

SECTION N: UTILIZATION MANAGEMENT

N.1. Description of Utilization Management Policies and Procedures

N.1 Provided a detailed description of your utilization management (UM) policies and procedures including but not limited to:

- *Specific levels and qualifications required for UM staff;*
- *Training you provide your UM staff;*
- *Industry products (Milliman, Interqual, etc.) used and how*
- *Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item R.1 of this part;*
- *If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls,*
 - *explain how you will track Louisiana MCO calls separately; and*
 - *how you will ensure that applicable DHH timeframes for prior authorization decisions are met.*

Amerigroup Louisiana (Amerigroup) complies with all provisions in RFP Section 8.0, Utilization Management, and all State and federal laws, rules, and regulations referenced within. We document details of our Utilization Management (UM) Program in our written UM policies and procedures, which will be submitted to DHH for approval within 30 days of contract execution in accordance with the terms of the Contract resulting from this RFP.

Our UM program promotes consistent use of nationally recognized, evidence-based medical management criteria and practice guidelines for medical necessity determinations; fosters continuity across care settings; maintains strict confidentiality of clinical and proprietary information; and promotes access to care for our Louisiana members. ***We were the first Bayou Health plan to achieve NCQA accreditation,*** and our program meets all NCQA standards; we achieved 28.42 out of a possible 29.31 points for UM on our last NCQA audit. We continuously evaluate our practices so that UM achieves its intended purpose in a problem-free, easy-to-navigate process.

The goals of our UM program are:

- To assure adequacy of service availability and accessibility to eligible members
- To maximize appropriate medical and behavioral health care
- To minimize/eliminate over- and under-utilization of medical and behavioral health services

We achieved 28.42 out of 29.31 possible points for UM on our last NCQA audit. 🌸

Our program includes a Utilization Management Committee (UMC) that provides relevant UM information to the Quality Management Program for quality improvement activities. This information includes identifying quality of care concerns, disproportionate utilization trends, duplicative services, adverse access patterns, and lack of continuity and coordination of care processes. The UM Program and the UMC achieve their goals and objectives by working collaboratively with a variety of other departments, such as Regulatory, Compliance, Provider Contracting/Provider Relations, Clinical Informatics, Quality, Pharmacy, Medical Finance, and the National Customer Care Department (NCC), which includes Member Services. The UMC is responsible for providing oversight of UM activities at the plan, provider, and membership levels. It convenes quarterly, but will meet on an ad hoc basis as needed.

Specific Levels and Qualifications Required for Utilization Management Staff

Amerigroup has adopted an integrated medical management model that addresses the physical, behavioral, and social needs of our eligible members throughout the health care continuum. We believe a coordinated, comprehensive approach leads to members receiving medically necessary, quality services at the appropriate time, in the appropriate setting. We accomplish this through our individualized, innovative programs and coordination of services within the MCO. One component of our integrated approach is our UM team.

It is composed of five experienced Medical Management Specialists in Louisiana and a designated unit of qualified, extensively trained employees who are centrally located in our national Call Center. Providers and members seeking authorization for services dial the toll-free number; if there is a question about the service meeting criteria, or there is a need for service coordination surrounding the request, the caller may be transferred to the Louisiana-based team. The team reviews requests according to medical necessity criteria and medical policies. Clinical staff and our Louisiana Chief Medical Officer participate as needed to develop a service package that fully addresses the member's needs in the most appropriate, cost-effective manner, while honoring the individual's preferences and health care goals.

Non-Clinical Representatives

Our non-clinical Medical Management Specialists, who support the local UM phone queue and clinical teams, must hold a high school diploma, three years of administrative and customer service experience, and knowledge of managed care or Medicaid/Medicare concepts.

They may also have a combination of education and experience that provides an equivalent background.

All UM employees are trained extensively on the geography, parishes, pronunciations, and culture of Louisiana. 🌸

Clinical Representatives

Our national nurse medical management clinicians must have two years of acute care clinical experience or a combination of education and experience providing an equivalent background. They must have an unrestricted nursing license, and an AS/BS degree in nursing is preferred.

Chief Medical Officer

Our Chief Medical Officer, Dr. Marcus Wallace, oversees all medical care for members and serves as principal medical advisor to the Administrator/Chief Executive Officer (CEO). The Chief Medical Officer is responsible for supervision, oversight, and evaluation of the UM Program, and identifies health priorities for the Plan's membership based on an analysis of data and trends. He has ultimate responsibility for the clinical decisions made as part of our UM program. Only the Chief Medical Officer or an associate Medical Director can issue a denial for a service request; however, he collaborates with the treating provider to negotiate an appropriate and acceptable treatment plan if requested services do not meet medical necessity criteria. The minimum qualifications for the Chief Medical Officer include:

- Certification in a medical specialty recognized by the American Board of Medical Specialists
- Active licensure, without restriction, issued by the Louisiana State Board of Medical Examiners as a Doctor of Medicine or Doctor of Osteopathy
- Masters in Public Health, MBA, or MA preferred

- Continuing education to remain current in medical and management areas
- Five years of clinical experience in the practice of medicine, two in medical and/or health administration with three to five years of management and/or clinical experience in a managed care environment

Dr. Wallace brings education, experience, and training that far exceeds our minimum qualifications. He is a diplomat of the American Board of Internal Medicine with extensive experience in managed care and direct practice as a Hospitalist.

Specialty Services

Amerigroup subcontracts with nationally recognized vendors who follow industry best practices and standards to evaluate medical necessity of specialty services. Using a specialty services vendor for UM enables Amerigroup to promote industry-standard decision-making, as well as consistency with guidelines used by other MCOs.

Our delegated subcontractors are

- **AIM Solutions** promotes the most appropriate use of diagnostic imaging and other clinical services through the application of widely-accepted, evidence-based clinical guidelines for monitoring cardiology and radiology. Solutions are delivered via an innovative platform of technologies and services.
- **LogistiCare** provides transportation.
- **Block Vision** manages vision services.
- **Dentaquest** covers our adult dental value-added benefit.

Delegation to an industry leader maximizes the efficiency of our UM employees, allowing them to focus on hospitalization and other prior authorized services, while promoting greater accountability for the dollars spent.

Training of Utilization Management Staff

Utilization Management representatives join Amerigroup with a strong clinical background and then receive intensive training specific to UM through WellPoint's (our parent company) My Learning. This program accelerates new employees' competence building, continuously works with employees and management to identify opportunities to improve performance, and engages employees through formal leadership programs and professional skills training. My Learning supports employee development by delivering a personalized learning experience, including optimal reporting and tracking, and easier access to online training. Our national Clinical Compliance team monitors employee progress to verify that all employees successfully complete all required clinical training modules.

We facilitate continuous learning for our clinical employees because medical practice and UM are dynamic and intertwined with new and emerging technologies. In fact, we train a dedicated team of employees focused solely on the development activities for our clinical staff, including those managing the UM program. Our robust training program begins at the point of hire and continues throughout our employees' tenure with Amerigroup.

Our new-hire training curriculum is outlined in Table N.1-1.

Table N.1-1. Facilitating Comprehensive Training

Phase	Description
<p>Phase I: General Orientation to Amerigroup</p>	<p>All newly hired employees, including UM staff, complete a company orientation that includes topics related to corporate history and structure, mission statement, values, ethics, leadership principles, benefits, performance evaluation process, sexual harassment policies, and basic safety and security principles.</p> <p>In addition, new employees must complete online learning modules on privacy requirements, cultural competence, and policies related to fraud, abuse, and ethics.</p>
<p>Phase II: Initial Clinical Staff Training</p>	<p>Initial training for employees who perform UM functions includes the following modules:</p> <ul style="list-style-type: none"> • Creating and working with authorizations • Performing concurrent reviews • Verifying claims • Entering outpatient service • Updating, approving, and denying service • Entering newborn information • Clinical criteria • Applying UM theory • Introduction to Utilization Management • The authorization process • Concurrent review process • Chief Medical Officer review • Discharge planning • Basic behavioral health services • Documentation • Rounds • Time management • Fee structures and reimbursement • Legal and ethical issues in UM • Quality management/terminology/resources
<p>Phase III: General Systems Training</p>	<p>General Systems training includes the applicable information systems and applications that support Amerigroup’s UM program. Topics include Outlook®, PeopleSoft, system training for customer service, UM and Case Management, application of relevant clinical criteria, HIPAA regulations and member rights, and access to tools through the Amerigroup Intranet and others.</p>

Continuing Education/On-going Training

Our UM employees continually build their skills through Continuing Education Units required to maintain licensure. Through the production of job aids that provide a quick reference resource for employees, and individual skill-building provided by managers, we maintain a continual improvement process for the competency and expertise of our staff. In 2013, for example, we targeted education on the tools and systems used within UM, such as our knowledge base system, our Member Grievance Tool, and the procedure for reviewing incoming requests.

Rigorous Oversight of Clinical Training

Providing rigorous oversight of all clinical training activities promotes strong employee performance. Amerigroup's clinical compliance program addresses the following areas:

- Training for clinical employees
- Monitoring and auditing mechanisms
- Policies and/or procedures outlining corrective action plans for non-compliance
- Tracking to verify that targeted employees fulfilled the training expectations, on-going training, and improvement initiatives
- Tracking on-going evaluation expectations, such as inter-rater reliability assessments

Such efforts promote consistent adherence to federal and State contractual or regulatory compliance, as well as NCQA or other accrediting body compliance and support organizational initiatives.

Effective Use of Industry Utilization Management Products

Amerigroup uses WellPoint's medical policies and guidelines, along with our purchased InterQual[®] Level of Care criteria, to evaluate the medical necessity, appropriateness, and efficiency of health care services, procedures, and facilities. Although our medical policy governs the medical necessity of individual services and procedures, we always first consider federal and State law and Contract language when determining eligibility for coverage. In Louisiana, medical necessity is guided by LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1).

In addition to these standards, we may also adopt national guidelines produced by health care organizations, such as individual medical and surgical societies, the National Institutes of Health, and the Centers for Disease Control and Prevention.

Our criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults 18 and older, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members holistically to authorize necessary support services within a safe environment optimal for recovery.

Our UM guidelines are developed and updated annually using clinical best practice guidelines from professional organizations, up-to-date clinical research, and practicing licensed and board-certified physicians through our national Medical Policy and Technology Assessment Committee (MPTAC). MPTAC is a multi-disciplinary group including network physicians from various medical specialties, clinical practice environments, and geographic areas. The committee considers information from a variety of sources, including the results of electronic literature searches; independent technology evaluation programs; and materials published by professional associations, such as the Blue Cross Blue Shield Association; technology assessment entities; appropriate government regulatory bodies; and national physician specialty societies and associations. The committee may also consider a service or procedure

being reviewed, with supporting documentation, as a standard of care in the medical community. For topics that represent a significant change or are otherwise required by law or accreditation, we also seek input from academic medical centers and specialty societies from around the United States. MPTAC has designated subcommittees for certain specialty topics, such as hematology/oncology and Behavioral Health. All guidelines and policies are current, having been reviewed within the calendar year.

We understand that providers working with multiple MCOs could potentially be asked to comply with conflicting practice guidelines. Basing our requirements on national, industry-supported criteria reduces the likelihood of that occurring. Our Administrator/Chief Executive Officer (CEO) and a representative from Provider Relations sit on DHH's Administrative Simplification Committee. The goal of the committee is to reduce the administrative burden on providers and streamline processes, thereby providing a vehicle for working with other MCOs to promote consistent requirements.

Our Louisiana Medical Advisory Committee reviews and approves criteria and guidelines annually with input from the Louisiana Quality Management Committee, which includes practitioners knowledgeable about local delivery systems. Providers may access Amerigroup UM criteria at any time through our provider portal. We also provide them to members and potential members upon request.

Amerigroup attempts to avoid denial of service requests because of failure to meet medical necessity criteria. The Nurse Medical Management clinicians work collaboratively with providers and facilities, discussing cases, asking for additional clinical information to clarify the need for the services, or finding an alternative service package that would more appropriately address the member's condition. If no further information or alternative service package can be identified, the nurse medical manager cannot approve the request and will then forward the request to a Louisiana Medical Director for further review. Our goal is to develop a collaborative working relationship with providers so that they see us as a clinical resource rather than a roadblock.

Our Utilization Management Phone Line is Distinct from Our Member Services Line

Amerigroup's UM phone line is fully integrated into our Provider Services phone line to simplify provider interaction with the health plan. We direct all provider calls to our national Provider Call Center to promote efficiency in operations. Providers who call are offered a menu of both automated and live agent services. Ten representatives from a designated team respond to UM calls to serve the Louisiana health plan.

We track all service levels to verify that they meet State requirements for call-handling performance using National Provider Identifier (NPI), health plan, and product data. On a daily, weekly, monthly, and quarterly basis, we produce reports from our call system for review by the UM team and the Quality Improvement Committee. The UM team promptly responds to any deviations from Louisiana service level requirements and reports them to the QIC. Historically, Amerigroup enjoys excellent results in promptly handling UM calls, and we are proud that our service levels contribute to positive provider relationships.

In 2013, our call center far exceeded all service level contract requirements for Bayou Health. Table N.1-2 displays our performance for the full year.

Table N.1-2. In 2013, the Provider Services Call Center Was Highly Responsive to Callers

Total Incoming Calls	Percent of Calls Answered	Percent of Calls Answered within 30 Seconds	Caller Chose to Speak to a Live Person		
			Average Hold Time	Average Length of Call	Percent of Calls Abandoned
130,697	99.6%	94.5%	60 seconds	5.82 minutes	0.6%

Call Center Minimum Standards: 95 percent of calls answered within 30 seconds; average hold time of three minutes or less; call abandonment rate less than 5 percent.

When providers contact the call center, they are prompted to enter their National Provider Identifier (NPI). The NPI enables the system to recognize the provider’s location and route the call to the Louisiana Team. The callers then enter the main menu. By selecting pre-certifications, they are connected to an appropriate member of the UM team. ***This process also allows us to track Louisiana calls separately.***

Clinical staff is available 24 hours a day, 7 days a week (24/7) to support provider and facility UM needs. Additionally, our voice portal technology, as well as a provider website, are available 24/7 to assist providers and their staffs with questions and concerns or to verify an authorization status.

Precertification requests are typically directed to non-clinical UM employees who apply medical necessity criteria to the clinical information presented. The UM employee approves all requests for services that meet medical necessity and document them in our system. As noted above, if the precertification clinician is unable to obtain additional information or an alternative plan of care, the request is routed to a Louisiana Medical Director, who makes the final determination. Any adverse determination regarding medical necessity is always made by a Louisiana-licensed Medical Director. The Louisiana Medical Directors will engage peer reviewers as necessary to render determinations for specialized requests.

Amerigroup works to engage providers in collaborative discussions. We focus our authorization requirements on those instances where we have the greatest impact, promoting provider satisfaction but also delivering value to the State in streamlined plan administration. We value our provider relationships, and our authorization process respects their clinical judgment. Amerigroup’s practices reflect substantial input from our network provider community, and those of our affiliate health plans, over the past several years.

Table N.1-3 summarizes the differences between the functionality of our Member Services line, described fully in Section R, and our Provider Services line.

Table N.1-3. Functionality of Each Line is Customized to the Type of Caller

Functionality	Member Services	Utilization Management/ Provider Services
Process for routing calls appropriately, including escalation; the type of	Recognizes callers’ area codes and routes members to a Customer Care	Routes the call to our designated Louisiana team based on the provider’s NPI.

Functionality	Member Services	Utilization Management/ Provider Services
information available to customer service staff and how it is provided	Representative using English or Spanish Voice Portal prompts. Based on the member's selection, our automated call distribution (ACD) system routes the call to a representative who is most appropriate to the member's need.	Providers select pre-certification from a list of available prompts to reach UM staff.
Process for handling calls from members with limited English proficiency or hearing impairments	Members are served by either bilingual phone representatives or are assisted by over-the-phone interpreters. Members with hearing impairment may access the line through the TDD/TTY service provided by AT&T Relay Services.	Providers may be served by bilingual phone representatives. An interpreter line is available for providers, but this situation would be unlikely.
Monitoring process for assuring the quality and accuracy of information provided to members	Random call monitoring and documentation reviews of member services representatives throughout the month	Inter-rater reliability audits on UM determinations
Monitoring process for verifying adherence to performance standards	Multiple call status reports at a variety of frequencies – ranging from every 15 minutes to quarterly – detailing our compliance with performance standards. They show trends for call volume, average speed of answer, and abandonment rate.	No difference in the process.
How our customer service line will interact with other customer service lines maintained by the State, parish, or city organizations	Representatives are able 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. Our Amerigroup Community Resource LINK gives members a searchable online resource for available community programs,	Not applicable to providers. Any members calling with a UM-related question will be served by a Customer Care Representative or Care Manager, who will follow the process described for Member Services.

Functionality	Member Services	Utilization Management/ Provider Services
	benefits and services displayed in easy-to-use format and searchable with GPS technology.	
After-hours procedures	After-hours availability from Amerigroup On Call	24/7 availability

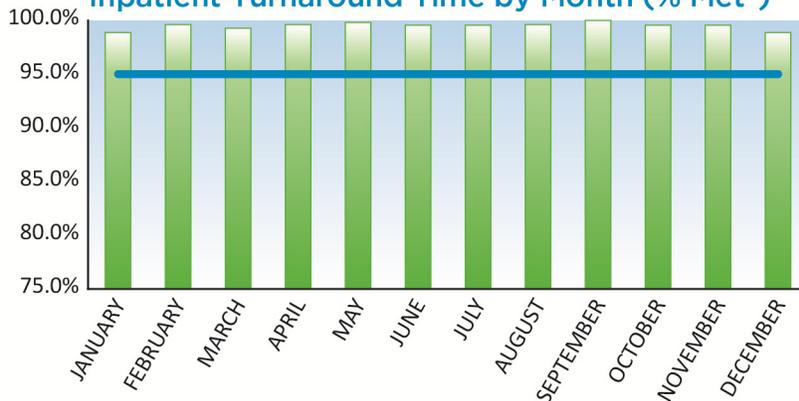
Continuing to Exceed Department of Health and Hospitals Timeframes

To promote compliance with DHH UM timeframes, our UM team reviews reports that track open cases daily to set priorities and focus on those requiring immediate action. Clinical Management reviews system-generated logs to identify and resolve potential barriers to timely closing of cases. They also monitor trended data in weekly or monthly reports to identify trends that may indicate problems with current processes or workload distribution. In Louisiana, pre-authorization determinations are made according to the following timeframes:

- Eighty percent of standard service authorization determinations will be made within two business days
- Non-urgent pre-service decisions and notifications will be made no later than 14 calendar days of receipt of the request
- Ninety five percent of concurrent review determinations will be made within one business day
- Ninety nine and a half percent of concurrent review determinations will be made within two business days of obtaining the appropriate medical information
- Urgent pre-service decisions and notifications will be made within 72 hours of receipt of the request

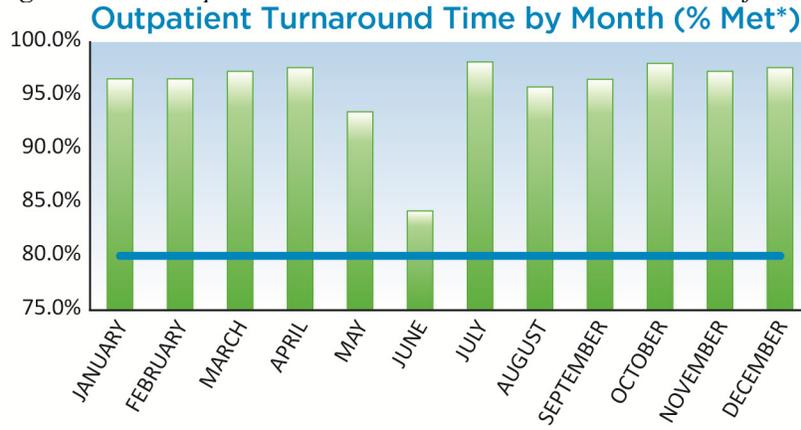
Amerigroup has consistently met and exceeded those required timeframes. Figures N.1-1 and N.1-2 display our results.

Figure N.1-1. Inpatient Turnaround Times Near 100 Percent
Inpatient Turnaround Time by Month (% Met*)



*Turnaround time <1 day = Met

Figure N.1-2. Outpatient Turnaround Times Far Exceed the Performance Expectation



*Turnaround time <2 day = Met

N.2. Confirming that Services are not Arbitrarily or Inappropriately Denied or Reduced

N.2 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

The Amerigroup Utilization Management (UM) Program facilitates delivery of the most appropriate medically necessary care to members in the most cost-effective setting. Key elements of our UM Program that help us confirm that services are not arbitrarily or inappropriately denied or reduced in amount, duration, or scope, include the following:

- Verifying the integrity of clinical decision-making through audits
- Applying credible clinical guidelines consistently
- Establishing local clinical leadership knowledgeable about local practice patterns
- Monitoring performance, effectiveness, and compliance

Our comprehensive approach allows members to receive services at the appropriate level of care through targeted, innovative programs in collaboration with our providers. The UM program directly contributes to a reduction in the rate of avoidable hospital stays and readmissions, a DHH objective, by applying evidence-based criteria to validate the appropriateness of admission and initiating discharge planning to verify that each member transitions safely to outpatient services. Our industry-leading systems and techniques improve efficiency for both Amerigroup and our providers, while promoting improved health outcomes and well-being for our members. All guidelines will be reviewed and approved by the Louisiana Medical Advisory Committee, which includes representation of Louisiana-based providers to align them with local practice patterns.

Amerigroup Limits Pre-Authorization Review to Select Services

Amerigroup recognizes that most outpatient services are not a source of inefficiency, waste, or abuse. Therefore, it is not cost effective for us to require prior authorization or precertification requirements. We limit our pre-authorization efforts to inpatient admissions, certain outpatient surgeries and procedures, certain non-emergent out-of-network services, home care, certain durable medical equipment, rehabilitation services, select medications, and certain diagnostic procedures. We educate our network providers about covered services and benefits available to members through our comprehensive provider servicing model, and we continually reassess our pre-authorization requirements for consistency with recommended industry standards. The request for service authorization provides us with immediate knowledge of the member's condition to allow the UM representative to arrange care coordination and discharge planning activities as indicated.

Review of Service Requests is Individualized

Amerigroup does not employ utilization controls or other coverage limits to automatically place limits on the length of stay for members requiring hospitalization or surgery. Length of stay is based on the needs of the member, rather than arbitrary limits. Members who are hospitalized or receiving surgical services are managed by an assigned Nurse Medical Management clinician. The clinical review for these services will specify authorization for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the nurse medical manager, working with the hospital, PCP/attending physician, and other parties, will monitor and continually review the case to determine discharge readiness and facilitate discharge planning. For members found to require extended benefits, as identified by the concurrent review of needs, severity of illness, and services being rendered, the nurse medical manager has the authority to extend the hospital stay or other services as needed.

Targeting Initiatives to Focus on Behavior Change

Amerigroup focuses our UM efforts on engaging providers in a productive dialogue about the level of care that will drive the greatest outcomes, rather than simply using UM as a mechanism for authorization or denial of requested services. Efficiency, accountability, and results drive our UM program design and operations. Amerigroup continually strives to identify and implement industry best practices to positively impact our members, providers, and State customers.

Reducing Administrative Burdens on Providers

Collaboration with our providers is at the core of our philosophy for establishing more efficient patterns of utilization. We facilitate provider access to data, information, and systems that ease the administrative burden of review and approval processes, and support the most effective delivery of services. Here are just a few examples:

- We provide real-time authorizations for telephonic and online requests from providers, or providers may request by fax. Upon receipt, calls are automatically routed to UM professionals who guide providers through the authorization process.
- We continually evaluate services requiring prior authorization to stay current with industry best practices and utilization guidelines.
- We provide evidence-based, clinical practice guidelines, new technologies, and best practices to assist providers in rendering optimal care to members.
- We conduct workshops for providers on relevant topics, including credits for continuing medical education.

Our quest for optimal member and provider outcomes is at the forefront of our UM program efforts from initiation of program design to implementation, operation, and maintenance.

Assuring Integrity in Clinical Decision-Making

We make medical necessity determinations using nationally accepted UM and medical policy guidelines. They promote consistency and integrity in clinical decision-making. In addition, we follow specific protocols, summarized in Table N.2-1, to support the integrity of coverage determinations. Any decisions that the member or provider is not satisfied with can be appealed and further reviewed. Our appeals process is detailed in this proposal in Section S, Grievances and Appeals.

Table N.2-1. A Comprehensive Strategy to Promote Integrity of UM Decisions

Protocol	Summary
Clinical Criteria	Our medical necessity criteria are evidence-based and nationally accepted. Prior to implementation, they are reviewed by the national Medical Policy and Technical Advisory Committee and the Louisiana Medical Advisory Committee to align them with local health plan needs. The national Medical Operations Committee reviews them annually to verify continued applicability.
Local clinical leadership	When the medical necessity criteria are not met, requests are referred to a Louisiana Medical Director who may engage a Peer Reviewer for further evaluation. We foster a provider-friendly UM approach. We strive to engage providers in collegial discussions to negotiate a treatment plan that is mutually satisfactory and appropriate, based on the member’s unique

Protocol	Summary
	case history. Only a Louisiana-licensed Medical Director will have the authority to issue a denial if we are unable to collaborate to develop an alternative plan.
Inter-rater reliability audits	All clinical employees are reviewed annually to verify consistency and accuracy in application of the criteria. Any who do not meet the targeted performance level are subject to a corrective action plan to bring their performance in line with plan expectations.

For more than 23 years, Amerigroup and our affiliate health plans have established and refined our UM program and policies to guard against arbitrary denials or reductions in service. We have a proven track record in 19 states, including Louisiana.

Peer-to-Peer Reconsideration Process

Providers are offered the opportunity to discuss a medical necessity denial with our Chief Medical Officer (or appropriate practitioner) when an adverse determination is issued. If the provider contacts us within five business days of the notice of adverse determination, we schedule a peer-to-peer discussion within one business day. Urgent requests are addressed the same day or as clinical need indicates.

Reconsiderations are conducted by the member’s practitioner and the Medical Director making the initial determination (or appropriate practitioner under the direction of the health plan Medical Director if the original health plan Medical Director is unavailable). We strive to reach a decision that meets the member’s need and is acceptable to the provider. When a member’s clinical information does not support the medical necessity of the service, our Medical Director will explore alternative treatment approaches with the provider.

Establishing Local Clinical Leadership Knowledgeable About Local Practice Patterns

Studies consistently show the practice of medicine varies significantly by region and geography. Knowing the importance of local health care practice and influence, our Louisiana-based and credentialed clinical leadership directs our UM program. Our Louisiana clinical team members and their responsibilities are the following:

- The Louisiana-based plan Administrator/CEO holds overall accountability for UM.
- The Louisiana-licensed health plan Chief Medical Officer oversees the clinical elements of the program.
- The Louisiana-based and licensed Director of Health Care Management Services is responsible for the implementation and daily operations of the UM program.
- The Louisiana Registered Behavioral Health Nurse Case Manager is accountable for interacting with DHH’s Coordinated Systems of Care Statewide Management Organization (SMO) to coordinate basic and specialized behavioral health benefits.

REAL SOLUTIONS
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REAL RESULTS

Amerigroup’s clinical criteria and guidelines are consistent with the industry standard for medical necessity reviews that are widely used by health plans, hospitals and governmental agencies. 

Ensuring the Utilization Management Program Is Responsive to Local Practice Patterns

As part of a national company, Amerigroup has a wealth of resources to support our Louisiana health plan. Our team includes national Medical Directors with specialized clinical experience and knowledge of industry best practices. They focus on the development and implementation of programs that support the efficient utilization of medical resources and the practice of quality (evidence-based) health care by our providers.

The blending of local clinicians with national program management expertise assures a robust UM program designed and managed with industry best practices coupled with local variations as appropriate. 🌸

Given the Medical Directors' broad knowledge across many states coupled with their clinical expertise, they are both dynamic and organized in their approach to best practices. Working directly with health plan medical and clinical leadership, they support the implementation of medical, and case and chronic care management programs that deliver appropriate and timely medical services to our members.

The Louisiana UM Program is reviewed and approved by the Louisiana UMC, QMC, and Medical Advisory Committee (MAC), assuring local accountability and consideration of regional practice variations. The Louisiana MAC will incorporate fully credentialed network providers, with representation from primary care and major specialty services. This includes guidance on our UM program and criteria.

One of the roles of the Louisiana QMC is to identify opportunities to improve services and clinical performance by recommending updates to clinical practice guidelines, based on review of demographic and epidemiologic information, that target high volume, high-cost, high-risk, problem-prone conditions.

Applying Credible Clinical Guidelines Consistently

The Amerigroup UM program is based on nationally recognized, evidence-based medical necessity guidelines. We apply medical necessity criteria based upon individual member needs and a thorough assessment of specific services available within the local delivery system. Our procedures are established, consistent, and apply to all prior authorization, concurrent, and retrospective reviews.

They provide a rules-based system for screening proposed medical care based on member-specific, proven medical care processes, and they consistently match medical services to member needs based on clinical appropriateness. Using InterQual[®] Level of Care Criteria and WellPoint/Unicare Medical Policies and Clinical UM Guidelines, we evaluate medical necessity and appropriateness of both physical and basic behavioral health services.

We are acutely aware of, and responsive to, the differing, complex needs of members with multiple chronic conditions. When using our criteria to match a level of care to a member's current condition, UM supervisors consider the severity of illness and presence of multiple conditions, as well as episode-specific variables. Our member-centric, holistic approach enables members to receive necessary support and services within a safe environment that is optimal for recovery.

Consistency Through Inter-Rater Reliability Audits

Amerigroup conducts inter-rater reliability reviews of physicians and non-physicians applying medical necessity criteria to verify consistency and accuracy in application of the criteria. All licensed clinical staff members are thoroughly trained to apply medical necessity criteria. Physician review for consistency is performed by our QM department with the Chief Medical Officer (described in detail later in this section). Every year, Amerigroup assesses inter-rater reliability of review decisions made by our clinical review staff. The following are the goals of our inter-rater reliability program:

- To measure knowledge of criteria (WellPoint Medical Policies, InterQual Level of Care)
- To minimize variation in the application of criteria
- To enhance staff recognition of potentially avoidable or inappropriate utilization
- To identify staff that need additional training
- To identify potential risks resulting from inconsistent application of guidelines

We use appropriate mechanisms, such as hypothetical UM test cases, or a sample of UM determination files using an NCQA-approved auditing method, to evaluate application consistency criteria.

Physician and non-physician reviewers are evaluated to assess their consistency and accuracy in application of the medical necessity criteria. All licensed clinical UM staff who apply medical necessity criteria participate in the inter-rater reliability process.

Results are reported to each Department Lead and the Chief Medical Officer, UM Committee, Quality Management Committee, and Medical Advisory Committee annually as required. Opportunities for improvement are identified and addressed by individual action plans.

Analysis of 2013 Inter-Rater Reliability Test Results

Amerigroup participated in the 2013 Inter-rater Reliability Audit. Amerigroup’s average score is computed as a weighted average of the testing of all our affiliate health plans. Scores greater than or equal to 80 percent meet the established threshold. Scores below 80 percent require action plans from the applicable affiliates. Table N.2-2 compares our 2013 performance to the prior year and demonstrates the maturation of our team.

Table N.2-2. IRR 2013 Results Show Strong Reliability

Area of Assessment	2012 Average Score	2013 Average Score	Change in Score
InterQual Acute Adult	85	89.3	4.3
InterQual Acute Pediatric	87	92.4	5.4
InterQual DME	Not done	94.6	N/A
InterQual Long-Term Acute Care	85	86.7	1.7
InterQual Outpatient Rehabilitation and Chiropractic	85	87.8	2.8
InterQual Procedures	87	89	2
InterQual Rehab	82	92.3	10.3
WellPoint Medical Policies	N/A	84	N/A

Quality Medical Performance Monitoring

In 2013, Amerigroup developed a formalized performance monitoring function. It helps identify opportunities for improvement leading to delivery of higher quality services, and/or increased efficiency of operations. Another purpose is to monitor for standardization of core processes within the MCO. That helps better identify gaps in processes that inhibit the program’s efficiency and effectiveness.

Amerigroup conducted regular process and timeliness audits of our UM associates to assess whether all managed cases were completed in a consistent, objective manner, in accordance with all applicable contractual, regulatory, or quality standards. A minimum of five cases for each staff member were audited monthly. If the employee’s overall score was 90 percent or greater for three months continuously, then the number of audits would decrease to two monthly. The results of inpatient and outpatient area reviews are displayed in Figure N.2-1 and N.2-2 below.

Figure N.2-1. Inpatient Reviews Display a Strong Upward Trend

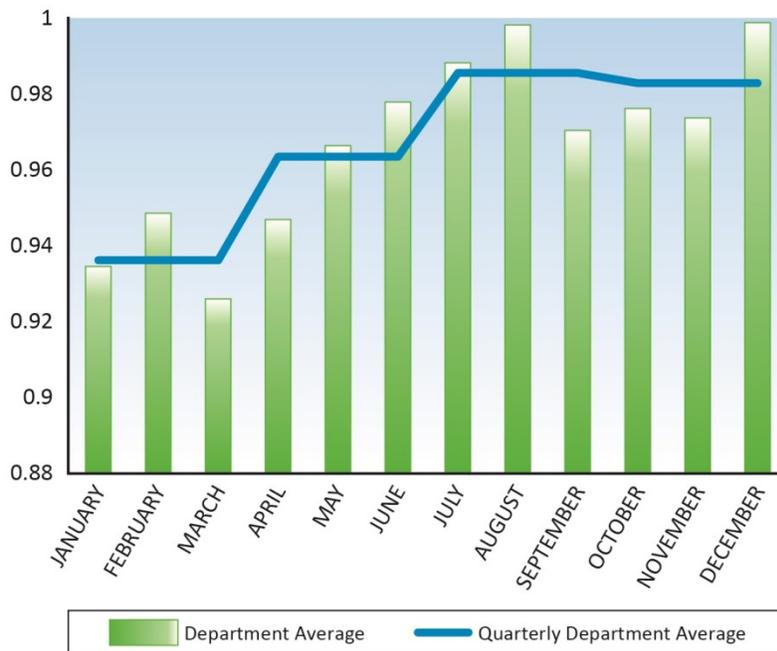


Figure N.2-2. Outpatient Reviews Achieve a Nearly Perfect Score



N.3. Utilization Data

N.3 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Continual assessment of utilization data enables Amerigroup to identify trends and refine our processes to promote superior performance. We maintain the systems, resources, and expertise necessary to support the gathering, analysis, and reporting of utilization data for our Louisiana health plan. We have proven expertise leveraging utilization data analysis to drive changes in operations to address negative trends.

Gathering, Analyzing, and Reporting Utilization Data

Utilization data is gathered through our core operations system – 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 (for example, data entry by UM or claims staff) or through application-specific data loads (such as daily enrollment/member file). All other Amerigroup applications interfacing with the core operations system map to its data structures to enable consistency in naming, formatting, and validation. This structure reinforces the availability of reliable and comprehensive information for analysis. Additionally, Amerigroup’s data warehouse, which stores utilization data, is an integrated repository fed directly from the core operations system to promote data control and consistency. It maximizes our capacity for data analytics.

Supporting the Louisiana health plan with **utilization data analysis and reporting** is an expansive team of professionals in our national Health Care Analytics department, which provides health care analysis, consulting, and analytical capabilities to help optimize business decision-making. The team’s expertise spans the following areas:

- Health care analytics
- Analytic platforms and services
- Provider network pricing
- Premium and claims integrity
- Analytics project management

This group collaboratively develop reports to monitor utilization each month, then drives improvements to utilization patterns with our local health plan business and clinical teams. Analysis begins with identifying opportunities at the detail category of service level, based on the valuation of mix- and benefit-adjusted trends. Where we identify utilization increases not explained by member mix or benefit changes we take the next step to identify outlier providers and members.

We review both PCP-panel utilization patterns and servicing provider billing patterns to conduct the provider-level analysis. The team identifies outlier providers based on relative distribution of services and then refers the cases to appropriate functional areas for intervention. Interventions range from fraud investigation, to pre- or post-payment claims adjudication prompted by possible waste or abuse, to revision of provider contracts, to panel reassignment, to inclusion in our provider quality incentive program.

We identify outlier members using a combination of predictive modeling techniques and well-documented fraud and waste algorithms. Predictive modeling identifies members appropriate for Amerigroup’s wide spectrum of successful Maternal-Child, Chronic Care and Case Management programs, including our innovative Emergency Department diversion program known as Right Care, Time, and Place.

Our national Health Care Analytics team enables Amerigroup to validate that our business decisions are grounded in reliable data. Their expertise complements the clinical and local market expertise found in each of our health plans.

Monitoring Under- and Over-Utilization

Amerigroup produces performance reports to identify both providers and members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans.

Practice and utilization data elements included in the analysis appear in Table N.3-1 below.

Table N.3-1. Mining Data to Identify Under- and Over-Utilization

Utilization Area	Measurements Evaluated
Acute/Chronic Care	<ul style="list-style-type: none"> • Re-admissions • Pharmaceuticals • Specialty referrals • Emergency department utilization • Home health and durable medical equipment utilization relative to diagnostic entity
Preventive Care	<ul style="list-style-type: none"> • Well-child/adult PCP visits • Age-appropriate immunizations • Mammograms • Blood lead testing

Our UM clinical team works with the Chief Medical Officer and Provider Relations staff to address aberrant provider patterns. The team reviews and validates the medical issue, develops an action plan, discusses the plan with the provider, and implements action items.

When a member’s utilization pattern shows outreach and education is warranted, our medical management clinical team will collaborate with the Chief Medical Officer to determine appropriate interventions, including outbound telephone calls to educate him/her about appropriate use of services, the importance of preventive care, or the need to refer to case management for care coordination.

Amerigroup analyzes utilization data for specific quality of care and utilization outliers. In particular, we create reports that analyze care by PCPs, including the following:

- Utilization of out-of-network providers
- Specialist referrals
- Emergency department utilization
- Hospital admissions, lab services, medications, and radiology services
- Clinical performance measures as indicated in Appendix J of the RFP

Our experience has shown that robust provider profiling and evaluation does not easily lend itself to the use of a single tool or approach. Consequently, we continually develop solutions and methodologies to fully examine all aspects of member care and its relationship to quality.

Our Potential Missed Care Opportunity (PMCO) report helps providers connect with and address care gaps for their members. It is shared in an Excel format, thereby allowing providers to sort and pivot the information to work best for their practices. The file includes six tabs containing group and individual provider summaries and information on their specific members. We review the report with the providers to develop plans of action that assist their outreach to the identified members.

In 2015, we will deploy a more dynamic approach to the profiling and evaluation of our network. We are working toward constructing tools that balance predictive accuracy, clinical relevance, and practical criteria, thereby driving improvement within the network.

The aforementioned HEDIS Data Sharing and the Potential Missed Care Opportunity reports will remain in use for the beginning of 2015; however, they will be replaced with the introduction of Symmetry Episode Treatment Groups® (ETG) and the Provider Case Management Solutions (PCMS) program.

The ETG program enables Amerigroup to offer network providers the opportunity to benchmark their resource utilization and expenditures for the treatment of different medical conditions against their peers in the same community. It will use enrollment data, available diagnostic and procedural information on medical and pharmacy claims, and health care services received to assign a member to a unique episode of care (ETGs). This assignment facilitates the provider-to-peer comparisons. We will distribute the reports and review them with the providers to determine what actions can be taken to improve performance.

The PCMS program is a web-based application that will be available to network providers. Using alerts, dashboards, and reports, PCMS gives practices the devices they need to manage their members' health. It will help practices stratify their memberships based on risk and prevalence of chronic conditions, and it will offer actionable clinical insights, such as the care gap messaging and preemptive flagging of members with high risk for readmission. Functionality will include provider- and member-level drill-down capabilities into quality performance metrics, and identification of cost of care savings opportunities, such as ED avoidance.

The home page of the application provides a high level summary of the provider's practice. This will include the following:

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

Each screen will be designed to enhance information presented on the home page. The application is intended to enable downloading these reports into an Excel format so providers have the option to further monitor and review the data.

We are committed to involving as many providers as applicable in the programs listed above because only through their awareness and involvement will quality improve. For the programs that we plan to introduce

in 2015, our approach will be to expose the majority of our network to the data sources so that they can self-manage the results. Then, we will focus our work more intently on provider groups that represent approximately 80 percent of our membership base.

An Example of Leveraging Utilization Data to Drive Performance Improvements – New Admission Initiative

In response to data utilization patterns suggesting overuse of inpatient services for conditions that could be safely managed in an outpatient or observation status, Amerigroup developed a new admission initiative. When Amerigroup was notified that a provider had requested an inpatient admission based on one of the following ambulatory sensitive conditions, the case was clinically reviewed by the nurse to evaluate the validity of the admitting diagnosis. Once validated, the case was pended to the Chief Medical Officer for a focused review to determine whether the admission was medically necessary and appropriate for inpatient acute care or could be safely managed in an outpatient setting. The following conditions were targeted for review:

- Angina/acute coronary syndrome
- Abdominal pain
- Asthma
- Bronchiolitis
- Cellulitis
- Chest pain
- Croup
- Dehydration/weakness
- Diabetes
- Dizziness/weakness
- Febrile illness without focal infection
- Gastritis/duodenitis
- Gastroenteritis
- Headaches
- Hyperemesis gravidarum
- Pneumonia
- Pregnancy-induced hypertension
- Pre-term labor, threatened
- Renal colic and kidney stones
- Seizures
- Supraventricular arrhythmias
- Syncope/collapse
- Transient ischemic attack
- Nausea/vomiting

The initiative led to a 1.08 percent improvement from 2012 to 2013 in medical and non-delivery obstetrical potentially avoidable variance determinations. It also led to the development and expansion of our integrated rounding process, described below.

Utilization Management Department Redesign - Integrative Rounding and Collaborative Discharge Planning

In 2013, our UM program continued to add depth to both leadership and employees by adding two nursing positions, one non-clinical position, and two full-time Medical Directors. With our team of 16 clinicians in place, the Inpatient UM program underwent a structural change to drive improvements in provider collaboration, alternate level of care movement, and overall length of stay improvements. The changes resulted in a half-day decrease in the overall length of stay.

Phase 1: Implementation of focused and collaborative discharge rounding

Teams met two times a week and focused on members with barriers to discharge, longer lengths of stay, and complex discharge needs. This led to inclusion of the stabilization, ED, and Complex Case Management teams on rounds to increase communication, improve the transition of members, build depth, and enhance the team’s skill set.

Phase 2: Reorganization

We reorganized the Nurse Medical Management clinicians into three strategically focused teams based on their strengths, expertise, and experience:

- Integrated medical/behavioral health
- Maternal-Child
- Alternate level of care (ALOC)

Phase 3: Facility-Based Interventions

We deployed the Inpatient Nurse Medical Management clinicians to high-volume and strategic inpatient, rehabilitation, skilled nursing facilities (SNF), and long-term acute care (LTAC) facilities, obtaining full electronic medical records access wherever possible to perform independent clinical and timely reviews. Our nurses facilitated complex discharges within SNFs and LTACs.

Integrative Rounding and Collaborative Discharge Planning resulted in a **half-day decrease** in the overall length of stay. 🌸

Nurse Medical Management clinicians are on-site at eight facilities with a ninth facility pending. We will continue to grow this model because of its success. Our on-site Nurse Medical Management clinicians have been well-received by the facilities. The nurses reduced the workload of their own administrative staff and discharge planners.

On-going

Currently, all UM nurses meet daily to discuss new admissions and determine whether members are being served at the right level of care. Twice a week, we continue to assemble our Integrated UM and Case Management teams to meet with the Chief Medical Officer and discuss cases that are not progressing optimally, such as those with long lengths of stay or complex discharge plans.

Our Behavioral Health Nurse Case Manager holds similar rounds with the state's SMO to discuss the needs of members with complex medical needs and behavioral health concerns.

Once a week, our Nurse Medical Management clinicians, dedicated to our members in the Neonatal Intensive Care Unit, meet with our national Maternal/Child Health Medical Director to discuss our youngest members with complex health care needs.

Inpatient Readmission Initiative

Further drill down in our inpatient data demonstrated a trend in overall readmissions. There has been a strategic focus on analyzing our total number of 30-day readmissions. We recognize that hospital readmissions are costly and represent a quality issue for our membership. The first 24 to 72 hours post-discharge represent the highest risk for readmissions, and delays in engagement indicate a missed opportunity, especially during the transition from acute care to the home. Using short-term case management strategies, our stabilization model has demonstrated a reduction of readmissions. The stabilization model exploits opportunities for coordination of discharge care and augments our existing UM and case management activities.

Our Nurse Case Managers target members with readmission scores (RAS) greater than 20 for this program. RAS is used to prioritize members on the Daily Census. A RAS of 40, for example, means that the member is 40 percent more likely to be readmitted within the next 30 days than one with a RAS of 0. This predictive modeling score is recalculated daily based on the most recent information, using demographic, clinical, and current admission data to determine the member's likelihood of readmission.

For members with a RAS greater than 20, the nurse medical management clinician and the assigned Nurse Case Manager collaborate with the hospital's Utilization/Discharge planning nurse to work with the members and/or their caregivers to establish a safe, comprehensive discharge/transition plan.

Contact between the Nurse Case Manager and member or caregiver is made either prior to discharge or within 72 hours to begin the transition management program. The following discussion points are reviewed with the member or caregiver during the 30 days after discharge:

- Precipitating factors: situations or conditions that led to an admission
- Medication management: new prescriptions ordered post-discharge and medication reconciliation
- Follow-up care and establishing a medical home: making appointments and having discussions regarding the importance of coordination through the member's PCP
- Assisting and encouraging members to manage their patient-centered records
- Condition-specific education

Our Inpatient Readmission Initiative avoided more than 600 expected readmissions leading to **\$2.9 million** in estimated savings. 

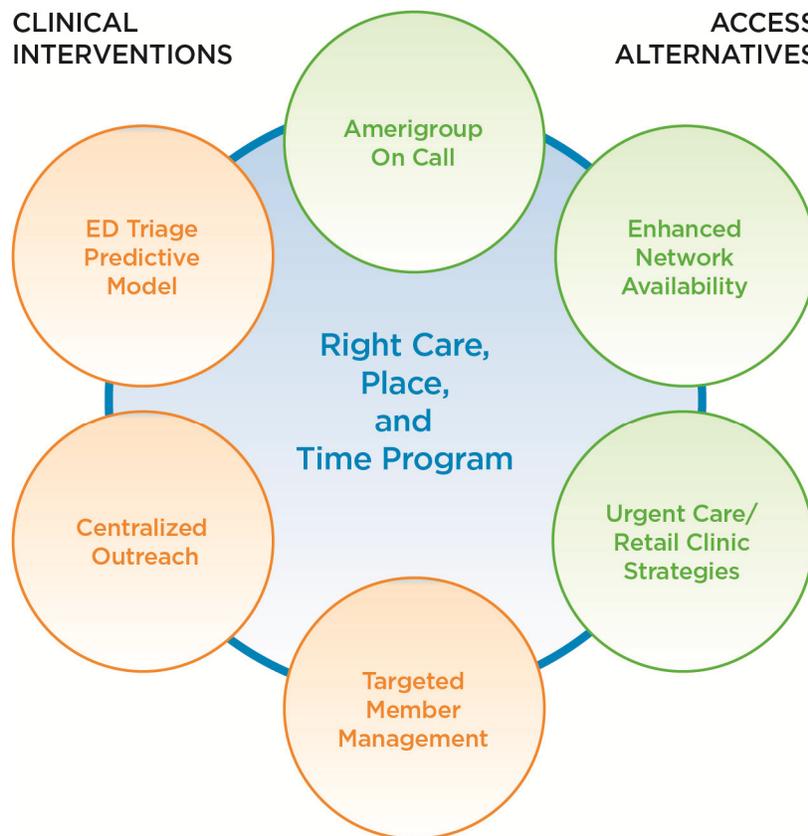
Since its implementation in November 2012, the program demonstrated better than expected results with more than 600 expected readmissions (based on RAS Score) avoided, leading to ***\$2.9 million in estimated savings*** across Amerigroup and our affiliate health plans.

N.4. Plan to Provide Care in the Most Appropriate and Cost-Effective Setting

N.4 Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with Sickle Cell Disease, chronic pain, dental, and/or behavioral health conditions.

Amerigroup’s Right Care, Place, and Time (RCPT) program, depicted in Figure N.4-1, is our plan to provide care in the most appropriate and cost-effective setting. It uses a multi-strategy approach to connect members to emergency department (ED) alternatives when appropriate.

Figure N.4-1. Right Care, Place, and Time Program



Throughout our history, Amerigroup Louisiana and our nationwide affiliates have actively pursued various strategies to reduce avoidable use of the ED. Our plan for continuing to promote care in the most appropriate and cost effective setting blends general member education with more intensive support, including the following:

- Education on appropriate ED usage through motivational techniques
- Alignment with PCPs and specialists based on an individual needs assessment, including appointment assistance

- Medication reconciliation and adherence reinforcement
- Transportation assistance
- Targeted educational mailings based on common non-emergent diagnoses, such as otitis media, headaches, and upper respiratory infections

Understanding the Drivers of Inappropriate Emergency Department Utilization Leads to Real Solutions

Our experience shows that members have the most positive outcomes when they are regularly engaged and connected to their PCP. To that end, we employ a data-driven approach to engaging members who experience frequent emergent situations and link them to on-going preventive care services. We continually analyze ED utilization patterns to understand which members are most likely to have avoidable ED visits. Within our suite of predictive models, our TRIAGE tool synthesizes member data (such as diagnoses, claims history, authorizations) and assigns risk scores to indicate likelihood of ED visits for ambulatory care-sensitive conditions.

Developing TRIAGE to Target Interventions for Greatest Impact

In 2010, we analyzed more than 190,000 ED visits from our affiliates in Maryland and Tennessee. Using an algorithm to classify utilization (developed by the New York University Center for Health and Public Service Research with input from ED and primary care physicians), we grouped ED visits into four categories:

- ED diversion opportunity
 - Non-emergent
 - Emergent, primary care provider (PCP) treatable
- No immediate ED diversion opportunity
 - Emergent, preventable
 - Emergent, non-preventable

The analysis concluded that, for 75 percent of ED visits, the member's condition could have been treated more effectively in an alternative setting.

Amerigroup then analyzed ED utilization patterns to understand which members are most likely to visit the ED. Using the results of this analysis, we created a proprietary predictive model that accounts for non-emergent and preventable ED use. The model is driven by an individual's clinical profile, including conditions that are preferably treated outside the ED, such as upper respiratory or urinary tract infections.

The predictive model examines member data, such as demographic and geographic characteristics, prior ED use, and internally developed metrics, to assign each member a relative risk score for future, multiple, low-level ED visits. Called the TRIAGE Score, it enables us to stratify members into meaningful intervention groups. These focused interventions are most likely to divert care for Preventable Emergency Department Diagnoses to settings better aligned and more appropriate to meet members' needs.

While frequent visitors, or super-users, experience the highest rate of repeated use of EDs, they represent a very small share (4.3 percent) of the overall number of lower-level ED visits and an even smaller percentage of Amerigroup members (0.4 percent). The vast majority of ED visits for lower-level conditions (95.7 percent) are driven by the rest of the population (99.6 percent) who use the ED infrequently.

Targeted and Multi-Layered Inventory of Emergency Department Solutions

Supported by our long experience in Medicaid programs and recent, updated data analysis, Amerigroup has developed an inventory of solutions that address the fundamental challenges of reducing non-emergent and preventable ED visits in these two population segments, outlined in Table N-4-1.

Table N-4.1. Tailoring Interventions for Each Population

Population	Challenges
Frequent ED Visitors	<ul style="list-style-type: none"> Actively coordinate care through intensive case management Manage transitions of care Meet special needs of unique subpopulations
Balance of Population	<ul style="list-style-type: none"> Develop and promote primary care alternatives to ED visits Conduct targeted member outreach Reconnect members to their Medical Homes

Strategies for Members with Higher Risk Scores. In the 2010 study of high-risk members enrolled in Amerigroup’s case management program, we found that after being managed for at least 90 days, members used health care resources more efficiently and required less emergent care, thus reducing costs while improving health outcomes. One such outcome was a significantly greater reduction in non-emergent ED visits and inpatient admissions through the ED, which indicates that members are receiving the right care at the right time. Overall, managed members demonstrated a 39 percent reduction in non-emergent ED visits.

For members at risk of an ED visit after a hospitalization, Amerigroup has adopted a transitional model of care delivering intensive short-term support to successfully shift individuals from inpatient to outpatient care. Nurse Case Managers (NCMs) work with the individual, using member-defined strengths, needs, and preferences to prevent escalation to an inpatient admission. Our NCMs also identify members who are most at risk of hospital admission, extended average length of stay, and frequent ED visits; have actionable gaps in care; or could benefit from additional supports. The NCM contacts the member by phone or face-to-face visit to identify issues causing frequent ED use and works collaboratively with the individual and his or her multi-disciplinary team to develop a plan to connect the member with on-going care.

Members identified by the TRIAGE Model also receive an Interactive Voice Response (IVR) approach that features an automated call with such question prompts as “do you have a PCP with whom you work well?” Respondents receive additional follow up via live outreach from a specialized unit that pursues interpersonal interaction to assist them. This unit also promotes *Nurse HelpLine*[®] and Amerigroup On Call in the conversation. In addition, at the member’s request during a call or when a member cannot be reached, we mail a brochure about alternatives to ED use.

Broad and Targeted Strategies for Members with Lower Risk Scores. Approximately 96 percent of lower-level ED visits are by members who go infrequently but for such conditions as upper respiratory or viral infections, which can generally be managed successfully in an ambulatory setting. For these individuals, we apply the broad and targeted interventions summarized in Table N.4-2.

Table N.4-2. Broad and Targeted Interventions

Strategy	Interventions
Developing and promoting alternatives to the ED, enhancing access to primary care services	<p>A comprehensive urgent care services network which broadens member access to ED alternatives, especially after hours:</p> <ul style="list-style-type: none"> • PCPs with extended hours • Urgent care centers • Retail clinics • Physician telephonic consults
Targeted member outreach	<p>When members do visit the ED for lower level visits, Amerigroup conducts targeted outreach, using multiple data sources to identify those individuals and various tools to reconnect them to a Medical Home.</p> <ul style="list-style-type: none"> • Outreach calls (clinical and non-clinical) to educate about appropriate use of ED • Automated educational calls • Print materials
Reconnecting members to their Medical Homes	<ul style="list-style-type: none"> • Establishment of Advanced Medical Homes • Provider profiling which informs PCPs about their members' use of the ED for low-level visits • Deploying Inpatient Utilization Nurses in specific high-volume facility UM departments to collaborate with staff, redirecting and aligning members to appropriate levels of care and Medical Home models • PCP outreach after an ED visit • Amerigroup On Call telehealth consults • Convenient, real-time online appointment scheduling for Medical Home sites • Strategic partnerships with LAHIE and local hospital facilities to proactively share real-time ED data

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N.5. Addressing High STI Prevalence

N.5 Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.

Taking Every Opportunity for Education and Assessment

Understanding that the prevalence of sexually transmitted infections (STIs) is impactable with targeted outreach, education, screening, and treatment, Amerigroup has embedded requirements for STI screening into nearly every interaction a health plan employee or provider has with a member. Our Health Risk Assessment and our Obstetrical Risk Screening Tool include questions about sexual history and risk. We include prevention education and encouragement to be screened in a variety of our member materials. Figure N.5-1 includes an excerpt from a brochure we distribute on pregnancy.

Figure N.5-1. Our Preconception Health brochure includes education on STI risk and testing.



Are you ready for pregnancy?

Can you find and afford child care? Child care is costly, and it's not always easy to find. Some people have family members who can help out, but this isn't an option for everyone. Think about your sources of support and what kind of child care you would need.

Am I physically healthy? The health of both mom and dad can affect the baby. It's a good idea to get tested for sexually transmitted infections (STIs). This will help ensure you don't have something you could pass on to your future child. Getting tested is easy, and it will help you and your partner stay healthy. Schedule a visit with your doctor for a complete physical exam. Ask the doctor to screen you for any genetic conditions, such as sickle cell anemia. You'll also want to find out your blood type and get up-to-date on any vaccines.

How can you talk about it with your partner?

Find a time when you can talk without interruption.
Be open and honest about your thoughts, feelings and concerns.

Amerigroup RealSolutions in healthcare
www.myamerigroup.com/LA

Preventive Care is a Critical Access Point

Preventive care settings are critical to early detection of STIs. Our clinical practice guidelines include a requirement that providers conduct recommended regular screening for STIs, and educate members about prevention when delivering annual physical exams and family planning services. We have adopted the recommendations of the United States Preventive Services Task Force, which recommend:

- Chlamydia infection screening
- Gonorrhea screening
- Hepatitis B virus infection screening in pregnant women
- HIV/AIDS screening
- STI counseling
- Syphilis infection screening

We monitor compliance through medical records review and certain performance metrics, and we are in the process of strengthening and deepening our audit process with PCPs and specialists, such as obstetricians and infectious disease specialists.

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Supporting Our Community Partners in Doing the Work

Our commitment to using every opportunity to discuss sexual health and infection prevention is strong, but we recognize that community partners who are interacting directly with our members may have a greater impact. Therefore, we support these partners through referral, involvement, and, when relevant, financially to continue the good work they do.

Quote from Lisa Breland, LCSW, Director of Client Services, NO/AIDS Task Force:

"When NO/AIDS reached out to the 5 Bayou Health Plans after the state discontinued the HIV case management waiver program [Amerigroup] was the only one to respond. They hosted several meetings with us to establish a seamless transition for the HIV case management component of their health insurance plan for our clients with Amerigroup. In addition, Amerigroup has been a sponsor in our annual Empowerment Conference for the past 2 years. Again, they were the only Bayou Health Plan to participate."

N.6 Plan for Prematurity Prevention and Improved Perinatal Outcomes

N.6 Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

- *Routine cervical length assessments for pregnant women;*
- *Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of pre-term labor or a short cervix found in the current pregnancy.*
- *Incentives for vaginal birth after cesarean (VBAC);*
- *Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery;*
- *Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and*
- *Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.*

From a broad perspective, Amerigroup Louisiana (Amerigroup) addresses prematurity prevention and improved perinatal outcomes through our comprehensive continuum of pregnancy outreach, condition, and case management resources, as described in Figure N.6-1 and more fully in Section K, Case Management. We understand that our members face an array of economic, cultural, and practical barriers that make it difficult for them to get basic health care or attain positive health outcomes for themselves and their babies. Our *Taking Care of Baby and Me*[®] program offers pregnant women traditional and high-risk case management programs to promote appropriate obstetrical, medical, and behavioral health care services. ***Taking Care of Baby and Me* engages members as advocates for their own health care by helping them understand the essential elements of assuring a healthy pregnancy and baby.**

Figure N.6-1 Maternal-Child Program Management Continuum

Maternal-Child Services Program					
Identification	Risk Screening	Assignment to CM Group	Outreach & Engagement	Assessment & Leveling	Care Planning
Members are identified through various avenues to assure maximum reach.	The potential need for case management is assessed using predictive modeling.	Based on the risk screening criteria, the member is assigned to one of four risk groups.	The member is contacted to explain the CM program, offer health promotion tools, and describe CM for high risk.	A comprehensive clinical assessment is administered and the member is assigned a complexity level.	A Care Plan is developed that includes goals, interventions designed to assist in meeting goals, and strategies to address barriers.

Utilization Management (UM), through our medical policies and clinical practice guidelines, supports the holistic approach to maternal-child health and perinatal care that is central to Amerigroup's mission. We have designed several incentive programs, both for providers and members, to encourage early, comprehensive prenatal care. We are also developing enhanced options for effective inter-conceptional care, such as inpatient placement of long-acting reversible contraceptives, which overcome payment obstacles to common sense care approaches.

Our Maternal-Child Health/EPSDT Coordinator has lead responsibility for promoting receipt of early prenatal care and completion of the postpartum visit. This employee works closely with the Quality Management Department to design and implement interventions that encourage maternal health and perinatal care, and develops and maintains connections with community partners to promote reproductive health.

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Taking Care of Baby and Me Program

Our Utilization Management (UM) strategies to improve birth outcomes fall under the umbrella of our maternity program. The *Taking Care of Baby and Me* program provides quality, culturally-competent case management services to pregnant members during the prenatal and postpartum periods and to their infants. Nurse case managers encourage pregnant women to take action to optimize the outcome of their pregnancies, to prepare for the delivery and homecoming of their infants, and to participate in their infants' care should a NICU stay be required. Coordination between the *Taking Care of Baby and Me* case management team and the UM team is essential.

In 2010, the National Minority Quality Forum awarded Amerigroup Corporation the first Health Promotion and Disease Awareness award, which recognizes an individual or organization making an outstanding contribution to the promotion of wellness in minority communities, for its efforts to help moms enrolled with Medicaid have healthy babies.

Taking Care of Baby and Me includes a full array of support tools that foster close communication between the health plan and the member, but also promote a healthy pregnancy and baby:

- **Prenatal Incentive Packet**—Includes information and incentives to encourage our pregnant members to attend pregnancy and postpartum office visits, as well as a *Planning a Healthy Pregnancy* booklet. Members may receive \$25 for attending prenatal appointments during the first trimester and \$50 for attending the postpartum appointment between 21 and 56 days after delivery. If she attends at least seven prenatal appointments during her pregnancy, she can qualify to receive a free portable crib or car seat.
- **SafeLink Phones**—Qualified Amerigroup members receive a free cell phone with 250 minutes per month and up to 200 additional lifetime minutes. These additional minutes give case managers real-time access to members to encourage them to keep appointments and fill prescriptions. Case managers also inquire about and assist with arranging transportation. Numbers pre-programmed into the phone give the pregnant woman an easy way to contact her obstetrician, case manager, and other essential service providers. In addition, our pregnant members receive a series of messages developed by our maternal health and pediatric specialists. These Amerigroup-specific pregnancy messages assist our members throughout their pregnancy, and infant care messages continue after their child is born.

- **Text4baby**—As a designated outreach partner, Amerigroup has joined with the text4baby program to promote this free text message information service. Once pregnant members enroll, they receive educational messages and helpful reminders tailored to the particular weeks of their pregnancy and through their baby’s first year.
- **Warm Health**—Warm Health is a service provided by our vendor Altegra, which provides maternal and newborn health education by interactive voice response or smart phone applications. Messages arrive twice weekly during the prenatal phase, weekly during the postpartum period, and weekly for well-child messaging. Members have access to education, answers, and support with two-way texting or live chat. The member is asked to respond to questions about her condition and needs. Based on the response, an “alert” comes to Amerigroup’s case manager to quickly and personally reach out and help those in need easily and effectively. Data validates that woman who opted to participate in the outreach program attended 30 percent more prenatal care visits and six percent more postpartum visits. The program increased obstetric screenings by 3.5 percent.
- **Smoking Cessation**—Appropriate interventions include the following:
 - The Five A’s of Smoking Cessation: Ask, Advise, Assess, Assist, and Arrange
 - Referral to the smoking Quit Line, 1-800-QUIT NOW
 - Physician counseling about smoking-related health risks
 - A videotape with information on risks, barriers, and tips for quitting in conjunction with provider counseling (10-minute session), a self-help manual, and follow-up letters
 - Pregnancy-specific self-help guide and a 10-minute counseling session with a health educator
 - Counseling in one 90-minute session, plus twice-monthly telephone follow-up calls during pregnancy and monthly after delivery
 - Education about the risk of exposure to secondhand smoke
 - Screening and intervention for alcohol and other drug use
 - Determination of the member’s intention to return to smoking after pregnancy
 - Assistance identifying social support systems to remain smoke-free
- **CenteringPregnancy**[®]— This is a multi-faceted model of group care that integrates the three major components of care: health assessment, education, and support. It uses a group setting to maximize the opportunity to educate women and help them learn from each other and their shared experience.
- **Nurse-Family Partnership**[®]—Public health nurses visit low-income, first-time pregnant women at risk during their pregnancy and until the baby is two years old. The nurses teach parenting and life skills, and help new moms gain access to job training and education programs.

Routine Cervical Length Assessments for Members at Risk for Pre-Term Labor

Through provider education and payment strategies for prenatal ultrasounds, Amerigroup promotes the practice of cervical length assessment among our network providers through an algorithm that guides them on the need for, and best approach to, monitoring changes in the cervix.

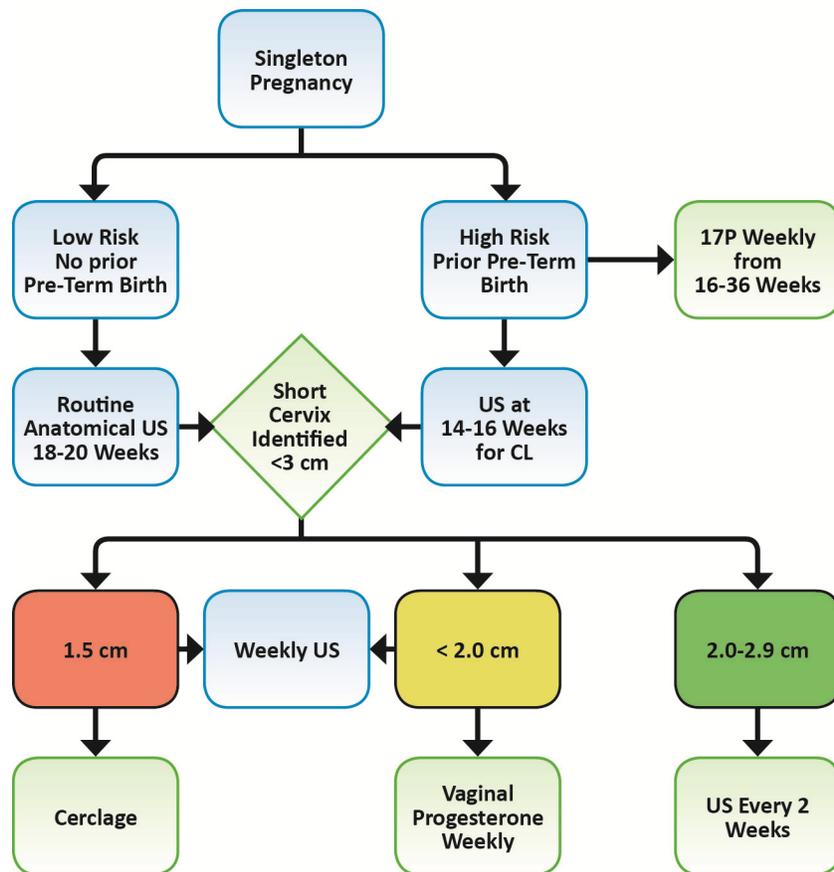
Cervical length (CL) is normally stable between 14 and 28 weeks and declines substantially after 28 to 32 weeks. A cervical length below the 10th percentile (25mm) is consistently associated with an increased risk of spontaneous pre-term birth. Short cervical length at 16-28 weeks is the cervical change most related to the risk of preterm birth, with a particularly correlation when it occurs before 24 weeks or in women with a prior pre-term birth. Evidence from randomized trials shows that performing a transvaginal ultrasound cervical length measurement at 18-24 weeks, then treating women with a shortened cervix with vaginal progesterone supplementation, significantly reduces pre-term births.

Women without a prior history of pre-term birth will usually undergo routine anatomical screening ultrasounds at 18-20 weeks. In these women, the American Congress of Obstetricians and Gynecologists (ACOG) recommends that the cervix be examined when clinically appropriate and technically feasible. The American Institute of Ultrasound Medicine, The American College of Radiology, and the Society of Radiologists in Ultrasound all endorse the same recommendation in their published guidelines for obstetric ultrasound examinations. Guidelines also state that transvaginal or transperineal ultrasound may be considered if the cervix appears shortened or cannot be adequately visualized during the transabdominal exam. This algorithm, therefore, assumes that the measurement of cervical length will not require an additional ultrasound, but should be incorporated into the current routine ultrasound exams.

Based on thorough research of best practices in the management of a shortened cervix and consistent with recommendations from ACOG, Amerigroup recommends that cervix monitoring occur according to the diagram in Figure N.6-2. This algorithm is recommended for use with singleton pregnancies, which excludes pregnancies with multiple babies, such as twins or triplets, and is based on more than 20 clinical resources published by such entities as the National Institute of Child Health and Human Development Maternal Fetal Medicine Unit Network and the American Institute of Ultrasound in Medicine.

Figure N.6-2. Our cervix monitoring algorithm promotes data-driven interventions.

Outpatient Management of Shortened Cervix



Prior Pre-term Pregnancy Program (17-Hydroxyprogesterone)

Amerigroup promotes the use of 17-Hydroxyprogesterone caproate, commercially available as Makena, for eligible pregnant women through education and provider notification through the Prior Pre-term Pregnancy Program. 17-Hydroxyprogesterone caproate has demonstrated efficacy in reducing the risk of pre-term delivery before 37 weeks' gestation in women with a singleton pregnancy and a history of prior pre-term delivery.

Studies reported in the New England Journal of Medicine (2003) and the American Journal of Obstetrics and Gynecology (2007) showed that 17-Hydroxyprogesterone caproate helped prevent pre-term contractions and premature delivery in women with a history of pre-term births. In 2008, the American College of Obstetrics and Gynecologists (ACOG) issued ACOG Committee Opinion No. 419, Use of Progesterone to Reduce Pre-term Birth, recommending use of 17-Hydroxyprogesterone caproate in the care for mothers identified as at-risk.

Amerigroup works with the mothers and providers to expedite access to this medication and covers it and services to administer it. This is just one example of our tailored interventions to keep women and their providers informed about current best practices and to support providers in delivering services effectively.

First, providers are sent a program introduction letter. Then, using information gained from an OB risk screening

survey, we generate a 17-Hydroxyprogesterone caproate provider report twice a week to identify potential candidates. Once a candidate is identified, an OB case manager contacts the member to confirm findings of high-risk and faxes an alert and 17-Hydroxyprogesterone caproate order form (with ordering options) to the provider. All members receiving 17-Hydroxyprogesterone caproate are enrolled in OB Case Management.

HEALTHY MOM — HEALTHY BABY

Because Aimee's first child was born prematurely at 27 weeks, Aimee's case manager, once finding Aimee was pregnant again, immediately contacted her. Aimee told her case manager she had gone to her obstetrician (OB) and was taking 17-Hydroxyprogesterone caproate to help her carry to full term. But moving four hours away kept Aimee from attending her prenatal appointments or receiving her medication.

To continue her care, Aimee's case manager helped her find an OB in her area and scheduled an appointment on her behalf. With Aimee's permission, the case manager also contacted the OB to share information about Aimee's previous pregnancy and delivery and request re-initiation of the 17-Hydroxyprogesterone caproate.

Together, Aimee and her case manager also found a pediatrician for her older child and the baby. They also reviewed the signs and symptoms of preterm labor and developed a crisis plan for Aimee, should she need it. Aimee attended prenatal classes and had one-on-one informational sessions with her case manager about taking care of herself, postpartum care, breast feeding and breast care, inter-conception planning, and what to expect when taking care of a newborn and toddler. Aimee's case manager also contacted the local WIC office and arranged for an appointment and transportation to the office. Aimee received her final 17-Hydroxyprogesterone caproate injection at 34 weeks — *one week early* — because Aimee's pregnancy was going so well. 🌸

REAL STORIES

As a result of the Prior Pre-Term Pregnancy Program, use of 17-Hydroxyprogesterone caproate has been increasing among our Louisiana members. The number of recipients using 17-Hydroxyprogesterone caproate per 1000 deliveries increased from 36.1 in 2012 to 40.8 in 2013. Overall, that's a 2.1 percent increase.

The Prior Pre-term Pregnancy Program demonstrated a decrease in the overall pre-term birth rate to 12.6 percent -- down from 13.5 percent in 2012 -- and decreased the number of infants born with a birth weight of less than 2,500 grams to 11.4 percent -- down from 12.1 percent in 2012.

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Maternal Postpartum Outreach Program

The Maternal Postpartum Outreach Program (MPOP) is an intensive live-call member outreach program that uses a web-based tracking tool. Amerigroup plans to implement the program in the fourth quarter of 2014 or early 2015. The program identifies all members who need a postpartum call and captures all relevant data related to the appointment process. It prompts our employee to call and remind the member of the appointment, offer assistance in scheduling the appointment, and then call the provider to verify the visit. It also captures member mailings and other postpartum strategies that may be indicated for a given member, such as home visits and transportation scheduling. An example of the screen that a case manager will see when using MPOP is in Figure N.6-3.

Figure N.6-3. MPOP Allows OB Case Managers to Identify All Member Needs at a Glance



Aggressive Outreach for Postpartum Care

As part of our efforts to promote postpartum visits, Amerigroup will contract with Allegis/Home Physicians, a successful program already in operation in our Maryland affiliate health plan, to provide in-home care to women who could not make their postpartum visit.

We will supply Allegis a list of members to contact, either by phone or mail, to schedule assessment visits. Our list will be supplied monthly, and include member name, address, and phone number. The Allegis provider then completes an initial comprehensive assessment of the member's condition, including physiological, functional, and environment needs. It also includes a review of the member's medical history, medications, diet, caregiver dynamics, and a full physical. Clinical information from the assessment will be shared with both the health plan and the member's PCP, when appropriate.

Interventions Between Pregnancies Improve Future Birth Outcomes

Amerigroup educates members about contraception, family planning benefits, and supplies to engage them in active decision-making about increasing the size of their family. We try to help them achieve appropriate birth intervals, which has been proven to lessen risks associated with a subsequent pregnancy too soon after delivery.

Amerigroup partners with our network providers to inform our members about preconception health and family planning. We require our providers to include anticipatory guidance and education on reproductive health and needs during member encounters. We also provide family planning information through our member handbook, our web-based portal, and contraceptive counseling upon request.

We will also be initiating a program to provide case management services, particularly reproductive health education, to women of childbearing age with a history of prior poor birth outcomes, such as those with pre-term deliveries at less than 37 weeks. Any woman can have a pre-term baby or experience a poor birth outcome regardless of risk factors. However, when one of our members has experienced a poor birth outcome, we have an opportunity to work with her on inter-conception health. Engaging women during the inter-pregnancy period enables us to encourage health care that will potentially improve outcomes of future pregnancies.

Our inter-conception health service will identify women of childbearing years who have delivered an at-risk child for management beyond the postpartum phase of traditional OB case management. The criteria for engagement will be women with a history of poor birth outcome and known risk factors, such as chronic medical and behavioral health conditions and social stressors. Interventions will include the following:

- Encouraging women to space pregnancies at least two years apart
- Folic acid supplementation
- Abstinence from nicotine, alcohol, and drug use
- Healthy relationships, free of interpersonal violence
- Risk factor reduction for transmission of sexually-transmitted infections
- Improvement of overall health, particularly with high-risk conditions, such as obesity, hypertension, and diabetes

We will make appropriate referrals for long-acting reversible contraception (LARC) and community resources that will best support our member and her children, including appropriate safe housing. We will also work closely with and support community partners who are doing similar work to avoid duplication and promote a single message about reproductive health.

When women participating in our reproductive health education program become pregnant, our established relationship with her will allow us to quickly refer and engage her in early, first trimester prenatal care and our *Taking Care of Baby and Me* pregnancy program. Our Nurse case managers will provide information to the member's OB regarding her previous birth outcome, which will be particularly important if she does not use the same OB as in her the earlier pregnancy.

Family Planning as a Vehicle to Improved Perinatal Outcomes

Amerigroup covers family planning services and supplies to help our members achieve appropriate birth intervals, which has been proven to lessen risks associated with a subsequent pregnancy too soon after delivery. Our family planning medical policies comply with the emergency rule published in the June 20, 2014, *Louisiana Register*.

We encourage our members in the inter-conception period to obtain a comprehensive medical history and physical examination annually or as indicated by her health care needs. Our providers include anticipatory guidance and education related to her reproductive health and needs during the visits.

Members may receive family planning services and related supplies from appropriate Medicaid providers outside of our network without restrictions and have access to contraceptive counseling as desired. Amerigroup does not exclude coverage of any service on moral or religious grounds. We cover all methods of contraception approved by the Federal Food and Drug Administration.

We intend to improve access to long-acting reversible contraceptives in an inpatient setting by changing current reimbursement policies and allowing providers to bill for placement of the contraceptive during the member's postpartum stay, in addition to the per diem rate paid for the delivery.

EDUCATION LEADS TO CHANGE

During her first pregnancy, 22-year-old Alice was referred to OB Case Management at 16 weeks because she was carrying twins. During the Health Risk Assessment, Alice told her case manager that the baby's father used alcohol and marijuana daily. She said he encouraged her to use marijuana weekly, but she stopped drinking alcohol when she learned she was pregnant. She also said she didn't think the drug would harm her baby and didn't tell her OB about her drug use fearing she would be drug tested. After providing educational information on drug use and assessing Alice's readiness to change, the case manager used motivational interviewing techniques to help Alice decide to stop using marijuana, even though that could have meant losing her boyfriend. The case manager included the new information in Alice's care plan, and when she checked on Alice a few weeks later, she found that Alice was still drug-free. In addition, Alice had given her boyfriend information from the "Health A to Z" link on the Amerigroup member website ("Alcohol or Drug Use During Pregnancy"), and he quit as well. ♣

REAL STORIES

Addressing Substance Use Disorders in Pregnancy

Substance use in pregnancy is associated with poor birth outcomes, including the following:

- Low birth weight
- Placental abruptions
- Pre-term birth
- Birth defects
- Neonatal abstinence syndrome
- Parenting difficulties

Identifying risky substance use in pregnancy, intervening to provide a woman with help to stop it, and providing case management and care coordination to help her access specialty services improves the chance of positive outcomes for her current pregnancy and subsequent care of the child after birth.

We screen all pregnant women for use of alcohol, illegal substances, and tobacco products. When a woman is contacted for OB Case Management, case managers use a screening, brief intervention, and referral to treatment (SBIRT) approach to substance use. SBIRT has been shown to be effective at reducing risky alcohol and other substance use, and is endorsed by CMS, ACOG, and the Substance Abuse and Mental Health Services Administration (SAMHSA). Using the OB High-Risk Assessment, we screen pregnant women for substance use with a modified 4Ps (parents, partners, past use, present use)

approach shown to be effective in maternal-child settings. The assessment includes specific questions about tobacco, alcohol, and drug use.

If any answers indicate current use, the case manager does a brief intervention, providing education and using motivational interviewing (MI) techniques to raise awareness of the specific risks identified during screening and increase the member's motivation to change behavior and make choices that support health. Providing brief interventions using MI, in the context of general health assessment, has been validated as effective in reducing risky use.

Members whose screening answers indicate a further need for assistance (for example, significant and continued alcohol use or use of opioids) are referred for inpatient or outpatient substance use disorder treatment services through the State's SMO.

Our clinical practice guidelines also require providers to screen pregnant women for potential substance use in pregnancy. We recommend the use of the following:

- TWEAK, which is a five-item scale developed originally to screen for risky drinking during pregnancy
 - T—Tolerance—“How many drinks can you hold?”
 - W—Worried—“Have close friends or relatives worried or complained about your drinking in the past year?”
 - E—Eye-opener—“Do you sometimes take a drink in the morning when you first get up?”
 - A—Amnesia—Stands for blackouts; “Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?”
 - K—K/Cut Down—“Do you sometimes feel the need to cut down on your drinking?”
- T-ACE to screen pregnant women for alcohol use. It detects lower levels of alcohol consumption that may pose risks during pregnancy
- The 4Ps (Parents, Partners, Past Use, Present Use)

Providers are asked to advise all pregnant women of the risks to their unborn child that alcohol use poses.

Promoting Full-Term Vaginal Deliveries to Reduce Risk of Adverse Outcomes

Non-medically indicated inductions and cesarean section births prior to 39 weeks of pregnancy commonly result in NICU admissions, serious disabilities, increased costs, and infant deaths. Louisiana's Birth Outcomes Initiative (BOI) was created “to improve the health of Louisiana's moms and babies by making positive impacts on women's health, infant health and hospital-based women and infant care,” and is a partnership with the National Institute for Healthcare Improvement. BOI developed the 39 Week Initiative to end non-medically indicated deliveries prior to 39 weeks of pregnancy. Amerigroup shares BOI's goal of assuring our youngest population of the best possible start to life by increasing compliance with clinical care guidelines and quality metrics.

The Centers for Disease Control and Prevention (CDC) has stated that the leading cause of neurological disabilities in children is pre-term birth, defined as births prior to 37 weeks of pregnancy. According to data the CDC released in December 2013:

- Pre-term births affect one of every eight births in the U.S. every year
- In 2005, pre-term birth costs were more than \$26 billion for the U.S. health care system
- In 2009, 35 percent of all infant deaths were pre-term-related

Various studies have demonstrated the need for Louisiana to improve the start of life for our children. For the year 2013, the following statistics have been released:

- America's Health Rankings listed Louisiana's national ranking for infant mortality as 48th
- The Leapfrog Group listed Louisiana's average rate of early elective deliveries (defined as the percentage of non-medically indicated births, delivered by Cesarean Section or induction, between 37-39 weeks gestation), as 3.9 percent as of January 31, 2014, while the national average for the same year was 4.6 percent

Amerigroup is a proponent and participant in Louisiana's BOI. We recognize that, while the BOI has made significant strides in educating women and providers on the importance of avoiding non-medically-indicated interventional deliveries, there is more to be done. Over the last 18 months, Amerigroup has infused the message of the importance of safe choices during pregnancy, including avoiding early elective deliveries, into our *Taking Care of Baby and Me* program and our provider network. We regularly collect data on deliveries at 37 and 38 weeks and identify those that were non-medically indicated. Our data is at the member and provider level, and allows us to outreach to practitioners who have rates of early deliveries significantly higher than their peers. We also include the rate on each provider's OB Profile report, described below. **Our efforts have resulted in a 14.4 percent decrease in early elective C-sections from calendar year 2013 through April of 2014.**

Providers participating in our Maternity and Pregnancy Quality Improvement Program will receive enhanced payments for achieving quality targets for members delivering at full term. We support an initiative to place a hard-stop mechanism in the process of scheduling an induction or C-section prior to 41 weeks unless medically necessary. The March of Dimes toolkit recommends identifying champions within the hospitals, especially the medical directors, to require by hospital policy that such elective deliveries cannot be scheduled. We will promote that practice in our network hospitals. We will require our network providers to record all deliveries in the Louisiana Electronic Event Registration System (LEERS) as a condition of payment. The LEERS Birth Module allows a provider to document why a delivery prior to 39 weeks was medically indicated. We will continue to work with DHH and our managed care partners to implement the 39 week initiative.

Our OB Provider Profile Drives Improvement at the Provider Level

Amerigroup tracks the use of services and interventions designed to improve perinatal outcomes at the plan level, but we also feel it is critically important to furnish that information directly to providers. It is said that what gets measured gets changed, and our OB Provider Profile report allows providers to compare their performance against others in our network to identify areas in need of improvement. The report includes both numerical and graphic comparisons of performance for the following measures:

- Pre-term birth rate
- C-section rate
- Early term elective C-section rate
- 17-Hydroxyprogesterone caproate use
- Timeliness of prenatal care
- Postpartum care

An example of our OB Provider Profile report can be viewed in Attachment N.6-1. Also under development is an easy-to-use HEDIS encounter reporting system that is tied to the claims system for OB providers to view outstanding gaps in care and report visit dates. This report will supplement the OB Provider Profile report.

N.7. Identifying and Addressing Underutilization of Services

N.7 Explain how you will identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with Sickle Cell Disease.

Amerigroup identifies and addresses underutilization of services in key areas—such as HIV and syphilis screening in pregnant women, use of long-acting reversible contraceptives, and appropriate pain management approaches in members with sickle cell disease—through a combination of powerful data analytics that examine utilization by provider and member to identify outliers and demographic and risk modeling techniques to identify pockets of lower than expected use. Our medical policies and clinical practice guidelines guide our Provider Network in the delivery of appropriate preventive, diagnostic, and treatment services to members in their care.

Using Data to Identify Utilization Patterns

Our data analytics team, described earlier in question N.3, supports the Louisiana Health Plan with utilization data analysis and reporting. This group collaboratively develops utilization monitoring reports on a monthly basis, identifying providers and members with outlier utilization.

We review both PCP panel utilization patterns and servicing provider billing patterns to conduct the provider-level analysis. The team identifies outlier providers based on relative distribution of services and then refers the cases to appropriate functional areas for intervention. Members are analyzed using care gap algorithms, and the team looks for certain services when the member carries a targeted diagnosis, such as pregnancy or sickle cell disease, or use of services under review, such as ED use.

Data-driven approaches address whole population analytics, such as reviewing the rate of HIV and syphilis testing per thousand members based on lab test codes. Our data analytics team can also associate a targeted diagnosis and claim type as a proxy for missed care opportunities. In this latter example, reports examine ED use by members with sickle cell disease and conclude that a high rate of ED use is associated with poor access to, or use of, primary or urgent care settings.

Amerigroup's reliable process for monitoring potential under-utilization of services includes performance reports to identify both providers and members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans.

Our UM clinical team works with our Chief Medical Officer, Dr. Marcus Wallace, and Provider Relations to address aberrant provider patterns. The team reviews and validates the medical issue, develops an action plan, discusses the plan with the provider, and implements action items. Performance is monitored and re-examined within six months.

When a member's utilization pattern shows outreach and education is warranted, our clinical team will collaborate with the Chief Medical Officer to determine appropriate member interventions, including outbound telephone calls to educate members about appropriate use of services and the importance of preventive care or referral to case management or disease management.

Clinical Practice Guidelines Support Appropriate Screening and Treatment

Our preventive care clinical practice guidelines include a requirement that providers conduct recommended regular screening for STIs, including HIV and syphilis in pregnant women, and educate members about prevention when delivering annual physical exams and family planning services. We have adopted the screening recommendations of the United States Preventive Services Task Force:

- Chlamydia infection screening
- Gonorrhea screening
- Hepatitis B virus infection screening in pregnant women
- HIV screening
- STI counseling
- Syphilis infection screening

We monitor compliance with this requirement through medical record review and certain performance metrics.

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Improving Access to Long-Acting Reversible Contraceptives

Long-acting reversible contraceptives (LARCs) include implantable devices such as intrauterine devices (IUD) and implantable hormone devices such as Nexplanon. For postpartum women, typically these procedures occur in the outpatient setting; however, there is an opportunity to provide women with the option of LARC procedures during the inpatient delivery admission. Women at risk for not keeping their postpartum appointments and adolescent women at high risk for shortened birth intervals are the best candidates for this option. It is well known that short inter-pregnancy intervals can lead to poor birth outcomes. Pregnancies conceived 18 months or less from an index pregnancy are at increased risk for prematurity, low birth weight, maternal complications, and neonatal death, likely due to depleted maternal nutrition.

We will improve access to long-acting reversible contraceptives in an inpatient setting. Currently, providers are not reimbursed for placing the device during the postpartum stay since they are paid a per diem rate. However, we will change the reimbursement policy to allow providers to bill in addition to the per diem rate paid for the delivery. Our South Carolina affiliate has already successfully implemented this new policy.

Providing Alternatives to ED for Members with Sickle Cell Disease

Members with sickle cell disease require rapid, compassionate pain intervention when experiencing a flare-up of their condition. Often, these members visit the ED to find relief. However, planned access to care in these circumstances can provide more cost-efficient treatment without the inconvenience of a long, uncomfortable wait in the ED.

Amerigroup maintains a strong commitment to quality care for our members with sickle cell disease. In fact, our Chief Medical Officer, Dr. Marcus Wallace, was the chair of the Sickle Cell Foundation's 5k Run in August 2014. Our plan for addressing the needs of our members with sickle cell disease includes the following:

- Focused education sessions for PCPs in each geographic region (Shreveport/Monroe, Baton Rouge, New Orleans) on how to provide quality care to members with sickle cell disease
- Co-branding with the Sickle Cell Foundation of educational material for members
- Sponsorship of blood drives with the Sickle Cell Foundation

- Inviting members with sickle cell disease to serve on our Member Advisory Council
- Developing a pharmacy-based program that provides members with specific information on pain management and a hotline for members with sickle cell disease

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N.8. Reducing Overutilization of ADHD Drugs in Young Children

N.8 Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age.

Use of stimulants in Louisiana's children has been a topic of great attention and concern. Suspected reasons for overutilization of stimulants include high demand from schools and parents, the rural nature of Louisiana, and the lack of availability of and access to behavioral health specialists. We support the concern expressed by DHH that there is a need to reduce inappropriate use of stimulants in children, particularly in children younger than seven years of age.

Prior Authorization of ADHD Drugs to Children Younger than Seven Years of Age

Amerigroup supports the use of prior authorization for certain uses of stimulant medications. We propose to develop a consistent, statewide approach in collaboration with DHH and other Bayou Health MCOs. Implementation of a prior authorization requirement must be done as a statewide policy to avoid adverse selection by members into MCOs that do not require prior authorization and to avoid providers leaving the networks of MCOs with the requirement.

Clinical Practice Guideline for ADHD

Our clinical practice guideline for the treatment of ADHD is designed to guide providers in the appropriate use of medications to treat children presenting with complaints consistent with ADHD symptoms.

Providers must conduct an initial history that includes birth history, developmental history, family history, and behavioral assessment in all settings, as well as history of the present illness. Regular vital signs with height and weight are indicated at the first visit and regularly at follow-up. A current/recent physical exam with a screening neurological exam is appropriate. Additional clinical indicators that should be included are the following:

- Vision and hearing screenings to rule out sensory contributors
- General laboratory studies and/or urine drug screen as indicated
- Electrocardiogram and cardiology consults are recommended if cardiac history is known or suspected, including family history of early sudden death of cardiac etiology or family history of cardiac conduction abnormality
- ADHD rating scales at diagnosis and for follow-up to track treatment response, including the Conners Parent and Teacher Rating Scales or the equivalent; may also include the Continuous Performance Test

For preschool children, the initial treatment for ADHD is an evidence-based parent- or teacher-administered behavior therapy. If the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function, then a medication trial is appropriate for consideration. In geographic areas where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment. The behavioral intervention should be continued with the medication management.

For school-aged children, stimulants and other medications are first-line treatments. Many children with more complex presentations require some additional behavioral/psychotherapy intervention involving the family. The school environment is part of any treatment plan for ADHD treatment of children.

Psychoeducation is indicated for all members and families. Social skills training and parenting training may be used as indicated. Academic performance should be accessed at each visit for all students. It is appropriate to encourage an Individualized Educational Plan or to support informal school modifications.

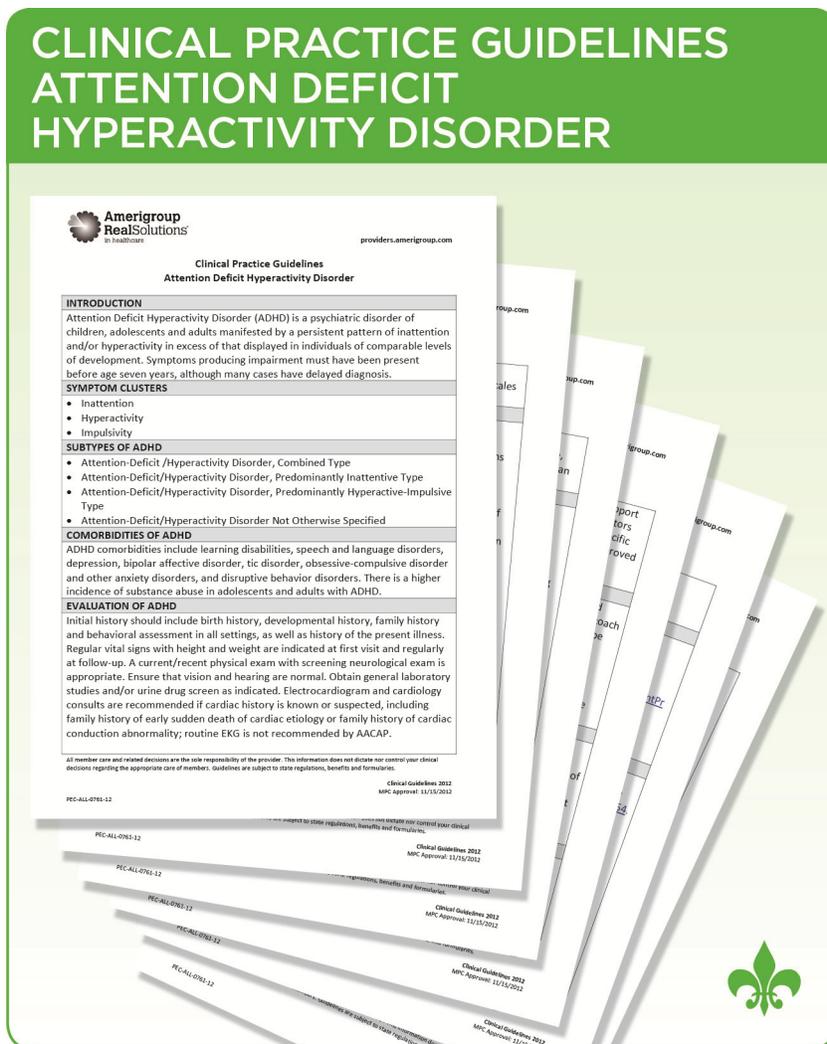
Interventions for Members with ADHD

Optimal treatment of ADHD is best addressed through a variety of interventions with members/families and providers. We work closely with the State’s SMO to coordinate care for members and send a single message to the community about best practices, but we also conduct a series of educational and interventional activities to promote best practices of our members, including the following:

- Member educational materials
- Member education call campaign
- Targeted pharmacist/provider education visits
- Increased formulary management
- Provider opportunities reports (follow-up care for individuals on ADHD medication)

We recently met with high-volume prescribers to discuss proper use of ADHD medications in conjunction with the state’s SMO, our Behavioral Health Medicaid Medical Director, and our pharmacist.

We will also be sending an outreach letter to prescribers of stimulant medication who are operating outside of our clinical practice guidelines, asking them to modify their practices and conform to our requirements. The letter template can be viewed in Attachment Q.6-1: ADHD Provider Outreach Letter.



Coordination with the State's Statewide Management Organization

While Amerigroup is responsible for basic behavioral health services, including treatment of ADHD by pediatricians and family practice providers, engagement with the state's SMO for specialized behavioral health services is indicated in many cases, particularly cases where very young children are seeking treatment. Our guidelines for referral include the following groups of members:

- Preschool children
- Members for whom the diagnosis is uncertain (for example, psychiatric disorder, parent-and-child-interaction problem)
- Members not responding to treatment or intolerant because of medication side effects

Our Behavioral Health Nurse Case Manager has a lead role in coordinating care with the SMO for children in need of behavioral health evaluations or adjunctive behavioral health services. If the member is also engaged in case management for a co-morbid medical condition or due to social factors indicating the need for case management services, the Amerigroup Case Manager works closely with the SMO to promote coordinated care for the member.

Monitoring Prescriber Patterns to Target Outliers

Identifying the highest volume stimulant prescribers by age band will allow us to identify those providers who are operating outside our clinical practice guidelines. Our Chief Medical Officer, Pharmacy Director, and Behavioral Health Nurse Case Manager, in partnership with our Provider Relations representatives, will conduct outreach and education to those providers and conduct targeted record reviews when prescribing patterns are of particular concern. Providers whose quality of care is in question may be referred for peer review.

The following features of prescribing patterns may indicate a need for outreach:

- Prescribing stimulants for children under the age of 7 at a rate significantly higher than peers
- Members assigned to the provider's panel who receive a prescription for stimulant medication written in an ED
- A higher rate of members who have been prescribed a stimulant medication who are on the gap in care list for missed follow-up visits

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N.9. Assessing the Quality and Appropriateness of Care to Enrollees with Special Health Care Needs

N.9 Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs.

While Amerigroup monitors the care delivered to all its members for quality and appropriateness, members with special health care needs receive targeted monitoring and coordination to promote the best possible outcomes. Our nurse case managers develop care plans that encourage community integration, self-advocacy, and self-direction, and they facilitate referrals, coordinating services as necessary, based on each individual's needs and strengths, including assistive technology as necessary to support community integration efforts.

Identifying Our Members with Conditions that Qualify as Special Health Care Needs

We adopt DHH's definition of Special Health Care Needs population and identify members with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk for individualized health care plans. Examples of conditions that may be deemed a special health care need after the nurse case manager's health risk assessment may include the following:

- Spina bifida
- Cleft palate/cleft lip
- Acquired or congenital heart disease
- Burns requiring surgical intervention
- Major orthopedic problems requiring surgical intervention
- Limited gastrointestinal or genitourinary conditions requiring surgery
- Hearing loss
- Vision disorders (limited)
- Craniofacial anomalies (selected)
- Seizures—outpatient care and drugs only
- Juvenile rheumatoid arthritis
- Genetic and metabolic conditions

Amerigroup identifies these members within 90 days of receiving the member's historical claims data or when notified by the member's PCP, the enrollment broker, or the member/family that the member has a condition that is considered a special health care need. Once the member is identified or referred, our nurse case manager contacts the member to conduct a clinical assessment to determine the member's treatment and service needs, whether the member could benefit from on-going case management or disease management, and to develop a service plan, if appropriate.

Amerigroup's assessment includes, at a minimum, a review of any historical health care data, including claims that are available at the time of the assessment. This may include data housed within Amerigroup's Member 360sm system for existing members or may include historical claims data provided by DHH for new members. Member 360sm includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data. The nurse case manager conducting the assessment also gathers any information from the member's PCP and other providers involved in the care of the member.

As described more fully in Section O, Chronic Care Management, our case managers coordinate with other providers and health plans involved in the member's care. As appropriate, and with permission of the member or authorized representative, Amerigroup shares the results and identification and assessment of that member's needs to prevent duplication of those activities.

Amerigroup provides continuation and coordination of all health care services to new members identified prior to enrollment as having a special health care need for up to 90 calendar days or until we are able to conduct a full assessment of the member and complete an individualized plan of care. It is our goal to promote movement of the member into our health plan with no disruption in services. At times, our review of the service package the member has been receiving allows for improved care once we more closely align the member's care with his or her condition and functional needs. We will not deny authorization for continuation of services solely on the basis that the provider is a non-contract provider. In fact, we make every effort to invite providers who have been serving our members to join the network as long as the provider meets our credentialing standards.

Predictive Modeling

Amerigroup uses a systematic, prospective approach when identifying our members with a risk for poor health outcomes, particularly those with complex, behavioral, and physical health conditions. Our approach centers on employing a proprietary Medicaid-specific predictive modeling tool that synthesizes member data (for example, diagnoses, hospitalizations, emergency department encounters, expenditures, and demographics) to develop individualized risk profiles.

We have a tiered approach to identify and prioritize members who will benefit the most from case management. Each month, every member receives a Chronic Illness Intensity Index score, which is calculated using clinical and demographic data. Once scored, the members are filtered through clinical criteria that prioritize individuals with clinically manageable conditions. Members are then assigned a Likelihood of Inpatient Admission index, which refines prioritization of members most in need by predicting the chance of an inpatient admission within 60 days, based on historic use of hospital services, diagnostic data, and demographic data. With this tool, Amerigroup, with a high degree of precision, identifies members with whom we can mitigate risk for use of high-cost health care services while also promoting the health of the member.

Those with the highest risk levels are referred for our most intensive level of case management. Case managers are skilled in using motivational interviewing techniques to engage members, and in using their knowledge and preference of services, providers, and community resources to coordinate care and services and arrange for efficient allocation of community services and supports. Member participation in case management allows the case manager to continually and objectively monitor the quality and appropriateness of care delivered to the member.

Condition-Specific Programs to Improve Member Outcomes

Confidential, proprietary, and/or trade secret language has been redacted from this page. Please refer to our proposal binders marked "Original" to access a non-redacted version of our response.

Online Peer Support

Amerigroup will enable members' increased personal responsibility and self-management by providing an online peer support tool to help members manage their chronic conditions. Amerigroup will partner with an external vendor specializing in the development of social networking tools to provide members with virtual peer support. This innovative program is a social networking platform that connects members to peer support and behavior change professionals for help in and managing chronic and behavioral health conditions. Members may participate in group chat, online meetings, and expert discussions. The program leverages gaming and online social networking techniques to build online peer support communities and behavioral modification programs. Programs treat a range of substance use disorders and behavioral conditions, including depression, anxiety, eating disorders, gambling, smoking cessation, and obesity. Delivered through a secure, HIPAA-compliant online and mobile platform, the program will provide members with access to integrated, condition-specific social health communities that offer emotional check-ins, evidence-based tools, and game mechanics to help them manage their own care and sustain positive behavior change.

Unrestricted Access Is Critical to Successful Care

Amerigroup requires that our network providers comply with requirements of the Americans with Disabilities Act (ADA). We also require providers to complete an assessment upon enrollment with us to identify any specialized services they offer so that we understand the range of providers who are capable of meeting the needs of our members with specialized service needs. Providers may have specially trained staff or equipment, such as wheelchair accessible dental chairs and lift-able exam tables, mammography, or other unique capabilities, to serve members with specialized service needs. We capture and make this information readily accessible to our member call center and case management representatives to allow them to quickly match our resources to our members' needs.

Mobile Health

We understand that even with ADA-accessible offices, some members may still have difficulty accessing care due to mobility concerns. For these members, we offer certain services in the home to avoid any instances where our member fails to receive needed care due to concerns about safe travel. Members have a choice of eight contracted Mobile X-ray companies. We have received 338 claims for those services since 2012. Additionally, we offer a Home Health Care benefit that provides in-home laboratory services.

Ensuring Network Adequacy for Members with Disabilities

We measure and verify access to care:

- Quarterly assessment of the network access against State standards
- GeoAccess[®] reports, out-of-network provider single case agreements, and medical and case management referrals to determine any network gaps
- Surveys and member complaints to assess network access, appointment availability, and provider compliance with after hours coverage
- Verification of ADA requirements

Amerigroup generates and reviews GeoAccess reports for members who are identified as having special health care needs and compares this to our provider network capabilities, particularly physical therapists, occupational therapists, speech therapists, DME providers, and audiologists.

On-Going Monitoring of Quality of Care

Our tracking of members with identified special health care needs includes reporting according to the following categories:

- Number of members identified with potential special health care needs using historical claims data
- Number of members with potential special health care needs identified by the member's PCP
- Number of members identified with potential special health care needs that self-refer
- Number of members with potential special healthcare needs identified by the MCO

Our Quality Assessment and Performance Improvement program devotes special focus to the quality and appropriateness of care to members in the above tracking categories through the following avenues:

- CAHPS[®] Survey. We also administer the Child with Chronic Conditions survey annually, and analyze the results to identify negative trends, perform root cause/barrier analysis, and develop member interventions to improve member satisfaction
- Monitoring grievances/appeals
- Monitoring and measuring PCP and specialty care provider availability

- Monitoring and measuring for member accessibility to case management
- Analysis of case management enrollment rates to identify areas of concern and determine if case management enrollment reflects the design of the program and the needs of the member population

Our outcome data for HEDIS measures that target chronic conditions, such as Comprehensive Diabetes Care and Controlling High Blood Pressure, can be reviewed in Section U.