and moreover, management to review cases without the need to go out of the system and open additional files.

One of the most beneficial features is the reporting component. These reports are available to the entire department to run as necessary. CID runs all reports on at least a monthly basis for status of all cases by state and category. Several standard reports are configured to provide CID management with real-time case information that assist in the prioritization of cases and risk assessment. For example, by reviewing cases by jurisdiction, and type, a trend may be uncovered to highlight a spike in pharmacy fraud cases in a given state, or even city. This intelligence would allow CID to develop a plan to review additional risk exposure in the specific area.

A distinct section of the database is limited to “leads”. These leads can develop from a variety of reliable sources, as highlighted under the detection section of this plan. However, generally speaking, leads are generated from reliable sources such as Law Enforcement Requests for Investigate Assistance (RIA) received from the National Health Care Anti-Fraud Association (NHCAA), or directly from any of the following: (list is not all inclusive)

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- FBI
- HHS-OIG
- State MFCU's
- State Attorney's General
- Fraud Workgroup/Taskforce Meetings
- State Regulatory Agencies

In addition to the above sources, leads are also generated from news articles, fellow associates, and other intelligence streams.

A lead is reviewed to assess exposure and risk. Upon the completion of that review, a lead may become a "case" or maintained strictly for information and intelligence purposes.

It should be noted that being listed in or referenced in the "leads" database does not necessarily represent wrongful, abusive, or fraudulent practices. A lead simply recognizes that enough information is available to warrant tracking of information.

OTHER PHYSICAL RESOURCES

The CID has access to a variety of useful public and restricted access databases. They include, but are not limited to:

- ❑ Lexis Nexis (Public Records) *pending contract evaluation & approval*
- ❑ Accurint (Public Records) *pending contract evaluation & approval*
- ❑ SIRIS (NHCAA's Special Investigation Resource and Intelligence System)
- ❑ United States Health & Human Services Sanctions Database
- ❑ State Licensing & Sanctions Web Sites

SYSTEM BASED FRAUD CONTROLS

As part of its fraud efforts, Amerigroup utilizes the following system based fraud controls:

□ EDIWatch Intelligent Investigator

Intelligent Investigator™ is a user-friendly, desktop fraud detection tool designed specifically for healthcare investigators, Special Investigations Unit (SIU) management and support staff. It is a retrospective, rules-based system that detects anomalies in data using thousands of statistics, rules, and patterns. These examinations track many different aspects of healthcare billing and payment activities and identify instances where values fall outside or in excess of norms. EDIWatch rules are based on objective industry reference sets maintained by sources including the AMA, CMS and state Medicaid plans; investigation staffs of EDIWatch clients; research by EDIWatch investigators; and from EDIWatch's participation in industry conferences such as NHCAA training programs, the Blue Cross and Blue Shield Antifraud conference, and other industry forums. EDIWatch releases new rules patterns and reports quarterly. These rules open the following questions for the investigator to answer:

- Is there an identifiable pattern of behavior?
- What is the potential impact?
- Who is responsible?
- How long has the scheme been in operation?
- Is it ongoing?
- Has it evolved?
- Who else may be doing the same thing?

Intelligent Investigator examines paid claim data in general categories of potential healthcare fraud to include:

- | | |
|------------|------------|
| ▪ Provider | ▪ Pharmacy |
| ▪ Member | ▪ Dental |
| ▪ Facility | |

Claim Check & History Checker

Amerigroup utilizes McKesson Corporation's ClaimCheck® software to perform prepayment audits on submitted claims.

ClaimCheck® automatically and comprehensively audits codes before claims are paid. The system identifies the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesiology procedures identified by CPT®-4 and HCPCS codes. ClaimCheck's sophisticated clinical logic is based on clinical practice and reimbursement standards, along with the knowledge and judgment of medical experts. The system incorporates clinical coding sources including CPT-4, HCPCS and ICD-9-CM, AMA and CMS guidelines as well as industry standards, medical policy, literature and academic affiliations.

PRE/POST PAYMENT REVIEW

Amerigroup has contracts with some States that require pre and post payment provider review in situations where fraud, waste, and abuse is suspected. The Operational Departments, including Claims, Medical Management, and the National Contact Center, have an affirmative obligation to inform the Corporate Investigations Department or the Corporate Compliance Officer of situations requiring pre and post payment review. The Corporate Investigations Department will investigate these referrals and also independently identify and investigate categories of claims or providers identified as potentially abnormal or suspicious.

The following procedures will be followed when appropriate for the detection of fraud, waste, or abuse:

- 1) The Claims Department will utilize ClaimCheck, McKesson Product, to systematically review provider billing patterns on a pre-payment basis to identify suspected fraud, waste, and abuse.
- 2) Claims Analysts shall review claims pended by system edits for potential fraud, waste, and abuse such as:
 - gender appropriate billing
 - billing multiple items for single time procedures
 - un-bundling
 - age inappropriate procedure billing
- 3) The National Contact Center shall identify potential fraud, waste, and abuse from member and/or provider calls such as:

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- ☐ Providers charging Medicaid beneficiaries for covered services
 - ☐ Providers billing for services not rendered
- 4) Profiling information will be utilized post payment to flag suspicious under and over utilization. Profiling via submission of encounter data will compare individual providers to members of the same peer group, while taking into account the individual provider's case mixture to identify:
- ☐ Below average well visits
 - ☐ Increased incidence episodes of care for a specific population, such as asthmatics, that is not supported by the medical records.
- 5) Outside vendors will be utilized to conduct chart reviews on selected hospitals in order to establish the accuracy of provider billing on a post payment basis, which would also identify altered, falsified, or destroyed clinical record documentation.
- 6) The CID will coordinate with the Provider Network Support Department to place the provider under review and monitor both pre and post payment claims transactions for a 90-day period if appropriate.
- 7) The CID will conduct reviews of providers identified and suspected of:
- ☐ misrepresentation of medical information to justify referrals and providers, and
 - ☐ failure to render medically necessary covered services that they are obligated to provide according to their subcontracts.
- 8) Amerigroup's credentialing and recredentialing process shall include use of the Federal Medicare Medicaid Sanction List or the List of Excluded Individuals and Entities (LEIE) or its equivalent, to identify excluded parties during the process of enrolling providers to ensure the Plan providers are not in a non-payment status or excluded from participation in federal health care programs. Amerigroup understands it must not employ or contract excluded providers and must terminate providers if they become excluded.

Additionally, CID collaborates with the Coding Validation Initiative (CVI) Team, which is part of Corporate Reimbursement Policy Management Department, to educate and/or perform post payment and pre-payment reviews of providers with possible aberrant billing patterns. These providers are categorized by the severity of the aberrancies. If a post payment review is conducted, the medical records are reviewed for accuracy, appropriateness for the code billed and standard documentation rules. Depending on the outcome of these reviews, the providers may be educated and monitored, placed on pre-payment review for a period of time until documentation supports the codes billed or referred to CID for full investigation. The investigation by CID could result in a referral to State and Federal agencies. CVI maintains communication with CID to ensure there is no duplication of efforts between current investigations open and providers being reviewed by the CVI Team.

PHARMACY FRAUD, WASTE AND ABUSE

Amerigroup CID has created an anti-fraud workgroup with Caremark, our delegated Pharmacy Benefit Manager (PBM). Through this workgroup, which includes representation from CID, Caremark's Internal Audit Department, and often associate's from Amerigroup's Pharmacy Department; we have developed a process to improve our overall fraud efforts in this high risk area. Some of the recent improvements include:

Special "ad hoc" reports have been developed by CID and are generated by Caremark on a monthly basis. These reports include:

- Pharmacies with highest number of prescriptions issued for the following drugs:
 1. Muscle Relaxants (Soma)
 2. Methadone
 3. Oxycodone
 4. Benzodiazepines
 5. Duragesic
 6. Hydromorphone (Dilaudid)
 7. Alprazolam (Xanax)
 8. Avinza
 9. Epogen
 10. Stimulants (Adderall)
 11. Pseudoephedrine products
 12. Anti-Psychotic Medications
 13. Expensive HIV Medications

- Top10 Amerigroup members with the highest prescription utilization by dollar.

- Any pharmacy where **1 provider** (or provider group) constitutes an inordinate amount of the total revenue/volume.

- Any pharmacy where **1 drug** constitutes an inordinate amount of the total revenue/volume.

In addition, we review a summary of field audit results of all pharmacies audited in order to identify any trends. We're establishing statistics and standard criteria for referring suspected fraud, waste, and abuse for additional investigation. This process not only provides excellent benchmarking of audit results, but removes objectivity from referrals of suspected fraud.

Based upon the review of all of the reports, audits are opened, tracked in an Audit Log, and discussed during monthly meetings. Based upon the reviews, CID or Caremark can identify pharmacies, providers, or members to be audited or investigated by either CID or Caremark. CID tracks pharmacy cases in their CIMS database.

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In addition, each year Caremark conducts a number of standard, as well as "blitz" audits. A "blitz" audit consists of a series of concentrated audits in a defined geographic area. These results are also tracked on the Audit Log and discussed monthly.

EMPLOYEE/ASSOCIATE DETECTION

The recognition and identification of potentially fraudulent claims by Amerigroup employees often precedes the referral of a claim or other situation to the CID. All claim and operations personnel involved in the processing and/or review of claims and enrollment, including supervisory personnel, must have the ability to recognize fraud indicators and/or issues that may warrant investigation by the CID.

Situations that may require a CID investigation can be identified by the presence of definite fraud indicators. Fraud indicators or red flags are factors that, based on industry experience over the years, have appeared frequently in fraudulent, abusive, or wasteful claims.

As noted previously, employees should be aware that there are other significant factors that sometimes justify a referral to the CID. Those factors include, but are not limited to, situations where there are informants providing information on a case, admissions of fraudulent activity, and/or law enforcement information.

The existence of a single factor or even a combination of fraud indicators is not conclusive proof that a fraud has been committed. All employees should be aware that the presence of these indicators requires that an investigation be conducted to establish a fact pattern that either indicates or excludes the existence of fraud, abuse, or waste.

As noted in the training section of this plan, associates are provided training and education to identify potential fraud through specific examples and a review of red flags.

CID DETECTION METHODS

As noted above, Amerigroup and the CID have implemented a variety of system tools and edits that provide both random and targeted approaches to aid in the detection of fraud, waste and abuse. Through the use of these tools CID is able to apply any and all of the following in their detection approach:

- Data Matching/Mining
- Data Analysis
- Trending
- Statistical Activities
- Claim Edits

In addition to the system tools, the CID also utilizes more traditional intelligence gathering techniques to enhance its fraud, waste and abuse detection and prevention capabilities. As noted previously, these techniques include, but are not limited to:

- Information Sharing with Other Carriers For Early Identification of Schemes
- Participation in Fraud Workgroups and Taskforces
- Use of the Special Investigations Resource & Intelligence System (SIRIS)
- Use of the SIRIS “Schemes” Database, a set of data related only to schemes, not specific individuals or entities.
- Review of News Articles Related to Fraud & Abuse Nationwide
- Dedication to Education & Training Related to Fraud & Abuse
- Coordination & Partnership with Internal Departments to Identify Areas of Risk

RED FLAGS OF POSSIBLE FRAUD (FRAUD INDICATORS)

The following red flags may be an indicator of possible **provider** fraud, waste or abuse:

- Member's Address is a PO Box
- Services (non emergent) billed on a Sunday or holiday
- Erasures and/or strikeovers on the claim
- Handwritten claim forms
- Provider refuses to supply supporting documentation
- All patients receive the same treatments and diagnosis
- Excessive diagnostic testing and no treatments
- Consistent submission of the highest level codes
- Excessive use of ALS (advanced life support)
- Ambulance transports with no corresponding facility claim
- Multiple submissions of the same claim
- Issuing narcotics without corresponding E&M visits
- Excessive use of "unlisted" procedures
- Claims submitted for the same DOS on both EDI and paper
- Medical Records appear to be the same for all patients
- Claims are resubmitted and "corrected" with new CPT or ICD code
- Unusual pressure from the provider for payment

The following red flags may be an indicator of possible **enrollee** fraud, waste or abuse:

- Serious conditions or surgery just after member joining Plan
- Excessive use of the ER without "emergent" diagnosis (to obtain narcotics)
- Multiple scripts from multiple physicians and/or pharmacies
- Treatment from provider other than PCP, without PCP visits
- Use of antagonistic medications
- Contraindicated and/or duplicative care
- Diagnosis is not consistent with care
- Non participating provider utilization in states other than the state of residence of record
- Enrollment not consistent with claims activity (e.g. enrolled due to pregnancy however, no OB care)
- Applicant is evasive in providing information
- The applicant is unable to complete "basic" personal information about self & family
- Applicant presents identification that appears to have been altered or is otherwise questionable
- Similarities between applicant and Amerigroup Sales Representative's handwriting
- Complaints from "applicants" regarding marketing techniques (direct calls, door to door etc.)

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- Applicant is unable, or unwilling to provide reliable supporting information (proof of income, etc.)
- Applicant lists a PO Box, or out of state residence

ADDITIONAL INTERNAL METHODS TO DETECT & PREVENT FRAUD
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Provider Fraud, Waste and Abuse

Amerigroup provider contracts require providers to obey federal and state laws and to permit Amerigroup, state and federal staff to review records pertaining to members;

Amerigroup provider credentialing and recredentialing process includes independent verification of key information (e.g., eligible for Medicaid/Medicare participation) according to **National Committee on Quality Assurance (NCQA)** and **Quality Assurance Reform Initiative (QARI)** requirements;

Amerigroup Provider Manual includes a section on requirements for physicians to notify Amerigroup of any event which changes their credentialing statutes (e.g., loss of licensure);

Medical Management associates collect patient information during the prior-authorization process and identify situations which may be fraud, waste, and abuse (e.g., request for authorization of an outpatient service for a member currently inpatient, request for authorization of a service not medically appropriate for the patient's condition, etc.);

Medical Management associates regularly review utilization reports, including pharmacy reports, to identify any unusual patterns of utilization which may indicate fraud, waste, and abuse (e.g., use of high cost pharmaceuticals medically inappropriate for the member's condition, billing for more inpatient days than authorized, etc.);

Enrollee Fraud, Waste and Abuse

Member I.D. cards have member identifying information and the Member Handbook urges them to show their card to their providers;

The Member I.D. card instructs the member that "Use of this card by any person other than the member is fraud";

Primary care providers (PCP) receive monthly lists of the members assigned to them;

Amerigroup Provider Manual urges providers to check the member I.D. card and call Provider Services to confirm the member is still enrolled;

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Members associated with ongoing investigations, and/or previous investigations that resulted in identified or strongly suspected fraud and/or abuse, may be required to provide a photo ID to obtain services;

Member Services, Nurse HelpLine and Medical Management associates check member eligibility every time a member calls;

Medical Management associates collect patient information during the prior-authorization process and identify situations which may be fraud, waste, and abuse;

Medical Management associates collect information during case management activities (e.g., patient is getting a nutritional supplement, but her boyfriend is selling it to others);

Medical Management associates regularly review utilization reports, including pharmacy reports, to identify any unusual patterns of utilization which may indicate fraud, waste, and abuse;

Fraud detection and prevention information is provided to members and providers through provider news letters and educational updates available to all providers.

INVESTIGATIVE PROCESS OVERVIEW

STAGES OF INVESTIGATION

The CID recognizes seven basic stages in the “typical” investigative process. They are:

1. Detection & Referral
2. Initial Assessment
3. Investigative Strategy
4. Information Gathering
5. Evaluation of Evidence
6. Determination of Action
7. Civil/Criminal Proceedings

Although each case does represent a unique set of allegations, facts and circumstances, experience has dictated that some element of each of these stages, except for the last stage, exist in every case. For the purposes of this plan, the following represents the “typical” scenario. However, it should be noted that specific case circumstances may require variance from this process.

When a referral has been received for investigation by the CID, it will be entered into the C.I.M.S database where it will be given a CID case number. In an effort to provide an overview of the subsequent investigative process, below is a brief summary of each stage, and some of the questions that are addressed during the specific stage.

Detection and Referral

Stage in which the suspected fraud is:

- A) Uncovered
- B) Notification of the allegation is made to the CID

Key questions during this stage, include, but are not limited to:

- ✓ Is the source of the case clearly documented?
- ✓ Why did the source make the complaint?
- ✓ Is the case built on a strong predication?

Initial Assessment

The primary goal in this stage is to firmly establish predication and the need for additional investigation. The CID staff member reviews the documentation gathered in

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stage 1, as well as, accumulates any additional information needed in the initial screening process.

Key questions during this stage, include, but are not limited to:

Provider

- ✓ Are there any prior related cases? If so, what was the outcome?
- ✓ Are the allegations in this case the same as any previous cases?
- ✓ Does the provider have an active license?
- ✓ Does the provider have any disciplinary history?
- ✓ What StarSentinel rules have been violated?
- ✓ Is the provider listed in SIRIS?
- ✓ Does Amerigroup have a contract with this provider?
- ✓ Has a “preliminary” investigation been conducted?
- ✓ Does the billing pattern reflect any “suspicious” activity?

Member

- ✓ Are there any prior related cases? If so, what was the outcome?
- ✓ Are the allegations in this case the same as any previous cases?
- ✓ Is the member still enrolled with Amerigroup?
- ✓ Are there additional family members enrolled?
- ✓ Does the member have any reviews/notations on their history?
- ✓ Does the member have any claims patterns showing particular behaviors?

Employee

- ✓ Has the employee ever been disciplined for other issues?
- ✓ Does the employee have appropriate access to systems, facilities, and information?

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The CID has access to a variety of useful public and restricted access databases. They include, but are not limited to:

- ❑ Lexis Nexis: Accurint for Insurance (Public Records)
- ❑ CPT-Inquiry Services
- ❑ SIRIS (NHCAA's Special Investigations Resource & Intelligence System)
- ❑ United States Health & Human Services Sanctions Database
- ❑ State Licensing & Sanctions Web Sites

These resources are utilized during the assessment process and are an integral part of the investigative process.

Investigative Strategy

Assuming the need for additional investigation has been established, an investigative plan is created, and case prioritization is assessed. During this vital stage, the logical and appropriate investigative measures are mapped out.

Key questions during this stage, include, but are not limited to:

- ✓ Have appropriate parties been notified, such as state agencies, Associate Services, and/or management?
- ✓ Is there a documented investigative plan?
- ✓ Have all of the elements/components of the charges you are pursuing been reviewed?
- ✓ Has all pertinent information been requested and received?

Information Gathering

This is what we all know as the "investigative" stage of the investigation. During this stage the investigator uses all available, legal and appropriate measures to gather information. At this time, interviews are conducted, records are obtained and reviewed, utilization histories are scrutinized etc.

Key questions during this stage, include, but are not limited to:

Provider

- ✓ Has the state issued permission to conduct an investigation?
- ✓ Was the provider ever advised how to bill properly?

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- ✓ Is the provider utilizing improper billing suggestions, received from an outside source?
- ✓ What do the records say?
- ✓ Do they appear to have been altered?
- ✓ Is there a possibility that they were altered?
- ✓ Do the claim submissions directly conflict with other investigative information?
- ✓ What do the patients say?
- ✓ What does the office staff say?
- ✓ How does the provider stack up against peers?
- ✓ Have you prepared and/or issued an Investigation Finding Report (IFR) to the subject?
- ✓ What did the provider say about the IFR? (see evaluation of evidence)

Member

- ✓ Has the state issued permission to conduct an investigation?
- ✓ What do the referring physicians say?
- ✓ What does the pharmacy staff say?
- ✓ What do the records say?
- ✓ Do they appear to have been altered?
- ✓ Is there a possibility that they were altered?
- ✓ Was there an undercover or pretext operation? If so, what did it show?

Employee

- ✓ Was there an undercover or pretext operation? If so, what did it show?
- ✓ Have you prepared and/or issued an Investigation Finding Report (IFR) to the subject?
- ✓ What did the interviews show?
- ✓ What did the documents from the personnel file say?
- ✓ Does the subject own any assets?
- ✓ Does the subject pose a flight risk?

Evaluation of Evidence

In this stage, all of the evidence that has been collected must be evaluated. Most certainly, this stage exists throughout the entire case, but on a smaller scale. However, in this stage **ALL** of the evidence accumulated is reviewed as a whole. An evaluation is then made to determine if there is reasonable evidence that a fraud occurred.

Key questions during this stage, include, but are not limited to:

- ✓ Did the subject have an explanation? Was it plausible?
- ✓ Was there any exculpatory evidence? If so, what does it mean?
- ✓ Is the evidence the right kind?
- ✓ Is it of a sufficient quantity?
- ✓ Is your evidence reliable?
- ✓ Is it direct or circumstantial?
- ✓ If overpayment involved, has a summary been established as a reference point?

Determination of Action

At this point the investigator, possibly in conjunction with counsel must determine if and how they plan to pursue the case.

Key questions during this stage, include, but are not limited to:

- ✓ Have the appropriate state notifications & reports been issued?
- ✓ Have you reviewed the state regulations and contacts for guidance?
- ✓ Are options for action limited by contract and/or regulation?
- ✓ Was a final investigative report written?
- ✓ Have you been consistent with this provider?
- ✓ Have you been consistent with like situations?
- ✓ Has a letter or Investigation Finding Report (IFR) been prepared and issued to the subject?
- ✓ What did the provider say about the letter or IFR? (see evaluation of evidence)

CID shares the investigation results with the Fraud Officer and with the provider, if the State regulations permit. If the provider's action were verified to be inappropriate,

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Amerigroup will then determine if the provider will be placed on a corrective action plan or have their contract terminated.

Criminal/Civil Legal Proceedings

In this, the final stage, the investigator will meet with the attorney responsible for litigation of the case. This may be either inside or outside counsel depending on the agency and/or company.

Key questions during this stage, include, but are not limited to:

- ✓ ALL OF THE ABOVE
- ✓ Is the case well documented?
- ✓ Have you been consistent with like situations

FILE ORGANIZATION

The CID Coordinator (PC) will create a file folder with the case number on it. The following initial case information will be placed into the folder and secured as necessary:

- Initial Case Referral Documentation to include, referral form, e-mail, memo
- A C.I.M.S. jacket page should be placed into the folder
 - AMISYS/Facets provider printout
 - AMISYS/Facets subscriber printout
- Create an electronic “Case Notes” document

INITIAL CASE ASSESSMENT

After the basic case file has been created, the PC will begin conducting the initial case assessment in an effort to assist staff and management in prioritizing cases. As each case represents slightly different circumstances, the PC is responsible for determining the optimal assessment process for each unique case. However, the “typical” assessment will include, but not be limited to:

Running a Prior Related Case Report (PRC) in C.I.M.S. This report, which is TIN driven, will provide key information regarding any historical investigations that may have been conducted by CID relative to the named entity. In addition, this report links in fields from the “Additional Subjects” page, which will identify parties related to the previous investigation. The report includes the following items of information:

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- CID Case #
- Case Name
- TIN
- Primary Investigator
- Allegation
- Status
- Name: Additional Subject
- ID #: Additional Subject

In the event prior related cases are identified, the PC will review the information and documentation contained within those cases for relevancy to the matter under review.

The PC will review the license activity to ensure that the provider had an active license in the state under review at the time of the alleged incident. In addition, a review of any state board disciplinary action will also be reviewed and analyzed for relevancy to the matter under investigation.

When logical, a review of surrounding state licensure and discipline action will also be conducted.

In addition, the PC, or assigned investigator will evaluate the following during the preliminary investigation in preparation for a more comprehensive investigation:

- Search the Health & Human Services Office of Inspector General (HHS-OIG) Exclusions list to ensure that the provider has not been excluded.
- Search SIRIS to evaluate the relevancy of any other cases relating to the subject.
- Review StarSentinel rule violations and compare subject against peers.
- Review & obtain detailed information regarding CPT codes under review.
- Review NCC (National Contact Center) Phone Logs for Relevant information.
- Review provider credentialing file, as appropriate.
- Review provider contract, as applicable.
- Obtain a basic exposure report to evaluate the estimated risk.

Upon completion of the assessment, generally there will be the following five (5) possible findings. They are:

- The information presented fails to definitively eliminate fraud, abuse, or waste, and as such, warrants a formal investigation.
- The information presented is questionable, but not such that requires CID intervention. In these cases, the information may be forwarded to an internal department for review and analysis.
- The facts to date are not yet supportive of a formal investigation, but the subject may be placed on prepayment review, where medical records are required.
- The matter is simply a mistake and a billing error that can be corrected through education.

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- The issue is an internal control weakness and/or error that needs to be corrected.

Once it is determined that the information requires a formal investigation, the case is prioritized and assigned to an investigator. The assigned investigator will complete an investigative plan detailing the allegation and investigative steps to be taken.

As required by contract and/or regulation (as defined in the addendum to this plan) a report will be issued to the state oversight agency, in the manner and format required.

Once the investigative plan is completed, the investigator is responsible for performing the following actions:

- Use investigative tools to make determination about the case;
- Develop theories and form hypotheses about the case and which techniques to use;
- Conduct a thorough and timely investigation;
- Be responsible for the case until its conclusion;
- Document all activity conducted on the case and maintain this information in the C.I.M.S. database and the case file;

It should be noted that during the course of an investigation, CID takes the proper measures to ensure and maintain the confidentiality of any patient information relevant to possible fraud, waste, or abuse.

INVESTIGATIVE REPORTS

The CID investigative reports or Report of Investigation (ROI) document the investigative efforts of the assigned investigator. CID recognizes that the ROI is frequently utilized by sources outside of the Company. Law enforcement agencies, healthcare oversight agencies, and legal authorities will frequently have occasion to examine and utilize the ROI. As such, the ROI is a professional product prepared with a high degree of care and accuracy. All final ROI are to be typewritten in accordance with CID training and desktop procedure. The ROI will include, but not be limited to the following information:

- The allegation under investigation;
- Statutes and/or regulations violated;
- Estimated overpayment; (if applicable)
- Summary of interviews and investigative activities;
- Suspect claim data;
- Supporting exhibits

Final reports are to be submitted on all investigative files where civil/regulatory action or criminal prosecution is anticipated. The report will document the investigative actions completed and clearly present the facts uncovered as a result of the investigation. Any relevant evidence obtained by the CID will be presented in a logical fashion to include the source of the investigative evidence. Material documentation will be referred to as "exhibits".

One of the goals of the report is to ensure that a reader, who may or may not have prior knowledge of health insurance, can read the report and fully understand the basis for the final disposition of the case.

The final report should be signed by the assigned investigator and submitted to CID Management for review. If management concurs with the findings, he/she will provide a second signature on the report, indicating that he report has been reviewed and approved by CID management. The report will be forwarded to Sr. Management at the Plan to take corrective action with the provider investigated, if appropriate.

INVESTIGATIVE REPORT FORMAT

- Case Summary
- ROI
- Exhibit Page
- Exhibits

As a general rule, the CID will not complete a formal ROI on cases where civil/regulatory action or criminal prosecution is not anticipated. In these cases, a Case Summary will be written advising of the initial allegation and the investigative steps/actions taken that

disproved the allegation. In some cases, such as an in the case of an “expedited referral” (defined elsewhere in the plan) a final ROI as described above may not be completed.

POST INVESTIGATION & RECOVERY
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An investigation shall be considered “complete”, or “cleared” when all reasonable and appropriate investigative leads and opportunities have been exhausted. Once complete, an investigation will have three potential findings:

- **Evidence Supports Allegation(s)**
- **Evidence Does Not Support Allegation(s)**
- **Inconclusive**

In addition, a case will be considered “cleared” when one or more violation in any identified pattern of possible violations of civil and/or criminal fraud related statutes have been sufficiently investigated and corroborated.

As a general rule, this plan provides that upon completion of its investigation, as described above, cases that are considered for civil/criminal prosecution meet the following standard:

1. Any application, claim, prescription, LMN (Letter of Medical Necessity), or other material document where the facts and circumstances create a **reasonable suspicion** that a person or entity has violated applicable statutes and/or regulations
2. There is sufficient **independent evidence corroborating the reasonable suspicion** described in #1 above, from which a person could reasonably conclude that the person or entity has violated the statute and/or regulation.

The facts and circumstances referred to in #1 above can include, but are not limited to, “fraud indicators” contained in the approved Fraud, Waste and Abuse Plan, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of the statute and/or regulation has occurred.

As referred to in #2 above, independent evidence corroborating the reasonable suspicion that a person has violated the applicable statute and/or regulation includes, but is not limited to:

1. A statement from a witness;
2. Documentary evidence that directly negates a material element of the claim, application, prescription, or LMN, or directly establishes the falsity of a material element of any document material to the provision of benefits;
3. A report of an expert; or
4. Additional apparent misrepresentations tending to negate a possibility that the misrepresentation was merely an error.

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In addition to recovery and referring cases to state and law enforcement entities if necessary, CID and CVI also place providers on pre-payment review, should their billing patterns continue to be aberrant after education and/or a record review. These reviews are conducted by the CPC's in the Reimbursement Policy Management department, as mention previously in this document. Providers are placed on pre-payment review for a period of time to ensure appropriate documentation supports the claims billed to Amerigroup.

CLEARED FILE ADMINISTRATION

Each investigator is responsible for ensuring that all cleared files contain all required documentation prior to filing. The following information must be in the final case file:

- Final C.I.M.S jacket page with final case status;
- State referral form; (as required)
- State acknowledgement form; (as available)
- Any documents contained in the original referral;
- Final Case Notes;
- Memorandums of Interview;
- Letter to subject or Investigation Findings Report; (as appropriate)
- Report of Investigation w/exhibits, or Summary Report;
- All correspondence

Cleared case files are to be maintained and filed in chronological order in a dedicated and secured cabinet.

Because of the critical nature of many of these cases and the possibility of litigation, all CID files, must be maintained at least through the applicable Statute of Limitations, but for no less than seven years.

EXTERNAL RELATIONSHIPS

In deciding whether to refer to law enforcement or any State Medical Boards, the following factors come into play:

1. The investigation has been completed.
2. A detailed report of the investigation has been completed.
3. Referrals have been made to the proper authorities in accordance with this plan.
4. The proofs available to establish intent to derive a benefit are not entitled.
5. State specific regulations do not prohibit additional referrals.

Any completed file will be reviewed and signed off by CID Management who will also approve any case referrals, and written reports.

CID'S RELATIONSHIP WITH REGULATORY AGENCIES

Relationship building with key internal and external partners is one of the critical success factors cited by the CID.

To optimize the relationships, the CID has initiated the following improvements:

- Regionalization of staff to allow investigators to be dedicated to a state, or states in which they can have specialization and improve relationships.
- Develop a goal to have CID staff maintain an informal monthly contact with state personnel to discuss specific cases and/or issues and concerns.
- Attend all quarterly meetings.
- Partner with state contacts to share intelligence and non PHI claim data with the state, and other carriers to develop unique and innovative approaches to share valuable case information.

CID's RELATIONSHIP WITH LAW ENFORCEMENT

As noted above, the CID maintains a strong working relationship with law enforcement/prosecutorial agencies.

Amerigroup is represented on the National Health Care Anti-Fraud Associate Board of Governors. In this capacity, Amerigroup has regular interaction with the NHCAA Law Enforcement Liaisons which at present include:

- **National Association of Medicaid Fraud Control Units**
- **US Department of Health & Human Services**
 - Centers for Medicare & Medicaid Services (CMS)
 - Office of Inspector General (HHS-OIG)
- **US Department of Justice**
 - Drug Enforcement Administration (DEA)
 - Federal Bureau of Investigation (FBI)
 - Fraud Section, Criminal Division
- **US Department of Labor**
 - Office of Inspector General (DOL-OIG)
- **US Department of Treasury**
 - Internal Revenue Service, Criminal Investigation Division (IRS-CID)
- **US Department of Veterans Affairs**
 - Office of Inspector General (VA-OIG)
- **US General Accounting Office**
 - Office of Special Investigations (GAO-OIG)
- **US Office of Personnel Management**
 - Office of Inspector General (OPM-OIG)
- **US Postal Inspection Service (USPIS)**
- **US Department of Defense**
 - TRICARE
 - Office of Inspector General, Defense Criminal Investigative Services (OIG-DCIS)
- **Connecticut Insurance Department**
- **Florida Department of Financial Services, Division of Fraud**
- **National Association of Attorneys General**
- **National Association of Insurance Commissioners, Fraud Task Force**
- **New Jersey Office of the Insurance Fraud Prosecutor (OIFP)**
- **Ohio Department of Insurance**
- **Iowa Insurance Fraud Bureau**
- **Texas Department of Insurance, Fraud Unit**

Additionally, as part of its corporate membership with the NHCAA, Amerigroup is provided with Requests for Investigative Assistance (RIA) from any of the above agencies. These written requests are a confidential, non subpoena request for

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information related to active criminal and civil investigations that may represent exposure to the Plan. Amerigroup responds to these requests in an effort to further the investigations of those agencies, and protect the Company assets.

- CID staff holds membership in a variety of industry/law enforcement associations that provide for sharing of information and coordination of investigative efforts.

AVOIDING INAPPROPRIATE DUPLICATE REFERRALS

C.I.M.S., the CID case database, provides specific fields for referrals to regulatory and criminal agencies. Through the tracking of this data, which includes referral dates, CID personnel can ensure that inappropriate referrals to duplicate agencies do not occur.

COMPLIANCE WITH REPORTING PROVISION**REFERRAL CRITERIA**

When the documents and evidence gathered during the course of an investigation indicate a potential fraud, abuse, or waste, the CID will make referrals to the appropriate agency in accordance with contractual and/or regulatory guidelines.

The specific guidelines for referral are set forth in the addendum to this plan.

AUTHORIZED INDIVIDUALS TO MAKE REFERRALS

As cited in the "Fraud Officer" section of this plan, the Chief Executive Officer of each Amerigroup subsidiary is the designated Fraud Officer, unless otherwise elected, responsible for all reporting of fraud, waste, and abuse to the Amerigroup Corporate Compliance Officer, as well as to appropriate state agencies.

However, the Fraud Officer may delegate reporting of fraud, waste, and abuse to the Corporate Compliance Officer, the Assistant Corporate Compliance Officer, or CID Management.

As a matter of practicality, the authorized designee at this time is:

**Amerigroup Corporation
Mary Beach
AVP, Corporate Investigations**

OR

**Kathy Runkle
AVP, Corporate Investigations
4425 Corporation Lane
Virginia Beach, VA 23462
(757) 473-2737
(757) 226-7473**

mbeach2@amerigroupcorp.com or krunkle@amerigroupcorp.com

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REQUESTS FOR INFORMATION

Amerigroup requests that any requests for information related to fraud and/or abuse are issued directly to the CID. Specifically, requests for information should be sent to the following:

**Amerigroup Corporation
Mary Beach
AVP, Corporate Investigations**

OR

**Kathy Runkle
AVP, Corporate Investigations
4425 Corporation Lane
Virginia Beach, VA 23462
757-473-2737
757-226-7473 (fax)**

mbeach2@amerigroupcorp.com or krunkle@amerigroupcorp.com

Access to Information

CID will permit all regulatory oversight agencies with proper authority, to have access to the place of business during normal business hours. In addition, CID will respond to all requests for information in a timely manner.

FRAUD TRAINING PROGRAM

GENERAL ASSOCIATE TRAINING AND EDUCATION

Amerigroup provides each new associate with access to Amerigroup's policies and procedures. One of the policies is the "Code of Business Conduct & Ethics." This section includes the following statement:

"Amerigroup Corporation, its subsidiaries and its associates are committed to maintaining the highest ethical standards in the conduct of their business and to maintaining a work environment that encourages full development of its employees as productive members of the Amerigroup team, as involved citizens of their communities and as devoted members of their families. Amerigroup recognizes the responsibility of associates to Amerigroup, as well as the responsibility of Amerigroup to its associates to apply these commitments without exception in the day to day conduct of its business. Fulfilling these commitments will enhance Amerigroup's ability to rely on the individual good judgment and character of its employees to:

- Carry out its obligations to shareholders.
- Fulfill contracts and agreements with government agencies and regulators.
- Deliver quality products and services to its customers.
- Otherwise fulfill its obligations to good corporate citizenship."

This policy, on business ethics and practices, goes on to discuss in detail Amerigroup's expectations that associates will:

- Avoid conflicts of interest;
- Not accept gifts, payments, fees, services, discounts, valuable privileges or other favors which might influence the way they conduct business;
- Not make any payments to others that are illegal, designed to secure preferential governmental or customer action, in violation of accepted ethical standards, could be construed to be a bribe or payoff, or would otherwise embarrass Amerigroup;
- Avoid potential nepotism;
- Comply with federal and state political contribution laws and not make political contributions in Amerigroup's name;
- Keep information confidential;
- Adhere to proper accounting practices;

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- Report candidly to management, independent auditors and outside counsel.

Training reinforces that failure to comply with all policies and procedures, to include this Code, or the applicable laws and/or regulations may result in corrective action up to and including termination from employment or association with Amerigroup and in appropriate cases, may involve civil or criminal sanctions. The policies governing associate conduct and performance, corrective action and suspension from work are introduced to associates via new hire orientation and are also contained in the Human Resources Manual which is continuously available via the associate intranet. Providers and subcontractors are advised of the consequences, including provider termination, of participating and/or contributing to fraud, waste, and abuse via the contractual agreement executed by the provider and the Plan. In addition, any changes to Amerigroup policies and procedures are sent to all affected areas, by the Office of Business Ethics, within 20 working days of the change occurring.

Amerigroup associates are educated on the general definition of fraud, waste, and abuse via our New Employee Orientation Program that occurs within the first 60 days of an associate's employment, and annually via our Corporate Compliance Program. Examples of fraud, waste, and abuse associated with healthcare are utilized in this educational process, as are examples of inappropriate activity that could result if an associate were to deviate from the "Business Ethics & Practice" policy noted above.

Amerigroup's Corporate Training Department maintains a log of all associates receiving the training. This log includes the name and title of the trainer, the name of the associates attending the training, the name of the training course, and the date and length of the training course.

Amerigroup has also educated its associates, again via the Corporate Compliance Program, on the proper way to report fraud and/or abuse. Anonymous telephone hotlines and email accounts have been established for those associates who would like to report, yet remain anonymous.

Amerigroup also allows individuals to communicate fraud, waste, and abuse concerns directly to company management and/or it's Board of Directors via communication channels implemented via its public website found at <http://www.amerigroupcorp.com>. As stated on the website provided, members may utilize the toll free number (1-800-600-4441) to report fraud or abuse. In addition, employees may utilize the previously mentioned internal and external telephone numbers to anonymously report fraud or abuse.

NON-RETALIATION

Finally, Amerigroup has a Non-Retaliation Policy that states "No associate who reports suspected fraud, waste, and abuse shall be retaliated against or otherwise disciplined for making a good faith allegation. To ensure compliance with the non retaliation policy,

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the personnel records of current and terminated associates shall be periodically reviewed.”

FRAUD, WASTE, AND ABUSE CBT

Amerigroup emphasizes the need to constantly educate their associates regarding fraud, waste, and abuse. An interactive Computer Based Training (CBT) program is in force which allows all associates to utilize Amerigroup’s web based fraud, waste, and abuse training program. The CBT which is integrated into a learning management system (LMS) includes flexibility to bookmark progress, track completion and includes knowledge checks throughout the training to assess comprehension.

The training includes fraud schemes and indicators, case examples, the definitions of fraud, waste and abuse, as well as other issues tailored to the identification and referral of suspected fraud, waste and abuse.

Upon the completion of this training, the trainee should have a clear understanding of the distinctions between fraud, waste and abuse, and billing errors. In addition, they should develop an understanding of the role of the CID and the appropriate referral process.

CID TRAINING

In an effort to provide training customized to the CID, the following areas will be targeted for internal training:

- Introduction to Insurance & Medicaid
- Claim Flow Process
- Standards of a Corporate Investigations Department
- Common Fraud Schemes & Indicators
- Sources for Cases
- The Role of the CID Associates
- Corporate Investigations Management System (C.I.M.S.)
- Case Prioritization
- The Investigative Plan
- Proprietary Claim History Reports
- Medical Record Audits
- Developing Contacts
- Public Records
- Interview & Interrogation
- Evidence
- Report Writing
- Fraud Related Statutes (Federal & State)
- Common Provider Defenses & Related Investigative Considerations
- Testifying

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CID associates also have the opportunity to participate in a variety of additional training specifically geared towards healthcare fraud, waste and abuse. Training will consist of a minimum of forty (40) CPE hours annually and may consist of any one or number of the following:

- ❑ Internal Training Designed by the CID
 - ❑ Lecture
 - ❑ Video
 - ❑ Self Study
 - Introduction to Fraud Examination (CFE)
 - Beyond the Numbers [Interviewing](CFE)
 - Investigating by Computer (CFE)
 - Using Benford's Law to Detect Fraud (CFE)
- ❑ Various CBT Programs (Computer Based Training)
- ❑ Internal Training Offered by Amerigroup
- ❑ Guest Speakers
- ❑ External Conferences & Seminars (e.g. NHCAA or CFE)

As a corporate member of NHCAA, periodic training tools and aids are made available. **Exhibit 3** details some of the training tools and aids. Finally, members of the CID maintain membership in a variety of associations, organizations and task forces, which supply periodic training.

OPERATIONAL STAFF TRAINING

Department specific (e.g. Claims, Utilization Review, Quality Assurance etc.) in service training is periodically provided to Operational Departments by CID associates. The training sessions will remind associates to constantly be aware of fraud, waste, and abuse indicators and how to report the suspicions to the CID.

COORDINATION WITH OTHER DEPARTMENTS OF THE PLAN

CID coordinates with other departments of the Plan in an effort to capitalize on detection methodologies and achieve the optimal results. This coordination includes meetings with the Fraud Officer(s) to discuss any prevailing fraud, waste, and abuse related matters.

In addition, on an as needed basis, CID works in conjunction with the following departments:

- Legal
- Cost Containment
- Medical Management
- Associate Services
- Claims
- Sales & Marketing
- Marketing Compliance
- Network Management
- Reimbursement Policy Management
- Office of Business Ethics

These meetings include but are not limited to the discussion of:

- Control and edit opportunities
- Education initiatives
- Review of forms and procedures
- Advertising and marketing materials to ensure they reflect accurate information about Amerigroup, on both the global and Plan level. These materials include but are not limited to any informational materials targeted to our members.
- Compliance issues
- Current pre-payment opportunities and results

FRAUD, WASTE AND ABUSE AWARENESS PROGRAM

Amerigroup believes that awareness is a vital part of an overall fraud, waste and abuse program. As such, “Successful Fraud Education within and External to Amerigroup” is one of the CID Critical Success Factors. As previously indicated, Amerigroup and CID are committed to ongoing education to associates in addition to making those outside of the Company aware of fraud, waste, and abuse.

The target audience for external fraud, waste and abuse awareness consists of the following:

- Enrollees
- Applicants
- Providers
- General Public

Awareness program vary, but include, and are not limited to:

- Public Speaking Opportunities
- Provider Education Materials
- Newsletters

Exhibit 4 includes advertising scripts utilized to educate the general public, as required in some specific markets, regarding fraud, waste and abuse.

EXHIBIT 1**Staff Qualifications****AVP OF CORPORATE INVESTIGATIONS****Mary Beach**

Has widespread background in Medicare, Medicaid, Durable Medical Equipment, and audit. She has completed several certifications specific to the health care field and has over 24 years of experience with federal and state statutes as well as commercial health insurance.

- **Indiana University**, Bachelors of Science, Business
- **Association of Health Insurance Plans**, Managed Healthcare Professional, Health Insurance Associate
- **NHCAA**, Accredited Healthcare Fraud Investigator
- **Certified Fraud Examiner** (1997)

Amerigroup (1/2007 - Current)

- AVP of Corporate Investigations

Disetronic Medical Systems, Inc. (12/2005 – 1/2007)

- Manager, Customer Reimbursement

TriCenturion LLC (Program Safeguard Contractor) (1/2003 – 12/2005)

- Manager

AdminaStar Federal/Anthem (4/1986 – 1/2003)

- Benefit Integrity Unit

Indiana Medicaid Fraud Control Unit (1/1985 – 4/1986)

- Auditor

AVP OF CORPORATE INVESTIGATIONS**Kathy Runkle**

Has extensive audit background consisting of approximately twenty years of both financial and insurance auditing positions, in addition to compliance experience and healthcare investigation experience.

- **James Madison University**, Bachelors of Science, Accounting
- **Certified Fraud Examiner** (2003)

Amerigroup (10/00 – Current)

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- AVP of Investigations (3/2009 – Current)
- Director of Investigations (05/2006 – 3/2009)
- Manager Investigations (01/2005 – 5/2006)
- Internal Audit Manager (05/2003 – 1/2005)
- Senior Auditor (10/2000 – 05/2003)

Bank of America (1984-2000)

- Accounting and Finance Department, Card Services Auditor

DIRECTOR RISK MANAGEMENT & AUDIT TECHNOLOGY
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Jeremy Mooney

Has extensive knowledge in the development and maintenance of databases. Has led several projects in the initiation of new programs and business tools in the health care industry and Medicaid services.

- **Old Dominion University**, Bachelors of Business Administration, Business Administration and Information Technology
- **Certified Fraud Examiner**, 2008

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- Director Risk Management & Audit Technology (4/2010 – current)
- Manager Corporate Investigations Analysis (10/2006 – 4/2010)
- Senior Technical Reports Analyst (12/2002 – 10/2006)
- Credentialing Specialist (4/2002 – 12/2002)
- Provider Information Specialist (2/2002 – 4/2002)

Coleman and Associates (for Verizon Online DSL) (4/2001 – 12/2001)

- Customer Care/Operations Representative

City National Bank (5/1999 – 8/1999)

- Customer Care/ Operations Representative

Department of Computer Science, University of Kentucky (10/1998 – 4/1999)

- Consultant/Grader

Department of Technology, Kanawha County Schools (5/1995 – 8/1998)

- Webmaster/Assistant Technologist/Software Developer

MANAGER CORPORATE INVESTIGATIONS

Jamie Johnston

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Has several years of Medicare and Medicaid auditing experience. Has worked in the private and public healthcare arenas conducting field audits and accounting responsibilities.

- **University of Tennessee at Chattanooga**, Bachelor of Science, Accounting and Finance
- **Association of Health Insurance Plans**, Certified Dental Benefits Associate (2008)
- **Association of Health Insurance Plans**, Health Care Anti-Fraud Associate (2008)
- **Certified Fraud Examiner** (2008)
- **National Health Care Anti-Fraud Association**, Accredited Healthcare Fraud Investigator (2008)
- **American Academy of Professional Coders**, CPC (2009)

Amerigroup (2006 – current)

- Manager (6/2010 – current)
- Senior Investigator (4/2009 – 6/2010)
- Investigator (4/2007 – 4/2009)
- Staff Auditor (9/2006 – 4/2007)

Blue Cross Blue Shield of Tennessee

d.b.a Riverbend Government Benefits Administrator (RGBA) (3/2001 – 9/2006)

- Senior Auditor (7/2005 – 9/2006)
- In-Charge Auditor (11/2002 – 7/2005)
- Field Auditor (3/2001 – 10/2002)

Cigna HealthCare

- Staff Accountant (5/2000 – 2/2001)

CLINICAL COMPLIANCE ANALYST

Linda Gilbreath

Has several years of clinical coding and medical billing experience including the hospital, private practice, and HMO settings. Has worked with all aspects of commercial, federal, and state insurance programs.

- **American Academy of Professional Coders**, CPC
- **American Academy of Professional Coders**, CPC-H (Hospital)
- **American Academy of Professional Coders**, CPC-I (Instructor)
- **American Academy of Professional Coders**, CEMC (E/M Coder)

Amerigroup (10/2007 – current)

Amerigroup Corporation
FRAUD, WASTE, AND ABUSE PLAN

- Clinical Compliance Analyst

Albany OB-GYN (9/2005 – 9/2007)

- Office Manager

Amerigroup (1/2003 – 8/2005)

- Clinical Compliance Auditor

Greenville Hospital System (12/1997 – 1/2003)

- Coding and Compliance Auditor (1/2000 – 1/2003)
- Supervisor Billing & Collections (12/1997 – 1/2000)

Physician Enhancements (8/1995 – 12/1997)

- Project Manager

Horton-Adamson Plastic Surgeons (1/1991 – 8/1995)

- Business Office Manager

SR. INVESTIGATOR

David Ross

Has many years of investigation experience in both health care and public assistance fraud. Has worked in the law enforcement and Medicare sectors conducting investigations and research in the financial fraud and white collar crime arenas.

- **Florida State University**, Bachelor of Science, Criminology
- Certified Fraud Examiner (2004)

Amerigroup (7/2007 – current)

- Sr. Investigator

TriCenturion (Program Safeguard Contractor) (4/2004 – 7/2007)

- Investigator

Florida Dept. of Law Enforcement

- Financial Crime Investigator II, Public Assistance Fraud (7/1997 – 4/2004)

Florida Dept. of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco (5/1994 – 8/1994)

- Internship

SR. INVESTIGATOR

Steve Ballew

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Has extensive experience in the investigation of Medicare, Medicaid, and Public Assistance fraud. Has several years of experience working with state and federal law enforcement entities to pursue prosecution of fraud, waste, and abuse.

- **Florida State University**, Bachelor of Science, Criminology
- **National Health Care Anti-Fraud Association**, Accredited Healthcare Fraud Investigator (2004)

Amerigroup (10/2007 – current)

- Senior Investigator

TriCenturion (1/2003 – 10/2007)

- Senior Investigator (9/2004 – 10/2007)
- Supervisor, SIU (9/2003 – 8/2004)
- Senior Investigator (1/2003 – 8/2003)

Palmetto GBA (11/1997 – 1/2003)

- Investigator

FL Office of Auditor General (1/1987 – 10/1997)

- Investigator

Florida State University Police Department (1/1985 – 12/1986)

- Law Enforcement Officer

SR. INVESTIGATOR

David Collins

Has a wide ranging expertise of the health care system, including Medicaid and Medicare, case management, and investigations. Has over 14 years of experience in fraud and abuse programs throughout the field of health care.

- **Culver-Stockton College**, Bachelor of Science, Criminal Justice
- **National Healthcare Anti-Fraud Association**, Accredited Healthcare Fraud Investigator
- Certified Fraud Examiner (2005)

Amerigroup (5/2008 – current)

- Senior Investigator

MAXIMUS (2007 – 5/2008)

- Director of Financial Services, Program Integrity Practice

Wellcare Health Plans (2006 – 2007)

Amerigroup Corporation
FRAUD, WASTE, AND ABUSE PLAN

- Senior Investigator

Palmetto GBA, TrustSolutions, TriCenturion (1999 – 2006)

- Senior Investigator II

SR. INVESTIGATOR

Barbara Jeffries

Has medical terminology knowledge, background check experience, in addition to experience coordinating communication amongst a variety of agencies.

- **Old Dominion University**, Bachelor of Arts, Criminal Justice
- **Pharmacy Technician Certification Board**, CPhT (2007)
- **Association of Health Insurance Plans**, Managed Healthcare Professional (2008)
- **Association of Health Insurance Plans**, Health Care Anti-Fraud Associate (2008)
- **Certified Fraud Examiner** (2011)

Amerigroup (2/2006 – current)

- Senior Investigator (4/2009 – current)
- Investigator (2/2006 – 4/2009)

Department of Veterans Affairs (8/2004 – 12/2005)

- Veterans Service Representative

Ticketmaster (6/2000 – 8/2004)

- Support Center Supervisor

SR. INVESTIGATOR

Jennifer Guyer

Has over four years of experience in the Medicaid fraud field through her work with both state and commercial entities. Has an extensive history of insurance fraud work to include the health, property, and employment arenas.

- **Saint Joseph's University**, Enrolled in Master of Science in Healthcare Administration (completion 2011)
- **Towson University**, Bachelors of Science in Sociology/Criminal Justice

Amerigroup (5/2009 – current)

- Senior Investigator

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Aetna Life Insurance Company (3/2007 – 5/2009)

- Investigator

Maryland Medicaid Fraud Control Unit (3/2006 – 3/2007)

- Medicaid Fraud Investigator/Analyst

Allstate Insurance Company (4/2002 – 2/2006)

- Property/Homeowners Adjuster

Trace America, Inc (6/2000 – 4/2002)

- Investigator

SR. INVESTIGATOR

Wesley Nichols

Has several years of healthcare fraud investigations experience in both Medicaid and Medicare areas. Has worked for both private and public sectors of healthcare.

- **University of South Carolina**, Bachelors of Science in Criminal Justice
- **Midlands Technical College**, Associates in Criminal Justice
- Certified Fraud Examiner (2004)

Amerigroup (9/2009 – current)

- Senior Investigator

Maximus, Inc. (6/2007 - 2/2009)

- Manager of Investigations, Financial Division

WellCare Health Plans (10/2006 – 6/2007)

- Medicare/Medicaid HMO Senior Investigator

Electronic Data Systems (CMS Contractor) (2/2005 – 10/2006)

- Senior Investigator

TriCenturion (CMS Contractor) (1/2003 – 2/2005)

- Senior Investigator

Palmetto GBA (CMS Contractor) (7/1997 – 12/2002)

- Senior Investigator

South Carolina Attorney General's Office (12/1996 – 5/1997)

- Intern/Investigator

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MAC Construction (6/1993 – 1/1997)

- Building Manager of Residential Construction

South Carolina Department of Motor Vehicles (2/1991 – 6/1993)

- Examiner

SR. INVESTIGATOR

Phyllis Heller

Has several years of management, fraud control, and investigation skills in the health care field. She has aided in the development of anti-fraud programs and investigative teams.

- **Kaplan University**, Associates in Criminal Justice
- **Norwalk Community College**, Occupational Therapy
- **National Health Care Anti-Fraud Association**, Accredited Healthcare Fraud Investigator (2007)

Amerigroup (2009 – current)

- Senior Investigator

Aetna Insurance Company (2006 – 2009)

- Investigator

US Detectives, LLC (2004 – 2006)

- Director of Investigative Services

Met Life Insurance Company (1997 – 2004)

- Fraud Control Coordinator

Travelers Insurance Company (1989 – 1997)

- Fraud Management Team Analyst
- Fraud Investigator
- Life and Health Fraud Investigations Consultant
- Technical Consultant

Principal Financial Group (1984 – 1989)

- Dental Claims Supervisor

SENIOR INVESTIGATOR

Brenda Wilkening

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Has over 20 years of experience of practical nursing in the hospital, nursing home, and insurance settings. Has worked in the areas of neonatology, cardiology, oncology, and home health.

- **Hampton University**, Bachelor of Science in Nursing
- **Purdue University**, Associates in Applied Science of Nursing (RN)
- **Academy for Healthcare Management**, Managed Healthcare Professional (2001)
- **American Academy of Professional Coders**, CPC (2009)

Amerigroup (2004 – current)

- Senior Investigator (7/2010 – current)
- Investigator (9/2007 – 7/2010)
- Appeals Specialty Unit Nurse (2004 – 9/2007)

Humana Military Healthcare Services (1999 – 2004)

- Quality Management Coordinator (2001 – 2004)
- Utilization Review Nurse (1999 – 2001)

Anthem Alliance (1998 – 1999)

- Senior Health Care Finder

Sentara Enterprises/TRICARE (1995 – 1998)

- Nurse – Ambulatory Care Clinic

John Short Associates (1992 – 1995)

- Staff Clinic Nurse

Greater Baltimore Medical Center (1989 – 1992)

- Charge Nurse/ Assistant Nurse Manager

Humana Hospital Bayside (1985 – 1989)

- Charge Nurse – Special Care Unit

St. Anthony Medical Center (1982 – 1985)

- Staff Nurse – Cardiovascular Unit

St. Catherine's Hospital (1978 – 1979; 1981 – 1982)

- Staff Nurse – Oncology Unit (1981 – 1982)
- Staff Nurse – Newborn Intensive Care Unit (1978 – 1979)

Personal Home Health Care Service (1979 – 1980)

- Visiting Home Health Nurse

INVESTIGATOR

Tina Sinclair

Has several years in the healthcare industry including experience with employee benefits, utilization management, and audit.

- **Bellevue University**, Bachelor of Science, Health Care Management
- **American Academy of Professional Coders**, CPC (2009)

Amerigroup (12/2004 – current)

- Investigator (9/2007 – current)
- Staff Auditor (12/2004 – 9/2007)

Trader Publishing (2/2004 – 6/2004)

- Benefits Services Analyst

Intermountain Health Care (7/1991 – 12/2003)

- Senior Auditor (1997 – 12/2003)
- Health Benefit Specialist (1991 – 1996)

INVESTIGATOR

Vivian Anderson

Has many years of provider relations experience to include contracting, training, negotiating, and claims issues. In addition, has experience in recouping overpayments and provider office audits to ensure compliance.

- **Florida Metropolitan University**, Associates Degree, Paralegal Studies

Amerigroup (6/2004 – current)

- Investigator (10/2007 – current)
- Account Executive (6/2004 – 10/2007)

University Community Hospital (1/2003 – 6/2004)

- Account Application Specialist

Aetna, Inc. (6/1991 – 9/2002)

- Provider Relations Representative (1996 – 2002)
- Provider Service Team Leader (1991 – 1996)

INVESTIGATOR

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Joanne Kropp

Years of experience including analytical and investigative activities related to claims, enrollment, accounting, and other healthcare operations.

- **Monmouth University**, Bachelor of Science, Criminal Justice

Amerigroup (8/2008 – current)

- Investigator

Horizon Blue Cross Blue Shield of New Jersey (9/1995 – 5/2008)

- Investigator (11/2001 – 5/2008)
- Fraud Analyst (3/1999 – 11/2001)
- Customer Service Consultant (9/1995 – 3/1999)

INVESTIGATOR

Leah Levy

Has experience in property and casualty and other types of investigation. Education in criminal justice in addition to experience in the law enforcement field.

- **Virginia Wesleyan College**, Bachelors’ of Arts, Criminal Justice and Political Science

Amerigroup (2009 – current)

- Investigator

Nationwide Insurance (2007 – 2009)

- Claims Investigator

Claims Verification, Inc. (2005 – 2007)

- Insurance Fraud Investigator

Virginia Beach Police Department, Crime Prevention Unit (2004 – 2005)

- Intern

INVESTIGATOR

Alethea Williams

Has several years of experience in both the Medicare and Medicaid managed care areas with knowledge of investigations, claims processing and compliance.

- **Eckerd College**, Bachelor of Arts in Business Management (projected to complete degree December 2010)

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Amerigroup

- Investigator, Corporate Investigations (9/2010 – current)
- Data Management Analyst III, Cost Containment (8/2009 – 9/2010)

WellCare Health Plans

- Medicare Compliance Specialist (2/2009 – 8/2009)

TriCenturion (Program Safeguard Contractor)

- Fraud Analyst (12/2003 – 1/2009)

HCA Patient Account Services

- Contract Analyst (1/2003 – 12/2003)

Blue Cross Blue Shield of Florida

- Internal Auditor (6/2000 – 1/2003)
- Membership and Benefits Representative (1/1996 – 6/2000)

SR COORDINATOR

Monica Putman

Has extensive knowledge of the health care industry and Medicaid programs. Has experience in claims systems, database maintenance, state regulations, and various computer applications.

- **Monroe College**, Bachelor's Business Administration, Information Systems

Amerigroup

- Senior Coordinator, Corporate Investigations (2009 – current)
- Coordinator, Corporate Investigations (12/2004 – 2009)
- Project Coordinator, Financial Controls (8/2000 – 12/2004)

Prudential Institutional Investments and Retirement Services

- Client Service Representative (4/2000 – 8/2000)
- Executive Assistant to VP of Client Relations (8/1999 – 4/2000)
- Senior Administrative Assistant, Client Relations Team (2/1998 – 8/1999)

Yeshiva University (12/1992 – 2/1998)

- Executive Secretary to Dean

COORDINATOR

Markieta Britt

Has experience with Medicaid and Medicare managed care through previous work with Amerigroup.

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- **ITT Technical Institute**, Computer Network Systems (2005-2006)

Amerigroup

- Coordinator, Corporate Investigations (8/2010 – current)
- Enrollment Analyst, Temporary (11/2009 – 2/2010)

Air Dominion, LLC (12/2007 – 11/2009)

- Assistant to Founder

Bank of America

- Customer Sales and Service Specialist II (8/2007 – 12/2007)
- Senior Customer Service Representative (2/2007 – 8/2007)

Opportunity Inc/Arbor E&T (12/2005 – 9/2006)

- Administrative Assistant

Pender & Coward (09/2005 – 12/2005)

- Asset Verifier

Job Descriptions

AVP, CORPORATE INVESTIGATIONS

JOB SUMMARY:

Investigative responsibilities include oversight of work units which conduct inquiries, interviews, and investigations into allegations of improper conduct/ethics involving employees, agents, enrollees, providers and vendors.

PRIMARY RESPONSIBILITIES

- Develops policy and executes strategy to reduce fraud and/or abuse (F&A), and control claim loss ratios.
- Assesses compliance with State contracts, governing laws and regulations and adequacy of internal policies and procedures to ensure compliance.
- Responsible for ensuring the development and filing of required submissions associated with F&A to regulatory agencies within time and quality standards.
- Develops inquiries to identify opportunities to detect errors and irregularities in billing.
- Acts as liaison with F&A software vendors to identify criteria, trends, analyze data and communicate findings.
- Manages the team that conducts investigations of highly sensitive, complex civil and criminal fraud investigations for multiple plans and/or functions.
- Provides consultative services for senior management on matters of fraud, ethics and control weaknesses.
- Conducts special studies such as those required to determine compliance applicability with new contracts, laws, or regulations.
- Directs the activities of subordinates including hiring, firing, performance evaluations, salary increases, development, coaching, etc.
- Assigns cases, monitors and controls performance and quality of investigators work.
- Assist the SVP, Risk Management and Audit in preparing and administering an organizational plan (Departmental dollar and manpower budgets) that will achieve the goals and objectives of the Investigations and Risk Management functions.
- Acts as technical resource to staff and provides guidance on how to analyze fraud trends, internal procedures and fraudulent activities; recommends appropriate action plans.
- Analyze data to assess risk to the company including evidence of deficiencies in processes, duplication of effort, or lack of compliance with laws, government regulations, and management policies or procedures.
- Reviews legislation, regulatory and internal policies to ensure investigations are conducted in compliant manner.
- Participate in business meetings, long range planning, budgeting, asset allocation, operational performance reviews and control self assessments as required to identify

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potential risks, contribute to the accomplishment of goals and objectives, drive control awareness and the appropriate ethics, compliance and risk management.

- Prepares and submits productivity and savings reports.
- Responsible for the development, maintenance and reporting associated with the fraud data base.
- Participates in the development and presentation of fraud awareness training materials.
- Train, educate, supervise, develop, mentor and evaluate staff personnel. Recommend manpower planning requirements, recruiting, performance, compensation and promotion actions.
- Keep the SVP, Risk Management and Audit informed of the status and findings of reviews, investigations and especially discuss unusual situations, findings and management issues.
- Develop and maintain suitable records, reports and files necessary to effectively administer and control the staff's activities.
- Assist the SVP, Risk Management and Audit in the day-to-day operation of the Department as requested.
- Adheres to company and department policies and procedures.
- Other duties as requested or assigned.

JOB REQUIREMENTS:

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and /or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Education and Experience:

- Bachelor of Science degree.
- A minimum of ten years experience in auditing, compliance, investigations, law enforcement, claims processing, finance, or other related experience.
- Prior experience working with regulatory agencies and prosecuting authorities.
- Some managed care industry experience preferred.

Certification and Licensure:

- CFE, CIA or CPA preferred.

Knowledge and Skills:

- Superior analytical skills.
- Ability to manage several projects across functional lines.
- Ability to conduct risk assessment.
- Participative management style.
- Ability to manage people and processes.

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- Ability to define problems, collect data, establish facts, identify root causes and draw valid conclusions.
- Ability to read, analyze, and interpret contracts, regulations, common policies and procedures, reports, and legal documents.
- Ability to interact with various levels within the organization and external agencies.
- Ability to effectively present information to top management, regulators and prosecutors.
- Able to work independently and use reference materials to resolve questions.
- Strong interpersonal skills.
- Knowledge of state guidelines and regulations applicable to Medicaid.
- Demonstrates initiative; is proactive in problem-resolution.
- Strong understanding of other departments within AMERIGROUP.
- Strong verbal and written communication skills.
- Appreciation of cultural diversity and sensitivity towards target population.

Physical Requirements:

- Must be able to work independently.
- Must be able to operate a computer.
- Must be able to operate a telephone.
- Must be able to travel on common carrier and adhere to Amerigroup's travel policies.

DIRECTOR RISK MANAGEMENT & AUDIT TECHNOLOGY**JOB SUMMARY:**

Responsible for securing technology solutions for business controls consulting engagements and/or fraud analysis in the Departments of Internal Audit, Risk Management, and/or Corporate Investigations. Provides technology consulting directly with internal and external business partners to identify, develop, and deliver analytical, data, and technology solutions. Designs, develops, directs, and maintains technology resources such as applications, analytic tools, and databases in support of Department business objectives. Partners with other departments, senior management, agencies, vendors, and contracted resources to drive business decisions critical to departmental initiatives. The position combines both hands-on performance and directing Department control consulting engagements and/or fraud analysis.

PRIMARY RESPONSIBILITIES:

1. Directs and performs controls consulting and/or fraud analysis management, lead and support roles for Department engagements. Directs and supports scoping of projects, designed to minimize risks to corporate assets.
2. Provides technology business controls consulting and/or fraud analysis services. Evaluates operational and information technology processes.
3. Partners with other departments, senior management, agencies, vendors, and contracted resources to drive business decisions critical to departmental initiatives and to gain comprehensive understanding of business operations, processes, systems, objectives, and risks to support analysis, interpretation, and Department objectives.
4. Supervises, trains, and mentors associates and/or interns in control consulting and data analysis techniques. Review processes and assesses performance of staff for engagement reviews. Provides technical support for analysis, database, query, application, and reporting issues. Administers formal appraisals for direct reports.
5. Determines technology solutions that provide business intelligence required to make effective decisions. Draws upon direct business experience to analyze

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business problems, outline potential solution options and develop recommendations. Researches problems/issues to develop effective solutions.

6. Participates in strategic and Department initiatives to evaluate areas of risk, evaluation, and improvement.
7. Defines, develops, implements, maintains, and enhances technology solutions.
8. Develops and manages highly complex and varied data mining tools for SQL Server and Oracle databases.
9. Responsible for data mining, data analysis, data quality, data integrity, and data transformation for strategic and Departmental projects. Performs data analysis across multiple data repositories and platforms.
10. Viewed as a subject matter expert in the development and execution of data mining and analysis.
11. Collaborates with operational and information technology subject matter experts to identify data resources to support strategic and Departmental engagements/projects.
12. Establishes and maintains excellent knowledge of data warehouse database design, data definitions, data integrity issues, system capabilities, programming languages, and analytical applications.
13. Develops and reviews programming code in support of controls consulting engagements.
14. Performs complex assignments requiring specialized technical knowledge.
15. Perform complex data analysis to identify patterns of suspicious activity, outliers, anomalies and other issues that represent fraud risk.
16. Supports risk management consulting services through design, implementation and evaluation of data analysis methodologies, tools and techniques.
17. Continues to improve technical skills and leadership ability. Continues to stay current with changes in corporate data resources and company initiatives/objectives. Maintains technical expertise and stays abreast of developments in the data analysis, managed care, fraud and abuse, information technology, internal audit, and risk management fields.
18. Perform other duties as assigned/requested.

EDUCATION AND EXPERIENCE:

Education

Required:

- Bachelors degree in one of the following disciplines: Economics, Statistics, Mathematics, Business Administration, Information Systems, Operations

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Research, Accounting, or other analytical discipline, and/or equivalent work experience.

Preferred:

- Advanced degree in one of the above disciplines.

Years and Type of Experience

Required:

- A minimum of 7 years experience in analytics role, including data analysis, statistical modeling, and data mining, with at least 3 years experience as a business control or fraud analysis consultant/manager and with at least 3 years of leadership/management experience.

Preferred:

- A minimum of 7 years experience in analytics role, including data analysis, statistical modeling, and data mining, in healthcare/managed care industry, IT, risk management environments or experience in serving as technical consultant within a diverse organization (technical, financial, IT and operations); with at least 3 years experience as a business control or fraud analysis consultant/manager and with at least 3 years of leadership/management experience.

Specific Technical Skills

Required:

- Demonstrated experience using TSQL (SQL Server) and PL/SQL (Oracle).
- Demonstrated strong experience using MS Access and MS Excel.
- Strong experience with data mining, analysis, conversion, transformation, reporting, business intelligence, and statistical techniques, applied to multiple platforms.
- Demonstrated technical expertise in designing and implementing database, data mining, business intelligence, or business activity monitoring tools.
- Strong knowledge and understanding of data warehouses, structures, and flows.

Preferred:

- Demonstrated experience using a healthcare claims system.
- Strong experience using TSQL (SQL Server) and PL/SQL (Oracle).
- Expert level of experience in MS Access and MS Excel.
- Demonstrated experience in VB, VBA, or VB.Net, strongly preferred.
- Expert level of experience with data mining, analysis, conversion, transformation, reporting, business intelligence, and statistical techniques, applied to multiple platforms.
- Expert level of knowledge and understanding of data warehouses, structures, and flows.

Certifications or Licensures

Required:

- None.

Preferred:

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- Certified Internal Auditor (CIA), Certified Information Systems Auditor (CISA), Certified Public Accountant (CPA), Certified Fraud Examiner (CFE), or equivalent certification.

Other:

Required:

- Possesses a highly developed quantitative/analytic ability and strategic insights to successfully manage, coordinate, and oversee the design, development, implementation, and tracking of data mining, analytical modeling, and other quantitative risk assessment tools.
- Must understand and/or learn (quickly) major business processes to design appropriate data analysis tests.
- Willingness to learn programming skills to support Department engagements.
- Flexibility and ability to thrive in a fast-paced, rapidly changing, highly complex environment. Must be highly and adaptive, quick thinking, responsive, open minded, persistent, and accountable.
- Demonstrated ability to manage multiple complex projects simultaneously. Strong organization and time management capacity to balance multiple project priorities with limited supervision
- Ability to think creatively and to innovate. Strong conceptual and quantitative problem-solving skills. Demonstrated problem solving and critical thinking skills. Proven effectiveness as a creative problem solver; ability to challenge conventional approaches and think outside the box. Strong investigative skills with ability to search beyond the initial results
- Ability to communicate ideas in both technical and user-friendly language. Ability to express complex analytical and technical information to senior management.
- Experience working in a team-oriented, collaborative environment. Strong customer service orientation. Good listening and interpersonal skills. Demonstrated leadership and mentoring skills.
- Exceptional attention to detail and work product validation.
- Self-motivated and directed. Works autonomously and with others to identify, isolate, and analyze problems issues. Must be able work independently.
- Builds trust and confidence in the appropriateness, completeness, accuracy, and timeliness of data analysis.
- Appreciation of cultural diversity and sensitivity towards target population.

Preferred:

- Demonstrated track record for constant desire to look for and execute on best practices in data analysis support.
- Skilled communicator with ability to influence others.

MANAGER CORPORATE INVESTIGATIONS

JOB SUMMARY: Responsible for conducting in-depth investigations of reported, alleged or suspected fraud involving providers, members and associates for the full range of products at Amerigroup for designated health plans. Ensures compliance with contractual requirements related to Special Investigative Units and fraud, abuse and waste investigations. Mentors and provides guidance to others in the unit. Develops and maintains working relationships with appropriate plan departments and outside agencies.

PRIMARY RESPONSIBILITIES:

- Maintains a full investigative case load by conducting investigations into reported, alleged or suspected fraud, abuse, and waste.
- Independently decides the most effective and efficient method of investigation for each individual case.

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- Prepares and documents investigative plans detailing the investigative plan of action according to department guidelines.
- Develops sufficient evidence to conclusively establish facts.
- Conducts and documents comprehensive interviews/interrogations with providers, members, associates and witnesses to obtain information which would be considered admissible under generally accepted criminal and civil rules of evidence.
- Trains, educates, develops, mentors, and evaluates other associates in the department.
- Establishes and maintains working relationships with all appropriate law enforcement personnel, regulatory personnel, and industry peers including FBI, Attorney General's Office, Departments of Insurance, State Fraud and Abuse Units, NHCAA and other MCOs in their respective markets.
- Develops and maintains close working relationships with all internal departments and senior management in the plan(s) to which they are assigned including CEOs, Chief Compliance Officers, Medical Directors, Provider Relations, Claims etc.
- Analyzes data as part of the investigative process using available fraud detection software and corporate resources.
- Prepares and submits findings and makes recommendations to senior management.
- Represents Amerigroup in conducting settlement negotiations with providers, counsel and/or other associated parties
- Effectively communicates accurate information to management, team members and other appropriate staff in a timely, accurate and courteous manner.
- Conducts special studies for management such as those required to determine compliance with new provider contracts, laws or regulations.
- Develops and presents fraud awareness training to members, providers, and associates.
- Attends anti-fraud training seminars as required.
- Provides consultation to other investigators and staff where high level technical expertise is necessary.
- Assist in defining departmental policies and procedures that are consistent with industry best practice.
- Participates in identifying new initiatives and/or projects that will identify and reduce fraud and abuse, to include pre-disbursement and post payment.
- Assists in the evaluation, design and implementation of strategies to flag and evaluate claims of certain providers who are billing beyond norms prior to disbursement of payments.
- Assists in the evaluation, design and implementation of strategies to send communications to providers who are billing out of normal ranges, to include training the providers and monitoring impact on future billing patterns.
- Regularly updates the department's Case Management System with pertinent case details.
- Testifies in criminal, civil, and administrative legal proceedings as required.

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- Adheres to company and department policies and procedures.
- Other duties as assigned.

EDUCATION AND EXPERIENCE:

Education

Required: Bachelor's degree or relevant work experience.

Preferred:

Years and Type of Experience

Required: Minimum of 5 years experience conducting full scale investigations and interacting with state, federal and local law enforcement agencies, or a minimum of 5 years experience in the field of Criminal Justice, Business, Insurance, Medical Insurance Claims, or other investigative field

Preferred: Law enforcement experience; clinical experience

Specific Technical Skills

Required:

- Solid knowledge of insurance law, federal, state, civil and criminal statutes.
- Working knowledge of Microsoft applications, especially Excel required.
- AMISYS, FACETS, or related claims processing system experience preferred.
- Understanding of HCFA 1500 and UB92 claim billing forms
- Understanding of common claim coding (CPT-4, ICD-9, HCPCS)
- Strong analytical skills

Preferred:

Certifications or Licensure

Required:

- AHFI, CFE, certification preferred
- Valid driver's license required

Preferred:

Other

Required:

- Excellent interpersonal skills, including the ability to work with all levels of personnel and the ability to work across all lines of the organization.
- Superior verbal and written communication skills
- Ability to multitask.

DECISION SUPPORT ANALYST III

JOB SUMMARY:

Responsible for the extraction, management, and analysis of data from internal/external operational processes, data repositories, business systems, and records to identify

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fraud, abuse and waste risks in support of Corporate Investigations Department business objectives. Implements, manages, and utilizes technology solutions to perform complex data mining, ad hoc analysis, and reporting functions to quantify fraud and abuse (F&A) exposure, provide reports for provider negotiations, achieve litigation requirements, determine recovery and restitution, and evaluate marketing regulatory compliance.

PRIMARY RESPONSIBILITIES:

- Performs complex data mining and ad hoc data analysis to identify patterns of suspicious activity, outliers, anomalies and other issues that represent fraud risk.
- Develops reporting and analysis solutions to support Department business objectives.
- Quantifies, prioritizes, and develops strategies for F&A cases, based upon data mining/analysis.
- Designs and implements Access databases, queries, and reports. Utilizes multiple Corporate data repositories, including SQL Server and Oracle databases.
- Uses management reporting tools to provide business intelligence required to make effective decisions.
- Utilizes a variety of applications (Access, SQL Server Management Studio, STARSentinel, AMISYS, and Facets) to achieve comprehensive analysis and support.
- Identifies technology solutions for process improvements.
- Understands healthcare fraud detection and prevention methodologies, practices, and theories. Understands departmental, corporate, and external business objectives and processes. Applies knowledge in providing effective analysis.
- Collaborates directly with associates, other departments, external agencies, and vendors to coordinate resources, analyze data, identify trends, and communicate findings.
- Applies statistical knowledge to perform sampling, extrapolation and forecasting techniques.
- Provides technical support for analysis, database, query, application, and reporting issues.
- Trains and coaches associates in data analysis.
- Other duties as assigned or requested.

EDUCATION AND EXPERIENCE:

Education
Required:
<ul style="list-style-type: none"> • Bachelor's degree in Computer Science, Finance, Economics, Business Administration or a related discipline or equivalent experience.
Preferred:
Years and Type of Experience
Required: Minimum of six (6) years experience with four (4) years of relevant experience.

Preferred: Managed care Decision Support/Medical Economics
Specific Technical Skills
<p>Required:</p> <ul style="list-style-type: none"> • Experience in the development of MS Access reports and databases. • Experience in ETL (Extract, Transform, and Loading) of data. • Strong analytical ability with proficient knowledge of a structured query language, such as Microsoft Access, VBA, TSQL, or PLSQL is required. • Experience with Microsoft Excel and other Microsoft Office products.
Preferred:
Certifications or Licensure
<p>Required:</p> <p>Preferred: Healthcare or related certifications or licensure (e.g. RN, LPN, CFE, CPC) or equivalent</p>
Other
<p>Required:</p> <ul style="list-style-type: none"> • Demonstrate ability in identifying, designing and integrating new methodologies, metrics, and techniques transforming complex data sets into actionable information. • Strong communications skills, both written and oral required –ability to present information effectively to corporate management, plan management, and provider leadership. • Ability to interface effectively with both technical and clinical business owners. • Ability to function effectively with minimal direction, relying on internal motivation and personal experience to analyze problems and seek out solutions. • Ability to interpret, and communicate results of data submissions and analyses.
Preferred:

SR. INVESTIGATOR

JOB SUMMARY: Conduct in-depth investigations of reported, alleged or suspected fraud involving the full range of products at Amerigroup. Ensure compliance with contractual requirements related to Special Investigative Units and fraud, abuse and waste investigations.

PRIMARY RESPONSIBILITIES:

- Maintain full investigative case load by conducting investigations into reported, alleged or suspected fraud.
- Independently decides the most effective and efficient method of investigation for each individual case.
- Prepares and documents investigative plans detailing the investigative plan of action according to department guidelines
- Develops sufficient evidence to conclusively establish facts.
- Conduct comprehensive interviews/interrogations with providers, members and witnesses to obtain information which would be considered admissible under generally accepted criminal and civil rules of evidence.
- Establish and maintain working relationships with all appropriate law enforcement and regulatory personnel, and additionally maintain rapport with industry peers.
- Analyze data as part of the investigative process using available fraud detection software and corporate resources.
- Prepare and submit findings and make recommendations to management.
- Independently represents Amerigroup in conducting settlement negotiations with providers, counsel and/or other associated parties
- Effectively communicates accurate information to superiors, team members and other appropriate staff in a timely, accurate and courteous manner.
- Conduct special studies for management such as those required to determine compliance with new provider contracts, laws or regulations.
- Assist in the development and presentation of fraud awareness training sessions.
- Attend fraud training seminars as required.
- Provide consultation to Fraud Investigators where high level technical expertise is necessary.
- Manage assigned cases and continuously update the department's Case Management System with pertinent case details.
- Perform out-of-office field investigation as appropriate, at times requiring out of area, overnight travel.

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- Testifies in criminal and civil legal proceedings as required.
- Adhere to company and department policies and procedures.
- Other duties as requested or assigned.

JOB REQUIREMENTS:

Education and Experience:

- A Bachelor's degree preferred.
- Minimum 2 years experience conducting full scale insurance investigations and interacting with state, federal and local law enforcement agencies; or.
- Minimum of 4 years experience in Criminal Justice, Business, Insurance, Medical Insurance Claims, or other investigative field required.
- Law enforcement experience preferred.
- Clinical experience a plus.

Certification and Licensure:

- Accredited Health Care Fraud Examiner (AHFI) preferred.
- Certified Fraud Examiner (CFE) Preferred
- Valid driver's license required.

Knowledge and Skills:

- Solid knowledge of insurance law federal, state, civil and criminal statutes.
- Working knowledge of Microsoft applications, especially Excel required.
- AMISYS or related claims processing system preferred.
- Excellent interpersonal skills, including the ability to work with all levels of personnel and the ability to work across all lines of the organization.
- Understanding of CMS 1500 and UB-92 claim billing forms
- Advanced understanding of common claim coding (CPT-4, ICSD, HCPCS)
- Superior verbal and written communication skills
- Intermediate MS Office skills
- Analytical and keyboard skills

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- Ability to initiate and coordinate activities to meet goals and objectives
- The highest levels of ethics, integrity and professionalism
- Ability to handle multiple priorities simultaneously with a high quality result.
- Appreciation of cultural diversity and sensitivity towards target population.
- Ability to work independently

INVESTIGATOR

JOB SUMMARY: Conduct in-depth investigations of suspected fraud involving the full range of products at Amerigroup. Ensure compliance with contractual requirements related to Special Investigative Units and fraud, abuse and waste investigations.

PRIMARY RESPONSIBILITIES:

- Conducts investigations into possible irregularities to detect, curtail fraud, and recover lost assets.
- Strive to develop sufficient evidence to conclusively establish facts.
- Conduct comprehensive interviews/interrogations with providers, subscribers and witnesses to obtain information which would be considered admissible under generally accepted criminal and civil rules of evidence.
- Establish and maintain working relationships with all appropriate law enforcement and regulatory personnel, and additionally maintain rapport with industry peers.
- Prepare and submit findings and make recommendations to management.
- Effectively communicates accurate information to superiors, team members and other appropriate staff in a timely, accurate and courteous manner.
- Conduct special studies for management such as those required to determine compliance with new provider contracts, laws or regulations.
- Assist in the conduct of fraud awareness training sessions.
- Attend fraud training seminars as required.
- Other duties as requested or assigned.

JOB REQUIREMENTS:**Education and Experience:**

- A Bachelor's degree or equivalent experience in Criminal Justice, Business, Insurance, Medical Insurance Claims, or other investigative field required.
- Minimum two years experience conducting full scale insurance investigations and interacting with state, federal and local law enforcement agencies.

OR

- A minimum of five years of law enforcement experience including demonstrated experience in conducting full scale investigations

Certification and Licensure:

- Certified Fraud Examiner (CFE) Preferred
- Accredited Health Care Fraud Examiner (AHFI) Preferred

Knowledge and Skills:

- Solid knowledge of insurance law federal, state, civil and criminal statutes.
- Working knowledge of Microsoft applications, especially Excel required.
- AMISYS or related claims processing system preferred.
- Clinical experience preferred.
- RN or LPN experience a plus.
- Excellent interpersonal skills, including the ability to work with all levels of personnel and the ability to work across all lines of the organization.
- Superior verbal and written communication skills.
- Ability to initiate and coordinate activities to meet goals and objectives.
- Ability to handle multiple priorities simultaneously with a high quality result.
- Appreciation of cultural diversity and sensitivity towards target population.
- Ability to work independently.

CLINICAL COMPLIANCE ANALYST

JOB SUMMARY: Incumbent will make claim adjustment and reimbursement recommendations based upon medical record reviews associated with pre- and post-payment reviews of claims in support of the Corporate Investigations Department's initiative to proactively address fraud, waste, and abuse. Incumbent will perform a variety of technical and administrative tasks essential to the efficient operation of the Corporate Investigations Department.

PRIMARY RESPONSIBILITIES:

- Responsible for the medical review of claims routed to the Corporate Investigations Department for aberrant billing/coding issues, or suspected fraud and/or abuse.
- Interfaces with operational department management, Health Plans and State representatives on fraud, waste, and abuse issues.
- Conducts coding audits and prepares and present reports defining audit observations.
- Assists in provider and staff education on medical code assignments and required documentation.
- Responsible for the technical oversight of contract coding review resources utilized by the Corporate Investigations Department.
- Develops appropriate process and case documentation to support the mission of the Corporate Investigations Department.
- Ensures continuing development of effective professional relationships with the Legal, Medical Management, Claims and Cost Containment Departments.
- Assist in the development of departmental policies and procedures regarding documentation and coding standards.
- Actively participate in training activities related to fraud, waste, and abuse.
- Keeps current with medical compliance and reimbursement policies such as medical necessity issues and proper coding.
- Other duties as assigned.

Education and Experience:

- Bachelor's Degree in Health Care Management, Accounting or Business, or equivalent experience.
- Licensed Practical Nurse or Registered Nurse preferred.
- Minimum of five years coding experience (ICD-9, CPT-4, E&M and HCPCS).
- Previous experience auditing professional fee coding.
- Previous experience providing physician training and education for E&M coding.
- Two years experience in claims, clinical or managed care environment.

Certification and Licensure:

- Certified Professional Coder (CPC) or CPC-Hospital Required.

Knowledge and Skills:

- Prior AMYSIS or other claims processing system knowledge preferred.
- Advanced understanding of medical terminology, body systems/anatomy, physiology and concepts of disease.
- Computer literate including Microsoft Office and Microsoft Access.
- Strong oral and written communication skills.
- Excellent analytical and problem solving skills.
- Demonstrates strong decision-making skills.
- Ability to manage multiple tasks in a demanding work environment.
- Appreciation of cultural diversity and sensitivity towards target membership population.
- High energy level, self-motivating and able to handle several projects at once.

SR COORDINATOR**JOB SUMMARY:**

Supports the Corporate Investigation Department (CID) and Coding Validation Initiative (CVI) to include research, data entry, file maintenance, intermediate to advanced level case referrals, record keeping, and reconciliations. Assisting the Corporate Investigations team, provides data analysis, investigative support and investigation of matters of suspected fraud and abuse or other dishonesty by employees, providers, enrollees, vendors and others.

PRIMARY RESPONSIBILITIES:

1. Accountable for maintenance and monitoring of accurate and timely information in the Corporate Investigations Management System (CIMS).
2. Monitors CID's fraud and abuse queue and provides direction regarding processing of the providers' claims to the Claims Department.
3. Conduct initial investigations of new lead referrals and strive to develop sufficient evidence to conclusively establish facts.
4. Conducts member investigations and prepare clear, complete, and concise investigative reports, audit findings and memorandum of interview.
5. Prepares and submits member case referrals to State agencies as required, and track information in CIMS
6. Prepares ad-hoc management reports for Corporate Investigations Management and Sr. Leadership.
7. Reviews requests for information from a variety of governmental law enforcement and regulatory agencies at the local, state, and federal level; obtains and analyzes data, responds timely, and tracks in CIMS.
8. Reviews intermediate to advance level claim transactions, including adjustments to claims due to reimbursements received from providers. Performs analysis and evaluation of data from search systems including, but not limited to claim data repositories, STARSentinel, public record databases, and various internet based investigative tools.
9. Supports CID staff in requests for data extracts and analysis, research, and investigative support functions.
10. Facilitates the training of CID/CVI Coordinators and new CID associates.
11. Utilizes computer applications, specifically MS Access, MS Excel, MS Word and others to optimize workflow and data analytics to detect, prevent and investigate fraud, abuse and waste.
12. Effectively interacts in all modes of communication (verbal and written) with associates, investigative personnel, members,

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- providers, and outside professionals, such as attorneys and law enforcement agents.
13. Accurately enters all PCA pends in the claims systems for providers placed on prepayment review.
 14. Serves as a resource to the Coordinator through development, mentoring, and training, and a back-up to the Coordinator when appropriate.
 15. Attends anti-fraud or technical training seminars
 16. Other duties as assigned.

EDUCATION AND EXPERIENCE:

Education

Required:

- High school diploma or GED.

Preferred:

- College Degree

Years and Type of Experience

Required:

- Minimum of 3 years of relevant experience such as healthcare fraud experience, or 5 years of relevant experience in medical claims processing experience or medical billing/collections experience.
- OR
- For Internal Associates: Demonstrated proficiency as a Coordinator Corporate Investigations for a minimum of one year.

Specific Technical Skills

Required:

- Advanced level Microsoft Office skills specifically in MS Access, MS Excel, MS Word.
- Knowledge of Amerigroup claims processing systems.
- Advanced understanding of medical terminology, claims coding, and standard claims forms used for physician and hospital billings.

Certifications or Licensures

Preferred:

- Certified Professional Coder (CPC) a plus

Other:

Required:

- Knowledge of state guidelines and regulations applicable to Medicaid.
- Excellent interpersonal skills, including ability to work with all levels of associates and across all lines of the organization.

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- Superior verbal and written communication skills.
- Able to initiate and coordinate activities to meet goals and objectives.
- Capable of handling multiple priorities simultaneously with quality results.
- Demonstrates initiative and is proactive in problem resolution.
- Able to work independently/limited supervision.
- Understand the importance of confidentiality and the need to be discreet in all investigations and projects.
- Utilize reference materials proficiently to resolve issues.
- Appreciation of cultural diversity and sensitivity towards target population.

SCOPE INFORMATION

Direct Reports: 0

Indirect Reports: 0

Budgetary \$ Responsibility: 0

PHYSICAL REQUIREMENTS:

The physical requirements described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Must be able to operate general office equipment including but not limited to: computer, phones and related media and information devices.
- Ability to communicate both in person and/or by telephone.

COORDINATOR

JOB SUMMARY:

Supports the Corporate Investigation Department (CID) to include research, data entry, file maintenance, entry level case referrals, record keeping, and reconciliations.

PRIMARY RESPONSIBILITIES:

1. Responsible for entering information in the Corporate Investigations Management System (C.I.M.S.) accurately and timely.
2. Review the CID monthly fraud and abuse reports for accuracy.
3. Create electronic and hard copy case files for CID.
4. Responsible for scanning medical records and assisting Investigators in organizing medical record photos.
5. Work with CID staff to make referrals to state agencies as required, and track required information in C.I.M.S.
6. Interpret, analyze and understand company records and systems.
7. Proficient in obtaining and reviewing data from FACETS, MACESS, and AMYSIS.
8. Responsible for monitoring CID fraud queues, including the FACETS contact log and CID Fraud and Abuse mailbox.
9. Monitor CID lockbox and identify, track and reconcile overpayments from providers to CID.
10. Utilize computer applications, specifically MS Access, MS Excel, MS Word and others to optimize workflow and gain efficiencies.
11. Perform administrative functions as required, including, but not limited to: telephone backup, photocopying & scanning, maintaining investigative files, tracking restitution, staff travel requests, and other required duties.
12. Other duties as assigned.

EDUCATION AND EXPERIENCE:

Education

Required:

- High school diploma or GED.

Preferred:

- College Degree

Years and Type of Experience

Required:

- Minimum of 3 years experience as administrative support

Preferred:

- Minimum of 3 years experience as administrative support to a department in healthcare with at least 3 years of medical claims processing experience and/or 3 years of medical billing/collections experience, as well as, data entry experience

Specific Technical Skills

Required:

- Intermediate to advanced level Microsoft Office skills specifically in MS Access, MS Excel and MS Word.

Preferred:

- Knowledge of Amerigroup claims processing systems.
- Understanding of medical terminology, claims coding, and standard claims forms used for physician and hospital billings.

Certifications or Licensures

Required:

-

Preferred:

-

Other:

Required:

- Understand the importance of confidentiality and the need to be discreet in all investigations and projects.
- Excellent interpersonal skills, including ability to work with all levels of associates and across all lines of the organization.
- Superior verbal and written communication skills.
- Able to initiate and coordinate activities to meet goals and objectives.
- Capable of handling multiple priorities simultaneously with quality results.
- Demonstrates initiative and is proactive in problem resolution.
- Able to work independently/limited supervision.
- Utilize reference materials proficiently to resolve issues.
- Appreciation of cultural diversity and sensitivity towards target population.

EXHIBIT 3**NHCAA Education & Training Programs****Level I (Basic)**

1. Health Care Fraud: Practical Applications for Investigative Skills (1 day)
2. Fundamentals of Health Care Fraud Investigation (1 1/2 days)
3. Combating Health Care Fraud: A Public and Private Alliance (2 days)
4. Establishing an Fraud Operation (1 - 1 1/2 days)

Level II (Intermediate)

1. Level II Training for Health Care Fraud Investigators (1 1/2 days)
2. CID Management Roundtable (1 1/2 days)
3. Managed Care and Its Implications for Fraud Specialists (1 1/2 days)
4. Legal Issues in Health Care Fraud (1 1/2 days)
5. Health Care Fraud Schemes in Provider Specialty Areas: I (1 1/2 days)
6. Health Care Fraud Schemes in Provider Specialty Areas: II (1 1/2 days)
7. Senior Investigators' Roundtable (1 1/2 days)
8. Hospital Fraud (1 1/2 days)
9. Pharmaceutical Fraud (1 1/2 days)
10. Internet Health Care Fraud Issues (1 day)
11. Civil/Criminal Investigations Academy for the Experienced Health Care Fraud Investigator (2 1/2 Days)

Level III (Advanced)

1. Case Study in Health Care Fraud Investigation and Techniques (1 day)

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2. High-Tech Tools and Techniques for Fighting Health Care Fraud (1 - 1 1/2 days)
3. Annual Training Conference (3 days)

THE NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

Publications and Products

Purpose: Provide useful, in-depth information on a wide variety of health care fraud topics to enhance understanding of fraud detection and investigation methodologies, fraud awareness concepts and practices, prevention techniques, and prosecutorial alternatives.

Utilizing several different medias, the publications and products include guidebooks, comprehensive reports, white papers, newsbriefs, video-based learning, workbooks, computer-based learning, self-instruction/study tools, and printed and on-line documentation.

PUBLICATIONS

1. "Health Care Fraud Investigation: A Guide to Fundamental Principles and Procedures"
2. "Fraud in Managed Health Care Delivery and Payment"
3. "Fraud in Electronic Submittal and Payment of Health Insurance Claims"
4. "Fighting Health Care Fraud: A Guide to the Benefits and Risks of Fraud Investigations"
5. "Recovering the Proceeds of Health Care Fraud: A Reference Guide to the Compensation of Health Care Fraud Victims"
6. "Guidebook to Insurer Compliance with State Fraud Requirements and Federal Fraud, waste, and abuse Control Program Guidelines and Requirements"

PRODUCTS

1. The Painful Price of Health Care Fraud (Training CD)
2. Chiropractic Fraud (Training CD)
3. "Health Care Fraud: A Breach of Trust" — Fraud Awareness Training Video and Presentation Guide
4. "Life and Health Television Network (LHTN) Health Care Fraud Video Series"
5. Health Care Fraud — Its Nature, Scope and Impact
6. Federal and State Law Enforcement Initiatives
7. Legal Issues in Fighting Health Care Fraud
8. Organized Fraud Rings
9. Chiropractic Fraud
10. Dental Fraud Issues
11. Using Technology to Fight Health Care Fraud
12. Communicating the Role of the CID
13. Patient Brokering in Health Care Fraud
14. Fraud Issues in Managed Care

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15. Florida's Model for Fighting Health Care Fraud
16. "Health Care Fraud Issues for Managed Care Organizations: A Federal Prosecutor's View"
17. NHCAA's Video Library

EXHIBIT 4**FRAUD AWARENESS MEDIA AND RADIO SCRIPT**

Amerigroup participates with other carriers through NHCAA to educate the general public regarding fraud, waste, and abuse in markets as required. This includes multiple ads in newspapers and periodicals, along with spots on radio stations. Following are examples of the scripts for 2008 and 2009.

MEDIA SCRIPT**The Many Faces of Health Care Fraud**

Young and old. Male and female. Mothers, fathers, sisters, brothers, sons and daughters. All are potential victims of health care fraud.

Health care fraud costs us all an estimated \$68 billion every year—and often manifests as medical identity theft. Many health care fraud victims have been subjected to unnecessary or unsafe medical procedures, while others have had their permanent medical records and legitimate insurance information compromised.

New Yorkers can take simple actions to protect themselves from health care fraud:

- Protect your health insurance card like your credit card. Never give out policy or insurance ID numbers to strangers.
- Read your police and Explanation of Benefits (EOB) statements carefully.
- Beware of “free” offers. These offers are often fraud schemes designed to bill you and your insurance company for treatments you never received.
- Report fraud. Call your insurance company immediately if you suspect you may be a victim of health insurance fraud.

For more information please visit:

www.nhcaa.org/NYPublicAwareness

RADIO SCRIPT

Radio Spot: 60 seconds

ANNOUNCER:

Car alarms. Keyless locking systems. The “Club.”

We protect our cars from thieves. We should. Car theft costs Americans about eight billion dollars a year.

But we ignore a crime that costs eight times that.

Health insurance fraud costs an estimated sixty-eight billion dollars a year.

You are the first line of defense against the scam artists and thieves who make insurance more expensive for everyone.

Here’s some tips:

Protect your health insurance card like a credit card. Don’t give out your ID number – over the phone, online, or to salespeople.

Beware of “free” offers. Many times they’re scams to run up charges on your insurance.

Read your benefits statements carefully. Make sure you received the treatments that are charged.

If something seems wrong? Notify your insurance company immediately.

For more information visits NHCAA.org. That’s NHCAA.org.

A message from the National Health Care Anti-Fraud Association and the New York Health Plan Association on behalf of their members.

EXHIBIT 5**HEALTH CARE FRAUD LAWS****A. Civil and Criminal False Claims****1. Introduction**

Amerigroup Parties shall not knowingly and willfully make or **cause to be made** any false statement or representation of material fact in any claim or application for benefits under any federal health care program or health care benefit program.

Examples of prohibited conduct include, but are not limited to, misrepresenting services which were rendered, falsely certifying that services were medically necessary, “up-coding,” billing for services not actually rendered, making false statements to governmental agencies about Amerigroup’s compliance with any state or federal rules, and/or failing to refund overpayments made by state or federal health care programs.

2. Criminal False Statements Related to Health Care Matters (18 USC §1035)

Amerigroup Parties shall not knowingly and willfully make or use any false, fictitious, or fraudulent statements, representations, writings or documents regarding a material fact in connection with the delivery of, or payment for, health care benefits, items or services. Amerigroup Parties shall not knowingly and willfully falsify, conceal or cover up a material fact by any trick, scheme or device.

3. Civil False Claims Act (31 USC §3729(a))

Amerigroup Parties shall not:

- a) Knowingly file a false or fraudulent claim for payments to a governmental agency, or health care benefit program,
- b) Knowingly use a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or health care benefit program; or
- c) Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.

Examples of false or fraudulent claims include, but are not limited to, multiple billing, upcoding, unbundling (the process of billing separate components of one medical procedure to increase reimbursement), submitting or processing claims for items or services not provided, submitting or processing claims for items or services not medically necessary, and billing for non-covered services.

4. Criminal False Claims Act (18 USC §286, 287)

Amerigroup Parties shall not knowingly make any false, fraudulent or fictitious claims against a governmental agency or health care benefit program. Conspiring to defraud a governmental agency or health care benefit program is also prohibited.

5. Criminal Wire and Mail Fraud (18 USC §1341, 1343)

Amerigroup Parties shall not devise a scheme to defraud a governmental agency or health care benefit program that uses the U.S. Postal Service, private postal carriers or telephone lines to perpetrate the fraud.

6. Criminal False Statement Act (18 USC §669)

Amerigroup Parties shall not embezzle, steal or otherwise without authority, convert to the use of any person other than the rightful owner, or intentionally misapply money, funds, securities, premiums, credits, property, or other assets of a health care benefit program.

7. Obstruction of Criminal Investigations of Health Care Offenses (18 USC §1518)

Amerigroup Parties shall not willfully prevent, obstruct, mislead, delay, or attempt to prevent, obstruct, mislead or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator.

B. Kickback Act (42 USC §1320a-7b(b))

Amerigroup Parties shall not knowingly and willfully solicit, offer to pay, pay or receive **any remuneration**, either directly or indirectly, overtly or covertly, in cash or in kind, in return for:

- 1) Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment may be made, in whole or in part, under a federal health care program; or
- 2) Purchasing, leasing, ordering, or arranging for, or recommending the purchasing, leasing, or ordering of any good, facility, services or item for

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which payment may be made in whole or in part, under a federal health care program.

Remuneration may include kickback payments, bribes or rebates.

C. Civil Monetary Penalties Act (42 USC §1320a-7a)

Amerigroup Parties shall not knowingly present a claim to any federal health care program or health care benefit program for an item or service the person knows or should have known, was not provided, was fraudulent, or was not medically necessary. No claim for an item or service shall be submitted that is based on a code that the person knows or should know will result in greater payment than the code the person knows or should know is applicable to the item or service actually provided.

The filing of inaccurate claims for reimbursement may result in the prosecution of Amerigroup, its subsidiaries and Associates. Prosecution under this Act carries extremely large civil fines or criminal penalties or both.

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EXHIBIT 6

ADDENDUM:	LOUISIANA
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FRAUD OFFICER

CEO of Health Plan, TBD
Amerigroup Louisiana

REPORTING

In accordance with 42 CFR §455.1(a)(1) and §455.17, Amerigroup shall promptly report suspected fraud, abuse, waste and neglect information, relative to the Provider Agreement, to the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) and Department of Health and Hospitals (DHH) within five business days of discovery.

If a complaint or the findings of a preliminary investigation give Amerigroup reason to believe that fraud or abuse of the Medicaid program has occurred, Amerigroup must report this information to the Program Integrity Section within three (3) business days.

If enrollee fraud is suspected, Amerigroup will refer the complaint to the Program Integrity Section within three (3) business days with all supporting evidence so the complaint can be referred to the Medicaid Eligibility Field Operations and MFCU in the Louisiana Attorney General's Office.

Amerigroup shall report these suspected fraud, abuse, waste and neglect referrals via the following mechanisms as provided by DHH:

- The fraud hotline toll free number, 1-800-488-2917;
- US mail, PO Box 91030, Baton Rouge, LA70821;
- Fraud reporting fax line 225-219-4155; and/or
- DHH's website www.dhh.louisiana.gov and click on the "Report Medicaid Fraud" button.

For each complaint that warrants investigation, Amerigroup shall provide DHH, at a minimum, the following:

- Name and ID number;
- Source of complaint;
- Type of provider;
- Nature of complaint;
- Approximate dollars involved if applicable; and
- Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.

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Additionally, Amerigroup, through its Compliance Officer, shall report all activities on a quarterly basis to DHH. These reports shall include, but are not limited to:

- Number of complaints of fraud, abuse, waste, neglect and overpayments made to Amerigroup that warrant preliminary investigation; and
- Number of complaints reported to the Compliance Officer

Amerigroup shall meet with DHH and the MFCU on a quarterly basis, to exchange information and discuss fraud, abuse, waste, neglect and overpayment issues. Amerigroup's Compliance Officer shall be the point of contact for these requested meetings.

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SECTION P: THIRD PARTY LIABILITY

P.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:

- o How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;*
- o Collection process for pay and chase activity and how it will be accomplished;*
- o How subrogation activities will be conducted;*
- o How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements;*
- o Whether you will use a subcontractor and if so, the subcontractor’s responsibilities; and*
- o What routine systems/business processes are employed to test, update and validate enrollment and TPL data.*

Third Party Liability and Coordination of Benefits

Amerigroup will promote sound fiscal management of the Louisiana Medicaid CCN program through our corporate **Cost Containment Department that is currently staffed with 84 employees** skilled in third party liability (TPL) programs, including both **cost avoidance through both coordination of benefits and recovery**. Our cost avoidance efforts will assure that Medicaid is the payer of last resort. Our recovery efforts will assure that liable third parties are billed when their responsibilities are identified following our payment of a claim for services and will be implemented in accordance with DHH requirements.

REAL SOLUTIONS *mean* REAL RESULTS

Our cost avoidance efforts will assure that Medicaid is the payer of last resort, by locating health insurance coverage primary to Medicaid and not paying a provider’s claim when we have established that another payer has primary payment liability.

The success of Amerigroup in coordination of benefits and third party recovery is rooted in a designated Cost Containment Department that leverages experienced financial personnel, automated applications and consistent, replicable processes. The Department is responsible for a wide variety of activities, including identification of Other Health Insurance (OHI), cost avoidance through coordination of benefits, overpayment/collections and subrogation. Our guiding principle is that member access to medically necessary services is paramount. **The Department adopts recovery and cost containment strategies to pursue all legal avenues to prudently manage CCN funds with the least impact on providers and members.** Further, our approach fosters provider engagement by working with network and non-network providers to identify and resolve the root causes of inappropriate billing.

Identifying Injury or Trauma to Determine the Existence of Third Party Liability

A claim submitted to Amerigroup for payment, in which indicators suggest the service rendered is the result of an automobile, liability or workers' compensation injury or illness, may mean that another entity has primary responsibility for the cost of health care services. Amerigroup pays the provider for the service rendered and then evaluates claims data in accordance with diagnosis and trauma codes designated in the code of federal regulations at 42 CFR 433.138. Specifically, we utilize the diagnosis codes identifying injury or poisoning in the range between 800 and 999.9 (excluding 994.6) in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and "E" codes (External Causes of Injury and Poisoning) in the range between E800 and E998. If we determine that pursuit of payment by another entity may be appropriate, we establish a case for further investigation and recovery of payments made.

Identifying Other Health Insurance Information

Amerigroup stores in each member's electronic record any available data regarding alternate insurance carriers, such as a commercial health care insurer or health maintenance organization (HMO); TRICARE (the health care program for active duty service members, National Guard and Reserve members, retirees, their families and others, formerly called CHAMPUS); or an employer-administered Employee Retirement Income Security Act of 1974 (ERISA) plan. In Louisiana, sources for this information are expected to include DHH and its contractor (Health Management Systems), with which Amerigroup also has a contract; providers indicating this information on or with claim submissions; and Amerigroup Provider Services or Member Services Representatives.

REAL SOLUTIONS *mean* REAL RESULTS

On behalf of Amerigroup, HMS accesses its data repository of health information from more than 150 health insurance organizations and uses telephonic and online verification tools to facilitate prompt confirmation of OHI.

All potential OHI leads are submitted to a dedicated unit for validation. This staff conducts a daily review of all potential OHI and TPL leads received throughout the company from members, providers and others. The information is validated with the primary carrier; if appropriate it is added to the member's record on a Coordination of Benefits (COB) tab. The COB tab includes the policy issuer and number, effective and termination dates and last date verified. The tab also identifies the policy holder, which is important if the member is a child and the insurance coverage is through an absent parent. For members with such information noted in their record, COB is automatically incorporated into the claim adjudication process.

Member demographic data is regularly shared with HMS. This Amerigroup corporate subcontractor uses the demographic data to search its extensive data repository of OHI information for any new, modified or terminated coverage for members. The findings are reported at least monthly to the Cost Containment Department for validation and addition to the member's record on the COB tab as appropriate.

Any member identified as having Medicare coverage will be reported to DHH for verification and disenrollment consideration.

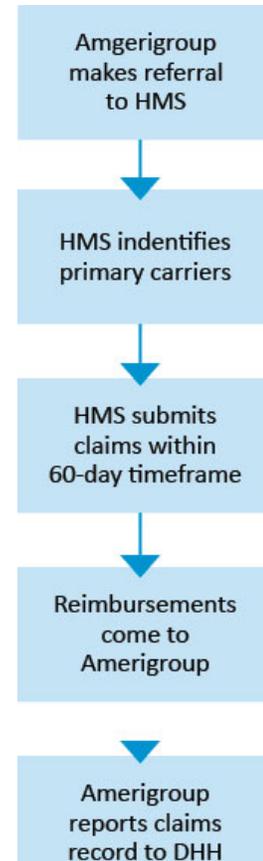
Provider Education Maximizes Cost Avoidance

A specialized unit within Amerigroup, the FORAGER team, conducts ongoing data analysis in partnership with the Cost Containment Department’s Recovery Audit Team and Provider Relations employees. Together, **staff works one-on-one with providers** to develop solutions to the root causes of overpayments. They follow such solutions through to confirm that they are in fact reducing recurrences. These recovery projects can range from **ongoing standard activities**, such as analysis of retroactive disenrollment and duplicate claim submission to **assessment of the impact of high level pricing methodologies**, such as the inpatient hospital Diagnosis Related Group (DRG) and outpatient hospital Ambulatory Payment Group (APG) payment systems. We will structure these educational efforts to the recovery statutes and contractual terms of the CCN program.

Collection Process for Pay and Chase Activity

In certain circumstances, such as claims for medical treatment associated with labor, delivery and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children or when the primary coverage is held by an absent parent, as required by federal regulations Amerigroup adopts a pay and chase methodology in which we pay the claim first and then pursue COB with the liable third party. **The determination is made by the analyst during the claim adjudication process based on services billed, information in the member’s record and Amerigroup COB guidelines.** Following payment for CCN members in Louisiana, we will make a referral to our corporate subcontractor, HMS, for recoveries from liable primary carriers. Our collection process is illustrated in Figure P-1.

Figure P-1. Pay and Chase Process



Post-Payment Recoveries and Subrogation

Amerigroup will gather all appropriate documentation and, through HMS, will submit a claim to the identified primary carrier within the required 60-day period following identification of the insurance coverage when OHI is discovered after a provider has been paid for services. All COB activity is reported in the appropriate encounter and regulatory reporting data file.

When our review of diagnosis and trauma codes on paid claims reflect the probability of another liable third party, we conduct an investigation to gather information necessary to develop a claim for reimbursement. We assure the existence of this liable third party is added to the member’s record on the COB tab so we can monitor future claims for health care service.

In accordance with the DHH requirement to seek reimbursement in injury/accident or trauma-related cases where claims in the aggregate equal or exceed \$500, and claims of lesser value if economically feasible, we file the required liens and negotiate settlements. Should the total amount of all claims, regardless of the amount of available funds, equal or exceed \$25,000, Amerigroup first will obtain approval from DHH.

Amerigroup acknowledges that we may retain 100 percent of the settlement amount collection only if the total amount received does not exceed the CCN financial liability for the member, there have been no payments made by DHH related to fee-for-service, reinsurance or administrative costs and the recovery is not prohibited by state or federal law. We also acknowledge that subrogation recoveries are treated as offsets to medical expenses for the purposes of reporting and risk-sharing calculations and are used in calculating future capitation rates.

Handling Coordination of Benefits and Adapting our System to Meet Contract Requirements

Amerigroup is experienced in both cost avoidance and post-payment recovery activities, and we **do not envision a need to modify our current operations to adapt to the requirements of the Louisiana CCN program**. The requirements established in the RFP are consistent with our process, which has been very successful in assuring savings for our state partners.

Cost Avoidance in the Claim Adjudication System

To avoid overpayment, as required in Section 5.12.2 of the RFP, **the Amerigroup claim adjudication system incorporates a series of edits to prospectively identify and correct potential overpayments** based on current alternate insurance information housed in a member’s record on the COB tab. These edits also check for inappropriate coding of charges or bundling of services and incorrect coding of procedures on submitted claims. When a member has coverage with another primary carrier, incoming claims are automatically pended for review when loaded into our core operations system. From this review, the claim record is updated with primary carrier payment information.

An important component of the TPL process is strategically evaluating activities and results to identify the root causes of overpayments to avoid recurrence.

During adjudication, our claim system’s COB logic rules compare the submitted dates of service to the effective and termination dates of the OHI coverage on the member’s file. If the dates of service on the claim are within the OHI effective and termination dates the claim is suspended for additional analyst review according to Amerigroup COB guidelines. If the claim reflects adjudication by the identified primary carrier and the required Explanation of Benefits (EOB) documentation is attached, the analyst reviews the claim to assure that any copayment, coinsurance or deductible amount required by the primary carrier is considered in determining any balance due to the provider and that the combined payments by the carrier and Amerigroup do not exceed allowable amounts. If the claim does not reflect adjudication by the identified primary carrier or references payment but the required EOB documentation is not attached, Amerigroup returns the claim to the submitting provider with instructions to bill the appropriate third party for payment adjudication

REAL SOLUTIONS *mean* REAL RESULTS

In 2010, our Cost Containment Department generated **\$345 million** in medical savings by identifying and coordinating benefits with OHI coverage and liable third parties. Of that, **\$258 million** was generated prior to claims payment, through cost avoidance, minimizing the need for more difficult and costly post-payment recoveries. Amerigroup identified **\$87 million** for post-payment recovery.

During adjudication, our claim system’s COB logic rules compare the submitted dates of service to the effective and termination dates of the OHI coverage on the member’s file.

and then re-submit a claim to Amerigroup if there is a balance owed. Claims appropriate for “pay and chase” are an exception; these claims are paid if other coverage criteria are met. See more about pay and chase below.

TPL Subcontractor

Amerigroup has a subcontractor relationship with HMS for both identification of OHI and pursuit of overpayments from liable primary carriers if coverage is not identified until after we have paid a provider.

HMS is responsible for regularly providing us with information about new OHI for our cost avoidance activities and submitting claims on a post-payment basis to identified primary carriers for recoveries. All post-payment claims are submitted within required timeframes. To submit the claims to primary carriers for recoveries, HMS retrieves a monthly paid claims file from the Amerigroup FTP site, which they download to their system. They track, follow up and perform customer service functions associated with these responsibilities. HMS is required to send to a specified lock box detailed invoices and recoveries on primary carrier recovered funds.

Testing, Updating and Validating Data

Our commitment to maximizing identification of third party payers, avoiding claims payment when there is evidence of alternate payment responsibility and recovery of any and all overpayments is underscored by the breadth and depth of the sources we have applied to this process. Our dedicated Cost Containment Department has well-developed policies and procedures and focused staff skilled at maximizing opportunities. This team is further supported by sophisticated technology that complements in-house capabilities. We will welcome any request from DHH to demonstrate our commitment to assuring the Medicaid CCN is the payer of last resort and that our third party liability efforts are more than sufficient to meet DHH standards.

Amerigroup and HMS also share information regarding cases for which post-payment recovery due to injury/accident or trauma is required.

All potential OHI leads are submitted to a dedicated unit for validation. Member demographic data regularly is shared with our subcontractor HMS, who uses the data to search its extensive data repository of OHI information for any new, modified or terminated coverage for members. New OHI is updated on our members’ COB tabs as appropriate. We also investigate any information regarding OHI shared with us by our members or providers. Collectively, this information and these activities serve to validate the third party insurance coverage information in our files.

Reporting to DHH

All medical savings generated by the Cost Containment Department are incorporated into each member’s claim record. With this data, we will produce detailed reports for DHH and/or the department’s fiscal intermediary or cost recovery vendor that summarize each type of medical savings – Cost Avoidance, Post-payment Recovery and Subrogation activities. Reports will be submitted in the format and medium described by DHH as required by the 15th working day of each month and ad hoc reports will be provided upon request within 30 calendar days.

Amerigroup will also provide a report, by the 15th working day of each month that identifies all members with third party coverage. In addition, all collections information will be included in the encounter data submitted to DHH monthly, including any retrospective findings via encounter adjustments.

Amerigroup will report to DHH as required any claim for which payment was not collected from a liable third party within 365 days of the date of service and give up the right to further recovery efforts if so desired by DHH.

Amerigroup will submit an annual report of all health insurance collections, plus copies of any Form 1099s received from insurance companies for the reporting period.

Hospital Credit Balance Reviews

Erroneous payments made to hospitals represent a portion of TPL recoveries. In many cases, these overpayments are recorded on the books of facilities as credit balances. Credit balances arise, in part, because of the complexity involved in managing the coordination of benefits process. For various reasons providers receive revenue from multiple sources and may have trouble reconciling accounts. Additionally, the speed at which hospitals seek payment for services and the volume of accounts their staff must manage further impede the third party payment process by causing errors in documentation. Payments to hospitals that should create refunds to Medicaid often go unresolved because provider efforts to refund overpayments are minimal and secondary to their priority financial activities – collecting accounts receivable and reducing any bad debt. Amerigroup conducts retrospective onsite audits of hospitals to identify potential overpayments and to assure their recovery.

SECTION Q: CLAIMS MANAGEMENT

Q.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.

Proven Experience

Amerigroup has more than 15 years of experience processing Medicaid claims. In 2010, we processed more than 1.9 million claims per month or more than **23 million claims annually**. Our average claims turnaround time was 4.9 days and 98.9 percent of claims were paid within 15 business days. **Accordingly, we have effective technology and experienced capable staff in place to ensure prompt, accurate claims payment and provider satisfaction.** We understand and commit to comply with all federal and state regulations regarding claims processing.

PROVEN EXPERIENCE
**MORE THAN
1.9 MILLION**
CLAIMS PROCESSED
PER MONTH

Amerigroup's claims management process offers significant advantages to DHH and Louisiana providers:

- **We will staff a claims processing team dedicated to the Louisiana CCN business using seasoned claims analysts who are experienced with Medicaid managed care claims** and are attuned to the needs of the marketplace; they will collaborate to solve any problems that arise, with minimal disruption to normal workflow
- Our claims **formats are industry-standard, HIPAA compliant, including CMS 1500 and CMS 1450 (UB 04)**
- **We operate an efficient, quick and reliable electronic claims processing system.** By combining our core claims transaction platform with electronic imaging, a workflow management system and Electronic Data Interface (EDI) claims solutions, we are able to efficiently capture and quickly adjudicate claims with minimum manual intervention; **this leads to faster, more accurate claims turnaround and provider payment.** We also maintain the capability to handle paper claims
- **Our Automated Clearinghouse (ACH) mechanism offers provider reimbursement using Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability;** this leads to faster receipt of payment from Amerigroup and the ability to quickly and easily review claims and remittance details
- Our **Claims Department features a designated team that processes claims for Mental Health/Substance Abuse (MH/SA) services and handles all MH/SA claims inquiries;** this team has expertise regarding the unique aspects of MH/SA, including provider types and coding, as well as issues that require coordination between MH/SA and physical health

Our procedures ensure that we meet and in some cases exceed all claims requirements specified in Sections 9 and 17 of the Louisiana CCN-P RFP as well as all applicable CCN policies and procedures and the terms of the Contract and Systems Guide. We offer examples of how we meet and exceed Louisiana

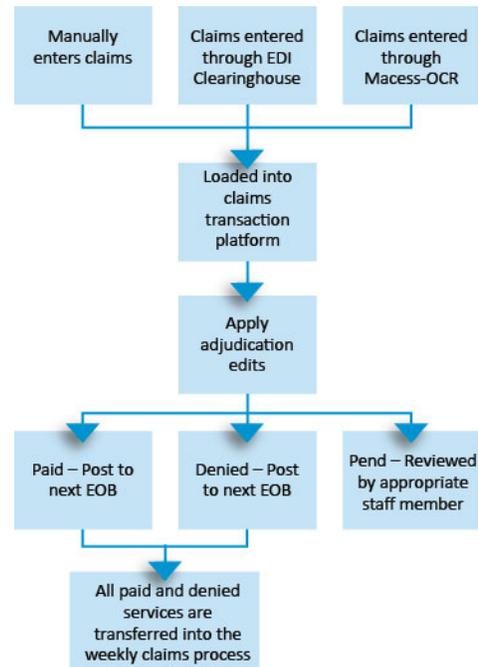
CCN requirements in the areas of: compliance with the National Correct Coding Initiative, clean claims paid within 15 days and clean claims paid within 30 days. **In summary, our dedicated team and robust technical solutions have enabled us to achieve and maintain an outstanding level of performance that will benefit DHH and Louisiana providers.** Table Q-1 at the end of this section details our ability to meet or exceed the LA CCN claims requirements.

Claims Management Overview

We offer electronic and hard copy claims adjudication. All claims are processed in our operations center located in Tampa, Florida. The Claims Department is responsible for all claims processing functions from the document receipt to the final adjudication and payment.

- All claims are processed on a first-in first-out basis. **Our advanced technology means we are able to batch, scan and enter claims for auto adjudication within 48 hours of receipt.** This helps to ensure we process claims within 15 business days of receipt of the clean claim.
- **All claim submissions are assigned a unique control number** that is used to track their progress from initial entry into our system, to final adjudication and online storage.
- As claims are processed through the nightly cycle, **edits are applied** based on eligibility, provider status, medical necessity, type and quantity of benefits, pricing and authorization.
- If the **claim successfully passes these edits**, it is set to auto-adjudicate and is **processed during the next twice weekly payment cycle**. If a claim does not pass these edits, it is denied (for example, if the member is not eligible at the time of service). All adjudicated claims receive a specific “explanation code” informing the provider of the level of payment or corrective action required to complete the claim.
- When a **claim does not meet clean claim requirements, we will notify the provider of the issue within five days of the receipt of electronic claims** and we will complete processing within 15 business days of our receipt of the requested information.
- We also **edit inpatient hospital claims for the presence of provider-preventable conditions** and if indicated, will reduce or deny payment for certain claims that demonstrate that the patient acquired the condition while in the hospital.
- **Our process ensures we do not pay claims submitted by providers who are excluded or suspended from the Medicare, Medicaid or S-CHIP programs due to fraud, abuse, or waste.** If we have a provider that has been sanctioned or suspended from these programs or is on payment-hold under the authority of DHH or its authorized agent(s), our Credentialing department reviews and takes the appropriate actions to terminate the provider from our network. We place a “pend” on the provider’s record to ensure that any current and future

Figure Q-1. Claims Processing Overview



claims submitted by the provider are flagged for review by the Fraud and Abuse department or denied with cause.

- **Our system generates a standard Explanation of Benefits (EOB) for all services.** These are generated in conjunction with the regular weekly payment cycle of physical checks. In addition, we will issue EOBs to members, in the format approved by DHH, in those circumstances where member EOBs are appropriate, such as when there is a cost-sharing amount. We will submit our member EOB process and schedule to DHH for review and approval within 45 days of Contract award.

Streamlined Claims Submissions Process

Amerigroup's claims submissions process balances the adoption of HIPAA-compliant Electronic Claims strategies that streamline plan administration and expedite claims processing with the flexibility to accept paper claims to address the diverse capabilities of Louisiana providers. We convert paper claims to electronic format so that they can be processed efficiently and accurately.

- **Electronic Processing** – Amerigroup actively encourages Electronic Claim Management (ECM) services for all providers, and we ensure that our ECM function meets all applicable requirements as specified in the RFP and Systems Guide. In 2010 we received 89 percent of claims through ECM which is available to all providers regardless of their network status for both professional and institutional claims. Our process eases the administrative burden on providers by allowing them to easily submit and track claims as well as respond to any claims issues that might delay provider reimbursement.

The ECM system is built on HIPAA-compliant, electronic health care transaction processing solutions supported by recognized industry leaders in electronic networks and health care claims handling. With these software technologies, we maintain consistent protocols and procedures across all provider groups. **Providers can directly enter claims through our website and upload any necessary attachments. Providers can also easily make corrections to a claim on-line. Once a correction is made it force pends the claims in our system for reprocessing.**

A key part of Amerigroup's ECM operations is a dedicated Electronic Data Interchange (EDI) unit that works with providers and ECM business partners to ensure all submissions are properly received, processed and acknowledged back to the submitter. This team also staffs an EDI Hotline to assist providers with electronic claims and to reach out to providers who submit paper claims to assist them with the EDI process and encourage them to submit electronic claims.

- **Paper Claims** - Amerigroup encourages adoption of electronic claims submission and promotes its availability in the provider manual, on the provider web site and in provider trainings. However, we recognize that not all providers are prepared to submit claims electronically and we have a process for paper claims as well. Paper claims are routed to our Document Management team who batch, scan and export the files to our data entry vendor throughout each production day. The vendor then produces 837 data files. The data files are loaded to a central repository where basic edits are applied to all claims. All claims that pass editing are loaded and then follow the standard adjudication process. Between ECM and paper claims conversion, approximately 99.7% percent of claims are received or converted into an electronic format.

Auto-Adjudication for Efficient Processing

Upon receipt of an original or converted electronic file, our data entry vendor processes that file through our HIPAA compliance checker that validates the data contents and format for compliance with the HIPAA standardized code sets. Once the file is deemed compliant, it is loaded into the claims processing system and we verify that the number of claims received is equal to the number of claims loaded into the system after completion of each batch or file.

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 is relevant, complete and contextually appropriate. **We apply value-added edits to comply with state-specific rules and regulations.** Claims passing all of these edits are forwarded to the adjudication engine for processing. This initial attention to pre-processing edits significantly enhances the efficiency by which we can process claims. **Incomplete claims are rejected quickly, within five days, so that providers can correct and resubmit them.**

During the adjudication process, **we apply hundreds of standard system edits** that support tasks such as verifying member eligibility, checking provider status, validating authorization requirements are met, ensuring the services are covered and checking for duplicate claims. **We also subject the data to other industry recognized products such as code review and code bundling software, as well as internally developed data verification applications.**

Provider Reimbursement Options

Amerigroup understands the challenges facing Louisiana providers in the transition of the Medicaid program from a fee-for-service environment to a coordinated care system. **We are dedicated to operating a timely, reliable claims processing system and maintaining provider satisfaction.** Currently, on average, **we reimburse providers within five business days of receiving a clean claim.**

5 DAYS
average turn around time
for provider reimbursement

Our initial provider training is designed to support the transition to the new coordinated care payment system. Our training covers program-specific information, includes all the topics found in our provider manual, and covers elements mandated through contractual requirements. Claims processing topics included in our training are:

- Payment and reimbursement mechanisms
- Claims procedures and claims payment system
- Claim payment dispute procedures
- Electronic claims submission
- Online tools demonstration, such as use of the Interactive Voice Response (IVR) system for claim status and the Provider Portal Claim Inquiry tool

Amerigroup pays providers through direct deposit or (EFT). Providers receive information to establish this direct deposit in our provider manual, through provider training and our web site. The service is free and makes available the option for (ERA) services. In addition, providers can select from a variety of remittance information options, including:

- Electronic remittance advice presented online and printed in your location
- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Amerigroup

Some of the benefits providers may experience include:

- Faster receipt of payments from Amerigroup
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors
- Ability to perform faster secondary billing

Claims Dispute Management

Amerigroup offers providers access to a timely payment dispute resolution process. Payment disputes must be filed within 90 days of the claims payment date. Disputes may be filed in writing or the provider may use the dispute submission tool on the Amerigroup Provider Portal.

Our Payment Dispute Unit's review process consists of research and a determination based on the available documentation submitted with the dispute and a review of Amerigroup systems, policies, and contracts. Any dispute received with supporting clinical documentation is retrospectively reviewed by a Licensed/Registered Nurse. Established clinical criteria will be applied to the payment dispute. After retrospective review, the dispute may be approved or forwarded to the Plan Medical Director for further review and resolution. The provider will be notified of the dispute resolution within 30 calendar days from the receipt of the payment dispute.

If the provider is dissatisfied with the initial dispute resolution then they may submit a request for independent review. Amerigroup will abide by the decision of the independent reviewer and pay any claims associated with the dispute, as well as the fee charged by the independent reviewer. If the decision is in favor of Amerigroup, the provider will be responsible for payment of the fee and will be billed by the independent reviewer

Encounter Data

Amerigroup recognizes the importance of complete and accurate encounter data and is committed to providing it to DHH in a timely manner. **The infrastructure and staff required to support encounter data management are operational today in support of our health plans in 11 states, and they are fully scalable to enable smooth expansion to include Amerigroup Louisiana, within 60 days of operation as required in the CCN RFP.**

Amerigroup has formal processes in place to ensure timely, complete, and accurate submission of encounter data. For our existing health plans, we submit encounters according to the state specified timelines (usually monthly and often weekly) and comply with each state’s data certification process. The commitment to processing and reconciling encounters is evidenced by our implementation of a comprehensive encounters management application to process encounters data according to state-specific criteria. This application handles all extraction, tracking, correction, reporting and archiving of encounter data. Because this solution is already in use for the submission of encounters for our current business, it will be easily configured to reflect the LA CCN-specific business rules, should they differ from existing encounter business rules.

Encounter data received from our ancillary vendors and all the claims/claims adjustment data processed by our core operations system since the last submission of encounter records are consolidated into our encounters management system. As part of our processing, system edits check for duplicate claims, validates member and provider numbers, and business rules are invoked to validate that the encounter records meet state-specific processing requirements. **Encounter records that pass all edits are formatted in HIPAA standard ANSI X12N 837 formats for submission to DHH.** Records failing the established edits are identified for the Encounters Management team to review and identify the corrective action needed to resolve the issue. This corrective action is coordinated with the appropriate operational unit such as Claims, Provider Data Management, and the (EDI) team.

For more specific detail on the Amerigroup encounter data system and process, please refer to Section R of this document.

Examples Demonstrate how Amerigroup Meets and Exceeds CCN Claims Management Requirements

Amerigroup Meets Coding Requirements

Amerigroup’s core operations system is the system of record for all provider, member (including enrollment and eligibility), claims and authorization data. **We process claims for all covered services except for vision services** where we have capitated payment arrangement with a subcontractor.

EXAMPLES IN OTHER STATES

- Amerigroup Meets or Exceeds Louisiana CCN Requirements:
- Current compliance with the National Correct Coding Initiative (7 states), with compliance in all 11 states by September 2011
 - 98 percent of clean claims paid within 15 days (11 states)
 - 99 percent of clean claims paid within 30 days (10 states)

Our core operations system is configured with standard code sets, including procedure and diagnostic codes and all benefit packages that drive claims processing. This integrated approach facilitates claims adjudication for members across all programs. **When a claim arrives, we capture the received date, assign a unique claim number, and apply data edits to ensure the data is compliant, complete, accurate and appropriate** under the terms of the contract and for eligible members and providers. Claims with valid data points are adjudicated. Claims with invalid data points are rejected or denied. Claim and claim detail information are maintained with processing information including interest payments, if applicable.

Example #1: Correct Coding Initiative: Amerigroup meets compliance with the National Correct Coding Initiative (NCCI) in 7 of our 11 markets; and we plan to be compliant in all current markets by September 2011.

Upfront data edits during claims intake and processing enable us to capture the data required to generate HIPAA-compliant encounters transactions for submission to DHH. Our edits include a check for appropriate codes (procedure, diagnosis, etc.) and provider numbers.

Our core operations system tracks and applies other health insurance as part of our claims processing and coordination of benefits. Transaction auditing and history are maintained for members’ eligibility spans, claims adjustments, provider data and configuration data. Audit trails can be combined with other transaction logs, error logs and update reports to trace data from the final place of recording back to its source data file or document.

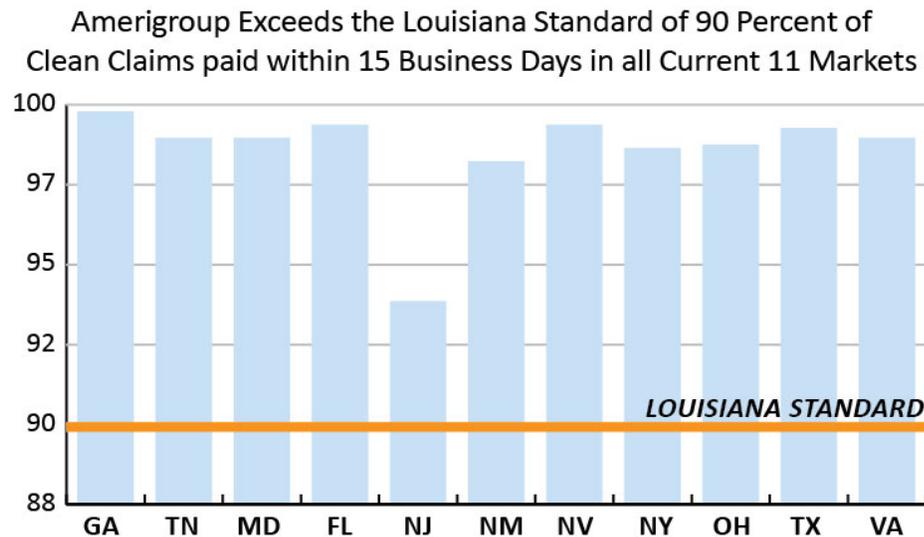
Amerigroup Meets and Exceeds Claims Processing Timeliness

Our robust technology infrastructure, skilled staff and quality controls promote quick and accurate claims processing. Amerigroup operates under varying state requirements for claims processing turnaround time and manages each state’s process accordingly. The claims operations for Louisiana will be structured to achieve the required claims processing turnaround times of 90 percent of clean claims within 15 business days from the date of receipt and 99 percent of clean claims within 30 calendar days of the date of receipt. In fact, based on our experience in other states, **we expect to exceed the LA CCN-P 15 day requirement.**

Example #2: Claims paid within 15 days: In 2010, for the 11 states where we operate, on average over 98 percent of claims were processed within 15 days, exceeding the CCN requirement that 90 percent of clean claims are paid within 15 business days.

Example #3: Claims paid within 30 calendar days: In 10 of the 11 states we served in 2011, we paid over 99 percent of the claims within 30 calendar days, meeting the CCN requirement that 99 percent of clean claims are paid within 30 business days.

Figure Q-2: Examples of Amerigroup Claims Payment Rates within 15 Business Day



Summary

Amerigroup offers a claims process that ensures providers are paid on a timely basis, that claims are paid appropriately and that reliable claims and encounter data will be available in a timely manner to the State. Our proven experience, knowledge and existing claims system capabilities position us strongly to get the CCN program up and running smoothly upon implementation and in full compliance with all specified claims requirements. Table Q-1 below summarizes our ability to meet the Key Claims Management Standards and Electronic Claims Management Functional requirements.

Table Q-1. Louisiana CCN Claims Processing Requirements

Requirement	Amerigroup Performance
Prompt Pay Requirements: <ul style="list-style-type: none"> 90% of clean claims paid within 15 business days of the date of receipt. 99% of clean claims paid within 30 calendar days of the date of receipt. 	Exceeds 98.9% claims paid within 15 days Meets 99.2% claims paid within 30 days
At a minimum, the CCN shall run one provider payment cycle per week.	Exceeds 2 payment cycles per week
The CCN shall maintain an (ECM) System that will track all DHH required claims and encounter data elements.	Meets
The CCN shall accept submission of paper claims from providers.	Meets
The CCN shall encourage providers to submit and receive claims information through an (EDI) and provide on-line and phone-based capabilities to access claims status information.	Meets
Require providers to use HIPAA compliant CMS 1500 and CMS 1450 forms.	Meets
Comply with the NCCI.	Will Meet (In process, established in 7 of 11 plans)
The CCN shall support an (ACH) that allows providers to request and receive electronic claims payments.	Meets
Provide Explanation of Benefits and Remittances Advices.	Meets
Full claims review within 5 working days of receipt of an electronic claim to determine if the claim is clean and if not issue an exception report to the provider detailing the problem.	Meets
Perform system edits that meet specified requirements including eligibility confirmation, medical necessity, and prior approval, duplicate claims, covered services, provider validation, service quantity and service dates.	Meets
Have qualified staff consistent with NCOA standards whose primary duty is to assist in evaluating claims for medical necessity.	Meets
Maintain a claims dispute process that includes independent review.	Meets
Submit Monthly Claims Payment Accuracy reports based on independent audits and that meets specified attributes.	Meets

Requirement	Amerigroup Performance
Submit 95% of its encounter data at least monthly no later than the 25 th calendar day of the month just ended.	Meets
Address 90% of reported repairable encounter data errors within 30 calendar days and 99% within 60 calendar days.	Meets
Submit quarterly Claims Summary Reports to DHH by GSA and claims type.	Meets

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Q.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:

- *The process for auditing a sample of claims as described in Key Claims Management Standards Section;*
- *The sampling methodology itself;*
- *Documentation of the results of these audits; and*
- *The processes for implementing any necessary corrective actions resulting from an audit.*

Claims Auditing to Ensure Claims Integrity

Amerigroup’s claims processing practices are based upon comprehensive policies and procedures that 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. **We have established and maintain an internal audit function independent of claims management which reports directly to the Corporate Board of Directors.**

In order to measure our overall performance on claims accurately, we use a stratified weighted calculation that is based on the claims structure described in Table Q-2 below.

Table Q-2. Claims Audit Structure

Audit Type	Sample
<p>Market-Specific Audits - Routine review based on daily state level audits used to identify potential issues and trends using state contract criteria. Our process analyzes 13 key attributes, including those required by the Louisiana CCN Section 17.5.3.2, and dozens of sub-factors based on a randomly selected sample of processed and paid claims and allows us to identify and remediate both overall and market-specific quality issues. All data points and trends are reported daily, allowing real-time identification and remediation as necessary.</p>	<p>Statistically valid random sample related to each market</p>
<p>High-dollar Audits - On-going, real time pre-payment audits of all high dollar claims where the payment amount is over \$30,000 or the denied claims amount is over \$100,000.</p>	<p>100% of all claims meeting high dollar criteria</p>
<p>Individual Focus Audits - Amerigroup conducts 10 real time pre-payment audits per day on all trainees for 90 days to specifically assess the manual claim processing accuracy.</p>	<p>Sample of 2% for each trainee is pulled weekly</p>
<p>Target Audits - Audits based on performance management or error remediation efforts.</p>	<p>Varies based on the audit intent, criteria and target.</p>

Sampling Methodology

Our sampling method for claims payment and financial accuracy meets Louisiana requirements and is calculated by a weighted stratification of all of the market audits based on 95 percent confidence level, plus or minus 3 percent with a 5 percent probability value, which results in **204-255 claims reviewed per state on a monthly basis.** In addition, we audit 100 percent of all claims, on a prepayment basis, with a value of \$30,000 or more. We also audit 100 percent of all denied claims with a billed amount of \$100,000 and more.

Documentation of Audit Results

All audit results, including error sourcing and attribute testing, are maintained in our Quality Audit Database tool. Our transaction-based core operations system maintains an audit history of data updates, including time and source of change. Surround applications are interfaced to the core operations system, real-time data warehouse, or reporting warehouse to leverage this integrated data. These surround applications provide extended functionality such as complaints, appeals and grievances tracking, eligibility, claims status and authorization status lookup, reporting, EPSDT service tracking, and health education and others. Our core operations system also maintains audit trails for any sub-application that is used to store and maintain systems-critical information. Whenever an authorized user makes a change to one of the database tables, the application automatically creates a history of the update transaction.

Our audit trails can be combined with other transactions logs, error logs, and update reports to trace data from the final place of recording back to its source data file or document. Audits trails are maintained that allow reports to be generated, which facilitate auditing of individual claim records as well as batch audits. The systems administrator will establish the audit trail criteria depending upon business needs and to satisfy the CCN-P RFP requirements. We will retain all audit trail information for seven years or archive it to off-line storage media at a mutually agreed-upon time.

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

Implementing Corrective Actions

Results from the audit findings are analyzed and presented in weekly Quality Management/Claims Partnership meetings to identify the root cause and remediate claim error trends. **Based on our audit findings we develop policy changes or edits to our claims processing system in order to mitigate future problems and improve our claims payment accuracy.**

Added Value - Transactional Accuracy Program

Amerigroup also maintains, for all markets, a Transactional Accuracy Program to improve claims processes. The program has been very successful over the last three years delivering on initiatives that drove significant improvements in claims payment accuracy, claims interest payments and overall strengthening of key processes that contribute to payment accuracy. Our overall **claims payment accuracy increased in two years by 5 percent to above 98 percent.** The accuracy program continues to identify process improvements that will further increase payment accuracy.

Q.3 Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures are met.

Claims Processing Adherence to Requirements

Proven Experience

Our claims processing practices are based on over 15 years of experience in 11 states, and have led to the establishment of comprehensive policies and procedures that guide both our claims staff and our independent audit staff in the monitoring and auditing of claims to verify timeliness, accuracy and integrity, and to evaluate the financial, payment and statistical accuracy of claims processing.

Process

Pre-payment edits are performed on all claims through our core processing system. All claims are processed through a HIPAA compliance checker and subjected to editing in the front end central system repository to verify data accuracy. Claims that do not pass the accuracy edits are rejected or denied back to the provider for correction with an explanation of the deficiency. In addition to edits built into our core system, we use ClaimCheck[®] software to provide additional editing ability, such as bundling/unbundling, incidental procedure and medical appropriateness of a procedure. We also review clinical appropriateness using the ClaimCheck Policy Administration Model (PAM) and Aetna Clinical Policy Bulletin (CPB).

In addition to the front end HIPAA compliance checks, ClaimCheck, CPB and PAM edits, there are multiple system-based resources to verify field content and proper billing practices. During the batch process our core processing system verifies basic data elements, including:

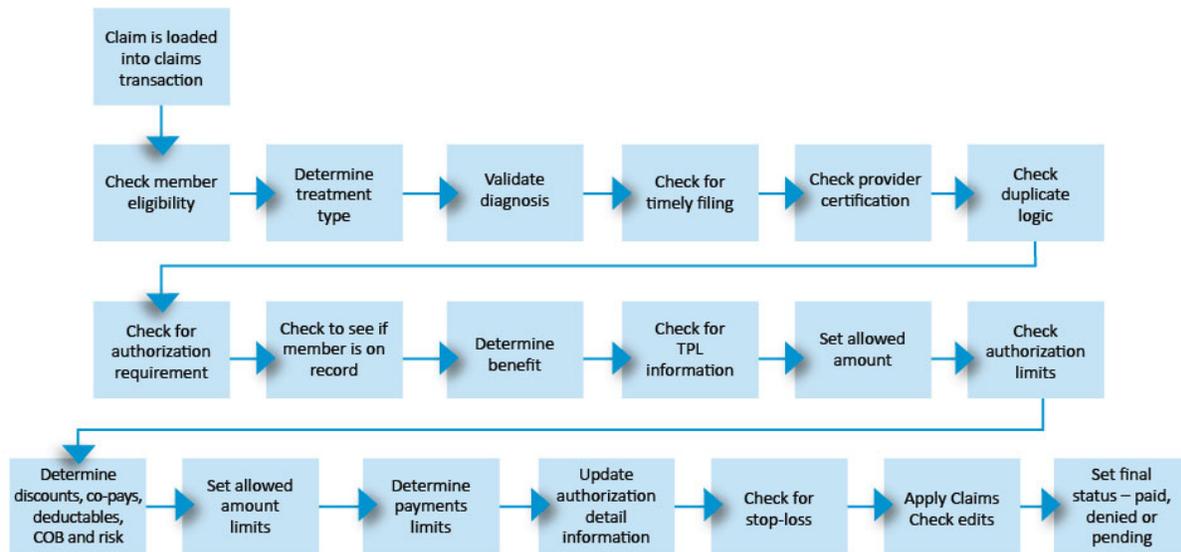
- Subscriber ID
- Member Suffix
- Member Name
- Diagnosis
- Servicing Provider
- Total Charges
- From & To Service Date(s)
- Place of Service
- Procedure Code
- Revenue Code
- Type of Service Code (TOS)

Our core processing system also verifies member eligibility, provider information, duplicate claim billing, authorization, and much more. Examples of specific edits are as follows:

- **Checks for valid procedure and diagnosis codes (such as obsolete codes, required number of digits):** Procedure and Diagnosis code validations are performed within the adjudication system against the code sets loaded in the core processing system. Amerigroup use of HIPAA compliance checks effectively rejects claims that are received with Invalid Procedure and Diagnosis codes prior to acceptance into the adjudication system. ClaimCheck and PAM are also used as our clinical editing software. ClaimCheck speaks to national coding standards, whereas PAM, allows Amerigroup to configure business rules upon which claims are validated.

- **Checks for valid members:** Member validation occurs at the time of receipt prior to entry to the adjudication system. If the member on a claim submission cannot be identified in our system then claim is rejected back to the submitter.
- **Checks for valid coding (such as recalculates the procedure coding valid for the members gender):** Valid coding editing is performed at the time of entry into the adjudication system. ClaimCheck is the software product used to validate coding.
- **Checks on field size: Field size validations occur in 2 places. The first check on field size** is at the time of receipt when claims are validated for HIPAA compliance on the front end. The second check on field size is within the core processing system.
- **Checks on date ranges (such as “to” date is after “from” date; no future dates):** Date verifications occur within the core processing system as well as at the time of data capture by the data entry vendor. Invalid or future date validations also occur through front end HIPAA compliance validating.
- **Checks for valid practitioners:** Provider validation occurs at the time of receipt prior to entry within the core processing system. If the provider cannot be identified on a claim submission the claim is pended to a work flow where a determination is made whether or not the provider listed on a claim will be set up in the system in order to allow the claim to process.
- **Checks for service authorization. Authorization edits all require manual processing and verification through the authorization portion of our core system:** If there is no authorization on file and one is required, the claim would be denied. If there is an authorization on file, but not a complete match to the claim, a request for verification is sent to the clinical team at the appropriate Health Plan. The determination is made after review to either deny as the authorization is not a match, or authorization corrections are made to the core system to allow for the appropriate processing. Some examples of authorization edits are as follows: units billed exceed authorization; authorization not on file; billed level of care not authorized; and, dates of service are outside dates authorized.

Figure Q-3. Amerigroup Process for the Adjudication of Claims and Edits



Service Authorization Reviews

Our Quality Assurance Unit, comprised of a team of nurses and certified professional coders, conducts service authorization reviews that focus on the following:

- Was authorization required for the service
- Was the authorization tied to the claim correctly
- Was the correct provider selected
- Were the days correct
- Was the Level of Care correct
- Were the dates correct
- Was there documentation to support overriding the authorization
- Clinical notes and application of criteria (reviewed in focus audits)

Summary

Amerigroup maintains a rigorous edit process to ensure all claims paid are accurate and appropriate. We will continue to build on our proven experience and processes to ensure the integrity of claims management system.

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SECTION R: INFORMATION SYSTEMS

R.1 Describe your approach for implementing information systems in support of this RFP, including:

- *Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;*
- *Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;*
- *System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and*
- *Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.*
- *Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:*
 - o *Key activities and timeframes and*
 - o *Projected resource requirements from your organization for implementing information systems in support of this contract.*
- *Describe your historical data process including but not limited to:*
 - o *Number of years retained;*
 - o *How the data is stored; and*
 - o *How accessible is it.*

The work plan should cover activities from contract award to the start date of operations.

Amerigroup Management Information System Overview

Amerigroup recognizes the significance of structured, expertly operated and well-maintained information management systems to a successful Medicaid operation in Louisiana. Our Management Information System (MIS) is fully operational and is currently supporting approximately 2 million members in 11 states. It is supported by a dedicated internal Technology Services (TS) Department of more than 300 MIS professionals who are not only highly skilled and experienced in information technology and managed health care, but are committed to delivering **Real Solutions** to our state customers.

Amerigroup will support Louisiana operations using a single, integrated management information system that meets federal and state Medicaid requirements and will facilitate the configuration required to satisfy Louisiana requirements. **Operating a single MIS across all markets provides a number of key benefits to our state partners:**

- Technology investments for one state health plan can be leveraged for other state clients
- Builds a strong and consistent knowledge base across business operations and technical staff

- Best practices are formed and shared across markets
- Focuses resources and technology investments on a single platform

After careful review of the requirements outlined in the RFP, **we are confident in our ability to meet or exceed all DHH requirements with our existing systems.**

A secure state-of-the-art systems infrastructure and high systems reliability are key initiatives of Amerigroup. In 2010, our systems availability averaged 99.95 percent. Our systems hardware and software architecture permits scalability of the technology platform to meet current and future capacity needs. We assess our architectural framework regularly – both hardware systems and applications software – to ensure that they are flexible and scalable enough to meet not only future markets, but the changing needs of Medicaid operations. We maintain and test business continuity and disaster recovery plans to confirm our ability to provide continuous operation in the event of a disruption of any size, including a major disaster.

In 2010, our MIS systems
availability averaged

99.95%.

Our secure, scalable, reliable and extensible Medicaid management information system includes five essential integrated components:

- **Core Operations System.** Our core operations system is the system of record for all provider, member (including enrollment and eligibility), claims, and authorization data. All updates to these data points are performed through the user interface or through application specific data loads, such as the daily enrollment/eligibility file. All other Amerigroup applications interfacing with the core operations system map to its data structures to enable consistency in naming, formatting, and validation
- **Care Management System.** Our clinical care management solution integrates seamlessly with our core operations system as well as our data warehouse. Within our care management system, information from sources such as pharmacy data, lab data, and immunization registries are gathered and organized, enabling proactive identification and management of members' health and increasing communications between members, providers, and the health plan
- **Data Warehouse.** Amerigroup's data warehouse is an integrated repository fed directly from the core operations system and supplemented with data from external sources such as delegated vendors, immunization registries, state FFS and claims, to create as comprehensive a set of data as possible and ensure data control and consistency. The data warehouse maximizes our capacity for data analytics and affords us the flexibility to produce targeted reports supporting our business processes, state customers, and providers
- **Provider Sharing/Collaboration.** Sharing and collaboration enables providers to stay informed and keep us informed about changes in status, demographics, specializations, certifications, and view other data from our core operations and other key systems. Our web and voice portals allow providers and their authorized delegates to submit claims and authorizations, view specific member data, as well as update their own demographic information while our secure message and download centers allow us to send messages and downloadable reports to specific providers and their delegates

- **Supplemental Applications.** Our MIS includes numerous integrated surround applications which support the overall functionality of Medicaid managed care, including provider profiling, EPSDT, HEDIS, member ID cards, PCP assignment, credentialing, imaging and workflow, desktop integration for contact center efficiency and workforce management. Dashboards/business intelligence analytical reporting and other supplemental applications maximize functionality, efficiency, security, and data analytics

A conceptual overview diagram of our MIS is included as Figure R-1. This diagram shows the flow of information coming into our MIS from Louisiana, members, and providers; the major functional processing components; and the flow of information going from our MIS to members, providers, and Louisiana.

We already transact all of the interfaces identified by DHH in the RFP requirements with various state agencies and their agents, including incoming and outgoing enrollment and eligibility data, claims and encounters, provider data, TPL, and specialized extracts as required. These existing capabilities will allow us to quickly implement the required data interfaces with the DHH MMIS, the Enrollment Broker and other state agents.

To sharpen our focus on the customers we serve – members, providers, and state agencies –our TS Department is fully integrated with our operations, including Claims, Care Management, Provider Data Management, Credentialing, Enrollment, and Member Services. Partnering technology and operations staff allows us to leverage the talents and experience of both while configuring and adapting our MIS to meet DHH requirements and provide the state with a cohesive Louisiana CCN Program. Integrating management of these functions also fosters a concentration within Amerigroup on implementing technology tools that strengthen customer relationships and drive operating improvements.

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Approach for Implementing our MIS in Louisiana

In order to guarantee a successful launch of the CCN Program in Louisiana, DHH needs a partner with a proven track record of implementing both business and systems operations. Amerigroup takes pride in our experience executing successful implementations, specifically in start up markets. In just the last six years, we successfully implemented Medicaid managed care operations in seven states. Our success is, in part, attributable to our experienced staff. Within the TS Department, the average tenure of an employee is more than 4 years and more than 20 percent have over 8 years with the company; the Louisiana implementation will be performed by team members who have experience adapting and configuring our MIS for start up markets. Throughout the course of these implementations, we have focused on incorporating best practices into our approach that help drive an efficient implementation.

Amerigroup’s MIS currently meets the DHH requirements as specified primarily in Section 16, along with other parts of the RFP, CCN-P Systems Companion Guide, and companion guides. Our primary focus during implementation of the Louisiana CCN Program will be to adapt and configure our systems to accommodate DHH business rules, data validation requirements and data exchanges/interfaces.

We are experienced in large-scale implementations of new health plans and products, and have built a methodology, processes and teams to support these efforts. Our Systems Development Life Cycle (SDLC) methodology promotes efficiency by tracking a project through initiation, requirements definition, development, implementation and operations, incorporating detailed testing and documentation prior to release. Our adherence to the SDLC and the availability of multiple test environments – development, user acceptance and State readiness – enable us to prepare for systems and operational readiness without compromising performance.

In order to implement the Louisiana CCN Program into our MIS, we will replicate best practices developed while implementing other startup markets. Our approach begins with a thorough review of the contract and the requirements, as well as the Louisiana benefits, systems requirement documentation and companion guides. Through this review and analysis, the tasks required to implement the Louisiana program in our MIS will be identified and incorporated into a detailed work plan. For every application that requires configuration or modification, we will follow our standard SDLC and change management processes.

Implementation Team

The key to a successful implementation is the development of the right team; a team comprised of experienced Amerigroup and DHH employees that encompasses a wide variety of operational, functional and technical knowledge. Our implementation management team centers on two key positions: a technical implementation lead, which functions as the technical liaison to DHH, and a project manager who focuses on the technical components of the work plan. These employees are experienced with our systems and operations across the organization and will be versed in the complete Louisiana contract and specifications. The technical implementation lead develops a strong working relationship with the technical counterparts of the State and any other entities involved in the implementation. The designation of a single point-of-contact as the technical interface who is knowledgeable in the entirety of the technical

A State Technical Point of Contact said...

“I am so grateful that I had a single, accountable, knowledgeable point of contact I could call about any implementation matter. Not having to track down who to contact made the implementation so much easier for us.”

implementation is also a differentiator and best practice of Amerigroup.

Within our TS organization, the development teams supporting the applications are aligned with the operational functions. The technical implementation lead and project manager work with the development teams and their business counterparts to convey requirements and answer questions in support of the MIS modifications.

Communication with DHH

Consistent communication throughout the implementation is also an Amerigroup implementation best practice. We will communicate regularly with the state and its agents from a technical standpoint via regular meetings and telephone conferences in addition to operational update meetings. Through regular status updates, we not only keep DHH apprised of our progress against the work plan and our ultimate system readiness, but also provide DHH with an opportunity to communicate any questions or concerns regarding the implementation.

Comprehensive, Integrated Testing

As part of our SDLC, our TS Department adheres to industry standard testing procedures. These testing procedures are consistently applied throughout the systems implementation phases. We include TS analysts, developers, and business subject matter experts (SMEs) in the testing process to produce thoroughly tested products for implementation.

Our developers and business analysts (BAs) unit test applications and the BAs and SMEs perform the QA testing, which is the gate to pass prior to production implementation. Collaboratively with departmental SMEs, the TS Department develops test plans and test cases to use in the testing of all core components and functionality. We are always looking to improve the testing and apply lessons learned from past implementations to foster increased success with subsequent implementations. When we have extensive repetitive testing to do, there are tools such as Mercury TestDirector and Rational Robot available as part of our testing toolset.

As an implementation best practice, we have invested in multiple test environments that allow us to support simultaneous testing cycles. This allows a test to be available for follow-up and integrated testing while other specific testing is occurring in another environment. This testing environment will be available to support testing for the Louisiana rollout.

Capability and Capacity Assessment

The implementation plan for Louisiana will include performance of a Capability Assessment that will confirm the ability of the Amerigroup MIS to meet the functional requirements contained in the Louisiana contract. We will complete and return the DHH Information Systems Capabilities Assessment (ISCA) within 30 days of contract signing, using the DHH format. Amerigroup has experience completing and passing ISCA's on an annual basis in other markets.

Our systems infrastructure is scalable in order to meet current and future capacity needs. We monitor utilization and have established thresholds (75 percent for CPU and memory utilization), which trigger expansion in capacity. In preparation of this proposal, we have already confirmed the ability of our current systems, processing, storage and communications infrastructure to maintain performance levels for existing operations while adding Louisiana Medicaid operations. In fact, we are able to scale and

sustain more than double our current membership on our current hardware footprint. Average utilization levels are currently:

- **CPU Utilization**
 - 26 percent for core operations system database servers
 - 15 percent for core operations systems applications servers
- **Memory**
 - 40 percent for core operations system database servers
 - 56 percent for core operations system applications servers
- **Network.** Current port utilization is 26 percent of switch capacity for our dual Cisco Nexus 7000 10Gb data center switches
- **Internet Connectivity.** Utilization is 16 percent for our OC-3 Circuit

Anticipated member and claims volumes are expected to represent a reasonable increase in our current volumes and will not negatively impact processing times:

- **Membership.** We currently have almost 2 million members. Several of our markets, including New Jersey, have enrollment numbers in the range expected for Louisiana. In one market with 130,000 lives, processing time is 2 hours and includes HIPAA compliance checking, data transformation and editing, and loading to our core operations system.
- **Claims Submission – web site.** In 2010, claims submissions via the provider web portal were 973,028. Since we encourage providers to use electronic data interchange (EDI) for claims submission, we carefully monitor web site statistics and performance.
- **Claims Adjudication.** We currently process approximately 100,000 claims per night with a 600 claims per minute throughput. Our claims adjudication system scales horizontally to keep batch time consistent as volume increases.

Annual Capacity Planning

The TS Department plans for adequate systems capacity as part of the ongoing planning processes. Each year our Executives collaborate and plan the multi-year vision for the organization. This strategic planning process sets the foundation for the annual planning processes where each major functional area defines a business plan that details the initiatives and specific activities to achieve their goals. These initiatives and activities are aligned across the organization and result in growth and capacity targets for the coming years. This information is included in the TS planning processes and the development of the annual TS Systems Refresh Plan and budget. As part of this process, upgrades and enhancements are identified so the Amerigroup technology platform will have the capacity and capabilities to support and sustain the coming years' business and growth. As required in the RFP, Amerigroup will submit a copy of our Systems Refresh Plan to DHH annually.

Confirming our Strategy

In the second half of 2010, Amerigroup hired a technology consulting firm to evaluate our business and determine if we could sustain doubling in size in terms of members and their associated business volume. The study assessed Amerigroup across a capability and maturity model across many areas, including systems, infrastructure, business owner participation, communications, SDLC, processes,

resources, knowledge and management to determine if we were positioned to be scalable enough to support substantial growth.

In its findings, Amerigroup was rated against the maturity model as average to above average on all points. The study confirmed that **Amerigroup has the technology, structure, processes and resources in place to double or more in size.** We are well positioned to perform Medicaid managed care operations in Louisiana.

Systems Configuration

Configuring our MIS to incorporate the business rules, data validation rules, and data exchanges to support the Louisiana CCN Program is a central component of the implementation work plan. Configuration activities touch many key business areas, including member eligibility/enrollment, provider data management, claims, authorization and care management.

In configuring our MIS for readiness to conduct business in production, we go through formal SDLC processes of documenting requirements, developing, testing, and implementing. The SDLC requires that SMEs and TS analysts and developers identify comprehensive and accurate requirements aligned to work across the organization, and then thoroughly test products ready for implementation.

All interfaces into our core operations system, such as eligibility/enrollment and claim loads, are developed under the TS Department's SDLC standards and rigor. We will customize the loads to meet DHH requirements and apply appropriate front-end edits to make certain that data going into the core operations system is clean, accurate and compliant. For instance, the enrollment load process will be engineered to meet the Louisiana processing requirement of 24-hour turnaround on a daily file from the Enrollment Broker. This is done by engineering the data loads to process all viable records and pend those requiring manual intervention due to data issues so the overall load process is not affected. When pending records are fixed, they are released for processing to complete the load process. We have the same 24-hour requirement in a number of our other markets and have engineered our processes accordingly.

During the system configuration phase of the implementation, the team will:

- Identify the development and quality assurance (QA) environments for Louisiana configuration, development and testing
- Configure our MIS based on the requirements. We will carefully review DHH documentation and configure our MIS to support the requirements
- Perform unit testing to validate the configuration and development. After the configuration is loaded, test results will be analyzed and any corrections to the configuration will be implemented and re-tested
- Perform user acceptance testing through the entire system
- Load eligibility, claims/service utilization history and current authorizations from DHH
- Load provider contract data and business rules

Execution of these tasks with rigor and attention to detail will confirm that the system is properly configured to accommodate all requirements of the contract.

System Set-Up for One-Time Data Feeds

Electronic exchange of data is a critical component of this implementation – both initial transition of care data and ongoing exchange of information. As a part of the implementation plan, Amerigroup will work with DHH to transfer care data from Louisiana’s MMIS to our MIS to enable continuity of care. Existing Medicaid recipients, and their claims/service utilization history and any active/open service authorizations must be accurately reflected in Amerigroup’s MIS at the start of operations to ensure continuity of care.

We will coordinate the format, timing, and delivery mechanism for receipt of these data feeds with DHH. Upon receipt, these data feeds will be validated for completeness and credibility, and then loaded into the production environment. The Amerigroup team has extensive experience with this critical implementation requirement and will partner with DHH to design an acceptance testing process that provides DHH with the confidence of continuity of care for members assigned to Amerigroup.

We are experienced with implementations in a new market or region and the initial data loads required to baseline operations. Therefore, our approach to system setup for intake, processing, and acceptance of one-time data feeds from DHH and other sources is based upon best practices learned from our experience with other state agencies.

Internal and Joint Testing of Data Exchanges

Rigorous testing of data exchanges is a critical component of our implementation plan. We understand that it is our obligation to demonstrate to DHH that data exchanges between the Fiscal Intermediary (FI), Enrollment Broker and Amerigroup systems are complete, accurate and reliable.

During this process, we will test incoming and outgoing data exchanges, including eligibility/enrollment files, member address and telephone number changes, and encounter data. After successful performance of unit testing, we take an integrated, “end-to-end” approach to testing. The testing process will encompass not only testing and evaluation of data and load reports, but also a review and testing of the communication protocol, data exchange scheduling and initiation timing and processes.

Implementation Work Plan

Amerigroup will maintain a **single, integrated work plan, in Microsoft Project, that identifies tasks, resources, timeframes and dependencies across all areas of the business** to effectively manage implementation of the Louisiana CCN Program. In this master work plan, there are a number of key activities, associated with the configuration of our MIS to support the Louisiana program from contract award through the start date of operations. The project manager maintains this work plan and regularly reviews deliverables and timing with the technical implementation lead. The collaboration between the project manager and the technical implementation lead and the coordination with the operational areas and development teams keeps the deliverables on track for their first needed production date and raises any issues in time for resolution. The start date of operations is the program’s go live date, however, many systems components, such as initial data loads and enrollment file processing, must be operational much earlier. Our work plan and experience enable us to identify and prioritize these tasks and interdependencies to prepare systems for the start of operations.

Attachment R.1.a is a customized view of the implementation work plan presented as an attachment in Section C of the proposal. In this view, tasks unrelated to information systems are collapsed, to facilitate review of tasks directly related to the configuration of our MIS for Louisiana operations. The work plan lists all project tasks and activities, start and end dates, dependent tasks, and required resources. The work plan demonstrates the tight integration of our technology and operations departments during implementation tasks by involving employees from across the organization in task performance. Our SDLC is employed throughout task performance.

This integration is demonstrated by placing TS tasks for any development effort under the business area that owns and participates in the task. For example, on row 440 of the project plan, “Enrollment Roster File” is listed as a task. Under that task, you see TS and Enrollment business-owned activities according to responsibilities dictated by the SDLC. The requirements are developed by TS and reviewed and signed off by the business, in this case, Enrollment. Development and unit testing are performed by TS and user acceptance testing is executed by the business, again, Enrollment. The result is a very rigorous, integrated process where ownership and accountability to the task and ultimate success of the end deliverable are collaborative and the joint responsibility of the business and TS.

Implementation work does not end after the first member effective date. Our MIS implementation team will remain focused on Louisiana operations to monitor and validate smooth operations throughout at least the first cycle of quarterly reporting.

Proven Experience

We have successfully implemented 82 managed care operations in 11 states during the last 15 years. Twelve of these implementations were new, start-up markets similar to Louisiana. Throughout these implementations, we have been able to fine-tune our methodology, including project work plan, dependencies, timeframes, and resource requirements, with lessons learned and best practices designed to streamline the configuration process and meet project milestones. We pride ourselves in successfully achieving operational and system readiness and in the fact that we have never needed to push a go-live date.

Historical Data Process

Storage and access of historical member, eligibility, claims and encounter data in a manner that supports ongoing processing as well as reporting and auditing is key to effective operations.

Amerigroup has policies and procedures in place and can meet or exceed DHH’s requirements related to historical data maintenance and access. Amerigroup’s core operations system will serve as the system of record for information such as member demographics and eligibility, provider demographics, claims adjudication, and authorizations; with the data warehouse housing claims from delegated vendors.

Amerigroup’s Records and Information Management (RIM) Policy governs the creation, receipt, use, access, security, privacy, reproduction, retention, preservation, and/or destruction of business records regardless of media or format (including electronic and paper). Each Amerigroup health plan establishes and maintains recordkeeping systems that comply with legal, regulatory, and contractual requirements. Health Plan management is accountable for ensuring that RIM policies and procedures are implemented at all levels of the office.

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 such other records used to make a treatment or payment decision about a member. Our Privacy Officer, in collaboration with our Technology Services Department and the business owners, is responsible for ensuring that we retain the designated record sets stored in an electronic format.

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 paper documents. According to our documented procedures, paper documents are archived according to a defined schedule and stored in an off-site storage facility operated by Iron Mountain. These documents are placed in archival boxes, labeled, catalogued, and stored in such a manner that they can easily be retrieved when needed. All data and documents are destroyed according to established procedures once they are no longer required. Paper documents are shredded; electronic versions of files are deleted; and electronic media formats such as CDs, diskettes, or magnetic tape are forwarded to the TS Department for proper disposal.

The core operations system maintains an audit history of data updates, including time and source of change. Audit trail information is maintained for no less than 10 years; online for no less than 6 years and then available from archive. Archived audit trail data is available within DHH’s 48 hour turnaround requirement.

Our current systems and record retention processes will support the requirements outlined in Section 16.13 Records Retention of the RFP, as depicted in Table R-1.

Table R-1. Records Retention Capabilities

Record Type	Louisiana DHH Requirement	Current Capability to Meet RFP Requirements
Electronic Information	<ul style="list-style-type: none"> • Online for 6 years; in archival system years 7-10 • Services with once in a life-time indicator are not archived or purged • Online access to claims by Medicaid recipient ID, provider ID and/or ICN (Internal Control Number) • Retrieval with 48 hours on 6 year old information, 72 hours on >6 year old data • Ability to prevent data from archival until all tasks or proceedings are completed 	✓
Paper Documents	<ul style="list-style-type: none"> • Retain paper (or image) for not less than 3 years • Provide document indexing, archival and retrieval • Allow DHH staff to request and obtain document copies 	✓
Encounter Data Submission	<ul style="list-style-type: none"> • Retain for 6 years 	✓

Record Type	Louisiana DHH Requirement	Current Capability to Meet RFP Requirements
Audit Trails	<ul style="list-style-type: none"> • Online for not less than 6 years • Archive for not less than 4 years, with 48-hour turnaround on request for electronic access 	✓

R.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH (to their Fiscal Intermediary and the Enrollment Broker). In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handling of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.

Ensuring the Integrity, Validity and Completeness of information

The first step in ensuring that all information provided to DHH, the Fiscal Intermediary and the Enrollment Broker is accurate and complete involves rigorous processing of incoming data. Tight controls and consistent application of validation edits and business rules on all data (electronic or paper) coming into our MIS is critical in order for us to generate clean outgoing data.

We have a comprehensive set of procedures and systems-based internal controls that we will apply to the implementation to ensure that we capture, process, and submit data in accordance with the quality and timeliness standards of the Louisiana program requirements. We will verify the integrity, validity, and completeness of all information we submit to DHH and its agents by using procedural and systems-based internal controls to:

- Manage the receipt of paper documents and electronic files
- Edit data entering our systems
- Process all data accurately
- Monitor additions, deletions, or modifications to data on incoming files
- Prepare data that is sent to DHH and its agents

We recognize the need for strict controls regarding the receipt of information to make certain that the data processed and maintained by our systems is valid and complete from inception. Clean data in our systems is the first step to ensuring that we can provide complete and accurate data to DHH.

All incoming data is 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 is accurate, complete, and valid with respect to format and presence. Incoming data includes but is not limited to member eligibility/enrollment, provider, claims, prior authorization, complaints, grievances, appeals, and financial information, as well as other reference data such as procedure codes and diagnosis codes.

We scan paper documents, as necessary, and process the information using procedures specific to each information type, including provider, claims, and prior authorization information. Employees entering data are required to have appropriate levels of security that permit data update capabilities to add, change, or delete information.

Maintaining Accurate Provider Data

Maintaining complete and accurate provider data provides a foundation for accurate claims and encounter data. We take a number of steps to ensure the ongoing accuracy of provider data so that it is available to system processes as well as our member population via our provider directories. Our overall strategy for ensuring provider data accuracy and completeness includes the following activities:

- An audit our Provider Data Management (PDM) staff conducts based on a random sample of provider data entry and update transactions.
- Monthly, our Quality Assurance Department audits a random sample of providers to verify the accuracy of the data in our core operations system. This audit process includes telephonic outreach to the provider to validate that demographic data is both current and accurate.
- Quality reports will be run that mirror DHH-specific business rules in order to self identify and drive correction of any provider data errors. In addition, the PDM staff researches all provider address issues identified through any state files submitted to us, including returned mail and incorrect faxes.
- We will regularly compare our provider data against a third party vendor's data to identify potential additions or corrections to the data in our system. The third party vendor's data is derived from client sources, published sources and direct provider outreach, as well as other sources.

We are currently implementing an overall quality framework and strategy for provider data that includes further development of each of the items above in addition to the implementation of several additional capabilities including automated quality reports and provider outreach.

Receiving, Editing, and Processing Claims Data Accurately

Providers submit claims to Amerigroup in two ways: electronic, using one of our three clearinghouse arrangements or our provider portal, and paper. We encourage providers to utilize one of the electronic submission methods and in 2010, 87 percent of claims were submitted via EDI. Our portal provides two means for electronic claims submission – direct submission of HIPAA-compliant 837 files and manual keying through a user interface. All paper claims are keyed to electronic claims transactions and loaded through our claims processing logic along with the electronically submitted claims. **All claims submissions methods are available to providers regardless of how they are paid.**

The current EDI rate throughout the Amerigroup health plans is

87%.

We maintain accountability for paper claims through the implementation of a high-speed, front-end scanning and data capture system that uses an Optical Character Reader (OCR) and pre-defined data entry templates to allow rapid and accurate entry of hard copy claims. Claims that are not processed through the OCR functionality are keyed and all claims entry processes are subjected to preliminary data validity and presence editing. A quality control process is performed to monitor the accuracy of data keyed and processed through OCR.

Regardless of whether the claims are received in electronic or paper format, we verify that the number of claims we received is equal to the number of claims loaded into the core operations system at the completion of each batch of file.

A series of edits and validations are applied to all claims throughout the claims processing cycle, regardless of the submission method, including:

- Front-end edits to validate content and apply market-specific rules
- Compliance checking of the transaction
- Validations against member and provider data, authorizations, member benefits, among others

Claims that fail edits are rejected and returned back to the provider with an explanation of the problem.

We capture all medical services, including utilization data and medical supplies, and we edit against standard code sets including HCPCS (including Level II), ICD-9, CPT (including Category II), revenue, CDT/ADA, and NDC codes. These edits are applied in our MIS for all medical claims we process. Our delegated vendors also edit against standard code sets in their systems and when we receive encounter data from our delegated vendors, we apply code edits. We maintain our code sets, updating them regularly, and are able to manage the codes with effective dates so they can be applied to claims appropriately based on date-of-service.

Encounter Specific Data Requirements

Amerigroup will meet the Encounter requirements specified in Section 17 of the RFP. We ensure the accuracy, timeliness and completeness of provider and subcontractor encounter data through dedicated staffing, a robust Encounter Management System (EMS) and a tightly managed submission schedule. An Amerigroup Louisiana Business Analyst will partner with technical resources, both internal and external to the Encounters Management Department, to meet all encounters reporting obligations; the team meets at least weekly to ensure that standards are being met. Our EMS handles all extraction, tracking, correction, reporting and archiving of encounter data.

Encounter data received from our ancillary vendors and all the claims/claims adjustment data processed by our core operations system since the last submission of encounter records are consolidated into our EMS. As part of our processing, we perform system edit checks for duplicate claims, validate member and provider numbers, and apply business rules to determine if the encounter records meet state-specific processing requirements.

Encounter records that pass all edits will be formatted in HIPAA-compliant 837I and 837P formats. Records failing the established edits are identified for the Encounters Management team to review and determine the corrective action needed to resolve the issue. This corrective action is coordinated with the appropriate operational unit such as Claims, Provider Data Management, and the EDI team.

Our system is capable of submitting claim denials and adjustments according to DHH requirements in addition to paid claims. For providers compensated through a capitation arrangement, Amerigroup will receive encounters as zero-pay claims through all claims intake methods used by our fee-for-service (FFS) providers. Claims from capitated providers will process through our core operations system, receive all the same edits and validations, and become part of the overall claims data set extracted by the EMS for encounter submission.

Encounter Data Quality

Encounter data quality is primarily validated during the claims adjudication process. During claim processing, 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 edits that we have developed to comply with state-specific rules and regulations, and other value-added edits. Claims that pass our front-end edits flow into the adjudication engine where additional edits, specific to claims processing, are applied as the claim is processed.

During claim adjudication, we validate data through HIPAA Level 6 in accordance with the Workgroup for Electronic Data Interchange's Strategic National Implementation Process (WEDI SNIP) standards, including the claim coding edits. We also apply state specific Level 7 edits within our front-end edits outside the compliance check. This level of compliance review has enhanced our operations by identifying potential issues early and enabling us to address root causes before they escalate or become chronic problems. For example, Level 5 compliance edits uncover inappropriate coding by providers that results in provider outreach and training.

We apply hundreds of standard system edits that support tasks such as verifying member eligibility, checking provider status, validating that authorization requirements are met, ensuring the services are covered, and checking for duplicate claims. We also subject the data to other industry recognized products such as code review and code bundling software, as well as internally developed data verification applications.

Before we submit encounter data to DHH, the Encounters Management team will process information through edit routines to verify that data is formatted correctly and that all fields contain accurate and complete information. We use an encounters management tool to extract, track, correct, report, and archive encounter data. We process all paid claims data, including data from our ancillary vendors. The system will be configured to edit and process all encounter records against Louisiana-specific requirements to ensure the completeness and validity of data submitted to DHH. The application edits for validity and completeness of member and provider data, date of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and date of claim payment, as well as assuring there are no duplicate claims. Claims that fail the edit process are identified so the data can be analyzed and corrected as appropriate. The system will format all claims that successfully pass the edit process into HIPAA-compliant transactions, according to the Louisiana CCN-P Systems Companion Guides, and send them to DHH.

In addition to reconciling total transactions included on the file, the Encounter Analyst reviews all transactions, including failed edits, and appropriate steps are taken to resolve any discrepancies. Steps may include returning claims to the claims processing team to adjust or otherwise resolve with the provider. This reconciliation process occurs prior to submission of each file.

Any encounter records not accepted by DHH will be evaluated by the Encounters Management team, analyzed, and corrected if the error is repairable. Returned encounters are analyzed to determine root cause and if possible, changes are made to system processes to increase the number of accepted encounter records.

Timeliness

Amerigroup will meet the DHH requirements for timely submission of encounters to the FI. The Encounters Management team operates on a strict submission schedule according to state requirements, extracting all available claims data from internal data stores, processing them through the EMS, transmitting encounter data to the state, and evaluating, analyzing and resolving, as necessary, state processing results.

Reconciling Encounter Data to Payments

To ensure all claims are accounted for in the encounter submission, internal reconciliation and certification reports are created for each file batch that allows the encounter analyst to identify inconsistencies and shortfalls in the claim counts and dollars.

- The Reconciliation Report displays the total claims and dollars that are available for submission for the reporting period and compares these totals to the total claims and dollars that were imported into the encounter processing system. This data is gathered from the claims processing system and the reporting repository that houses the delegated vendor claims. This report identifies any claims available for the reporting period that did not get imported for encounter submission.
- The Certification Report is a detailed report that displays the number of claims and dollars:
 - For claims in the encounter processing system
 - Submitted on the encounter files
 - Held due to incomplete/inaccurate data that must be reviewed and remediated for submission at a later date
 - Excluded from submission based on state guidelines (for example, claims denied as duplicates).

Any variations in numbers of claims or number of dollars are reviewed and analyzed and any necessary corrections are made to ensure encounter file accuracy. When necessary, program changes are made to enhance encounter processing and reporting.

Monitoring and Auditing

Our state partners need the ability to monitor and audit the data, processing and procedures of the implementation on a regular basis in order to confirm that requirements are being met. We encourage DHH to become active partners in our efforts to actively monitor all information systems aspects of managed care operations in Louisiana, including data exchanges, individual claims, and reports.

Our infrastructure and MIS are designed to facilitate secure access for monitoring and auditing by our state partners. We will provide secure access to our systems for DHH personnel or individuals authorized by DHH. As discussed in our response to question R.16, we maintain strict security policies and procedures to protect the personal data of our members and providers. We require all employees, state partners, consultants and anyone given access to the system to use a unique user identifier to gain access to workstations or systems. The access management function also restricts users by varying hierarchical levels of entry based upon system function. DHH employees involved in monitoring or

auditing activities will be granted remote or on-site access to systems necessary to meet auditing requirements.

Our MIS maintains Audit Trails that track changes to source data. Whenever an authorized user makes a change to one of the database tables, the application automatically creates a history of the update transaction. The data maintained is stored in an Audit Table with the before and after picture of the data being updated along with other identifying information, including:

- The unique log-on or terminal identification number of the person who made the change
- The subsystem used to generate the change
- The time and date of the change

To facilitate claims auditing, our MIS follows COBIT controls and is compliant with generally accepted accounting principles (GAAP) as well as SOX. We are audited to SAS-70 compliance. Our audits are based on the industry standards in place at the time of the audit, so as standards change, our auditing procedures are reviewed and updated.

As part of the Louisiana implementation, the TS Department will create an EDP Policy and Procedures document. This document will be adapted from our internal controls, policies and procedures included in our SDLC and will contain standards all programmers follow for coding, testing, executing and documenting all system activities, including standards for the Graphical User Interface (GUI) of screens used throughout the system. As required by DHH, this manual will be available for a yearly audit.

DHH-Initiated Audits

We acknowledge the need to establish methods for DHH employees to initiate data integrity, validity, and completeness audits. We will work diligently with DHH to comply with such audits. With another state, we are already actively participating in their encounter data initiative. The initiative is a series of edits, processes, and standards, including:

- Evaluation of encounters for duplicates
- Evaluation of reported billed, allowed, and paid amounts on encounters
- Appropriateness edits on coding
- Application of HIPAA edits at all levels

We also have experience supporting other auditing compliance efforts, including facilitating the processing of electronic files as test data to allow the agency to validate that all data was accurately entered, processed, and evidenced back to the state.

For Louisiana, we will implement processes to allow DHH to review samples of documents received and verify the integrity, validity, and completeness of the data within the MIS. Our TS Department is familiar with annual auditing processes and regularly complies in one that currently allows systems and applications to be audited by KPMG, an annual General Controls Audit, and regular audits of financial reporting.

We are accustomed to working with state auditors and providing them with files in a format and media compatible with their facilities. If an audit report documents discrepancies or errors, Amerigroup is committed to providing a corrective action plan to DHH within 10 days of receiving the report, should a

plan be necessary. All audit reports, corrective action plans, and yearly findings and recommendations will be incorporated into the EDP manual.

Independent Audits

Amerigroup currently contracts with an external firm to perform annual EDP and compliance audits on our systems, so we are able to comply with the DHH requirement for an independent audit. We are comfortable with the requirement for ongoing and annual audits commencing at the conclusion of the first 12 month operation period. Findings will be delivered to DHH within 30 days of the completion of the audit.

If the audit identifies any deficiencies, we will provide DHH with a corrective action plan within 10 days of receiving the audit report. Audit reports and findings will be incorporated into the EDP manual.

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R.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph, or indicate whether these technologies and management strategies are already in place.

Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

Investment in Systems Availability

Amerigroup devotes significant corporate resources to ensure system availability to meet business needs. For many systems, such as our core operations system and telecommunications infrastructure, availability is maintained 24 hours a day, 7 days a week (24/7), except during periods of scheduled maintenance. We have developed our Management Information System and technology architecture and positioned it to adapt to the distinct needs of our state partners and the changing environment of Medicaid managed care, while maintaining the highest level of systems reliability and availability. We are committed to internal monthly systems availability of 98.5 percent and in 2010 performed at an average of 99.95 percent. **After a systematic review of the requirements contained in the RFP, we are confident that we will be able to meet or exceed DHH expectations for systems availability and performance.**

System and data availability is paramount to Amerigroup. We understand how vital our systems are to the state of Louisiana, our employees, external vendors, providers and our members. Whether it is day to day system and data availability or disaster response, Amerigroup has gone to great lengths to prepare. Amerigroup closely monitors core systems; we have detailed policies and procedures as well as service level agreements on core system availability and connectivity. Amerigroup understands the importance of critical communication to our customers during system challenges. Additionally, we have a very well thought out and comprehensive plan dedicated to effective business continuity/disaster recovery.

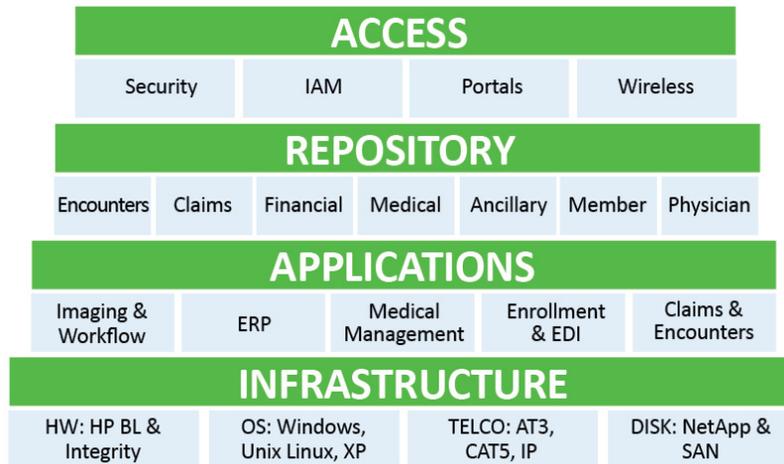
Recovery time objective for our mission-critical applications is less than 24 hours.

Technology Overview – Information and Telecommunications Systems Architecture

Our architectural framework focuses on four major technical layers: Infrastructure (Hardware and operating software), Applications, Repository, and Access. Each layer is a foundation for subsequent layers focused on providing reliable, scalable, extensible and interoperable tools to support each of our business processes. The n-tiered systems hardware and software architecture permits scalability of the technology platform to meet current and future capacity needs. We plan capacity annually as part of our overall corporate business planning. Response times and processing windows are monitored on an

ongoing basis throughout the year. Redundancies are built into the layers to maintain business continuity. This framework is illustrated in Figure R-2.

Figure R-2. The Amerigroup Technology Framework



The **Infrastructure** layer is our telecommunications and network foundation and is supported by premier third-party vendors. The **Applications** layer supports the core transaction and operations processing such as enrollment, claims, encounters, provider contracting, finance, and clinical. The **Repository** layer allows real time, flexible reporting and offers many business functionally specific views. Also, the flow of business data from the Applications layer to the Repository layer is unidirectional, which preserves transactional integrity and data controls. The databases supporting the applications and repository layers are relational and use RDBMSs such as Oracle and MS SQL Server. The **Access** layer enables members, providers, state partners, and Amerigroup employees secure and efficient access to the tools and information.

Technology and solutions in all layers are a combination of acquired industry leading and custom developed applications and tools. Amerigroup’s database systems architecture incorporates industry standard relational database management platforms such as Oracle and MS SQL. All layers are highly extensible and enable “plug and play” component transparency. Security, data integrity, and accessibility are managed in all layers.

Amerigroup’s Technology Services Department has HIPAA-compliant policies and procedures for the security of our data and systems. Security is enforced at all levels including:

- Physical facility security where proximity-access badges are required to be worn and utilized by all employees
- System access management where access to applications is limited, and within applications access to functionality is controlled and capabilities, such as read and write, are also controlled
- Entry point accessibility is controlled through logins requiring complex passwords with limited life, workstations are set with an inactivity timeout, and remote access is controlled

TS Security is currently in the first phase of our Identity Access Management (IAM) initiative. We are increasing our ability to monitor, track, and report system access and are increasing our self-audit

capabilities. Today we utilize state-of-the-art monitoring tools to audit system access, utilization, account, and resource usage. Intrusion Detection and Prevention Systems (IDS/IPS) along with security management systems provide 24/7 real-time security event monitoring and reporting. We follow the COBIT framework for information technology controls.

Our enterprise communications network architecture for data, voice, and video is full-mesh Multiprotocol Label Switching (MPLS) transmitting IP. The full mesh topology provides maximum reliability and redundancy and MPLS provides faster traffic flow and improves manageability and quality of service. Redundancies are built into all levels throughout the communications network and include active and passive routers and geographically redundant Internet connections. Interoperability is a key design premise of our platform.

Our new Network Operations Center (NOC) went live in March 2011. At this new facility, shown in Figure R-3 our TS Department proactively monitors our core technologies and applications to prevent system latency and outages. The NOC provides a dedicated work environment where TS employees can effectively plan and analyze system characteristics, while fostering immediate interdisciplinary collaboration among technologists. Located adjacent to our primary data center operations in Virginia Beach, the NOC will help Technology Services continue to improve service for all of our customers.

Figure R-3 Network Operations Center



Systems Availability

Systems availability is, understandably, a critical component of the DHH requirements for the Louisiana CCN Program. Amerigroup is committed to providing reliable, available systems. We understand that we are not responsible for the availability and performance of systems and infrastructure outside our span of control. **We will meet the requirement for our core systems unavailability not to exceed 12 hours during any continuous 20 business day period.**

The paragraphs below detail our commitment and current ability to meet DHH requirements presented in Section 16.10, Information Systems Availability, of the RFP.

Access to Data for Data Mining and Review

At Amerigroup we understand the importance of mining data for review and we have several access points to mine critical data. Our Technology Services employees are well versed in our data models and are able to quickly produce ad-hoc reports that DHH personal, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office may need for review and analysis. Additionally, we will implement a DHH Data Access Portal which will provide DHH and their designees access to run queries directly against our Louisiana data.

Availability of Critical Member and Provider Information Functions

Member and provider data and our member and provider web sites and Voice Portal system is available 24/7, as required by DHH. Maintenance on these critical systems normally occurs on a weekend and we will coordinate scheduled maintenance with DHH.

Our web portals provide vital data to our members and providers. Among other things, members can review detailed information on our programs and services and specific member benefits, search the provider directory, utilize mapping features, or ask questions or submit comments online. Our provider portal may be accessed by our participating and non-participating providers. We showcase basic tools such claims submission and status, formularies, eligibility verification and reimbursement policies, as well as the searchable directory.

Our Voice Portal system offers many of the same services that our member and provider web sites offer. Our enterprise communications network architecture for data, voice, and video is engineered for maximum reliability and redundancy with faster traffic flow.

Availability of Other System Functions

Our critical core systems will be available between 7 a.m. and 7 p.m., Central Time, Monday through Friday, except during periods of scheduled downtime and periods of unscheduled unavailability. As a routine part of operations, the TS Department monitors and tracks systems availability and performance. The TS Department maintains service level agreements with the business owners to ensure that systems are available and performing at levels required to support business activities. It is extremely important for the state of Louisiana, as well as other Amerigroup health plan customers, that systems are operational, available and performing efficiently at all required hours of the day.

We carefully monitor systems and processes associated with data exchanges with DHH's FI and/or Enrollment Broker and its contractors to ensure that they are available and operational. We automate many of our file processing tasks so that our systems retrieve files at the most efficient time. Our Operations Department is manned 24/7 to retrieve and send files that are not automated. We are fully prepared to meet the needs of the state, the FI and the enrollment broker for Louisiana Medicaid operations.

Recovery Time of Major Systems

Amerigroup has defined the Recovery Time Objective for our mission-critical applications to less than 24 hours. Additionally, we have taken steps to minimize the Recovery Point Objective (RPO) and thus

Near real-time data replication provides us with a Recovery Point Objective of 15 minutes or less.

minimize the data loss associated with an outage. For the most vital of our mission-critical applications, those that serve as the system of record for our member, provider, claims, and authorization data, we have invested in a solution where the application is staged in our secondary geographically distributed data center for immediate failover. We perform near real-time data replication. The replication for these solutions provides us with a RPO of 15 minutes or less. We apply this optimal recovery solution for our core operations system, care management system, our medical criteria, and our

workforce management application, among others.

New applications are assessed as they come online in support of our business to determine the appropriate Recovery Time Objective (RTO). We continually reevaluate each application's RTO to assess

its ongoing appropriateness. Through such ongoing assessment, we identify additional applications as mission-critical and work through the associated redundancy and replication planning.

Our redundant data center is located in an AT&T Internet Data Center (IDC). In order to recover operations, not simply applications, we have a work area recovery contract with SunGard. We also maintain daily full backups with an offsite tape rotation. For the core operations system, Amerigroup has also invested in complete redundancy for all tiers of the application thus providing a high availability (HA) instance in addition to the production and disaster recovery instances. This HA solution is located in our primary data center in Virginia Beach, Virginia, and in the event of a non-disaster issue with our core operations system we are able to switch to this HA solution.

Communication in the Event of a System Problem

Clear and immediate communication is vital when systems are unavailable. Amerigroup will assign an Account Manager to DHH who will be responsible for communicating systems issues. **As a result of our essential personal focus, we will meet the requirement to provide updates on an hourly basis via phone and/or electronic mail of any core system availability issues.**

We will meet the requirement to notify designated DHH employees via phone fax and/or electronic mail within 60 minutes upon discovery of the problem that may jeopardize availability of critical functions, including scheduled exchange of data with DHH, the FI, or the Enrollment Broker. Communication will include specific details regarding the impact to critical path processes such as enrollment management and encounter submission.

Amerigroup has an extensive history and proven record of accomplishment in the generation of compliant, timely, and accurate reports on a weekly, monthly, quarterly, annual, and ad-hoc basis for its state contracts. The Amerigroup Regulatory Department ensures that reports are delivered on-time and will be in direct contact with the state of Louisiana and the business department at Amerigroup in the rare event of a problem.

We understand the importance of delivering regulatory reports on time and that DHH systems may be configured to search for critical reports on a specific schedule. Amerigroup will notify DHH employees via phone, fax, and/or electronic mail within 15 minutes upon the discovery of a problem that results in delay of state regulatory reports distribution, or problems in online access to critical core system functions. Regulatory and technical points of contact will be assigned to keep DHH apprised of the availability of these vital resources.

Amerigroup will meet the requirement to resolve and implement system restoration within 60 minutes of official declaration of unscheduled system unavailability of critical core systems caused by the failure of system and telecommunications technologies within our span of control. Unscheduled systems unavailability of other system functions caused by system and telecommunications technologies within our span of control will be resolved within eight hours.

In the unlikely event that issues with our critical core systems result in non-compliance with the required availability time, we will provide DHH with full written documentation within five days of the occurrence that includes a corrective action plan describing the steps we will take to avoid a recurrence. We believe this is key to our commitment to the state of Louisiana, our members and our providers.

Business Continuity-Disaster Recovery Plan

With the goal to swiftly and seamlessly respond to an emergency with minimal impact on all constituencies, **we maintain a detailed emergency response continuity of operations plan**, also referred to as our Business Continuity and Disaster Recovery (BC-DR) Plan. The BC-DR Plan represents a detailed blueprint of our preparation for and planned response to any emergency, including a pandemic or natural disaster. It specifies the policies, procedures, and tools that it uses to assure successful continuity and recovery of business processes for all Amerigroup health plans. The breadth and depth of our operations across the country, complemented by a strategic partnership for alternate work area recovery sites, promote resiliency in our response to temporary interruption of any business operations.

In the event of an incident, an Incident Hotline relays important information and keeps employees abreast of developments or changes. Our Emergency Notification System (ENS) allows us to distribute broadcast text messages and emails and converts text message to speech so we can send messages to home phone numbers.

Our BC-DR Plan covers all Amerigroup locations, both corporate and health plan, and identifies key individuals and business functions. Our BC-DR Plan is proprietary and available on-site for review by DHH.

The BC-DR Plan designates a Recovery Leadership Team (RLT), which consists of department leadership or senior technical leads for departments that perform essential business functions, including representation from the local health plan when affected. The primary focus of this team is to resume normal business operations in the event of an interruption. Upon notification of an event, the local RLT works in concert with the corporate Incident Management Team (IMT) to evaluate the scope and level of the incident and identify appropriate actions. The IMT Lead facilitates communication among all team members. Each team member is guided by a specific checklist that details the steps to take within each respective department or function, including details for initiating continuity, recovery, and resumption activities. The process also incorporates a post-incident debriefing to assess the operating status and identify lessons learned that may drive revision of our plan.

Key Employees

In addition to members of the IMT, the role of key employees is commensurate with the nature and scope of the emergency. The BC-DR Plan identifies key employees within each functional area and designees within each health plan as part of the Recovery Team. Each corporate department and health plan designates a primary and at least one alternate recovery team representative. The IMT Lead is responsible for engaging our corporate President/Chief Executive Officer and Chief Operating Officer as quickly as possible.

Command Center

The BC-DR Plan specifies where and how Incident Management Team members will assemble. A primary and three alternate command centers are designated. Depending on the nature and geographic impact of the incident (local versus regional), the command center and audio conferencing enables us to create a virtual command center that links all key employees and team members.

Contingency Plans for Essential Business Functions

Continuing services throughout an occurrence is critical for Amerigroup. Whether it is a short-term incident, such as inclement weather, or a longer term emergency, including a pandemic or natural disaster, we have established protocols that guide business continuity and data recovery. Further, we leverage SunGard's LDRPS online information availability tool, as our repository and maintenance tool for the BC-DR Plan. LDRPS is hosted by SunGard on secure systems in a secure data center facility, with replication to an alternate, geographically separate, secure facility and systems. Therefore, the BC-DR Plan information is accessible at all times via the internet without reliance on our Technology Services infrastructure.

Regardless of the nature of the emergency, our redundant operations will minimize disruption for Louisiana members and providers. Each work site has a recommended recovery location. Because we maintain redundant operations for key functions, including care management, the call center and claims offices, with telecommunications and networking technology that enables transparent transition among remote sites, we can quickly and seamlessly re-route member and provider calls to an unaffected work site. For example, should a local or regional incident affect the availability of our call center in Nashville, Tennessee, calls will be routed to Virginia Beach, Virginia or Tampa, Florida. Should an event restrict access to the Louisiana administrative office, all employees will be prepared to work from home or a remote Work Recovery Area.

Technology Tools Supporting Home-Based Work

Especially in the event of a pandemic, we will rely on remote systems access to facilitate continuing operations. We maintain technology tools that enable employees to seamlessly access necessary systems remotely. Through the use of our Citrix Access Gateway, employees can utilize critical applications from any location that provides Internet access. The availability of almost 200 Citrix servers allows fast, efficient remote access to all critical applications.

Contracted Work Area Recovery Sites

If a local alternate Amerigroup work site is unavailable and telecommuting is not effective, we maintain a contract with SunGard to enable use of Work Area Recovery sites that are geographically or regionally close to our offices. Should employees from a local office be unable to access their office or our network, SunGard Work Recovery Areas provide temporary work space with access to all Amerigroup systems.

Systems Hot Site

We contract with AT&T for our internal disaster recovery hot site, which is located in an AT&T Internet Data Center (IDC) in Dallas, Texas. The facility is 142,000 gross square feet, with 72,150 square feet of raised floor data center area. The AT&T IDC is a tier 3-4 data center with N+1 redundancy on all critical infrastructure systems, including the following capabilities:

- Dual uplinks directly connected to the AT&T global IP backbone for network connectivity
- Multiple local communication carriers for customers' private connectivity
- 24x7x365 on-premise security and system support
- Continuous closed circuit video surveillance
- Electronic key card access with biometric scan and personal access code

- Fire detection and suppression analaser (HSSD)
- Conventional smoke and heat sensors
- Redundant commercial power feeds to (4) 2,500 and (1) 2,000 k VA transformers
- Five backup diesel generators, for a total 2,000kW/2 MG, which start when commercial power is interrupted for more than seven seconds
- UPS modules, with N+1 redundancy, providing clean power to connected critical loads

The Amerigroup hot site is a secure cage facility within the AT&T IDC. The hot site includes equipment to support our most critical medical management and member/provider contact applications, including our core operations system, clinical criteria, Fax II/Rightfax databases, imaging and workflow document management, and call center workforce management. Continuous real-time replication occurs between the production data center in Virginia Beach and the hot site facility to keep the critical applications in sync with production.

The AT&T IDC is a node on the Amerigroup MPLS wide-area network, providing network connectivity to all Amerigroup locations. There is a direct DS3 MPLS connection between the production data center in Virginia Beach, VA, and the Dallas, TX, hot site. Also, the hot site provides an Internet access scalable to 100Mbps, providing immediate backup Internet access for the entire enterprise.

The Dallas AT&T IDC provides a secure, reliable environment for the Amerigroup internal disaster recovery hot site. It also provides a very scalable environment, with tremendous capacity for additional space, power, HVAC, UPS, and all other critical infrastructure components, as our requirements increase over time.

Contingency Plan Scenarios

Our BC-DR plan is “scenario neutral” and addresses any situation that disrupts normal operations, from minor incidents to major disasters. We have carefully reviewed the list of scenarios described in Section 16.11.4 of the RFP and are confident that our BC-DR plan addresses not only those situations, but is thorough enough to accommodate many more.

Testing the BC-DR Plan

To monitor readiness, we test the BC-DR Plan at least annually, assessing our technology recovery capabilities as well as our business continuity preparedness.

As dictated by the BC-DR Plan, the TS Department schedules and conducts backup and recovery tests and exercises no less than once each year to demonstrate readiness and ensure the success and viability of the BC-DR Plan. The TS Department establishes simulated disaster or recovery scenarios and employs the procedures in the Plan. This includes testing and restoration of our applications at the Dallas, Texas facility and verifying the ability of alternate locations to assume business operations for a health plan that is experiencing a disruption. Amerigroup has also tested recovery at a SunGard Work Area Recovery site. Upon testing completion, a full report is developed that summarizes the response and specifies lessons learned, including vulnerabilities that must be corrected.

Our business continuity plans are also tested at least annually using a combination of tabletop exercises and testing of our Work Area Recovery Sites. Tabletop exercises are structured to simulate an incident that escalates to disruption. Designated employees participate in the simulation and discuss the steps to

be taken in accordance with the BC-DR Plan. In Work Area Recovery Site testing, employees simulate an incident which requires them to telework or relocate to a SunGard Work Area Recovery site, in which they test access to all Amerigroup systems. Detailed summary reports are also produced to highlight our performance with respect to the BC-DR Plan.

Our BC-DR Plan in Action

As detailed above, our redundant operations and systems capabilities and geographically dispersed employees enable us to rapidly transition calls from one facility to a designated back-up facility. Employees at the back-up facilities have access to the same data and tools to assist callers in the affected market. This process has been triggered numerous times and has proven to be successful in easing the impact of a local or regional incident or emergency on members and providers.

Of particular value to our members and providers during an emergency is our Electronic Service Record (ESR). The ESR includes components of an electronic health record, but also incorporates enhanced features designed to provide more comprehensive information that may be necessary to support health care continuity in the event of a local or regional disaster. Such information includes contact information, information on a members' ongoing medical needs (such as dialysis), transportation or housing needs. Our objective is to create a tool that not only supports day-to-day needs, but also can be leveraged by the members, our care managers, our providers, our state customers, and potentially first responders as a resource when developing disaster recovery plans, promoting continuity of care for Medicaid consumers. Such a tool would be particularly beneficial to the State of Louisiana, which is vulnerable to hurricanes along the Gulf Coast.

Our decisive and multi-faceted response to actual incidents and emergencies best illustrate the strength of our planning.

Inclement Weather

The most common reason for initiation of recovery protocols is inclement weather. Whether an office is closed due to snow or closes early because of tornadoes in the area, we activate the plan, rerouting calls and functional responsibilities according to the Plan. We regularly handle such temporary business disruptions with little impact on members or providers.

Hurricane Ike

In September of 2008, as Hurricane Ike bore down on the Texas coast, we initiated planning for the anticipated disruption of our operations in Houston. Following our Hurricane Response Plan, we mapped out the strategy for maintaining operations expecting that many members, providers, and employees would be affected by the storm. In planning before the storm, among a long list of tasks, we established telecommunications re-routing to the designated back-up facility, located in Dallas-Fort Worth, to maintain continuity of services for members and additionally re-routed all email for key employees to email servers in Virginia.

Once the storm subsided, our entire Texas team burst into action, although many were directly affected by the storm themselves. With extensive support from our Dallas-Fort Worth, Corpus Christi, San Antonio, and call employees, we reached out to every member to ascertain if they needed assistance, particularly critical for our aged, blind and disabled members with ongoing needs, such as oxygen or dialysis. Our Case Management team contacted special needs members to assess how they were

affected by the hurricane and what immediate needs they had. Not only were our local technology systems (phones, email, and network connectivity) brought back online once power was restored, more importantly, our dedicated team maintained our member and provider wellbeing as their primary focus, going above and beyond to promote continuity of care and service.

Off Site Storage and Remote Back-Up

Amerigroup employs a strategy of daily, weekly, monthly, and yearly backups to disk and/or tape with retention between 5 weeks and 10 years depending on the data type and back up frequency. Offsite backups are stored in a secure, offsite location with appropriate environmental controls and fire protection.

Our off site storage and back-up procedures meet the DHH requirements specified in Section 16.12 of the RFP. As technology and business requirements change, the back-up plan is reviewed and updated as required.

We perform full daily backups of data for all production systems and maintain a tape rotation that includes off-site data storage through Iron Mountain, Inc. Tape backups allow for the range of recovery from individual files to the complete restoration of an entire application. Quarterly audits are performed to ensure the integrity of tape backups in the offsite storage facility. The process is fully documented in a policy and procedures manual that maintains a complete list of backup server names and the frequency that the backup is performed. Back-ups are also performed on all instructions, procedures, reference files, and systems documentation supporting our systems.

Systems Help Desk

Amerigroup maintains an internal Service Desk and will utilize its capabilities, technology and knowledgeable employees to deliver a DHH Systems Help Desk.

Amerigroup Service Desk

The TS Department maintains a Service Desk (SD) to support all of our system users and other technical functions. The SD provides support to all employees during regular business hours. The SD is also available for situations that require immediate attention after hours. The TS Department provides the tools necessary for our SD personnel to log, track, and monitor all requests for assistance or instances of system problems.

Access to Experienced Employees

Our Service Desk, located in Virginia Beach, Virginia, is accessed through local and toll free telephone service as well as through email. The SD is staffed with well-trained individuals who are able to respond to most first-level systems issues. All authorized users can direct dial a specified internal telephone extension or send an email to report a problem. Technicians log, and track all reports of systems problems, such as system outages. SD Technicians can assist users with password resets, application usage, and minor fixes. Level two issues are logged, tracked, and referred to special technicians who have been trained to handle and repair issues that require in-depth knowledge or on-site assistance.

The SD Technicians pride themselves in their responsiveness to their users. They answer all calls promptly and courteously. The SD notifies callers by email when an issue is logged; the caller can track

the problem status through the on-line tracking system. The caller also receives an email notification when the issue is resolved.

The telephone system allows callers to leave a message during off hours. In case of an emergency, callers can page a technician for immediate response. Technicians review all messages in the morning and log calls into the tracking system. The calls are then routed to specific employees who must return the calls no later than noon. SD Supervisors monitor all messages to provide quick and accurate responses for all calls.

Service Desk Management

We maintain an automated system to log and track all calls and incidents reported to the Service Desk. The system assigns a unique tracking number to each issue; this is reported to the user via email. The technician receiving the call documents the issue, categorizing the problem and assigning a priority. The application provides an area of free form text to describe the problem and the resolution.

If the technician who receives the call does not resolve the issue, they can route the outstanding issue systematically to a second level/support technician. This system allows all Service Desk personnel to view and monitor outstanding issues and respond to them on a first-in-first-out basis. If needed, technicians can escalate problems based upon their priority and the length of time the issues are outstanding. If an issue's priority is changed, the support technician working on the issue is systematically notified.

The SD management team can generate reports to identify reoccurring issues or problems and to identify all problems assigned to a support technician or a support group. Reports can be reviewed by category of issue and time that it takes to resolve issues.

DHH Systems Help Desk

Amerigroup will create a Systems Help Desk for DHH that capitalizes on the existing capabilities of our internal Service Desk, most importantly, ready access to knowledgeable employees. The Systems Help Desk will provide authorized DHH systems users, and other agencies that may have access to our systems with support from 7 a.m. to 7 p.m. Central time Monday through Friday. Upon request by DHH, the Systems Help Desk will be staffed for extended hours, or on weekends or holidays. Service Desk employees will be able to differentiate between Amerigroup callers and staff from DHH or its agents and respond accordingly. During implementation we will provide DHH with telephone numbers and other access methods to reach the Systems Help Desk.

Systems Refresh Plan

Amerigroup continuously reviews and assesses the need to modify, upgrade, or replace application software, system operating hardware and software, telecommunications infrastructure, information management policies and procedures, and systems management policies and procedures. Our TS Department recognizes that all health plans, as well as DHH, are subject to changes caused by evolving business requirements, technology obsolescence, and employee turnover, among other factors. Our practice is to develop a positive culture of continuous review and assessment of our IT business operations. In support of that practice, all TS employees have a written performance goal each year to identify and recommend changes that will improve the department's ability to operate efficiently and effectively.

To provide outstanding information technology services for the Louisiana CCN Program, we will submit a Systems Refresh Plan each year, which provides details for planned systems' improvements and upgrades for the upcoming year. Our Systems Refresh Plan is highly confidential and can be made available to DHH for review after contract signing. The plan includes:

- Assessment of the need to modify, upgrade, or replace:
 - Application software
 - Operating hardware and software
 - Telecommunications capabilities
 - Information security capabilities
 - Information management policies and procedures
 - Systems management policies and procedures in response to business requirements, technology obsolescence, staff turnover, and other relevant factors
- Verifying that version and release levels of all system components are supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third-party authorized by the OEM or SDF to support the system component

The TS Department constantly reviews our infrastructure, applications, and policies and procedures. As they make recommendations, the TS Department's management maintains an ongoing list of proposed changes or upgrades. We take a cautious approach to system changes. TS management reviews and evaluates the value of new products and makes certain any new product is tested thoroughly by industry usage prior to implementation in the platform. When we consider an upgrade or application replacement, our review process includes analysis of hardware and operating system impacts, data input/output transfer impacts, data storage and distribution requirements, telecommunications requirements, as well as other interface implications. The TS Department plans for all possible consequences of the proposed change and have contingency plans in place for any potential adverse effects.

For all third-party products we use, we have maintenance contracts that require the TS Department to upgrade to new releases within specified times. The IT philosophy includes the need to remain current with third-party software once vendors have been able to demonstrate that their new releases are stable and function according to their documentation. Our TS Department evaluates third-party upgrades to verify there are no adverse effects to health plan members or providers prior to implementation of products.

Amerigroup is committed to the effective use of technology. The TS Department monitors and reviews the current systems, assesses new technologies and products, and implements upgrades and replacements when it is beneficial for business and our business partners.

Hardware and Software

Our current desk top workstation hardware and software and network and back-up capabilities meet or exceed DHH requirements as specified in Section 16.3.11 of the RFP. Employee productivity is critical to efficient operations and Amerigroup will provide all Louisiana health plan employees with desktop workstation hardware and software that allows them to effectively perform the responsibilities of their position.

Amerigroup maintains a Hardware/Software Lifecycle Management program that identifies standard configurations and details our technology refresh cycle. The TS Department also researches new technology and tests hardware and software for new initiatives, with the goal of providing Amerigroup with a reliable and cost-effective electronic infrastructure, creating a sustainable environment that delivers the highest quality information technology and telecommunication tools to support operations.

Desktop Workstation Hardware

Table R-2 depicts our current configuration standards against DHH requirements.

Table R-2. Desktop Workstation Hardware

DHH Requirement	Current Amerigroup Configuration	Performance Against Requirement
IBM-compatible PC using at least a Dual Core Processor (2.66 GHz, 6 MB cache, 1333 MHz FSB)	IBM-compatible PC with a Dual Core Processor (3 GHz, 6 MB cache, 1333 MHz FSB)	Exceeds – faster processor
At least 4 GB of RAM	4 GB of RAM	Meets
At least 250 GB HDD	HDD 1 X 160 GB	Meets – Our practice is to save work files to backed-up network drives and utilize local hard drives for application software, swap space and temporary files. As such, employees utilize a nominal (typically 30% or less) amount of the 160GB hard drives in our current standard. Our standard baseline was recently updated to include 250GB hard drives so, as we install workstations in the LA office and replace aged workstations throughout the company we will be installing to the new standard. And, in working with DHH during the implementation, if an employee supporting Louisiana work needs to have more space, we will install the larger drive in advance of the replacement schedule.
256 MB discrete video memory	1024 MB discrete video memory	Exceeds – more memory

DHH Requirement	Current Amerigroup Configuration	Performance Against Requirement
A Color monitor or LCD capable of at least 800x640 screen resolution	Color monitors/LCD configured to 1280x800 or even 1366x768	Exceeds – higher resolution
A DVD +/-RW and CD-ROM drive capable of reading and writing to both media	DVD RW (R DL) / DVD-RAM	Meets - To ensure data security write access is provided on an as needed basis
1 gigabyte Ethernet card	1 Gigabit Ethernet card	Meets
Enough spare USB ports to accommodate thumb drives, etc.	The standard number of USB ports is 4 with 2-3 available on average	Meets
Printer compatible with hardware and software	All workstations can access shared compatible laser printers that are connected to the local area network and in close proximity to work areas	Meets

Desktop Workstation Software

Table R-3 depicts our current software configuration standards against DHH requirements.

Table R-3. Desktop Workstation Software

DHH Requirement	Current Amerigroup Configuration	Performance Against Requirement
Operating System should be Microsoft Windows XP SP3 or later	Microsoft Windows XP SP3	Meets
Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts	Microsoft Internet Explorer v7.0	Meets
An email application that is compatible with Microsoft Outlook	Microsoft Outlook 2007	Meets
An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later	Microsoft Office 2007	Meets
Each workstation should have access to high speed internet	All workstations have access to high speed internet	Meets

DHH Requirement	Current Amerigroup Configuration	Performance Against Requirement
Each workstation connected to the internet should have antivirus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered	McAfee Antivirus for anti-virus and anti-malware, with virus definitions updated on a daily basis. An administrator performs required maintenance and support functions. Symantec MessageLabs provides anti-spam protection	Meets
A desktop compression/encryption application that is compatible with WinZIP v11.0	All desktops support Microsoft Compressed Folders; WinZip is available as needed	Meets

DHH requirements indicate that all workstations, laptops and portable communication devices must be installed with full disk encryption software. Amerigroup is able to meet these requirements as follows:

- Workstations – do not have encrypted disks in our current configuration standard. As new workstations are cycled in, new machines will have encryption. If the workstations must be encrypted for the Louisiana contract, then the upgrade schedule will be accelerated. Since workstations are not portable, we feel the security risk is minimal due to:
 - Policies against workstation movement
 - Practices regarding storing data on network servers, rather than workstation hard drives
 - Physical security measures, including access control and cameras
 - Hard drive data destroyed prior to disposition
- Thin Clients – do not have a disk, these do not require encryption
- Virtual Machines – are housed in a secure computer room
- Notebooks – are all protected with the Pointsec encryption software
- Blackberries – are fully encrypted. After 10 failed logins, the device clears its memory. A clear command is sent to the device if it is reported lost or stolen
- iPad – email and the Nurse application are encrypted. Encryption on the device is implemented at the application level. A clear command is sent to the device if it is reported lost or stolen
- iPhone – email is encrypted. Encryption on the device is implemented at the application level. A clear command is sent to the device if it is reported lost or stolen

Amerigroup uses the COBIT control framework to enable us to define and test our compliance with standards such as NIST and ISO. Our physical and procedural safeguards are defined in policies and procedures based on COBIT. These are implemented and tested against COBIT on a quarterly and annual basis. Overall, we test quarterly and annually against 32 COBIT controls, including physical and

procedural safeguards controls. Other controls include SDLC, account management, general, and access, among others. Our use and quarterly internal testing of the COBIT key controls supports our SOX Section 302 compliance and the annual third-party testing supports our SOX Section 404 compliance.

In addition to the COBIT control framework, we utilize the ITIL framework for asset management and TOGAF for architecture.

Amerigroup provides secure email for both sending and receiving information. Additional information regarding this capability are provided in our response to R.16.

Network and Back-Up Capabilities

Amerigroup maintains a high-performance and fault-tolerant nationwide voice/data Wide-Area-Network (WAN) that connects all health plan locations to the corporate campus/Metropolitan-Area-Network (MAN). The corporate infrastructure provides access to applications, network storage and the internet. Local-Area-Network (LAN) infrastructure within the health plans provides workstation connectivity to local shared devices such as servers and printers, as well as to the WAN. WAN connectivity for any given health plan's LAN is scaled to the size of the health plan and often includes local servers depending on specific needs. No matter the infrastructure, all Amerigroup health plans have appropriate and scalable access to all application, storage and internet resources.

To protect our network from an external breach, we utilize Cisco Routers to provide firewall protection, IBM's Intrusion Detection and Prevention device, and Cisco's Intrusion Detection and Prevention device. Vontu is used to provide data loss prevention for all traffic and Symantec MessageLabs monitor all email traffic.

Amerigroup has defined processes to back-up network server data to protect users and the company from data loss. We employ a strategy of daily, weekly, monthly, and yearly backups to disk and/or tape with retention between 5 weeks and 10 years depending on the data type and back up frequency. Offsite backups are stored in a secure, offsite location with appropriate environmental controls and fire protection.

All network equipment is protected by UPS devices which provide surge protection, buffer power fluctuations, and provide backup power during outages. The UPS equipment that supports network closets, computer rooms and similar installations is monitored by an automated management system. When any UPS device supporting a server reports a low power condition, a graceful shutdown is initiated for that server.

Amerigroup's National Support Center in Virginia Beach has two generators, each with a fuel tank sufficient to operate for three days. The combination of the two generators will support both the Call Center and the Data Center for six days without refueling. Additionally, the Corporate Offices, Nashville Service Center, Document Control Center (DCC), Tampa Call Center and the Disaster Recovery center all have generators to provide backup power.

Technologies and Management Strategies are Already in Place for DHH

Amerigroup has these technologies in place today ready to support the Louisiana CCN Program.

Implementation Success with Other State Clients

We have implemented/integrated seven new markets on our technology platform since 2005, and we have a plan and methodology, as well as dedicated experienced technical leads, who have participated in each of these implementations. As noted elsewhere in our response, our technology is completely scalable and we assess and manage capacity on an annual and continual basis.

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R.4 Describe in detail:

- *How your key production systems are designed to interoperate. In your response address all of the following:*
 - o *How identical or closely related data elements in different systems are named, formatted and maintained:*
 - *Are the data elements named consistently;*
 - *Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);*
 - *Are the data elements updated/refreshed with the same frequency or in similar cycles; and*
 - *Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).*
 - o *All exchanges of data between key production systems.*
 - *How each data exchange is triggered: a manually initiated process, an automated process, etc.*
 - *The frequency/periodicity of each data exchange: “real-time” (through a live point-to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.*
- *As part of your response, provide diagrams that illustrate:*
 - o *point-to-point interfaces,*
 - o *information flows,*
 - o *internal controls and*
 - o *the networking arrangement (AKA “network diagram”) associated with the information systems profiled.*

These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.

Key Production Systems Interoperability

Interoperability is a key design premise of Amerigroup’s MIS platform. Our MIS is designed as a core operations system feeding an integrated data warehouse (DW) supplemented by surround applications. The core operations system is the system of record for all member, provider, claims, and authorization data. All updates of this information are completed within the core operations system directly, or through its interfaces. All applications interfacing with the core operations system map to its data structures to enable consistency in naming, formatting, and validation.

The data warehouse accommodates front-line operational reporting using all data available from the core operations system supplemented with data from external sources, including delegated vendors, immunization registries, and state FFS claims. The data warehouse has been designed for consistency in data element names and data types with the corresponding source systems.

Our data warehouse maximizes our capacity for data analytics beyond the functionality provided via the core operations system, and gives us flexibility to produce targeted reporting supporting our business processes and our customers including our providers and DHH. Additionally, we support online dashboards/business intelligence analytical reporting. Several additional applications exist that are

integrated with our core operations system and data warehouse extending the functional capabilities of our platform.

Surround applications are an integrated component of our MIS and support the overall functionality of Medicaid managed care, such as provider profiling, EPSDT, HEDIS, member ID cards, PCP assignment, credentialing, and imaging and workflow.

Each component of our MIS exchanges data needed to coordinate functions across our entire operations, with the frequency needed to support the business function. The timing of these exchanges is designed to preserve consistency of information across systems. Components of our MIS are integrated and interoperate where they need to, but are adequately independent to provide the specialized functionality required.

Maintaining currency of data across our systems is of key importance to our system operations. As the sole integrators of our MIS, our TS Department maintains a thorough understanding of the method and timing of data exchanges and the data dependencies between processes. If business needs change and more current data is needed for a process (for example, nightly rather than weekly), we are agile enough to analyze the situation and quickly implement the necessary changes.

Consistent Data Element Names, Formats and Maintenance Across Systems

Amerigroup maintains consistent naming standards across all of our systems. As part of the design and development of the data warehouse, database naming standards were defined, utilized, and published for use in future development. Running directly off the core operations system or off the DW are a number of surround applications that extend our functional capabilities. Whether these applications are custom developed internally or internally integrated third-party applications, our database naming standards are employed to allow for standardization of data element naming, formatting, and validation.

Data Exchanges – Method, Triggering and Frequency

Interoperability in the exchange of data between our systems is generally accomplished in one of three ways:

- **Web Services based interfaces mainly for real-time integration.** Asynchronous interfaces exist between all of our core systems. We are currently processing 7mm transactions per month between environments. SOAP/Web Services are used for smaller transactions where large batch file processes would be too cumbersome, inefficient and slow. For instance, single member eligibility lookup can be accommodated in real time rather than awaiting a file upload, processing and validation of the file and then sending back a response file
- **Batch file based interfaces utilizing ETL (Extract/Transform/Load) tools.** Interfaces used to move data from our core systems to a reporting or data warehouse environment often use ETL. These interfaces are typically batch based interfaces that run on a scheduled frequency based on business requirements (for example, Daily, Weekly, Monthly). Job control and scheduling for these interfaces is managed by our enterprise scheduling software. Interfaces are built using industry standard tools designed for moving and integrating large volumes of data quickly. These ETL tools allow for Metadata management and code re-use within the development process to ensure consistency of data-length, data types and data format across systems

- **Storage system based data snapshots or Replication.** These interfaces are mainly storage system or database system replication based interfaces that are utilized to maintain a secondary online or near line copy of a production system for High Availability or disaster recovery

Our data exchanges between key production systems fall into two main categories: third party integrations and custom built. For third party integrations, we rely on vendors to provide the integration between purchased products. Examples of these interfaces include core operations system to prospective payment system, core operations system to care management system, and core operations system to clinical editing software. These interfaces are typically real-time and web services based.

We use custom built interfaces where our core systems have pre-built Application Program Interfaces (APIs) and extensibility. These interfaces allow us to develop specific functionality to meet business needs where the requirements are not met by standard system functionality.

The frequency and trigger of critical data exchanges among our key system components is shown in Table R-4.

Table R-4. Data Exchange Schedule and Trigger Method

Information / Data	From	To	Method	Frequency	Trigger
Member, Provider, Claim, Authorization	Core Operations System	Care Management System	ETL	Nightly	Automated - Timed
Disease and Case Management	Care Management System	Core Operations System	ETL	Nightly and Real-Time	Automated - Timed
Member, Provider, Claim, Authorization	Core Operations System	Data Warehouse	ETL	Nightly\ Weekly\ Monthly	Automated - Timed
Member, Provider, Claim, Authorization	Core Operations System	Web Portals/IVR	Web Services	Real-Time	Automated
Member, Provider, Claim	Core Operations System	Imaging and Workflow System	ETL	Nightly	Automated - Completion of Batch Adjudication
Member, Provider, Claim, Authorization	Compass (Call Center)	Core Operations System	Web Services	Real-Time	Automated

Required Diagrams

As requested, we have provided a number of diagrams depicting networking, information flows and internal controls within our technology platform. These diagrams should provide insight into how our systems are organized and how they will interact with DHH systems for the purposes of exchanging information and automating and facilitating specific functions associated with the Louisiana program.

The following diagrams are included:

- **Point to Point Interfaces.** Figure R-4, MIS Integrated Systems – Point to Point Interfaces depicts the interfaces between the components of our integrated MIS
- **Information Flow Diagrams.** We have included a number of diagrams to show the processing and information flow of major processes:
 - Figure R-5, Information Flow – Amerigroup MIS, presents the overall flow of information between our systems, members, providers, and DHH
 - Figure R-6, Information Flow – Enrollment, presents the data and process flow associated with processing the 834 transactions from the Enrollment Broker
 - Figure R-7, Information Flow – Claims, presents the data and process flow associated with the processing of both paper and electronic claims
 - Figure R-8, Information Flow – Encounters, presents the data and process flow associated with the creation and transmission of Encounters to the DHH FI
 - Figure R-9, Information Flow – Audit Trails, present the data and process flow associated with the audit trails created when records are changed
- **Internal Control Diagrams.** We have included a number of diagrams depicting internal controls that exist throughout our systems:
 - Figure R-10, Internal Control – Business Continuity & Disaster Recovery, depicts the configuration of servers and entities that support our BC-DR plan
 - Figure R-11, Internal Control – Software Change Management, shows the process for implementing software changes
 - Figure R-12, Internal Control – Code Set Update, presents the process for approving and coordinating code set updates across the MIS
- **Network Arrangement and Communications Diagrams.**
 - Figure R-13, Amerigroup Internet Connectivity Diagram, depicts the connection type and speed between Amerigroup and the Internet
 - Figure R-14, High Level Network Diagram, depicts the networking arrangement between our locations

We have additional, more detailed diagrams available, but they are very large and could not effectively be submitted in the 8.5x11 format of the proposal. Copies of these diagrams can be provided to DHH upon request. Available diagrams include:

- Detailed network diagram of our major sites, which includes all Virginia Beach operational facilities as well as the National Contact Center sites and the Dallas backup data center/disaster recovery site
- Detailed network diagram of all of our health plan sites, including the planned Louisiana site
- Detailed telecommunications

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Figure R-6. Information Flow – Enrollment

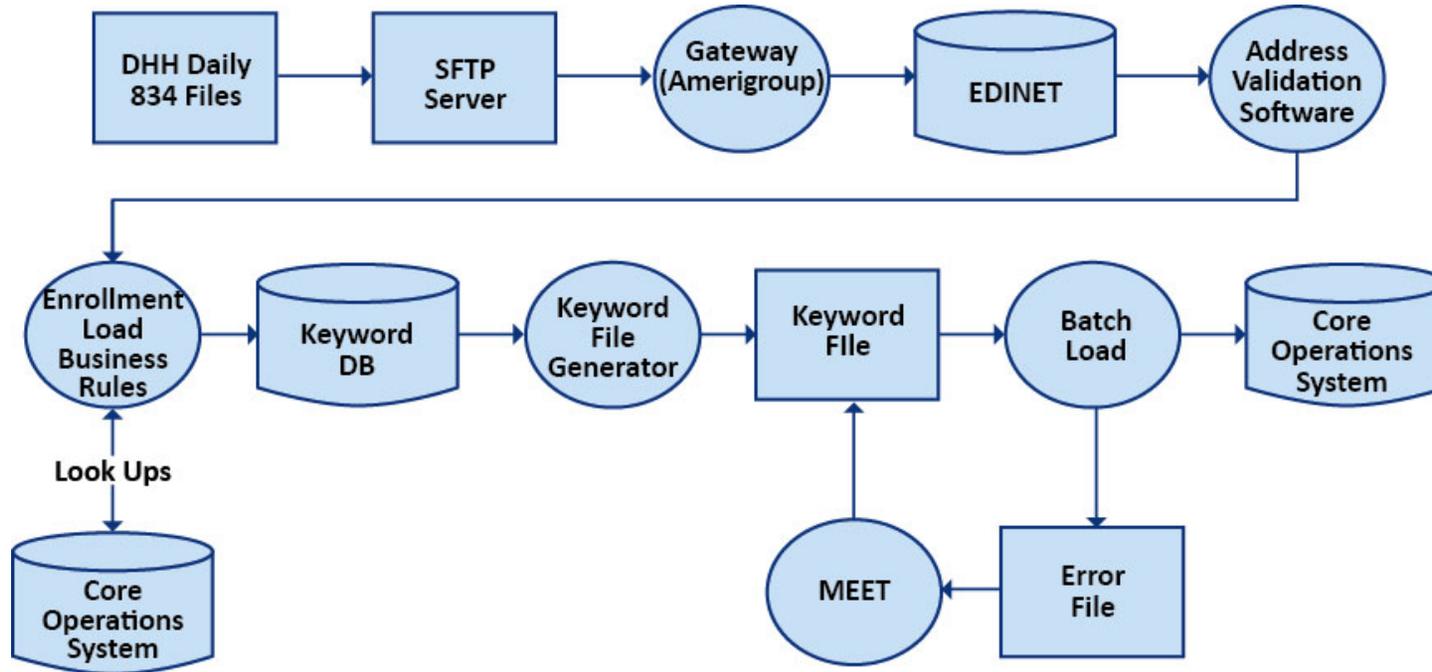


Figure R-7. Information Flow – Claims

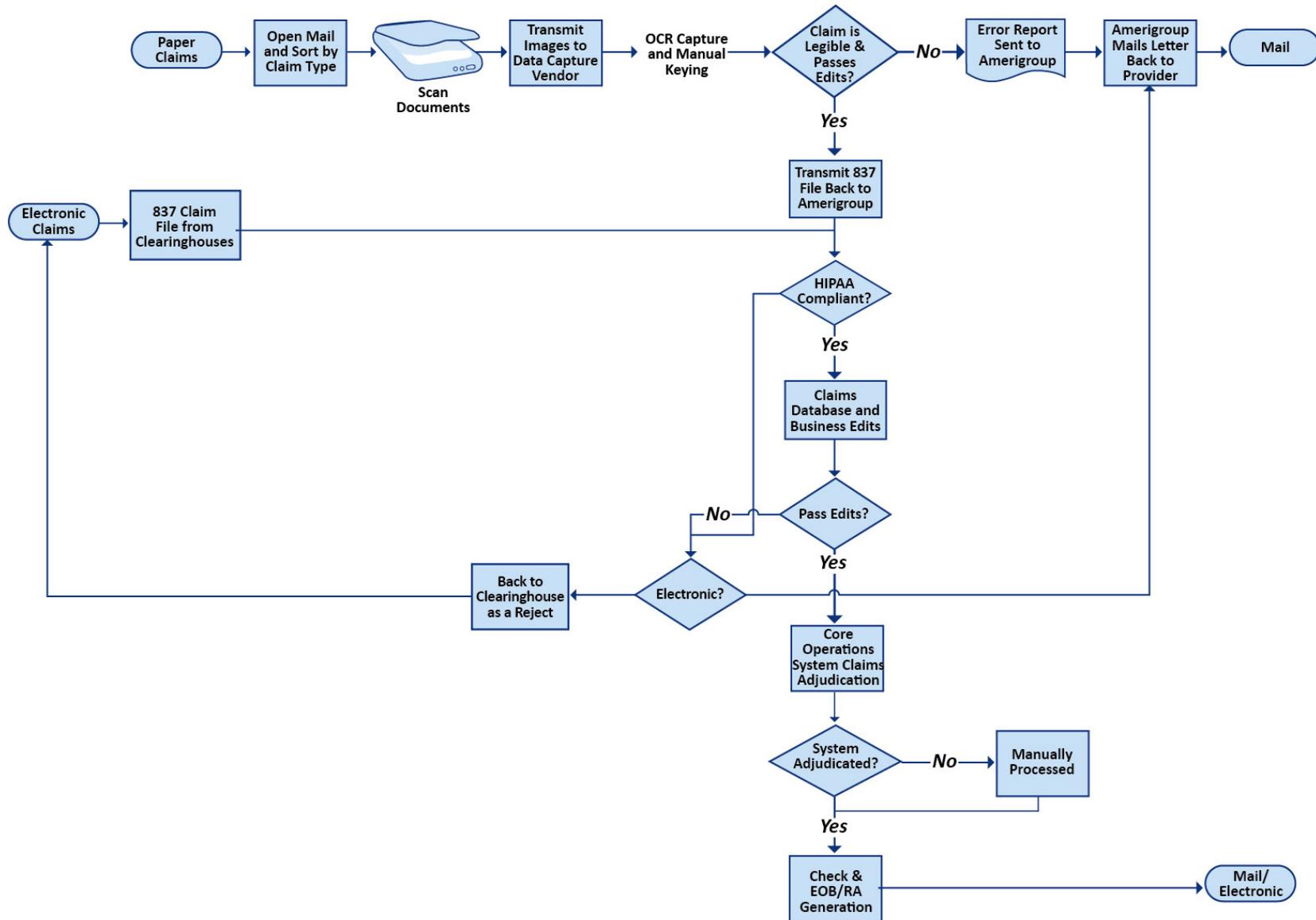


Figure R-8. Information Flow – Encounters

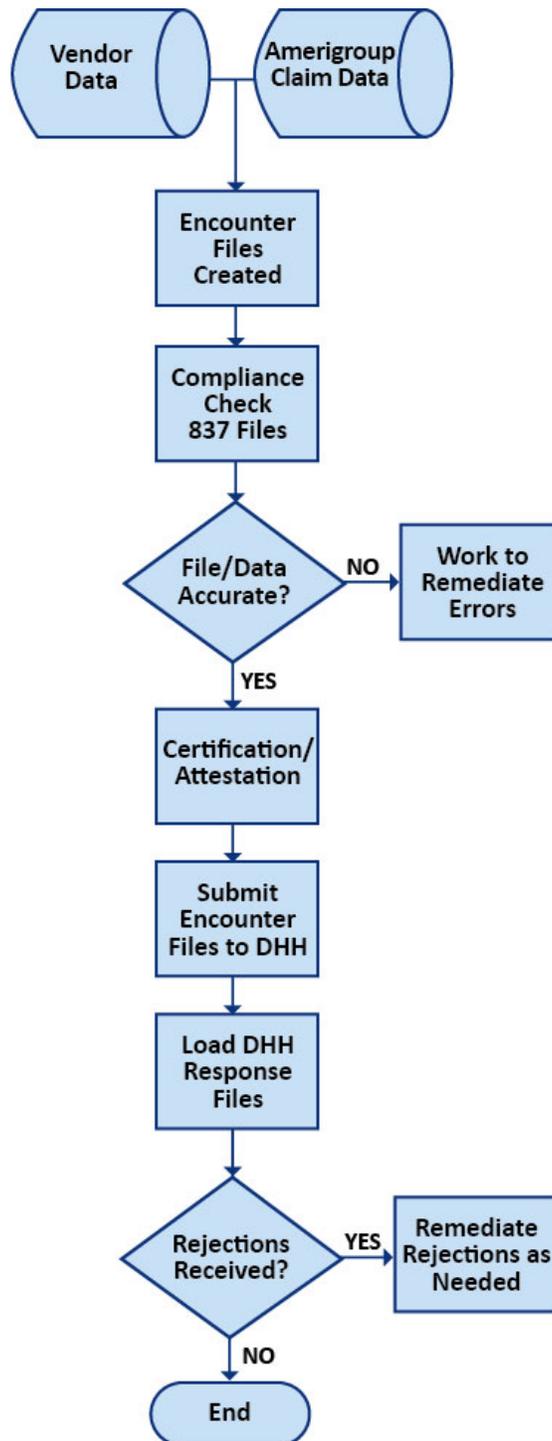
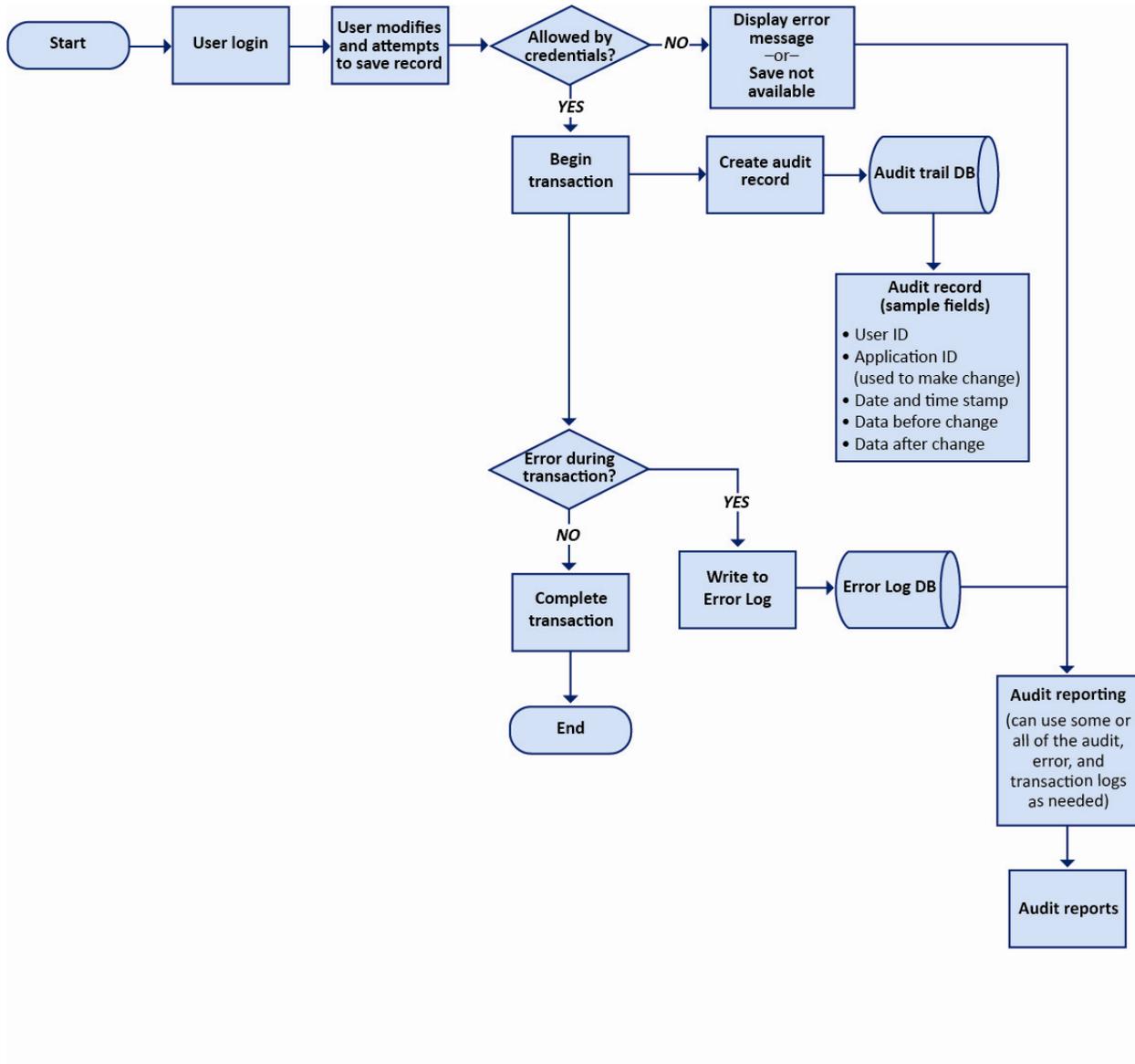


Figure R-9. Information Flow – Audit Trails



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Figure R-11. Internal Control – Software Change Management

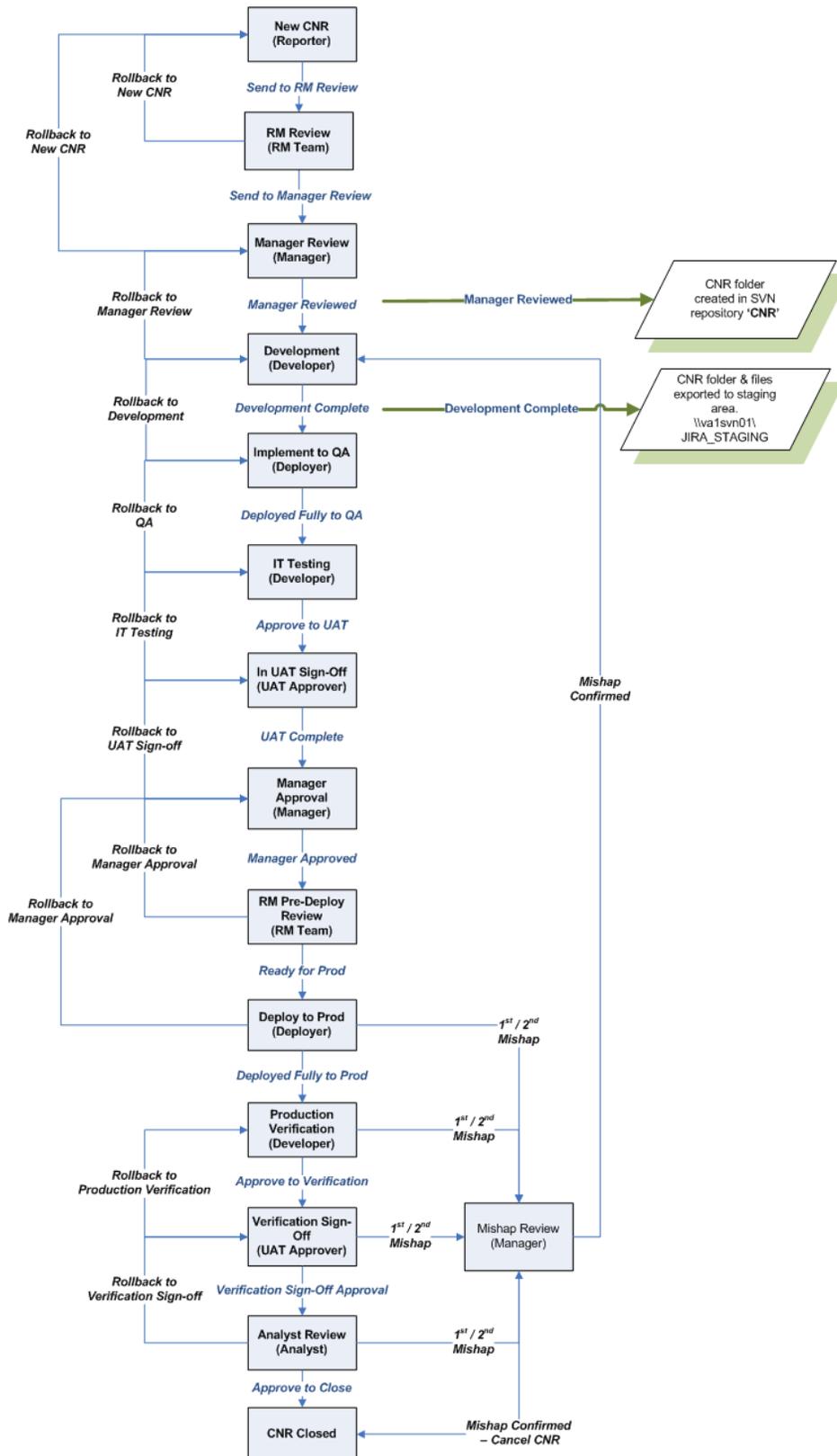


Figure R-12. Internal Control – Code Set Update

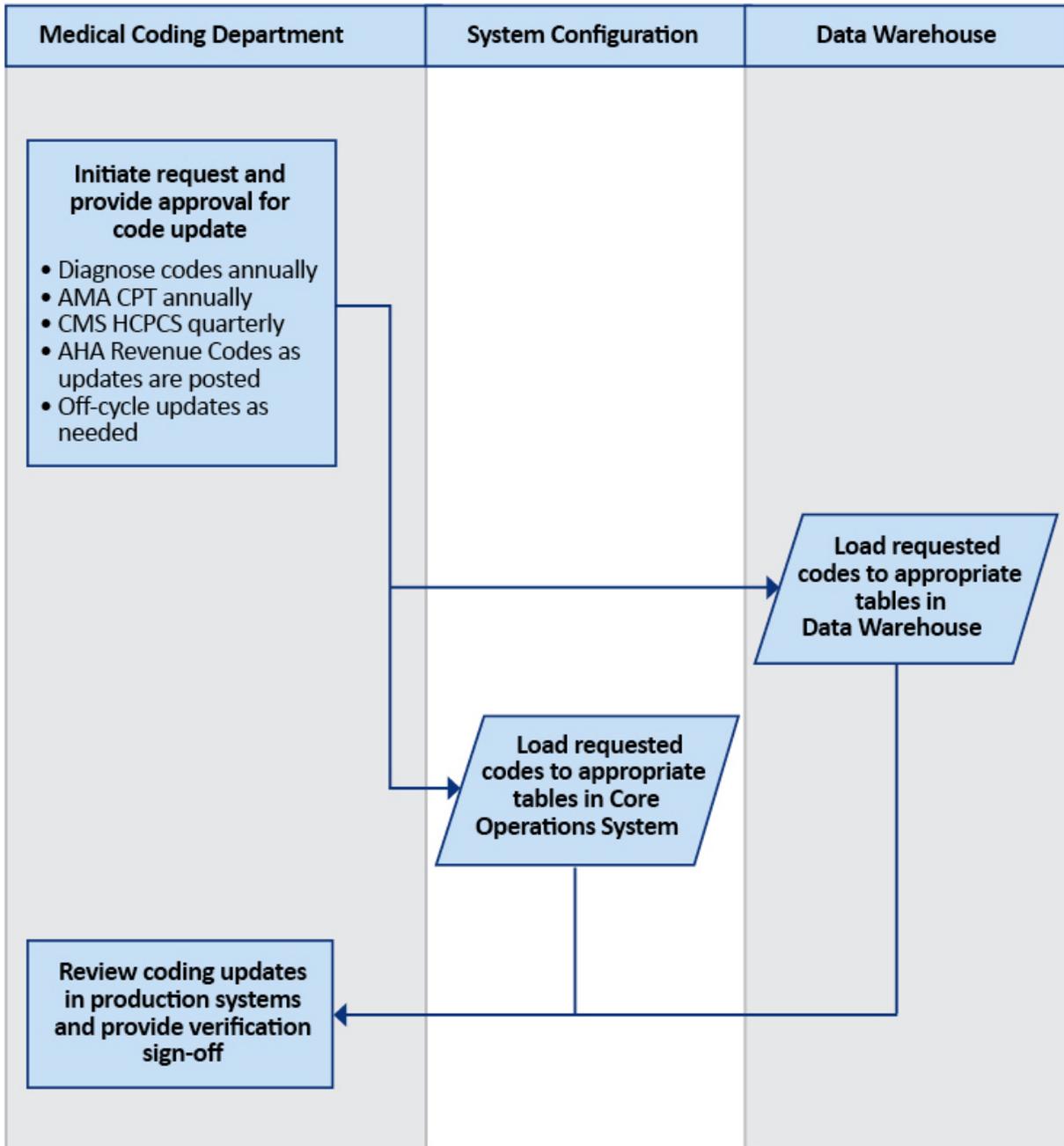
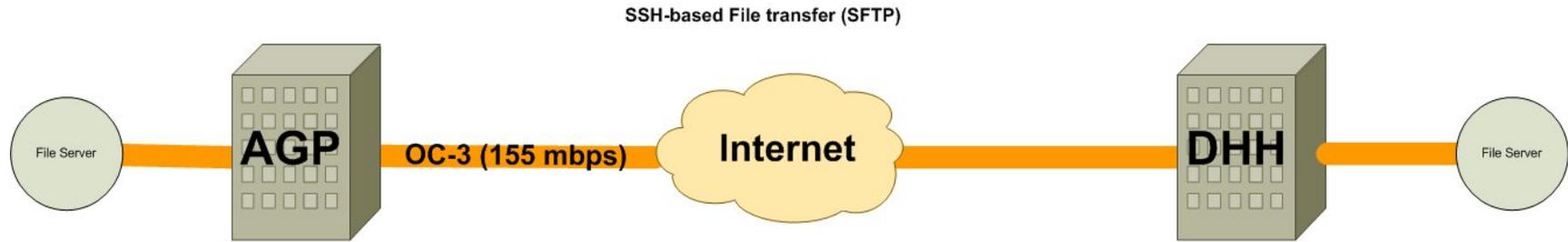


Figure R-13. Amerigroup Internet Connectivity Diagram



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R.5 Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.*
- *If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*
- *Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.*

Meeting and Exceeding Encounter Data Requirements

After careful review of the Louisiana RFP, specifically Section 17.5.4. Encounter Data, **we are confident in our ability to meet and exceed the requirements for Encounter Data with our existing MIS, policies and procedures.** We currently provide encounter data to all of our state partners in either an x12 standard or the state’s proprietary format, according to state requirements. Amerigroup is committed to complying with DHH’s needs for encounter submission.

Exchanging Encounter Data with the DHH Fiscal Intermediary

Amerigroup has experience with multiple transmission standards and working with a state designated fiscal intermediary. Many of our current state partners request that we transmit the encounter data to an intermediary instead of directly to the state, so we have experience in building confident working partnerships with state designees.

We understand the importance of transmitting and receiving encounter data accurately, securely, efficiently, and in accordance with the state’s schedule. Most of our encounter submissions are transmitted utilizing HTTPS or secure FTP and we are confident in using both methods. We currently receive and transmit encounter data in the ANSI X12 837 format as well as client specific formats and will customize our encounter extract in accordance with the specific requirements of the Louisiana CCN-P as specified in the requirements and the Systems Companion Guide.

Understanding the claims data elements required for DHH encounters is an important step of the implementation process. We will carefully review available documentation, including DHH provider billing manuals, and work closely with DHH and FI employees as necessary to create encounter files that are compatible with DHH and FI billing requirements.

We will submit encounter data to the FI within 60 days of operation in the 837 I and 837 P provider-to-payer-to-payer COB formats. As part of our implementation, we will certify HIPAA transaction readiness through EDIFECs, prior to submission.

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 CCN-P Systems Companion guides. Our HIPAA gateway is used to verify that the electronic files we receive are compliant with the standard HIPAA transaction standards and code sets. We will generate HIPAA-compliant files for transmission to DHH, specifically the ANSI X12N 837 provider-to-payer-to-payer COB transaction formats for Professional and Institutional claims.

We edit against standard code sets including HCPCS, ICD-9, CPT, revenue, CDT/ADA, and NDC codes. In addition, we maintain and utilize HCPCS Level II and Category II CPT codes, allowing both Amerigroup and DHH to evaluate performance measures. Code edits are applied in our core operations system for all medical claims we process, in the systems of our delegated vendors, and to the encounter data loaded into our data warehouse from delegated vendors.

We maintain our code sets, updating regularly, and are able to manage the codes with effective dates so they can be applied to claims appropriately based on date of service. Code set updates are a collaborative effort between our Medical Coding Group, system configuration team, and the data warehouse managers. Updates to code sets are initiated by our Medical Coding Group. Upon receipt, system configuration loads the code sets into the core operations system while the data warehouse manager loads the code sets into the warehouse. Efforts are coordinated so that transaction data reference the correct code sets in both environments. Once completed, Medical Coding employees inspect the loaded code sets and provide approval.

Accuracy of Encounter Data

We ensure accuracy by applying edits to all incoming claim records, regardless of whether they originate on paper, are entered through our web site, or transmitted via EDI. Only claims that pass compliance checks and all front-end edits are loaded into our core operations system, which will eventually become the source for encounters. Once adjudicated and paid, claims are ready to process and submit as encounters in HIPAA standard 837 I and 837 P formats for transmission to DHH. Records failing established edits are flagged by our EMS for our Encounters Management team to review and correct. Corrections are coordinated with the appropriate operational unit. We commit to the electronic submission of accurate, complete and timely encounter records to DHH according to the required procedures and formats.

We use automated routines to extract data for transmission to DHH. Prior to releasing the encounter files, our procedure is to conduct independent validation reviews and review a random selection of records in each file for accuracy and completeness. Once it passes the validation review, we will transmit the encounter file to the DHH FI.

We understand that the FI will apply edits to the encounter submission to identify valid and invalid encounter records. In cases where the DHH FI finds it appropriate to return records to us for research and resolution, we will act quickly to research and resolve encounter data issues. We are able to comply with the requirement of correcting 90 percent of repairable errors in 30 days and 99 percent of repairable errors in 60 days, as specified in the RFP.

Completeness of Submission

Amerigroup will submit a single 837P and a single 837I encounter file to the DHH Fiscal Intermediary that contains all encounter data, according to DHH requirements, regardless of source of claim or type of provider. We believe strongly in our responsibility to collect encounter data from our delegated vendors and include it in our overall encounters submission. We contractually require our vendors to submit the data to us on a schedule that enables us to incorporate it into our encounter submission files and meet the state specified schedule.

We contract 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. 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 who fail to consistently submit complete encounter data.

We also contract with delegated vendors for services such as vision and transportation. When possible, we contract with vendors with whom we have relationships in other health plans and have already established reliable encounter data submission and monitoring processes. Moreover, contractual language holds delegated vendors accountable for the submission of encounter data, along with penalties for non-compliance. As noted above, vendor encounter data are imported, subject to edits, and incorporated into our overall claims history data for submission as encounters.

Oversight for our delegated vendors is provided through our Vendor Selection and Oversight Committee (VSOC). VSOC is comprised of representatives from the following corporate departments: Health Care Delivery Systems, Finance, Quality Management, Senior and Special Services Organization, Office of Business Ethics, Health Care Management Services, and Legal. Additional departments are included as needed.

Amerigroup will meet specific DHH requirements for complete encounter data:

- **Encounter Denial Codes.** We are able to track and report our denied claims to the groupings specified in the CCN-P Systems Companion Guide and the RFP
- **Repairable Denials.** We have employees and processes to address the repairable denials for resubmission according to DHH requirements and timeframes
- **Contractor Encounter Data.** We employ formal processes to ensure that all data provided by our contractors is scrutinized for accuracy and validity prior to loading into the data warehouse. By loading the data into the data warehouse, we can submit all encounter information to the DHH in the required single file formats of 837I and 837P. We provide a feedback loop to our contractors in case there are errors

REAL SOLUTIONS *mean* REAL RESULTS

Amerigroup, through our Vendor Selection and Oversight Committee (VSOC), retains oversight of the delegated services performed on its behalf and all risk or gain share arrangements. VSOC oversight ensures compliance with state, federal, NCQA, and any other applicable regulatory and accreditation standards.

- **Settled and Adjusted Claims.** Encounter information sent to DHH will also include settled and adjusted claims processed in our core operations system. These claims will be stored in the data warehouse and transmitted to DHH along with our normal encounter file submission
- **Capitation Arrangements.** Amerigroup has experience supporting capitated reimbursement arrangements with various types of providers including PCPs, specialists, physician/hospital organizations and laboratories. We recognize that to best manage a patient’s care, information is needed for all services rendered by a provider, therefore, we contractually require all encounter data to be submitted when a capitation arrangement is implemented
- **Adherence to Federal and/or DHH Payment Rules.** We will follow all federal and DHH payment rules, as defined in the RFP, in the treatment of certain data elements, including units of service, to ensure accurate and complete encounter data submissions

Timeliness

We acknowledge and will meet the DHH requirements related to complete, accurate and timely submission of encounter data, including:

- Submitting complete and accurate encounter data within 60 days of beginning operation in a geographic area
- Submitting 95 percent of our encounter data at least monthly by the 25th calendar day of the month
- Having the Louisiana health plan CEO or CFO attest to the truthfulness, accuracy, and completeness of the encounter data
- Addressing any issues that prevent processing of an encounter according to negotiated timeframes with DHH, or the following standards:
 - 90 percent of reported repairable errors addressed within 30 calendar days
 - 99 percent of reported repairable errors addressed within 60 days

Three Currently Live Instances for Encounter Data

Amerigroup is compliant with the Louisiana submission requirements as stated in the RFP. Across our markets we meet or exceed the submission of 95 percent of our encounters at least monthly and of those submissions, across the markets requiring reported repairable errors to be addressed within 30 calendar days or less, we are averaging over 98 percent of reportable errors addressed within 30 days. We also work in collaboration with our state partners to identify solutions to prevent or minimize the error reasons where possible.

All of our markets have requirements, including coding, data exchange format, transmission standards, and specifications, similar to those specified by DHH. Markets closest to overall DHH requirements are Tennessee, Texas, and Georgia. Our Tennessee and Georgia references, found in our response to question B.27, can attest to Amerigroup’s success in meeting encounter submission requirements. We exchange encounters with each of these states in the HIPAA X12 837 I and P formats and transmit the encounters over secure FTP.

In each of these markets, our providers are primarily compensated fee-for-service, but we do have capitated providers. We receive zero-pay claims from these capitated providers and process them through our core operations system. They flow into our encounters management system and are part of the overall encounters submissions and edits just like any other claim.

For these three markets, and with all of our markets, we use standard codes compliant with the HIPAA Code Sets regulation. We account for state specific processing rules according to state provider billing manuals and other documents, both at the point of claims intake and processing, as well as encounters processing. State specific processing rules include handling denials, correction of repairable errors, and adjustments.

With our years of Medicaid experience and specifically encounters processing and submission experience, we are cognizant that it takes complete claim data to create a successful encounter; much more so than to pay a claim in a commercial market. We are compliant with data certification requirements in each of these three markets, as we are in all markets requiring certification.

Specific submission and compliance metrics from the three markets include:

- In Texas, we submit more than 99 percent of our encounter data in 30 days and the dollar value of our accepted encounters reconciles to the fiscal statistical report (FSR) more than 98 percent quarterly since the second quarter of 2010, which meets and exceeds the contractual requirement of 98 percent
- In Tennessee, since October of 2010 we have been 100 percent compliant with the repairable standard of 90 percent in 30 days
- In Georgia, we submit 100 percent of critical data elements as per the contract specification

Meeting Requirements

Amerigroup has the infrastructure, experience and past performance necessary to meet all encounter data gathering and reporting requirements presented in the RFP. With our extensive knowledge and experience with the 837 I, 837 P and the detailed information provided in the DHH CCN-P Systems Companion Guide, **Amerigroup is confident that we will be able to submit accurate and complete encounter data to DHH within 60 days of operation in a geographic area.**

Lessons Learned

We often reflect on lessons learned through the implementation of encounters with other state clients. We have learned that it is critical to carefully review the state companion guides and the state-specific values when preparing the 837 submissions. While we have significant experience implementing the 837 standards for encounters with various states where we do business, there are often some market nuances that must be taken into account. During requirements analysis, it is critical to map edits between the state system and our MIS to fully understand the methods used to validate submitted encounter records. During encounter testing, careful review of denied encounter records is critical to ensuring future compliance with submission requirements. Additional focus during the implementation phase will help with the transition to production operations.

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R.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Sections 16 and 17, and CCN-P Systems Companion Guide. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.*
- *If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*
- *Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.*

Amerigroup Data Exchange Capability

Secure ongoing data interfaces are a strength and core competency of Amerigroup’s Technology Services Department. We have 15 years of experience exchanging data with our delegated vendors and states and their agents, including enrollment brokers, fiscal intermediaries, external quality review organizations, recovery audit contractors, and others. With our current systems capabilities, we are able to meet the DHH data exchange requirements.

The TS Department is experienced in establishing the appropriate protocols for connectivity to and from MMIS vendors, enrollment brokers, other state third-party contractors, clearinghouses, community organizations and state agencies. The TS Department develops solutions to foster interoperability and conformance to generally accepted open systems architectural standards when working with customers. Additionally, both professional and institutional providers are encouraged to submit claims electronically either through our web site or a clearinghouse.

Currently we support interfaces in the HIPAA standard x12, HL7, NCPDP, as well as many state specific formats. We exchange data in the 4010 x12 834, 837 I, P, and D, 835, 820, 824, 277U, 271U, 270/271, and 997 formats. Through our 5010 corporate project, we will be compliant with the 5010 standard for all of these transactions and the NCPDP D.0 by the compliance date of January 1, 2012. We also have the capability to exchange the 276/277 and 278 transactions. Additionally, we have a corporate project underway to meet the ICD-10 compliance date of October 1, 2013.

In all data exchanges, Amerigroup applies comprehensive system and process checks to monitor the data integration and confirm that data is successfully imported and exported. TS employees monitor all data interfaces, address any transmission or data errors and confirm successful processing. When establishing new data interfaces, we collaborate with the external entity to identify detailed data transmission requirements and thoroughly test the interface in a simulated environment prior to launch.

Eligibility/Enrollment Data Exchange

Amerigroup currently supports automated processing of HIPAA compliant X12 834 enrollment data on a daily, weekly, and monthly basis according to the timelines designated by our state partners. We receive daily enrollment/eligibility files from eight of our state partners and have an established 24 hour turn-around time for processing these files, matching the DHH requirement of loading enrollment data within 24 hours of receipt. Recognizing that the enrollment process depends on the timely availability of accurate member data, we leverage technology to streamline the data exchange processes while facilitating transaction tracking and reporting.

Scheduled secure FTP downloads across secure connections such as VPN are established with the state or its Enrollment Broker to enable timely receipt of daily, weekly, and monthly enrollment files. After passing state specific data edits and business rule validations, the enrollment process creates and/or updates member records in the core operations system using information received on the inbound file(s).

Our core operations system is the system of record for all member enrollment and eligibility information, providing a fully integrated database that supports functions such as member reporting, claims processing, PCP assignment and utilization management. Our enrollment load processes are structured to achieve optimal processing time and accuracy. Individual records with problems are pended so that complete records can be loaded. Pended records are reviewed and where possible, modified and triggered for processing. When the issue cannot be immediately resolved, the Enrollment Analyst works with state-provided sources, systems and staff, to obtain the missing information necessary to process the enrollment record. At various check points during the enrollment process, reports are generated to balance records processed and identify any member errors that need to be corrected and reprocessed to accomplish a complete load into the system.

Amerigroup has incorporated numerous technology efficiencies which facilitate timely access to member data as well as attainment of State service level agreements. Rather than re-loading every record within the entire 834 enrollment file, we process only member data that has been changed or added since the last file processed. This reduces the number of transactions and time to process by over 80 percent. An automated job scheduler is used to initiate the member enrollment process according to a predetermined schedule, reducing human intervention and tracking successful completion of the process. Use of an integrated error reprocessing system streamlines the correction of any issues which cause a record to pend before completing initial processing. This reprocessing system accounts for all records pended during the load and enables them to be processed in accordance with state mandated timelines.

Member Mailings and Transmitting Member Changes

Following enrollment updates to the core operations system, additional processes are run to assign PCPs and generate ID cards and mailings for new member Welcome Packages so both IDs and Welcome Packages are received by members in a timely manner.

Amerigroup is able to meet the requirement of transmitting member address changes and telephone number changes to DHH in DHH's specified format. We do this today with several state partners in the 834 X12 format and with several others in proprietary/report formats. These transmissions can be performed as frequently as daily or on a schedule specified by DHH.

Unique Member IDs Across Systems

Amerigroup assigns each member a unique number that allows us to track and manage the member throughout all systems within our span of control, including our relationship with delegated vendors. This number stays with the member even as a member changes eligibility categories and products. Variation in the member's eligibility category and product eligibility are managed through uniquely dated eligibility spans within the core operations system. In addition to tracking a member by this specific number, Amerigroup also maintains the state's assigned Medicaid ID for a member, the member's social security number, and the member's Medicare number, if one exists. Amerigroup is also able to track family relationship information if this is provided in the enrollment data, which allows us to link family members together.

Identification of Duplicate Member Records

During the automated load process, we compare several data elements, such as name, address, date of birth and social security number, to identify potential duplicates for the Enrollment Operations Analyst to review and correct. These records are pended for review prior to loading, thereby avoiding the creation of most duplicates. The Enrollment Operations Analyst works with our state partners to make a final determination regarding the disposition of identified records and updates the member data as directed by the state. A secondary check for duplicate member records is performed as part of a weekly enrollment data review. Any duplicates identified as part of this review are resolved by merging the member records when claims history is not present for both member IDs. If claims history is present for both member IDs, a link between them is added instead.

Provider Enrollment

Coordinating codes between DHH and Amerigroup systems is important and we are able to utilize Louisiana Medicaid provider types, specialty and sub-specialty codes to support communication with DHH.

Capturing and Maintaining Comprehensive Provider Data

Provider configuration data, including provider name, address, NPI, taxonomy, payment information, and relevant provider ownership information, is collected as part of our application and credentialing process and entered into our core operations system by our Provider Data Management team for each new provider added to Amerigroup's network. This data is revised and updated as needed, triggered by provider notifications and ongoing daily operational processes. Individual provider group affiliations are also maintained, along with office hours and provider languages spoken. This information is published in both printed and online provider directories to assist members in locating and selecting an appropriate provider.

Current credentialing status is monitored and updated in the system by our Credentialing and Provider Data Management (PDM) departments. Our system captures license numbers and expiration dates and we are currently proactively alerting providers about license expiration in a number of markets and will provide this functionality to DHH. We conduct ongoing sanction monitoring to identify state mandated exclusions and compare them to our current network. We are also currently interfacing electronically with medical boards that have this capability.

Maintaining Audit Trails of Data Changes

As with all data modifications made in our core operations system, whenever a change is made to provider information, a history of the update transaction is automatically created that includes the time and source of the change. Audit trail data through our core operations system is available for inquiry and reporting. Audit trail data will be maintained online for not less than 6 years and once archived, will be available for recovery in 48 hours or less for not less than 4 years. Please see our response to R.16 for additional detail regarding audit trail capabilities.

Encounter Data Exchange

As detailed in Section R.5 of this response, Amerigroup has a well thought out and executed encounter data management process to accommodate the collection of required data elements and attain compliance with the DHH required formats, 837I and 837P, for reporting all services delivered to members. We understand DHH's need for complete, accurate, and timely encounters submissions.

Amerigroup has an integrated encounters management system (EMS) for the extraction, tracking, correction, reporting and archiving of all encounter data, including service data from delegated vendors/subcontractors such as vision and non-emergent transportation. Data selection criteria and reporting periods will be built according to DHH specific requirements. We currently submit monthly encounter files, a requirement in many of our existing markets. Due to the robust design of our EMS, we are able to quickly adapt to a change in the Encounter Data Transaction requirements within the timeframes required by DHH. Any change in Encounter Data Transaction requirements would follow the systems change management procedures in our systems development methodology and include analysis and modification of format, business rule and data validation components. Any changes would be coordinated with our delegated vendors/subcontractors as well.

Three Currently Live Instances of Eligibility/Enrollment Data Processing

Amerigroup is currently successfully receiving, processing, and updating eligibility/enrollment data in accordance with the requirements of eleven states. Among others, our implementations in the following three states have requirements similar to Louisiana:

- Florida
- Tennessee
- Georgia

Almost every state sends enrollment/eligibility files in the 834 X12 standard and Amerigroup successfully processes the 834 file, adapting our systems for any market nuances. Amerigroup has established a well-designed and thoroughly tested enrollment requirements analysis, development and testing process which will facilitate a successful implementation for the Louisiana Medicaid CCN program.

Amerigroup's eligibility/enrollment file load process is engineered to meet each state's processing and timeline requirements and currently accommodates 24-hour turnaround requirements for daily files in all markets. In each market the eligibility/enrollment file load processes all viable records and pends those requiring manual intervention so the overall process timeline is not impacted. The Amerigroup Enrollment team manually reviews pended records and is able to correct many data issues, such as

missing gender, and work with our state partners to promptly resolve other issues. Once pending records are fixed, they are released for processing to complete the load process. We work issues in consultation with our state partners so the member can receive access to care while outstanding issues are resolved.

Amerigroup produces a daily 834 file for submission to several state partners, including Tennessee and Georgia, which contains address and phone numbers changed since the previous submission. In Florida, we also send an 834 for long term care enrollment/disenrollment. In each instance, these files meet HIPAA and state companion guide requirements.

Ability to Meet DHH Requirements

Amerigroup has the systems, infrastructure, people, and experience necessary to meet all DHH data exchange requirements.

Challenges and Lessons Learned

Amerigroup operates on a principle of continuous improvement. A “we’ve always done it this way” attitude is not acceptable and employees throughout the organization are focused on learning from every situation and applying lessons learned. Throughout multiple successful implementations, Amerigroup has been able to fine-tune our eligibility/enrollment systems and processes with best practices and lessons learned to enable us to deliver the best results to our state partners.

One important best practice we have adopted is that all data provided on the inbound 834 file is valuable and should be stored in its entirety and leveraged to support member transition wherever possible. There are also several data points we have found to be particularly valuable, such as family link and Medicaid eligibility redetermination date, and we will request this information if not already part of the standard file specification or companion guide. We have confirmed with DHH that this data is available.

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R.7 Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

Ability to Meet or Exceed DHH Requirements

DHH has provided a comprehensive set of Information Systems requirements for the Louisiana CCN Program, along with a detailed set of response questions. After careful review of provided materials, Amerigroup is confident the ability of our current Management Information System to meet, and often exceed, DHH requirements. Throughout Section R of the Technical Proposal, we have taken care to provide a complete discussion of Amerigroup capabilities in response to each question, while at the same time addressing specific requirements in the RFP.

The ability of Amerigroup to meet many of the requirements listed in Section 16 of the RFP is detailed in other areas of our Section R response. In the paragraphs below, we provide a high level summary of our ability to meet, or exceed, DHH requirements, along with a “road map” to where additional detail around our capabilities is presented in other subsections of our Section R response.

16.1. General Requirements

Amerigroup has an existing MIS that meets the functional and technical requirements of DHH and complies with DHH and federal reporting requirements. Our MIS uses relational database management systems, Oracle and MS SQL Server, and other industry standard technologies for data query (structured query language and tools) and connectors, including ODBC and OLE. Our systems have sufficient capacity to handle the DHH workload and are able to interoperate with DHH systems.

Please see our response to R.1 for more detailed information on Amerigroup’s ability to meet these requirements.

16.2. HIPAA Standards and Code Sets

We are currently transmitting, receiving and processing data in current HIPAA compliant formats using secure FTP over a secure connection, including VPN. We use an industry-standard HIPAA compliance checker and currently exchange, or have the ability to exchange, all transaction types listed in Section 16.2.3 of the RFP. We will continue to comply with changes to any applicable federal and HIPAA standards and regulations, and will adhere to other standards developed jointly with DHH.

Please see our response to R.6 for more detailed information on Amerigroup’s ability to meet these requirements.

16.3. Connectivity

In accordance with U.S. Postal Service conventions, we use a standard postal software package to correct and standardize mailing addresses for all system mailings. We recognize the importance of mail reaching its audience, the need to reduce returned mail and the cost of mailing. The software formats all addresses with ZIP +4 and sorts mail by ZIP Code for increased efficiency.

Amerigroup understands that DHH information under this contract is owned by DHH and that we require written permission from DHH to share or publish information.

We acknowledge that we are responsible for all initial and recurring costs required to access DHH systems. If DHH contracts with a new FI during the Contract, we will comply with transitional requirements as necessary.

Please refer to Table R-5 for a description of our ability to meet remaining requirements in 16.3 and the area of our response where more detailed information can be found.

Table R-5. Ability to Meet Connectivity Requirements

Amerigroup Capability	Response Section with Detailed Information
Amerigroup will interface with DHH, the FI, and the EB for the exchange of data. We will meet the data interface and connectivity requirements and we have the capability for real time connectivity to DHH approved systems.	R.6
We currently meet the DHH standards for data and document management.	R.1
When required, Amerigroup is committed to working with DHH to implement a secure, web-accessible health record for members and working on statewide efforts to create a health information exchange. We welcome the opportunity to participate with DHH on developing strategies that actively reinforce the health care reform initiative.	R.15
We will complete the DHH Information Systems Capabilities Assessment no later than 30 days from contract signing.	R.1
Amerigroup will supply employees with desktop workstation hardware and software that meets current DHH requirements. Offices are connected to a secure, protected network. Back-up processes ensure protect data.	R.3

16.4. Resource Availability and System Changes

Amerigroup meets the requirements of the Systems Help Desk through our internal Service Desk today, and will make these services available to DHH and its designees as the Systems Help Desk. We meet the systems documentation requirements through our SDLC and training processes and will comply with the notification requirements around changes to major/core systems.

Please see our responses to R.3 and R.8 for more detailed information on Amerigroup’s ability to meet these requirements.

16.5. Systems Refresh Plan

Amerigroup continuously reviews and assesses the need to modify, upgrade, or replace application software, system operating hardware and software, telecommunications infrastructure, information management policies and procedures, and systems management policies and procedures. We develop an annual Systems Refresh Plan and will make it available to DHH.

Please see our response to R.3 for more detailed information on Systems Refresh Plan.

16.6. Other Electronic Data Exchange

Amerigroup maintains an imaging and workflow system that uses OCR technology to capture images of documents for storage and retrieval. Documents are indexed to allow retrieval by key data elements like member identification number, provider identification number and claim identification number.

16.7. Electronic Messaging

Amerigroup maintains a fully functioning email system for communication within our company and with our state partners and their agents. The system is compatible with attaching and sending documents created in the DHH standard Microsoft Office software. We currently use VPN as a means of secure communication and can establish this capability with DHH as needed.

Please see our response to R.16 for information regarding our capability to send secure email.

16.8. Eligibility and Enrollment Data Exchange

Amerigroup currently supports automated processing of HIPAA compliant X12 834 enrollment data on a daily, weekly, and monthly basis according to the timelines designated by our state partners. We receive daily enrollment/eligibility files from eight of our state partners and have an established 24 hour turn-around time for processing these files, matching the DHH requirement of loading enrollment data within 24 hours of receipt. We are able to meet all DHH requirements for eligibility/enrollment processing.

Please see our response to R.6 for more detailed information on our capabilities and experience with eligibility and enrollment data exchanges.

16.9. Provider Enrollment

Our MIS allows for the capture and storage of all provider information listed in Section 16.9 of the RFP, and performance of all functional requirements. We are capable of generating letters to providers alerting them of nearing license expiration.

Please see our response to R.6 for more detailed information on our capabilities and experience with provider enrollment.

16.10. Information Systems Availability

Amerigroup makes our systems available to meet business processing requirements. For many systems, such as our core operations system and telecommunications infrastructure, availability is maintained 24/7, except during periods of scheduled maintenance. Our MIS and technology architecture is positioned to adapt to the distinct requirements of our state partners and the changing environment of Medicaid managed care, while maintaining the highest level of systems reliability and availability.

Please see our response to R.3 for more detailed information on the steps that Amerigroup takes to ensure the continued availability of our systems.

16.11. Contingency Plan

Amerigroup maintains a detailed Business Continuity-Disaster Recovery plan to protect our operations in the event of a disruption, whether minor or major. The BC-DR Plan represents a detailed blueprint of

our preparation for and planned response to any emergency, including a pandemic or natural disaster. It specifies the policies, procedures, and tools that it uses to assure successful continuity and recovery of business processes for all Amerigroup health plans.

Please see our response to R.3 to learn more about our Amerigroup's comprehensive BC-DR plan.

16.12. Off Site Storage and Remote Back-Up

Amerigroup employs a strategy of daily, weekly, monthly, and yearly backups to disk and/or tape with retention between 5 weeks and 10 years depending on the data type and back up frequency. Offsite backups are stored in a secure, offsite location with appropriate environmental controls and fire protection.

Please see our response to R.3 for more detailed information on Amerigroup back-up and off site storage capabilities.

16.13. Records Retention

Amerigroup is able to meet DHH requirements for record retention and the access to historical data for the type of information retained and the length of time that data is available online and via archive.

Please see our response to R.1 for more detailed information on our capabilities.

16.14. Information Security and Access Management

We employ multiple layers of security to protect access to our facilities, systems and data. Recognizing the need to share confidential data over the internet, via email or other tools, encryption technology is available to all employees and policies are in place surrounding its use. Amerigroup's comprehensive program meets DHH requirements in Section 16.14, Information Security and Access Management.

Please see our response to R.16 for more detailed information on our ability to meet DHH security requirements

16.15. Audit Requirements

Our MIS facilitates the auditing of individual and batch claims. Amerigroup maintains policy and procedures that will be made available to DHH upon request, and as required, adapted into an EDP Policy and Procedures manual.

Please see our response to R.2 for more detailed information on monitoring and auditing capabilities.

16.16. State Audit

We are accustomed to working with state auditors and providing them with files in a format and media compatible with their facilities.

Please see our response to R.2 for more detailed information on monitoring and auditing capabilities.

16.17. Independent Audit

Amerigroup currently performs annual SAS-70 and general controls and compliance audits on our systems, so we are able to comply with the DHH requirement for an independent audit. We are

comfortable with the requirement for an ongoing and annual audits commencing at the conclusion of the first 12 month operation period.

Please see our response to R.2 for more detailed information on monitoring and auditing capabilities.

Effort and Time to Meet Requirements

We are currently able to meet all requirements contained in Section 16 of the RFP. Implementation requires standard configuration and development activities typically performed during the implementation process.

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R.8 Describe your information systems change management and version control processes. In your description address your production control operations.

Systems Change Management

Systems changes are inevitable, whether necessary to correct a problem or to conform to future federal or DHH standards. At Amerigroup, the Change Management (CM) function is responsible for managing and coordinating change requests and releases to the production environment. This includes infrastructure, network, system components, protocols, configurations, hardware, and software related changes.

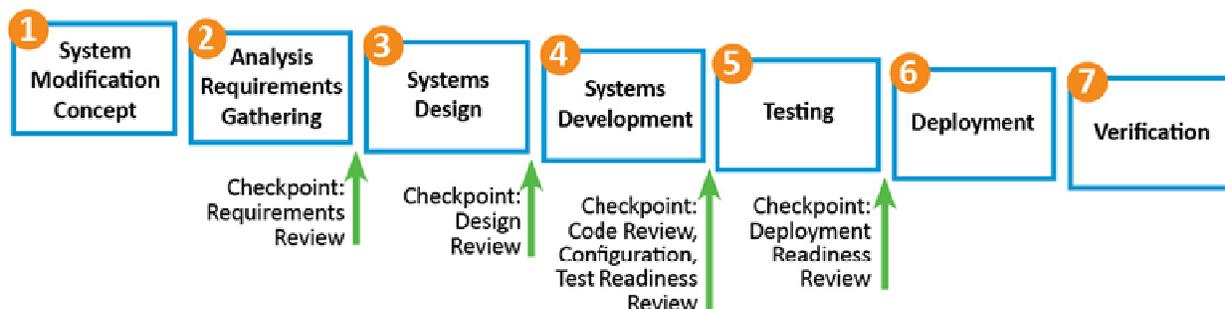
The CM Process is built upon the concept of a Change Control Board (CCB). There are two types of control boards in the CM process, the Change Control Board (CCB) and the Change Advisory Board (CAB). The CCB is responsible for approving, reviewing, monitoring and governing changes for all high risk and high impact requests for change. The CAB is a team of technologists that review, approve, monitor, schedule, and govern changes that occur in the production environment. They also ensure that scheduled changes in a given maintenance window are compatible, mitigating risk as needed.

We have a comprehensive set of policies and procedures that govern development and review of Change Notification Requests (CNRs) as part of the Release Management (RM) function.

Systems Changes and our SDLC

Our information systems change management and version control processes are tightly integrated with our Systems Development Life Cycle methodology. For all system changes, the TS Department follows formal change notification policies and procedures that include standards for requirements gathering, analysis, design, tests, and implementation. As illustrated in Figure R-15, our SDLC follows a traditional waterfall methodology and is typically implemented in an iterative manner.

Figure R-15. Systems Development Life Cycle



The TS Department uses change management software during maintenance and implementation of all application software and documentation. Changes to documentation begin at the initiation of systems requirements and continue through testing. We use the updated documentation as a basis to train all employees affected by the change before deployment.

Our documented policies and procedures include all methodologies required to manage the life cycle of our applications and systems. We have procedures, templates, checklists, and processes that enable

systems projects to move from a system design concept through requirements gathering, requirements tracking, systems design and development, complete systems testing, user training, documentation updates, and controlled deployment of new or changed source code. The processes are documented and repeatable. The processes are monitored and subject to continuous process improvement activities. As required based on the nature of the change, key DHH, FI, or Enrollment Broker staff will be integrated into the process to provide insight and to assist with the testing process.

Requirements Analysis

Requirements analysis is the first step in the SLDC. The TS Department gathers, documents, and maintains an approved list of project requirements. A trained group of Business Analysts works with business owners to identify the business requirements, develop system requirements, and document the results in a Requirements Review Document. This document must be reviewed and approved by the business owners before the systems design is started. Once the document is approved, it is placed under configuration management and can be changed only through a documented change procedure. This allows the TS Department to maintain tight control on all requirements for the project. Using the Requirement Review Document, we validate the traceability of requirements through the systems design, development and testing processes.

During the Requirements phase, we also identify modifications to documentation, including systems documentation and user manuals, necessitated by the change. We will provide DHH with electronic copies of documentation revisions at least 30 days prior to implementation of the change. If the revision impacts printed documentation, updated manuals will be available within 10 days of the revision.

Technical and Usability Testing

The testing process begins after approval of the Requirements Review Document. The TS Department tracks requirements through the design and development phases of the project and verifies that all requirements are accounted for in the design phase. We also begin to develop test scenarios and test scripts for each requirement. Thus, by the time system development is completed, we have a document defining the testing approach. Business Analysts develop complete test data for each test script that fully exercises system capabilities. DHH and FI staff, and others as appropriate, are important members of the testing team and will work with Amerigroup to validate that our systems are ready for Louisiana operations.

Unit Testing validates that each component or module is functioning properly. The test results are reviewed and tests are repeated until they verify that the module is functioning properly. Second, we begin Integration Testing to validate that each module is functioning properly as it interfaces and operates with all other modules of the system. Next, Operational Readiness Testing verifies that the change is ready for a production environment. The last step is User Acceptance Testing to validate that the change satisfies user expectations. DHH will be integral member of the testing team and employees, as well as the FI, will be given sufficient access to allow performance of testing activities for all data interfaces. If a change affects external entities, for example the eligibility/enrollment data exchange with the Enrollment Broker, the entity is heavily engaged in the testing process to validate production readiness.

We use subsets of production data to test specific scenarios and simulate the production environment as much as possible. Once all testing is completed and the Deployment Readiness Review has been

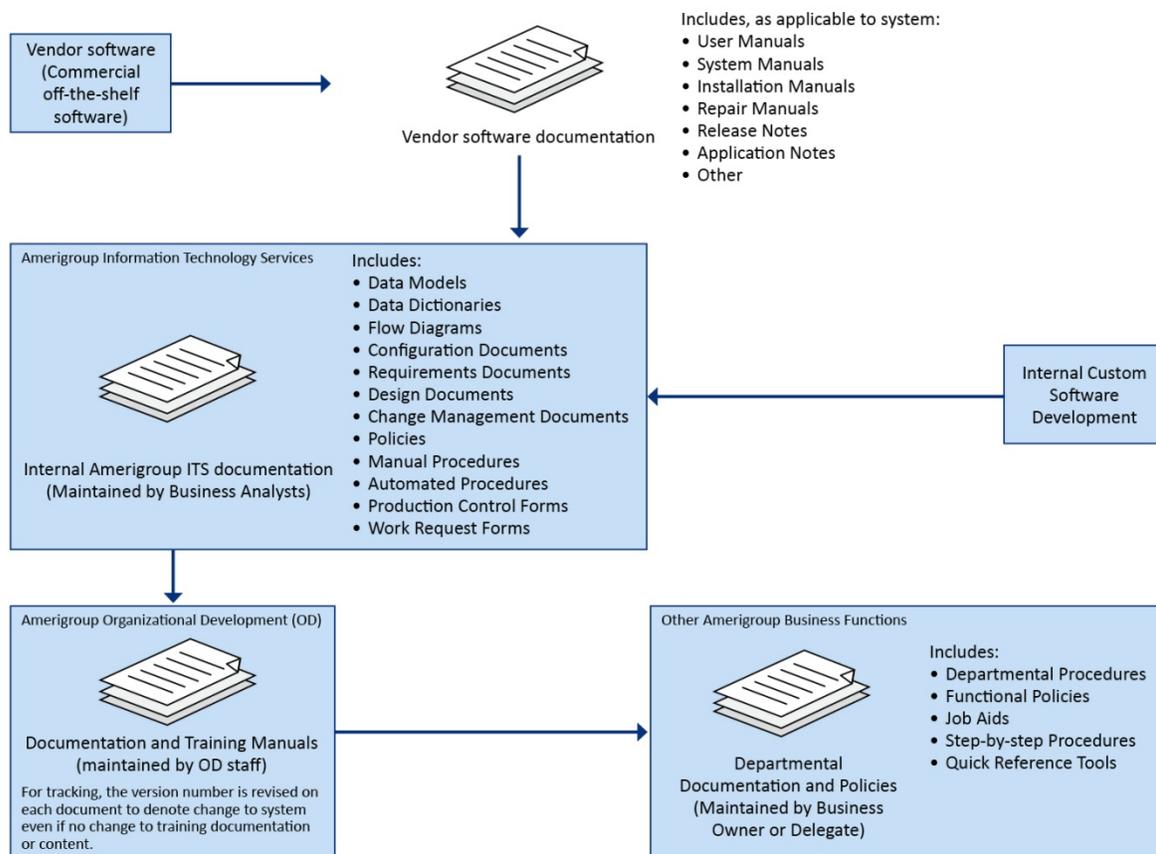
approved, training begins for all individuals affected by the change. Training occurs before changes are promoted to the production environment.

Documentation Requirements

Comprehensive documentation is a requirement of our SDLC. Where it exists, we leverage vendor documentation to supplement internally developed documentation. As illustrated in Figure R-16, the TS Department maintains a complete set of documentation, comprised of:

- Vendor (third party) software documentation, including user and system manuals, installation manuals, and release notes
- Internal TS documentation, including data models, data dictionaries, flow diagrams, requirements and design documents, and change management documents
- Training manuals
- Policy and procedure documentation

Figure R-16. Information Systems Documentation



The TS Department will provide DHH with the documentation outlined in Section 16.4.2, Information Systems Documentation Requirements, of the RFP.

Timing and DHH Notification of Systems Changes

Systems availability is critical to efficient operations in Louisiana and we will schedule all system maintenance that results in systems unavailability during times that do not compromise critical business operations. Our usual practice is to schedule system down time on weekends. If we must schedule maintenance during normal systems operational hours, we will coordinate with DHH for scheduling and approval.

As our partner in Louisiana, DHH will be notified at least 90 days before major changes are made to these core processes:

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management

In the event that Amerigroup were to execute a major conversion of a core transaction management system, we would notify DHH at least 90 days in advance. We will respond to DHH notification of system problems according to the schedule listed in Section 16.4.3.5 of the RFP.

Production Control Operations

The TS Department safeguards all systems from unauthorized modifications by the use of systems tools and strict procedures that require a Production Code Move Sheet for every change or maintenance request and an appropriate review meeting prior to deployment. Figure R-17 depicts the process for moving a change into production.

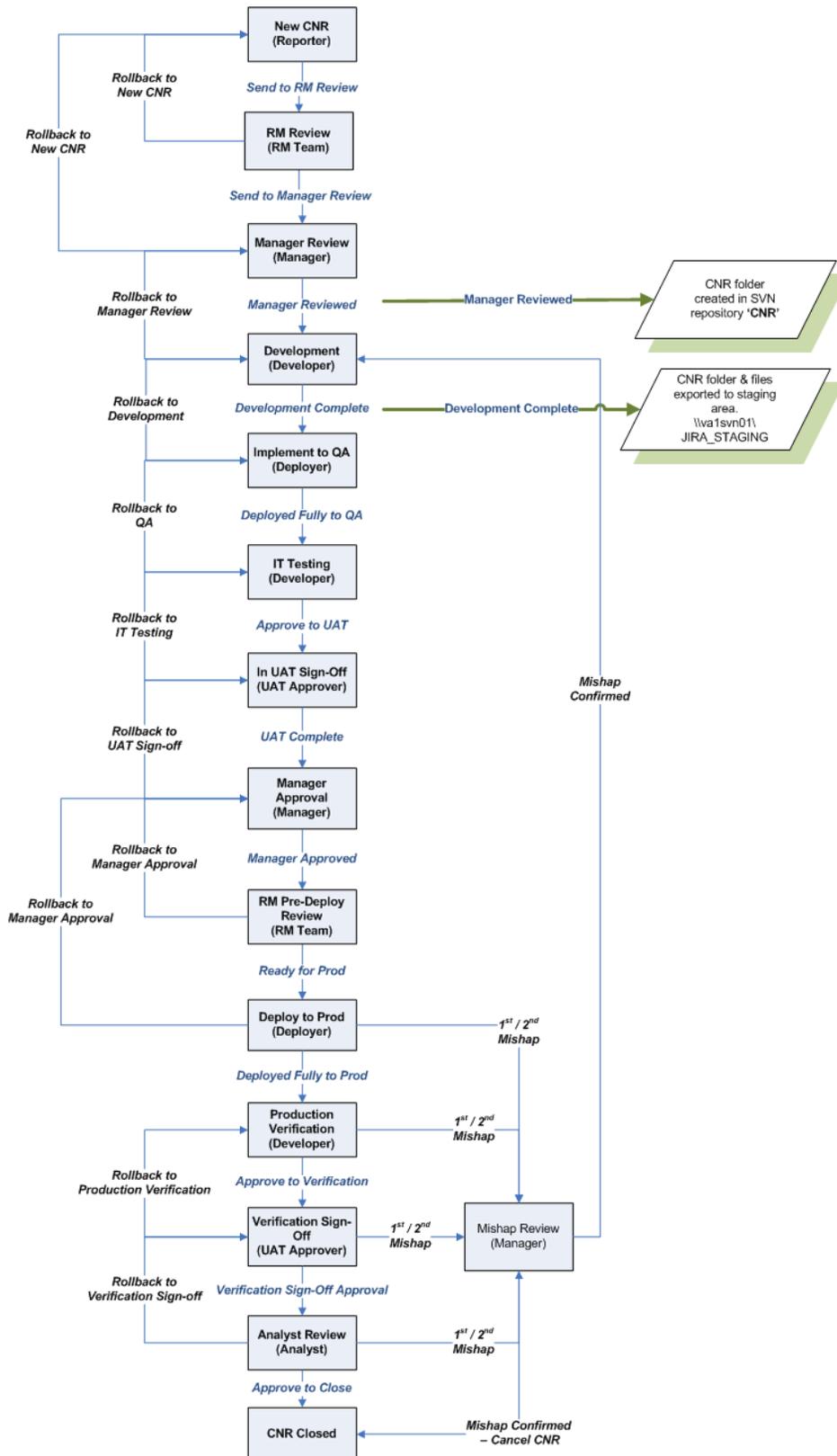
Prior to the review meeting, the development group notifies the change control group that new production code is ready for promotion. For routine maintenance requests (low risk), the TS Department conducts a desk check procedure. For all high-risk requests, we conduct a Pre-deployment Review Meeting. Each of these reviews certifies that the change being requested has been completed according to the requirements and design documents. It validates that appropriate documentation updates have been made, that testing has occurred and the business owners for the areas affected by the change have reviewed and approved the test results and have agreed to implement the change.

The TS Department maintains a separate group of individuals who have the ability to promote code changes or new code to production libraries. The development group develops and tests the code, obtains approval for the completed product, and plans the implementation strategy. The change control group moves the approved code into a designated staging area. We use a release management tool to monitor and control the entire process.

Once approval is obtained from the desk check or the Pre-deployment Review Meeting, the Data Center Operations organization follows the instructions on the Production Code Move Sheet. This document covers the promotion of code changes or detailed instructions for the introduction of new code to an application.

The Data Center Operations organization does not allow any code to be placed into a production environment without the appropriate documentation and required approvals.

Figure R-17. Production Control for Systems Changes



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R.9 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:

- ***provider contract loads and associated business rules;***
- ***eligibility/enrollment data loads and associated business rules;***
- ***claims processing and adjudication logic; and***
- ***encounter generation and validation prior to submission to DHH***

Demonstrating Readiness to DHH

It is our responsibility to demonstrate to DHH that our systems are ready to meet the requirements of Louisiana Medicaid operations before the first member effective date or “go live” date. **Our approach to demonstrating system readiness includes involving DHH in the entire implementation process**, regular communication of project status, and conducting tests throughout the implementation phase where DHH has the opportunity to validate business rules, review test results, and observe system processes, including incoming data loads, outgoing data exchanges, and reports.

Strategic involvement of DHH builds the type of partnership that Amerigroup has identified as a best practice.

Planning for system readiness begins when we are notified of contract award. During the implementation planning process, the implementation management team will work closely with DHH employees to identify specific opportunities where DHH can conduct validations and check-points as a means of increasing confidence in the implementation. Strategic involvement of DHH in the implementation process builds the type of partnership that Amerigroup has identified as a best practice in implementing Medicaid managed care operations.

As required, we will conduct desk readiness reviews to allow DHH to verify the accuracy and completeness of our policy and procedure manuals, training materials, user guides, and documentation.

During the Transition period of the Contract, operational and systems readiness will be demonstrated via the exchange of reports and data files, including those with subcontractors, as noted in the contract, Appendix JJ, and related documents.

Amerigroup will comply with all testing/readiness activities, including receipt and processing of eligibility/enrollment data, adjudication of a representative sample of claims, and submission of encounter data to DHH for their review, as well as any other activities jointly identified during implementation planning. Amerigroup will host onsite or online reviews of systems and data, allowing full visibility of the core operations system for verification of readiness.

Provider Contract Loads and Associated Business Rules

Accurate provider contract data and business rules are an important part of a successful implementation. We follow a documented process to load provider contract data into our MIS according to Amerigroup business rules and DHH requirements. When we receive an executed provider contract, we begin verification process that includes:

- Verification of demographic information (including National Provider Identifier and Medicaid ID Number)
- Confirmation that the provider application is complete
- Validation that all credentialing documentation is complete
- Verification of contract details
- Final loading into our core operations system

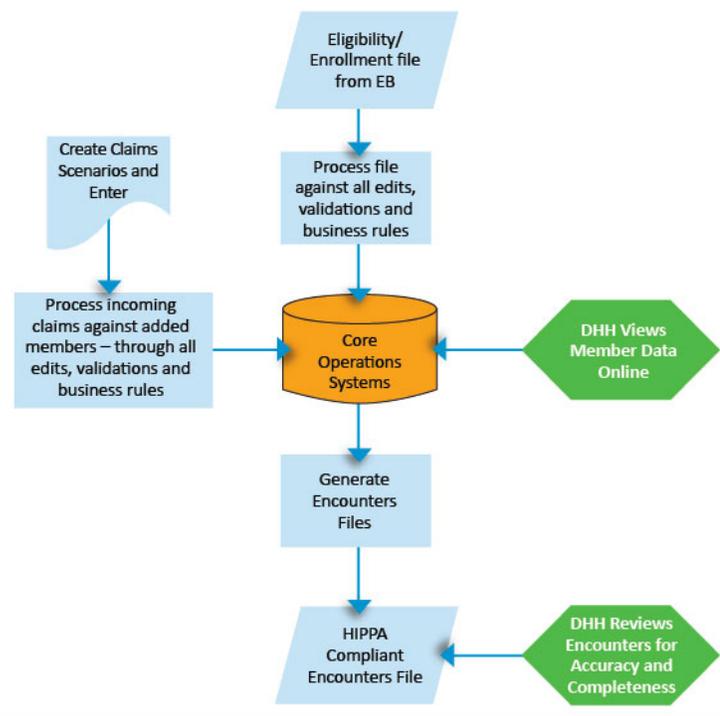
We carefully monitor the process so that after completed and credentialed provider applications are received, provider data is verified, loaded and available for operations. We will demonstrate the readiness of our provider contract loading process by allowing DHH to view this data in our core operations system prior to go-live and by producing provider network reports.

Our Operations team manages and validates the business rules associated with provider contracts. Extensive system testing is performed to validate that provider contract configuration is working properly against claims submissions. We invite DHH to review systems test documentation as part of demonstrating readiness.

Integrated Testing – Eligibility/Enrollment, Claims Processing and Encounters

The most effective way to demonstrate readiness is to walk DHH through an integrated test in our separate State Readiness test environment. The test begins with the processing of an actual eligibility/enrollment file from the Enrollment Broker, continues with the processing of claims scenarios, and ends with generation of encounter files. This method, depicted in Figure R-18, allows DHH to validate system readiness through actual system input, processing and output.

Figure R-18. Integrated System Readiness Testing



Eligibility/Enrollment Data Loads and Associated Business Rules

We will test our eligibility/enrollment data exchange process by taking a file from the Enrollment Broker and loading it into our system within the DHH requirement of 24 hours.

Either on site or using a web conferencing tool, we will use the member inquiry functions within our core operations system to display specific members to review. We suggest that DHH specifically select members for review not

previously identified to us, and review data in our systems until they are satisfied that eligibility/enrollment information received from the Enrollment Broker is accurate and complete.

Claims Processing and Adjudication Logic

Claims processing and adjudication logic will be reviewed by identifying specific claims scenarios that cross multiple claim types and situations. We will work with DHH to create a comprehensive list of claim scenarios for this phase of system readiness testing.

Claims will be for members that were loaded during the first step. Our Systems Test Team will lead this test, along with the technical implementation lead, and manage the entry of the test claims.

After processing, DHH employees can view claims processing and adjudication results online either onsite or using a web conferencing tool. DHH employees should check adjudication results and cross check to the contract until they are satisfied that the system will pay claims according to the requirements.

Encounter Generation and Validation

Encounter generation and validation is a critical step to demonstrating system readiness to DHH. After adjudicating the various claim types the data will be processed through the encounters management system and files will be produced and sent to the DHH FI. This will enable DHH to validate the encounters submission and compliance with encounter data rules and process requirements. The encounters files also provide an additional means for DHH to evaluate our claims processing against the defined scenarios. This encounters data review method more closely mirrors day-to-day operations.

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R.10 Describe your reporting and data analytic capabilities including:

- *generation and provision to the State of the management reports prescribed in the RFP;*
- *generation and provision to the State of reports on request;*
- *the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an ad-hoc basis; and*
- *Reporting back to providers within the network.*

Amerigroup fully understands the reporting requirements and obligations of our state clients and the operational commitment necessary to meet them. Regulatory compliance is an essential part of our corporate culture, and we work continuously to meet our state partners' expectations and requirements as defined in each contract; reporting deliverables, whether formatted reports or data files, are no exception. Since the need for reports is dynamic, we have staff dedicated to the creation of required regulatory and management reports and on request reports within our TS Department. These employees are well-versed in our systems and data models and can quickly meet the needs of DHH for the delivery of on request reports as well as ongoing defined regulatory reports. We also have a Data Access Portal that will provide the ability for DHH staff to create their own ad-hoc reports against Louisiana data contained in our data warehouse.

Our Data Access Portal will provide the ability for DHH staff to create their own ad-hoc reports from our data warehouse.

Data Warehouse – Powerful Information and Access for Reporting

Amerigroup maintains an integrated data warehouse, comprised of data from internal and external sources, to support the ongoing requirement for scheduled reports, specialized on request reports and ad-hoc reporting needs. Internal data include claims, membership, authorization/utilization management, provider, capitation, and customer service information. Data from external sources include items such as claims history, laboratory results, delegated vendor claims, immunization registries data or data for carved-out services (such as dental and pharmacy). Data received from an external source is loaded into the data warehouse and is integrated and made available immediately through surrounding applications.

The data warehouse is fed directly from source systems to ensure data accuracy and employs a well designed relational data model. The DW is a homogeneous data model, independent of the heterogeneous data sources, and its design is based on how Amerigroup health plans use the data for reporting and analysis. The TS Department's comprehensive understanding of this data, as well as its understanding of the reporting needs of managed care health plans, provides our state partners with the expertise necessary to meet both current and future reporting requirements.

Amerigroup's database systems architecture incorporates an operational data store (ODS) as well as a data warehouse, both built using industry standard relational database management platforms such as Oracle and MS SQL.

The ODS serves as a primary stepping stone into the DW and also accommodates front-line operational reporting using all data available from the core operations system supplemented with data from external sources such as delegated vendors, immunization registries, state FFS claims. The ODS has been designed for consistency in data element names and data types with the corresponding source systems.

The DW is a data repository that supports the analysis of point administrative data and functional operational data stores. The DW is a copy of transactional data specifically configured for online analytic processing (OLAP) using multi-dimensional data models (cubes) structured for speed and efficiency to support complex analytical and ad-hoc queries using business intelligence tools such as MS SQL Server Analysis Services and MS SQL Server Reporting Services. Specialized subject area cubes (claims, provider data management, member/enrollment, authorization/appeals, and call center operations) provide end users with a self-service reporting tool that universally applies business rules and accommodates the need to see both high-level trends and low-level details.

Generation of Management Reports

Amerigroup has an extensive history and proven record of accomplishment for generating compliant, timely, and accurate reports on a weekly, monthly, quarterly, annual, and ad-hoc basis for all of its state Medicaid contracts. We currently generate hundreds of reports to meet the needs of our current state partners. Our dedicated health plan team, along with the Amerigroup Regulatory Compliance Department, will use well established and documented processes to confirm that all required reports are available to DHH in accordance with the RFP and all other contract documentation. We will work closely with DHH to ensure the content, formats, submission media, and timetables meet contract specifications.

Section 18.8 of the RFP identifies the format of some reports as “TBD”. During implementation, we will review the format of existing reports with DHH to determine their ability to meet business needs in that area.

We have carefully reviewed the summarized list of reports presented in 18.8 Report Submissions Chart of the RFP, along with reports described in other sections of the RFP, and **we are confident in the ability of Amerigroup to exceed DHH reporting requirements.**

Generation of Reports On Request

Our state partners often need special, on request reports to meet ongoing management and data analysis needs and our reporting tools enable us to extract meaningful and actionable information from our data warehouse. In addition to reporting for regulatory purposes, our employees use these tools to create specialized on request reports for our state partners, as well as reports for Amerigroup leadership in support of day-to-day operations and long-term strategic planning. Reports, data, and tools are accessible throughout the organization to meet role, function, and capability requirements.

A dedicated reporting team exists within the TS Department that partners with the business operational departments and focuses on analyzing, designing, developing, testing, and delivering many of our regulatory reports and operational reports. We are experienced at delivering reports according to required monthly, quarterly, and annual schedules, as well as complying with special report requests. During implementation we will develop procedures with DHH for submitting an on request report to the TS Department.

Ad Hoc Reporting

We will provide DHH with the ability to create their own ad-hoc reports through our Data Access Portal. The TS Department maintains strict security policies and procedures that will allow us to provide authorized DHH employees with secure, inquiry-only access to Louisiana data that can be used in ad-hoc reports. This capability will provide DHH staff with a powerful tool for data inquiry and analysis.

It is an Amerigroup best practice to customize both the data view and the technology tools for ad-hoc reporting to the specific needs of our state partner. A great deal of information is available and there are a number of tools that can be used for the development of ad-hoc reports. During implementation we will analyze DHH requirements for ad-hoc reporting to make sure that we expose the data in a way that is meaningful to DHH staff and meets anticipated reporting needs. During implementation we will also determine the best tools for DHH to use for ad-hoc report development. We have a number of tools available, but they vary in their complexity. Our goal is to identify the best tool for the type of user anticipated by DHH.

Reporting to Network Providers

Network providers are an important recipient of health plan reports. Amerigroup PCPs receive monthly panel listings of members who have chosen or been assigned to them for primary care services. PCPs are also sent a monthly listing of children who are due for well child visits according to the EPSDT periodicity schedule. RAs and remittance reports are distributed to providers with details regarding claims payment. We provide a secure download center for distribution of key collaboration reports to providers.

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R.11 Provide a detailed profile of the key information systems within your span of control.

Amerigroup's Management Information System is an integrated set of applications that are either purchased from third party vendors or developed in house by our Technology Services employees. The integration of these applications into a cohesive Medicaid managed care processing system is a strength of our TS Department. Thorough knowledge of our technology infrastructure and diligent application of our SDLC, including use of common reference files and application of data element naming and formatting standards, helps integrate all components of our MIS, regardless of source. This integrated platform provides us with the agility and the flexibility to efficiently implement new client operations and adapt to changing requirements within the industry.

Selection of Third Party Applications

When selecting an application from a third party vendor, our philosophy is to select a mature application that meets our stringent requirements for functionality, scalability, technology and vendor experience. In evaluating functionality, we thoroughly map business requirements against existing and planned application features. When evaluating the vendor, we look to confirm the vendor's long term commitment to the product in terms of maintenance releases and functional enhancement.

Amerigroup's in house TS Department is comprised of experienced applications development employees with expertise in our MIS and extensive knowledge of Medicaid managed care. We have developed many in-house applications to meet specific business needs, especially when supporting innovative programs where third party applications are not available in the market.

We continuously monitor the market, looking for new offerings and evaluating our key information systems against available products. We are active participants at conferences and vendor meetings in an effort to understand and drive new features and functionality. Our TS Department is agile and insightful enough to analyze all available information and make best business decision for our customers.

Detailed Profile of Key Information Systems

Table R-6, presented on the next two pages, provides a detailed profile of key information systems within our span of control. For each of these systems, major functionality is provided, along with whether the system is a third party application or is a custom application developed by internal TS employees. The location of the data center housing the system as well as the database technology used by the system is also highlighted.

Table R-6. Profile of Key Information Systems

Key Information System	Third Party or Custom	Data Center	Database	Major Functionality
Core Operations System	Third Party Application	Amerigroup Corporate	Oracle	<ul style="list-style-type: none"> • Enrollee eligibility data — current and historical • Disenrollment for other than loss of Medicaid eligibility • Provider network information, including provider affiliations and credentialing information • Claims processing and adjudication including claims for capitated providers • Claim payment records including claims for capitated providers — current and historical • Authorization and disease and case management data • Grievance and appeals management and tracking • Outcome reports
Data Warehouse	Amerigroup Custom Application	Amerigroup Corporate	SQL Server	<ul style="list-style-type: none"> • Supports analysis and reporting and surround applications • Facilitates reporting across multiple systems
Claims Auditing	Third Party Application	Amerigroup Corporate	Oracle	<ul style="list-style-type: none"> • Audit accuracy of coding and claims billing patterns prior to claim payment
Imaging and Workflow System	Third Party Application	Amerigroup Corporate	Oracle	<ul style="list-style-type: none"> • Document imaging • Workflow management
Medical Criteria Software	Third Party application	Amerigroup Corporate	SQL Server	<ul style="list-style-type: none"> • Application to facilitate quality of care and clinical resource utilization by providing objective criteria based on well-researched scientific knowledge and real world clinical experience to assess the appropriate care for individual patients

Key Information System	Third Party or Custom	Data Center	Database	Major Functionality
Voice Portal	Third Party Application	Amerigroup Corporate	Oracle	<ul style="list-style-type: none"> • Voice recognition technology used to direct calls and answer member inquiries • Voice recognition technology used to direct calls and answer member inquiries • Provides access to core operations system data for voice responses to provider inquiries • Assists call center personnel with identifying caller information before answering the call
Online Inquiry Tool	Amerigroup Custom Application	Amerigroup Corporate	Oracle, SQL Server	<ul style="list-style-type: none"> • Provider Portal • Member Portal
Premium Reconciliation	Amerigroup Custom Application	Amerigroup Corporate	SQL Server	<ul style="list-style-type: none"> • Supports reconciliation of premium payments to membership
ERP	Third Party Application	Amerigroup Corporate	Oracle	<ul style="list-style-type: none"> • Employee human resource management • Accounting and financial management
Encounters	Third Party Application	Amerigroup Corporate	SQL Server	<ul style="list-style-type: none"> • Preparation and submission of encounters data
Regulatory Reporting	Amerigroup Custom Application	Amerigroup Corporate	Oracle, SQL Server	<ul style="list-style-type: none"> • Produce and deliver reports required by each state for their markets and products

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R.12 Provide a profile of your current and proposed Information Systems (IS) organization.

The TS Department currently has more than 300 full-time employees supporting multiple disciplines, including programming, analysis, database management, web site development, systems engineering, telecommunications, operations, network engineering, technical support, security, quality assurance, project management, and contract and financial management. All TS employees are dedicated to the development, support, maintenance, and operation of Amerigroup managed care operations and infrastructure. In addition to being information technology professionals, the TS employees are also heavily experienced and knowledgeable in health care.

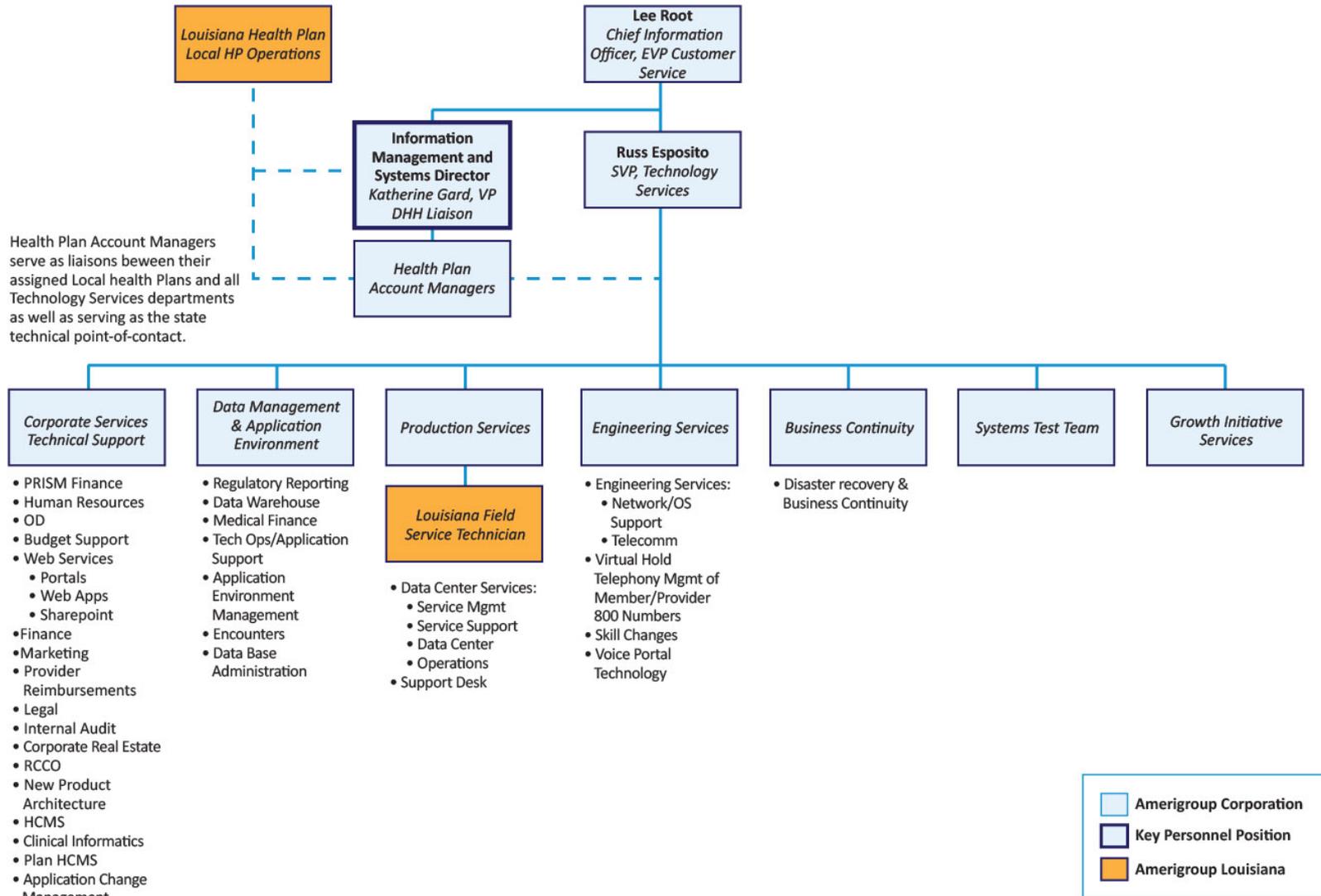
TS is a corporate function reporting to the Chief Information Officer (CIO). The CIO is also the Executive Vice President, Customer Service and reports directly to the Amerigroup Chief Operations Officer. Reporting to the CIO is the Senior Vice President, Technology Services who is responsible for the operations and results of the Technology Services department. TS is organized into three primary areas: Application Management and Support, Infrastructure and general service functions. The Applications Management and Support area is organized into two teams, one supporting the corporate business operations, health care management, eBusiness, and enrollment functions and the other supporting reporting, the data warehouse, health care economics, encounters, call center, claims and provider data management. Our Infrastructure area is also divided into two major teams, with one supporting production services and the other supporting engineering services. The major service functions within TS include business continuity and disaster recovery, systems testing, TS project management and growth initiative support. An organization chart for the TS Department is provide as Figure R-19.

The differentiator for Amerigroup is the tight integration of the Technology Services Department with business operations departments. Our experience over the past 15 years has demonstrated to us that complete coordination between the functions that the business units perform with the technology used to support them delivers the best value to our state partners. As evidenced by our implementation work plan, business operations works side-by-side with the TS Department to deliver define, test and deliver a cohesive MIS to support state Medicaid operations.

Technology support for all health plans emanates from the corporate TS team. Field Service Technicians located at each health plan provide onsite desktop and technology support. A best practice of Amerigroup is the assignment of an Account Manager as the technical liaison and single technical point-of-contact for the state. The Account Manager attends regular state meetings and provides an accountable conduit into Amerigroup for state technical personnel.

We recognize the value of technology employees to smooth health plan operations. The TS Department strives to hire experienced information technology professionals with a background in health care. We are also committed to employee retention and ongoing training. **Across the TS Department, the average employee tenure with Amerigroup exceeds four years.** The longest tenured employee in TS has 15 years with Amerigroup and there are 63 employees (more than 20 percent) in TS with 8 or more years of time with the company.

Figure R-19. Technology Services Department Organization Chart

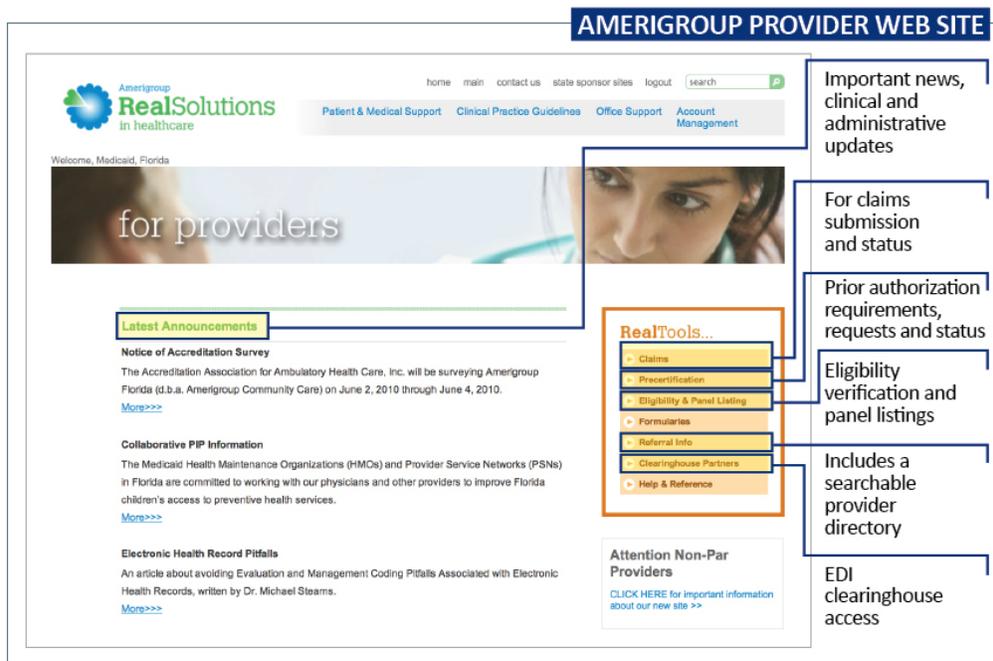


R.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

Effective use of technology with our providers is vital to timely claims processing and maintaining provider satisfaction. To facilitate timely claims filing, we accept electronic and paper claims submission. Electronic claims submission is accepted via three different clearinghouses and our provider web portal. **The rate of EDI submission has steadily grown to 87 percent** as we continually work with providers to encourage its use. We also encourage providers to take advantage of our Electronic Funds Transfer (EFT) program which improves cash flow through immediate access to claims payments.

Our provider portal is a valuable tool not only for disseminating relevant and valuable information to our network providers but also to establish technology as a vehicle to enhance provider interaction with Amerigroup. A screen shot of our provider web portal is shown in Figure R-20.

Figure R-20. Provider Web Portal Contains Several Self-Service Tools



We also communicate with our providers through direct outreach, targeted mailings and provider training. We value provider satisfaction and seek to support successful provider participation with the Louisiana CCN Program.

Promoting Electronic Claims Submission

One of the most powerful ways that Amerigroup promotes electronic claims submission is by giving providers the choice of methods for electronic claims submission:

- Through one of our three EDI clearinghouses which then submits claims to Amerigroup in 837 format
- Using our web portal

Amerigroup offers two electronic claim submission methods for providers via our provider web portal. Participating providers can use the web site to directly enter claims for processing through a graphical user interface. Depending upon the provider's billing agreement with Amerigroup, they can enter professional and/or facility claim types using this method.

The web portal also offers a direct 837 submission option for those providers who can create a HIPAA-compliant 837 file from their billing/AR system. After completing an EDI trading partner agreement and undergoing a brief testing process, a participating provider may submit their claims by posting an 837 file directly via the Amerigroup web portal. There is no cost to the provider for either method.

Our model of flexibility in electronic claims submission is working. In the past 12 months, we received 91.03 percent of the institutional claims electronically and 87.92 percent of the professional claims electronically. Most electronic institutional claims came through our EDI clearinghouses; and, while this is also true for the professional claims, there was approximately a 4 percent increase in the use of our web site for electronic submission of professional claims.

To encourage more participation in electronic claims submission, we target providers with high volume paper claims submission. We will reach out to them to discuss EDI methods, explaining how electronic claims can work in their office and the benefits they can achieve. We also discuss EFT at this time.

Promoting Electronic Funds Transfer

Paying providers faster and more efficiently is a priority of Amerigroup because it is a key component of provider satisfaction. Today, we pay many providers through EFT. The service is free and offered through our claims settlement solution vendor, which, in addition to EFT, also offers providers the option of electronic remittance advice (ERA) services. They can view the ERA online and print it at their office, download a HIPAA-compliant 835 data file for processing in their practice management system, or receive paper remittances via mail. Many providers receive payments for clean claims within five days of submission. The EFT program provides:

- Electronic deposits directly to designated provider accounts
- Remittance Advice (RA) statements that can be downloaded electronically
- RA archive with fully integrated reporting functionality
- 835 file compatibility with most electronic billing software

As of April 2011,
32 PERCENT
of our providers are
receiving claims
payment via EFT.

We educate providers on establishing EFT via our provider manual, provider training, and our web site. Our overall adoption rate of EFT among our providers is 32 percent as of April 2011. By provider type, 46

percent of our facilities, 31 percent of our groups, and 20 percent of individual providers are receiving payment via EFT.

To encourage further adoption of EFT within our provider network, we post alert messages and updates on the portal announcement area as reminders to sign up. We have also launched a multi-pronged provider engagement strategy that includes:

- Covering EFT in all of our provider training (forums, town halls and orientations)
- Targeting high-volume providers for direct outreach concerning EFT
- Including an EFT brochure with claims payments to network providers not currently participating in EFT

We are confident these tactics will advance the adoption rate within our exiting provider community, and will serve as catalysts for early adoption by our Louisiana network providers.

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R.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

Amerigroup's internal Technology Services Department has been providing the sole support for our Management Information System for 15 years. The TS Department provides support for all systems, interfaces and infrastructure components. No components of our MIS are supported by outside entities.

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R.15 Describe your plans and ability to support network providers’ “meaningful use” of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.

Meaningful Use of Electronic Health Records

Amerigroup supports HITECH’s goals and objectives pertaining to Meaningful Use of providers’ Electronic Health Record (EHR) systems. Current Amerigroup efforts include the creation of training guides which can assist providers on the CMS Meaningful Use requirements, allowing them to be eligible for related incentive dollars available from CMS. We inform providers on the various levels of potential incentive amounts. Our communication further outlines the specific mandatory and optional system components for Stages 1 through 3. Amerigroup looks forward to working closely with DHH to ensure such information is provided in a timely fashion to reinforce current and future DHH related provider compliance efforts.

We will also educate our providers of the consequences of delaying adoption of Electronic Health Record systems. Implementation after 2016 will result in forfeiture of Medicaid incentive payments for all providers and hospitals will experience reductions if implementing in 2014 or later. Eligibility to participate in any Medicaid incentive program is based on various criteria and has to be re-attested annually. A minimum time in use standard of 90 continuous days has to be met for the first year.

Health Information Exchanges

The ability to share health care data confidentially among health care providers can be a valuable tool in creating administrative efficiency and promoting patient safety, especially in an emergency or real-time situation. Amerigroup is fully committed to working with our state customers to remain abreast of the dynamic Health Information Exchange (HIE) field. We are especially interested in developing a seamless ability for HIEs to maintain data for patient populations that may move across health plan programs. We welcome the opportunity to collaborate with DHH on the integration of HIEs in Louisiana and in developing strategies that actively reinforce the health care reform initiative.

Our technology infrastructure is now configured to support HIEs, and our platform is flexible enough to accommodate HIE requirements. We are already Level-1 compliant with the new EDI standards (HIPAA 5010) that are scheduled to roll out in January 2012. For clinical records, Amerigroup is now working with Health Level 7 (HL7) standards – the most common standards among health care providers today -- ensuring that we are able to comply with HIE interface requirements.

Additionally, to ensure that we remain ahead of the industry, we regularly meet with key technology vendors – such as Ingenix, IBM, and Microsoft – to determine how those organizations are positioning HIE tools for their customers. This proactive engagement of industry leaders enables Amerigroup to remain responsive to the evolving HIE trends. Remaining active in understanding how HIE technology and strategies develop allows us to anticipate and prepare for rapid adoption of HIE protocols.

Utilizing 5010 and ICD-10

Our privacy, security and transaction code sets are currently HIPAA-compliant and our Technology Services Department stays abreast of

Amerigroup is on track for 5010 and ICD-10 compliance.

changing IT federal mandates to ensure that we thoroughly understand future requirements to ensure HIPAA compliance. We are well into our projects for compliance with the new x12 5010 EDI standards for Jan. 1, 2012, and for ICD-10 codes for Oct. 1, 2013. As dictated by our work plans for these projects, we will execute tests with each of our state partners to validate compliance.

Approach to 5010 Compliance

Amerigroup's approach to 5010 is to adopt and implement to the transaction standard and **we are on track to be Level-2 compliant by January 1, 2012**. We initiated a corporate program in January 2010 that has executive buy-in as well as overall organizational support. We have a detailed project plan to support the tracking and management of the project through implementation to our state partners.

Currently, Level-1 and 1A (our internally defined level to handle any changes to the TR3 standard driven by state specific CGs) development and testing is well underway for all of the major transactions, including cases where we have received CGs from the states. We are actively Level-2 testing with delegated vendors who are ready for trading partner testing on the key transactions – 834 eligibility to vendors from us and 837 encounters to us from vendors. We are Level-2 testing with state partners as they become ready to test.

To support our Level-1 testing, we purchased a converter tool that takes our current 4010 files and converts them to compliant 5010 files. Where the 5010 has data elements not available in 4010 files, it prompts for missing data to complete the 5010. This tool enabled us to have 5010 test files to support our internal testing until we had trading partners ready to test.

In addition to our focus on transactional compliance, we are also focused on the functional requirements and opportunities the 5010 transactions bring. We have a parallel analysis task to functionally analyze the key changes in the transactions with our business and technical teams to determine which changes are likely to drive operational and systematic changes.

Approach to ICD-10 Compliance

Amerigroup's approach to ICD-10 is to adopt and implement the code set standard and **we are on track to be compliant by October 1, 2013**. We are taking a functional/operational impact assessment approach to ICD-10, where we are working with all business areas across the organization to identify ICD-9 usage and potential for ICD-10 impact. Once the functional impacts are identified they will be analyzed and any resulting work will be prioritized and designed/developed for implementation in time to support 10/1/2013 operational and systems compliance. For some functions, such as prior authorization, implementation will be well in advance of 10/1/2013 in order to support claims with the 10/1/2013 date-of-service. The required timing of tasks such as implementation and associated training will be laid out in detail as the impacts are identified and the project plan progresses.

R.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via email or the Internet.

In today’s high technology and digital environment, it is important to provide the strictest of controls for all electronic and other forms of information and data. We employ multiple layers of security to protect access to our facilities, systems and data. Recognizing the need to share confidential data over the internet, via email or other tools, encryption technology is available to all employees and policies are in place surrounding its use. **Amerigroup’s comprehensive program meets DHH requirements in Section 16.14, Information Security and Access Management.**

Protecting personal information belonging to our members and providers is a top priority for Amerigroup.

Information Security

For more than 15 years, Amerigroup has respected the security, privacy, and confidentiality of our health plans’ members and their personal information. **Since the effective date of the HIPAA Privacy and Security regulations, we have worked diligently both with our employees and providers to make certain HIPAA Privacy and Security standards are in place and observed at all levels.** In 2003 we received company-wide HIPAA privacy compliance accreditation from the Utilization Review Accreditation Commission (URAC).



**ACCREDITED
HIPAA PRIVACY
Covered Entity**

Amerigroup was the first public-sector managed care company in the nation to be awarded this prestigious accreditation. We strictly enforce a standard that allows employees and users to access only the data needed to perform their job. Since the initial award, we have retained the accreditation, which is currently in effect through November 2011. Additionally, our TS Department provides state-of-the-art security systems to protect health plan facilities, networks, systems and data stores. We provide extensive company-wide training to keep employees aware of HIPAA and company-related standards.

The TS Department has stringent policies and procedures to restrict access to data to those individuals who require its use. We use third party software to automate data protection and to manage security processes. We conduct regular reviews of our policies and procedures for compliance and update these policies and procedures as necessary.

Policies and Procedures Protect Member and Provider Confidentiality
Amerigroup maintains strict security policies and procedures to protect all data maintained within our systems and applications. The first line of security is to limit access to our facilities. Next, the TS Department limits access to systems, applications and data warehouses to individuals who actually have a business “need to know” for the data maintained in the systems. The access management function also restricts users by varying hierarchical levels of entry based upon system function and the information available. Additionally, the TS Department limits remote access to only those individuals

Access to systems, applications and data is restricted to individuals who have a business “need to know.”

who actually need to work from a distance and cannot be physically located in an Amerigroup facility. All system access requests must be entered into our Security Access Request (SAR) centralized account management application, which integrates with our personnel system and our service desk application. Every request must be approved by the employee's manager to be processed.

User IDs, Passwords, and Unauthorized Access

Amerigroup requires employees and duly authorized state partner representatives to use a unique user identifier and password to gain access to workstations or systems. The supervisor or manager must request access to the specific systems and applications that are required in order for the user to accomplish their assigned duties. The TS Department employs Active Directory to provide an initial security level that limits access to a system or application, and role-based security within applications. The role-based security limits update capabilities and access to application functionality. Therefore, **users with inquiry-only privileges are not able to modify or update information.** These different security functions enable us to provide users with multiple levels of privileges. We grant access to data and information based upon job responsibilities and the sensitivity of the data stored. Global access to all functions will be limited to those specified employees jointly agreed to by Amerigroup and DHH.

All workstations and systems are guarded by security policies that lock out access if an individual tries to log-in and has three unsuccessful attempts. The Security Department receives system-generated reports and alerts on unsuccessful attempts to access systems and web sites. Additionally, users must change passwords every 60 days and are instructed to never share their passwords with anyone. Passwords must be complex in nature and include three of the following four items: a digit, a special character, English uppercase character, and English lowercase characters. The domain policies require limited password life, required password length and password history that expands beyond one year.

Audit Trails

The core operations system maintains an audit history of data updates, including time and source of change. Surround applications are interfaced to the core operations system, real-time data warehouse, or reporting warehouse to leverage this integrated data. These surround applications provide extended functionality such as complaints, appeals, and grievances tracking, eligibility, claims status and authorization status lookup, reporting, EPSDT service tracking and health education, and others.

The core operations system maintains audit trails for any subsystem used to store and maintain systems-critical information. Whenever an authorized user makes a change to one of the database tables, the application automatically creates a history of the update transaction. The data maintained is stored in an Audit Table that can be used to generate reports that detail the before and after picture of the data being updated along with other pertinent data such as:

- The unique log-on or terminal identification number of the person who made the change
- The subsystem used to generate the change
- The time and date of the change
- Audit trail reports can be generated that facilitate auditing of individual claim records, as well as batch audits. For integrity purposes, the system also keeps transaction logs (used for commit and rollback of transactions) and error logs (recording failed operations). All of these logs can be used to create comprehensive reports of system and user activity.

Audit trail information is maintained for no less than 10 years; online for no less than 6 years and then available from archive. Archived audit trail data is available within DHHs 48 hour turnaround requirement.

Protecting Privacy over the Internet

Amerigroup provides secure email for both sending and receiving information. The email system automatically encrypts outbound messages if key numbers are detected. Keywords will also trigger encryption. An extensive list of keywords related to drugs, treatments and diseases is used to determine if encryption should be applied. Additionally, the sender can request encryption by using the word “encrypt” in the message.

On the receiving side, a message is delivered with an encrypted PDF attached that contains the original email. First time users are required to create a complex password that is more than 8 characters long and contains a mix of character types and formats. To read the PDF contained in an encrypted message, the password must be entered. A secure and encrypted reply can be sent by clicking on the reply link in the PDF.

Physical Security and Safeguards

Amerigroup strictly restricts access to all facilities. Access is controlled by using proximity based electronic security badges. Alarms triggered by inappropriate entrance are centrally monitored by a full service commercial office building access control vendor. This service includes web-based access to comprehensive independent security applications for all properties providing multi-level security for individual facility programming and control. The Corporate Real Estate Department controls and monitors the issuance and use of security badges. In addition, security guards are stationed at the entrance to our offices in Virginia Beach, Virginia. All data centers have formal policies for visitor control, vendor and contractor access. We limit data center access to established network engineering, system administration, and network security employees. All servers and data storage devices are located within secure areas of the data centers that can only be accessed by individuals with special clearance. The primary data center entry points are located in the surrounding TS Department operations area that is also controlled with need to access restrictions.

All employees and visitors must complete a security access request form and obtain approval signatures prior to gaining unsupervised access. All departmental spaces are secured by electronic locks that are activated by security badges. After-hours access to facilities requires the use of specially coded security badges for building access, and department access.

Amerigroup grants access to state partners in two ways: either by signing in as a visitor and being escorted by a representative at all times, or by completing a security access request and being granted an access badge when required for routine business. We will grant DHH personnel access for data center facilities as needed. For data center access, DHH representatives must sign in as a visitor and be escorted by an employee at all times.

The central data center, with 5,200 square feet of raised floor, incorporates environmental controls such as UPS, moisture detection, heat ionization detection, temperature alerts, and backup generators. The TS Department uses these controls in our supporting data centers when appropriate. Security and safety controls such as smoke detectors, electrical alarms and an advanced fire retardant system help prevent the spread of fire damage to the data centers.

Data Network Security

Amerigroup utilizes state-of-the-art monitoring tools to audit system access, utilization, account, and resource usage to verify constant compliance with established policies. Cisco and Internet Security Systems Intrusion Detection and Prevention Systems (IDS/IPS) along with Trustwave, McAfee, Symantec and Vontu security management systems provide 24/7 real time security event monitoring and reporting capabilities every day of the year. Established and documented policies and procedures address all areas and detail routine and non-routine systems monitoring, security log processing and constant reviews of system usage. A formal security incident handling process is in place that includes security incident response reporting. A Security Officer enforces policies and monitors all security issues.

The TS Department controls server and application security through usernames and passwords. They only grant access to systems based on user needs for their job function in keeping with the minimum necessary requirements of HIPAA Privacy. Within the core operations system, the TS Department enforces role-based security by using security templates. We also control user access in the local and wide-area network environment through the use of file, directory, and drive level security. NetIQ Enterprise Administration Suite, CiscoWorks Management Software, WebSense, Symantec MessageLabs, Internet Security Systems suite, and a combination of Cisco Pix, Cisco IOS and CheckPoint Firewalls are used to manage and protect our networks. We follow the COBIT framework for information technology controls.

We restrict access to systems from outside attack using third-party tools. Where critical health care information is concerned, surveillance is not good enough. The third-party software the TS Department employs provides a security solution that fights known and unknown threats to our network and web portals with speed and intelligence. These tools automate and streamline the security assessment process, thereby providing accurate and comprehensive protection. Table R-7 below presents a concise view of the products used and the function they perform in our TS Department’s data management strategy.

Our toolsets are designed to assist the TS Department with safeguarding its network, its web sites, and the information it maintains in its systems. The TS Department policies and procedures related to system security, access, and use that are readily accessible to employees. We periodically remind all employees of the policies and procedures and of their responsibility for awareness and compliance. As part of HIPAA Privacy and Security compliance, Amerigroup conducts extensive education; ongoing training materials serve as continuous reminders to employees.

Table R -7. Amerigroup Systems Products: Comprehensive and Flexible

Product	Functionality
Cisco Routers	Provide access control to internal networks
Altiris	Asset tracking including O/S and application patch management to verify that all PC-based applications and other server-based applications have the most recent updates including security updates
WebSense	Provides for Web traffic monitoring; allows employees to monitor and respond to unusual Web traffic concerns
Symantec MessageLabs	Allows us to monitor and manage spam coming into the email system, or control messages leaving the network; this product also maintains some antivirus protection

Product	Functionality
NetIQ Enterprise Administration	Security Administration
Trustwave SIEM	Supports Enterprise log data and provides Security log correlation monitoring and reporting
Vontu Network Monitor	Monitors data loss comprehensively (for example, email, Web, Secure Web, FTP)
Symantec Antivirus	Provides virus protection for file servers
McAfee Antivirus	Provides virus protection for Exchange servers
McAfee Enterprise Antivirus	Provides virus protection at the desktop level; used with scheduled updates forced through a push mode
Internet Security Systems IPS	Provides network and host based intrusion detection and prevention
Internet Security Systems Internet Scanner	Provides vulnerability assessment and management capabilities to the TS Security Department
Internet Security Systems Vulnerability Management Service	Provides external third party vulnerability assessment and management reporting to the TS Security Department
CiscoWorks IDS/IPS	Provides network and wireless intrusion detection and prevention

Security Incident Reporting

The TS Department tools capture attempted intrusions and proactively prevent intrusions. While the primary objective during a suspected intrusion attempt is to prevent unauthorized access, the TS Department will notify DHH, of any high-risk security incidents that occur within our span of control for incidents affecting Louisiana-specific data or applications. During the implementation process, we will work with DHH to develop and schedule delivery of a report that lists any proactively identified or reported security incidents related to Louisiana data or applications, including attempts to hack into our systems. We will alert DHH of any attempts to inappropriately access or maliciously cause harm to our systems or the data the TS Department maintains.

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