

SECTION G: NETWORK DEVELOPMENT

G.1 Plan to Build an Adequate Statewide Provider Network

G.1 Provide a plan to build a statewide provider network to adequate (Section 7.0) for a membership of 250,000 members that in accordance with the specifications found in Section 7.0 of the RFP and specific efforts to recruit and retain participation quality providers in the Louisiana Medicaid program.

Include your process and policies for utilization of out of network providers and your plan to address any gaps in local coverage and maintain adequacy throughout the term of the contract.

Amerigroup Louisiana (Amerigroup) has a Provider Network Development and Management Plan that meets the requirements contained in Section 7.0 of the RFP, Provider Network Requirements, and is used to develop, maintain, and monitor a comprehensive Medicaid provider network. ***Attachment G.1- Includes a copy of the Plan.***

Amerigroup has a strong record of developing and maintaining a provider network that meets and often exceeds DHH adequacy and sufficiency standards. Our robust network currently serves approximately 127,000 members throughout Louisiana. ***Based on our analyses, our provider network has the capacity to enroll a membership well beyond 250,000 members.*** Since we started providing services to Medicaid recipients in Louisiana, we have never been issued a notice of non-compliance or sanction for failing to meet network adequacy standards.

Amerigroup's Network in Louisiana includes:

- 156 Hospitals
- 2,300+ PCPs
- 8,750+ Specialists 

We understand Louisiana's provider community and the health care needs of Medicaid members. We have built trust and developed collaborative working relationships with providers through our on-the-ground approach. Providers are not new to our programs, processes, or procedures. Our successful relationships with Louisiana's providers position us at the forefront of the contracting process when we need to expand our network, such as we are doing now for the newly covered hospice and personal care services providers. We continually seek to improve our network by listening and responding to our members, providers, stakeholders, and community partners. This collaborative approach to developing, assessing, and updating our network offers a comprehensive and accessible network for our members.

We diligently monitor access to and the availability of our provider network. On a quarterly basis, we generate and evaluate GeoAccess[®] reports for physical and geographic access to make sure members have ample choice of providers. We also continually monitor information obtained through our Network Strategy Workgroup and Health Education Advisory Committee, as well as provider relations, medical management, quality management, and member services units to identify opportunities to improve the network and address any deficiencies.

When we identify a deficiency in meeting access standards, our provider relations representatives promptly develop a detailed action plan—including staffing, responsibilities, resources, and a timeline—to correct the situation. Once launched, we monitor the progress and effectiveness of the plan until we meet or exceed standards.

The Amerigroup Louisiana Network

Amerigroup has built a statewide comprehensive Medicaid network to serve Bayou Health members. Our network covers all parishes and includes 156 hospitals, more than 2,300 primary care providers (PCPs), and more than 8,750 specialists.

We ease administrative burden by delivering claims, eligibility, and benefits tools to providers through Availity, a multi-payer portal. Through Availity, providers can access multiple payers' information with a single, secure sign-on. 🌸

Our success is based on our local, hands-on approach. Our Louisiana-based Provider Network team entrenches themselves in the community, meeting face-to-face with providers to build trust, open communication, and develop collaborative relationships. We engage with those providers who share our goal of delivering the best combination of positive health care outcomes at the most appropriate cost.

We do this through the following:

- Developing collaborative relationships, including extensive, one-on-one outreach
- Offering proactive, comprehensive provider education in a variety of venues and participation methods
- Implementing provider incentive programs that reward physicians who deliver measurably better care and achieve more positive patient outcomes (described later in this section)
- Working with selected PCPs to assist them in transforming their practices into patient-centered medical homes
- Assisting physicians at the point of care by providing them with member utilization data to identify gaps in care and to make sure that the member receives all appropriate services
- Delivering sound reimbursement practices, including prompt and accurate claims payment
- Streamlining utilization management practices, including electronic submission of authorization requests
- Simplifying and minimizing administrative burdens

As an existing MCO in Louisiana, Amerigroup has strong, positive relationships with providers who serve Medicaid recipients. We have developed collaborative relationships with providers in Louisiana, and we strive to continually improve the level of service we offer. We are out in the community meeting daily with providers in their offices to make sure we meet their needs and answer their questions. We meet with approximately 240 providers each month.

Our Chief Medical Officer and Provider Relations staff meet with approximately 240 providers every month. 🌸

Summary of Our Network Provider Development and Management Plan

Our Plan addresses the requirements contained in Section 7.9 of the Scope of Work. Following these elements, it also addresses the remainder of the Provider Network Requirements included in the Scope of Work (Sections 7.0 - 7.8 and 7.10 - 7.15).

Our Plan reflects the Louisiana health care landscape and needs of Louisiana’s Medicaid recipients. It is locally developed, refined, and evaluated by our Louisiana-based provider relations team and receives on-going input from our Louisiana Network Strategy Workgroup. This cross-functional workgroup includes representatives from provider relations, medical management, quality management, compliance, community outreach, government relations, and finance. The workgroup provides valuable insight and feedback to make sure our network has the right number, mix, and geographic distribution of providers to meet the needs of our members and complies with Amerigroup standards and Contract requirements.

Below are highlights from our Network Provider Development and Management Plan.

Designing the Network of Providers

Amerigroup develops and maintains our provider network to offer members access to core benefits and services (covered services) within DHH access standards. Our Provider Relations department takes the following factors into account to identify providers (hospitals, physicians, FQHCs, RHCs, and ancillary providers) to promote access and choice. In recruiting and selecting providers, we consider the following:

Anticipated Number of Medicaid Members

We base our network development activities on an anticipated minimum of 250,000 Medicaid members.

Expected Utilization of Services and Numbers and Types of Providers

We draw upon our experience serving Louisiana’s low-income and underserved populations and our understanding of the types of providers needed to meet the health care needs of members. For instance, in examining the provider types most used by our Louisiana members, our network provides comprehensive coverage as demonstrated in Table G.1-1.

Table G.1-1. Our Provider Network Exceeds Requirements

Provider Type	Amerigroup Provider Count
PCP	2,363
Allergy/immunology	55
Cardiology	343
Dermatology	72
Gastroenterology	134
General surgery	382
Nephrology	151
Neurology	129
OB/GYN	505
Ophthalmology	208
Orthopaedic surgery	194
Otolaryngology	158
Pediatric cardiology	185

We continue to actively recruit additional providers, where appropriate, to continue offering a robust network of choice as we anticipate growth in our membership.

Numbers of MCO Providers Who Are Not Accepting New Members

Amerigroup considers the effect of providers who are not accepting new members in designing the network and assessing capacity. PCPs are the only provider types that can close their panels to Amerigroup members. Of our 2,363 PCPs, only 265 (11 percent) have closed panels. Therefore, in evaluating PCPs with open panels, we have a compliance rate of 99.7 percent for members in urban areas and 100 percent for members in rural areas.

In addition to closed panel status, Amerigroup deliberately scrutinizes our network to identify providers who may not be meeting availability standards. We are steadfastly committed to providing members access and choice of providers, and we take stern measures to identify and prevail upon providers who may not be abiding by their duty to see Medicaid patients.

We identify providers who may not be meeting availability standards through the following:

- **Provider Utilization Analyses**—Every quarter, we generate a report of network providers who have not submitted a claim in the previous six months.
- **Member Input**—Amerigroup’s member Health Education Advisory Committee, focus groups, and one-on-one member interactions provide us information on the adequacy and availability of network providers.
- **Employee Feedback**—Our provider relations, case management, quality management, and member services employees relay information on the access and availability of network providers.
- **Network Strategy Workgroup**—This cross-functional workgroup provides valuable insight and feedback to make sure our network is accessible and available to our members.
- **Member Grievance Information**—We review member grievances and provider complaints to monitor provider adherence to access and availability standards.
- **Appointment Availability Audits**—Amerigroup conducts an annual audit of a random, statistically valid sampling of PCPs to assess appointment availability and after hours coverage.

Amerigroup’s Chief Medical Officer and Provider Relations staff promptly reach out to providers we identify. Using face-to-face and telephone contact, they re-engage providers and reinforce their contractual obligations to be available to our members.

Geographic Location of Providers and Members

We evaluate the geographic characteristics of network providers and members, including distance, travel time, means of transportation, and physical access for members with disabilities. We will apply DHH standards for distance and membership ratios (Appendix UU). Our goal is to exceed DHH required standards.

Demonstrating Access to Services and Benefits

Amerigroup diligently monitors the access to and availability of our provider network according to DHH requirements and federal regulations, including 42 CFR §438.206. At the network level, we monitor for geographic access to verify that our members have comprehensive and accessible access to covered services. At the provider level, we monitor to confirm that providers offer members timely access to care. We use proven techniques to monitor and evaluate our network and seek and obtain input from various sources, including members, providers, stakeholders, and DHH, to verify that our network meets the needs of the members we serve.

GeoAccess Maps

On a quarterly basis, we generate and evaluate GeoAccess (version 2013, 2, 1, 0) reports for network adequacy for physical and geographic access to make sure members have ample choice of contracted providers. GeoAccess reporting features to evaluate network adequacy for physical and geographic access include the following:

- **Geographic Overview Maps:** Displays PCP and specialty care provider locations by geographic area.
- **Provider and Member Location Maps:** Plot members and providers of any or all specialty/specialties—or combinations of both; these maps overlay the provider network against the membership base with the appropriate radius encompassing each provider to identify geographic coverage in a particular area.
- **Member Accessibility Summary:** Provides an overview of the entire analysis displayed in a given report. It details the number and percentage of members with and without access to a PCP, as well as key specialists (for example, number and percent of members with and without access to a gastroenterologist).
- **Access Comparison:** Provides a graph that demonstrates the point at which the percentage of members attains compliant status with the specified provider type and defined access standard.
- **Accessibility Detail:** Presents counts of members with and without access to care under the defined access standards. It provides the total number of members, providers, and a member-to-provider ratio for the demographic or geographic area analyzed. The report also provides a detailed analysis of a member's choice of up to five providers and the average distance to achieve that access.

If the network adequacy standards are met but our members' needs could be better served by a provider outside our network, Provider Relations Representatives identify and work with the provider to participate in our network. If a deficiency occurs, there are policies and procedures in place to take immediate action to remedy the situation. To address any deficiencies in our provider network, our provider relations team develops action plans that identify staffing, responsibilities, resources, and a timeline to correct the situation.

Amerigroup continually seeks ways to enhance access to services and benefits. For example, building on the success of our Clinic Days, we are implementing *Enhanced Clinic Days* at select PCP practices. Through this innovative program, PCP practices agreed to have dedicated appointment times for Amerigroup members. Amerigroup then contacts members with missed and upcoming EPSDT visits to schedule appointments during these time slots. 🌸

Primary Care Providers

Amerigroup's network includes more than 2,300 PCPs. Amerigroup allows the following provider types, including FQHCs and RHCs, to serve as PCPs:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics
- Nurse Practitioners

Amerigroup's network includes key providers, including the Louisiana Office of Public Health (OPH) and OPH-certified School Based Health Clinics (SBHCs). We reach out to all significant traditional providers (STPs) and make a good faith effort to gain their participation in our network. As we learn of new STPs, we contact them in person or by telephone to introduce Amerigroup, answer any questions they might have, and begin the contracting process.

Medically vulnerable populations often need a level of service that is best met by a specialist who assumes the PCP role. Members may request a specialist as a PCP, or their case manager may arrange for a specialist as a PCP in consultation with the member. All requests must be approved by our Chief Medical Officer, who verifies that the specialist understands and agrees to provide all services required by PCPs and agrees to adhere to PCP access standards. Generally, members may choose a specialist as their PCP when the specialist has previously provided care to the member or if the specialist has experience treating the member's specific condition.

Access to Specialists

Amerigroup's network includes more than 8,750 specialists. Our experience confirms that efficient and cost-effective care does not require referrals for specialty care; therefore, Amerigroup provides members with direct access to specialists. In addition to direct access to specialists, many members with special health care needs require highly specialized network providers to accommodate their unique medical and other specific service needs.

We are actively expanding our network to include providers for the newly covered services, Personal Care Services (PCS) for members 0–20 years of age, and hospice services.

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We will continue our successful strategies to outreach to and contract with these providers. To offer our members continuity of care, we have already identified providers currently providing these services to the eligible population. These providers have also earned the trust of individuals, offer the appropriate services, maintain close geographic presence, are keenly aware of the diverse needs of that population, and have access to key local resources in their communities.

We already have more than 300 PCS providers under contract and are in active discussions with hospice providers to join our network. Upon Contract award, we expect to advance our contracting efforts to meet access requirements.

Our network includes the providers who serve Medicaid recipients, including:

- The Louisiana OPH
- All OPH-certified SBHCs
- All small rural hospitals
- 101 FQHC locations
- 106 RHC locations

While we will continuously receive and review provider requests to join our network, we will focus our recruitment efforts for the remainder of 2014 on the following areas:

- Western Calasieu and Cameron Parishes: Endocrinology and Infectious Disease
- Central Louisiana: Dermatology

Access to Hospitals

Amerigroup's network includes 156 hospitals (representing 99.5 percent of Louisiana's hospitals) and tertiary care facilities, including the Ochsner Health System, Baton Rouge General, Children's Hospital of New Orleans, Willis Knighton, and Women & Children's Hospital.

Identifying and Addressing Gaps in the Network

Amerigroup has a comprehensive process to assess and monitor the current status of our network, project future needs, and readily identify network gaps. This process, combined with our extensive knowledge of the provider community, affords us insight to promptly address barriers and gaps.

Identifying Gaps

Amerigroup proactively and continually monitors the adequacy of our network, anticipates future needs, and readily identifies network gaps to make sure that members have access and that we continue to meet standards. We review multiple data sources to identify patterns and trends and service demands specific to the region or parish:

- **Weekly Network Changes**—We review all additions, deletions, and PCP capacity changes to our network on a weekly basis. We review this by provider type and location.
- **Quarterly GeoAccess Analyses**— On a quarterly basis, using data analytic tools, we conduct a network assessment against DHH standards to verify that our network (hospitals, groups, PCPs, specialty providers, behavioral health providers) meets adequacy and accessibility standards to deliver covered services to our members. We generate and review GeoAccess reports to determine any network gaps based on where our members live. We use a grid to track covered services against a list of all providers in the region that shows their capacity.
- **Member Satisfaction Surveys**—On an annual basis, our Quality Management department engages a qualified, DHH-approved vendor to administer the most current version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We conduct research and information using focus groups and one-on-one member interactions.
- **Provider Satisfaction Surveys**—Our annual provider satisfaction survey includes key questions about the quality and adequacy of our provider network. We also conduct provider focus groups to solicit feedback from our providers on Amerigroup's services and adequacy and availability of our provider network.
- **Employee Feedback**—All Amerigroup employees continuously search for opportunities to improve our network design and performance. Our provider relations, case management, quality management, and member services employees provide feedback on the quality, access, and availability of our provider network to maximize success. Amerigroup Provider Relations Representatives, Case Managers, and Community Relations Representatives are in the field daily working with stakeholders—members, families, providers, and community-based organizations. These stakeholders are best poised to provide feedback concerning needs and opportunities, help us solve challenges, and ensure

Amerigroup's locally based Network Strategy Workgroup provides valuable insight and feedback to our Plan to make sure our network has the right number, mix, and geographic distribution of providers. 

we are delivering the best possible array of services to meet member needs.

- **Network Strategy Workgroup**—This cross-functional workgroup includes representatives from Provider Relations, Medical Management, Quality Management, Compliance, Community Outreach, Government Relations, and Finance. The workgroup provides valuable insight and feedback to make sure our network has the right number, mix, and geographic distribution of providers to meet the needs of our members and complies with Amerigroup standards and Contract requirements. The workgroup is led by the Director, Provider Engagement and Contracting and meets on a monthly basis. Our Chief Executive Officer, Chief Medical Officer, and Chief Operating Officer also serve on the workgroup.
- **Health Education Advisory Committee**—We seek input from our Health Education Advisory Committee on our provider network. Members of the committee include Amerigroup members and representatives from community-based organizations.
- **Member Grievance Information**—We review member grievances as well as provider complaints to monitor provider adherence to access standards. Our Member Services representatives review, log, and categorize grievances by cause, disposition, and type. This includes grievances regarding access to care.
- **Appointment Availability Audits**—Amerigroup conducts an annual audit of a random, statistically valid sampling of PCPs to assess appointment availability and after hours coverage.
- **Projected Changes in Population and/or Covered Services**—We closely monitor potential changes in the population and services covered by our Contract to verify that our provider network includes the number and types of requisite providers.

If a network inadequacy or gap is discovered, we promptly initiate interventions to fill network gaps and resolve barriers. Our Provider Relations team develops an action plan to address the issue. The action plan identifies staffing, responsibilities, resources, and a timeline to correct the situation. Strategies to correct the deficiency include the following:

- Identifying and recruiting additional providers
- Working with existing providers with closed panels who may meet requirements for re-opening
- Identifying providers for single case agreements
- Working with providers to meet physical access requirements
- Arranging for transportation for the member, when appropriate

After we launch the action plan, we monitor the progress and effectiveness of the plan until we meet or exceed standards for physical and geographic access. We will continue these activities for the new Contract.

Processes and Policies for Utilization of Out-of-network Providers

When a network provider within the travel distance requirements is not available to meet a member's non-emergency needs, the member may be authorized to seek out-of-network service. In this instance, a Nurse Medical Management clinician monitors and administers the case from the time the member requests an out-of-network authorization and makes sure that treatment is available and delivered. Upon receipt of an authorization request, our Utilization Management staff verifies member eligibility. If the member is eligible, the staff evaluates the reason the service was requested from an out-of-network practitioner or facility. The Utilization Management staff assesses the member's health needs and

forwards cases that require continuity-of-service coordination to the Nurse Medical Management clinician for review and discussion with our Chief Medical Officer. If the Chief Medical Officer deems services from the out-of-network practitioner are medically necessary, the following actions are taken:

- Our Medical Management Department approves the authorization for services to be provided by an out-of-network physician.
- When we authorize care, we check to verify the provider is licensed, there are no licensure sanctions, and the provider is not listed in the Office of the State Inspector General List of Excluded Individuals or Entities or the Geographic Service Area Excluded Parties List.
- Our Provider Relations department approves a comparable in-state/network rate, the State Medicaid Fee-for-Service rate, State-approved out-of-network provider payment methodology, or a negotiated fee schedule.
- Our Provider Relations department may encourage the out-of-network provider to join the network.
- Our Medical Management department develops a strategy to coordinate a member's transition to a network provider once the member is stable or if the care requires long-term treatment available from a network provider.

We cover out-of-network services when emergency services are needed by a member when either in or outside the service area, regardless of whether the provider is part of our network. No pre- or post-authorization is required for emergency services. In an out-of-network emergency situation, it is not necessary for the member or provider to contact us prior to treatment. While we will not deny claims based on failure to receive notification of Emergency Department services, we encourage members and providers to contact us within 24 hours of treatment. This step enables us to begin care management, facilitating any necessary authorizations for on-going service or transfers to network providers. Follow-up activity is based on the severity of the member's health issue.

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G.2 Tertiary Care Providers

G.2 Describe how you will provide tertiary care providers, including trauma centers, burn centers, children’s hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

The Amerigroup network already offers a full range of tertiary care providers, such as trauma and burn centers, children’s hospitals, rehabilitation facilities, medical sub-specialists, and Level III maternity care and high-risk nurseries. All tertiary providers are available 24 hours a day, seven days a week (24/7), as specified in our participating provider agreements.

We expect a vast majority of member needs will continue to be addressed through our network providers, as they are today. In the unlikely event our network is ever unable to meet a specific need for tertiary services, we will authorize and coordinate care from an out-of-network provider. We maintain specific protocols to accomplish the following:

- Facilitate a smooth and timely referral when this occurs
- Remain engaged with each member throughout care received from out-of-network providers
- Seamlessly transfer the member back to a network provider for on-going treatment, when appropriate

We currently hold contracts with 44 tertiary care facilities, including the following:

- The Ochsner Health System
- Baton Rouge General
- Children’s Hospital of New Orleans
- Willis Knighton
- Women & Children’s Hospital

When required, our members also have access to the full range of tertiary care providers from our affiliate MCOs in other states. This includes many nationally notable tertiary facilities for specialized care:

- | | |
|---|--|
| • Memorial Hermann Hospital (TX) | • Johns Hopkins Hospital (MD) |
| • Children’s Medical Center of Dallas (TX) | • Cincinnati Children’s Hospital Medical Center (OH) |
| • Children’s National Medical Center (DC) | • Mount Sinai Hospital (NY) |
| • Georgetown University Medical Center (DC) | • Vanderbilt University Medical Center (TN) |
| • Children’s Healthcare of Atlanta (GA) | • Inova Fairfax Hospital (VA) |
| • Emory University (GA) | |

Amerigroup Louisiana is contracted with all but one of the tertiary care facilities in the state—that’s **99.5 percent** of all hospitals. 🌸

Transfer Protocols and Arrangements with Out-of-network Providers

When a tertiary care provider is not available to meet a member's needs, we authorize care out-of-network. A Nurse Medical Management clinician:

- Monitors and administers the member's care from the time the member requests an out-of-network authorization
- Confirms out-of-network treatment is available and delivered timely
- Engages with the member, our transportation vendor, and/or other providers to help manage care through transfer back into network and completion of treatment plans or stabilization

Upon receipt of an authorization request, our Utilization Management staff:

- Verifies member eligibility
- Evaluates the reason the service was requested from an out-of-network provider, if the member is eligible
- Performs an assessment of the member's health needs
- Forwards cases that require continuity-of-service coordination to the Nurse Medical Management clinician for review and discussion with our health plan Chief Medical Officer

If the Chief Medical Officer deems services from the out-of-network provider are medically necessary, we take the following actions:

- Our medical management department approves the authorization for services to be provided by an out-of-network provider
- When we authorize care, we check to verify the Provider is licensed, there are no licensure sanctions, and the provider is not listed in the Office of the State Inspector General List of Excluded Individuals or Entities, or the Geographic Service Area Excluded Parties List
- Our Provider Relations Department approves a comparable in-state/network rate, the State Medicaid Fee-for-Service rate, State-approved out-of-network provider payment methodology, or a negotiated fee schedule
- Our Provider Relations Department may encourage the out-of-network provider to join the network
- Our medical management department develops a strategy to coordinate a member's transition to a network provider once the member is stable or if the care requires long-term treatment that is available from a network provider

REAL SOLUTIONS
mean
REAL RESULTS

From tools and resources to drive improvements in quality and patient care to enhanced compensation — we are committed to supporting providers, especially those providers who traditionally serve Medicaid recipients. 

Emergency Out-of-network Services

We cover out-of-network emergency services when needed by a member. No pre- or post-authorization is required for emergency services, and it is not necessary for the member or provider to contact us prior to treatment. While we will not deny claims based on failure to receive notification of Emergency Department services, we encourage our participating members and providers to contact us within 24 hours of treatment. This step enables us to begin care management, facilitating any necessary authorizations for on-going service, transportation, or transfers to network providers. Follow-up activity is based on the severity of the member's health issue.

If a member requires transfer from an out-of-network facility to a network facility, Amerigroup first requires the attending physician at the transferring facility to certify the member is medically stable for transfer. Upon receiving that determination, we identify available network facilities with required levels of services to meet the member's medical needs and facilitate an attending physician at the receiving institution to accept the case and transfer.

Monitoring Compliance with Availability

Amerigroup recognizes the importance of 24/7 availability of tertiary care providers. We reinforce this through provider education, and we monitor compliance to access standards. We are steadfastly committed to delivering member access and choice of providers, and we take specific measures to identify providers who do not meet standards through the following:

- **Member input**—Amerigroup's member Health Education Advisory Committee, focus groups, and one-on-one member interactions provide us information on the adequacy and availability of network providers.
- **Employee feedback**—Our Provider Relations representatives, case managers, quality management employees, and member services representatives relay information on the access and availability of network providers.
- **Network Strategy Committee recommendation**—This cross-functional committee provides valuable insight and feedback to make sure our network is accessible and available to our members.
- **Grievance and complaint information**—We review member grievances and provider complaints to monitor provider adherence to access and availability standards.

Amerigroup's Chief Medical Officer and Provider Relations staff promptly reach out to providers we identify as non-compliant. Using face-to-face and telephonic contact, these employees re-engage providers and reinforce contractual obligations to our access and availability standards.

G.3 Keeping Provider Information Accurate and Current

G.3 Describe how you will keep all required provider information accurate and current, both internally and the information submitted to DHH for the provider registry.

We know accurate provider data delivers a firm foundation for quality, as the data is integrated with our other system components to support activities like claims processing, provider directory management, and weekly outbound files to Molina for use by Maximus.

A single, integrated source of provider information verifies data accuracy, timeliness, and consistency. ♣

Amerigroup’s core operations system maintains security controls and comprehensive information on all our network providers, including, at a minimum, all requirements noted in the RFP Scope of Work Section 16. ***Maintaining a single, integrated source of provider information verifies data accuracy, timeliness, and consistency—internally, for our Web-based and printed provider directories, and for information submitted to DHH.***

Getting it right, right from the start

More than 70 employees from our national Provider Data Management (PDM) department support Amerigroup Louisiana and our affiliate health plans, providing additional manpower and analysis to deliver continuous quality. This PDM support model capitalizes on the breadth and depth of knowledge that comes from dedicated support of national data sets, like trending changes to ZIP or area codes, system-wide data edits and requirements, and returned mail or feedback received in our provider call center.

Several steps are taken to confirm the completeness and accuracy of our initial provider system set-up:

- Checklists for each provider type help verify that we capture all required information during the application and credentialing process
- We apply a series of data entry edits designed to prevent keying errors in fields like telephone number, National Provider Identifier (NPI), and Louisiana Medicaid ID
- These data entry edits also flag potential duplicate providers
- Each month, audits of a random sample of provider applications occur to check transactions for accuracy of keyed information and adherence to established processes. Employees promptly correct any issues and take steps, such as staff education and training, to prevent recurrence

Maintaining Data Control

Providers have many ways to submit changes to their demographic or practice information: our provider website or provider call center, by mail or email, or through their assigned provider relations representatives. ***No matter the methods by which changes are received, each update goes through the same verification and data integrity checks before changes are made in our system to the provider’s record.*** Amerigroup also takes many proactive steps throughout each provider’s contract life cycle to verify data accuracy.

We tightly control changes to provider data to protect on-going accuracy. Only certain PDM team members have system access that permits changes to a provider’s data set. Any changes made to the system appear in audit trail history archives and are reported on a weekly changes list reviewed by supervisory staff for compliance with business rules and accuracy.

On-going Accuracy

Our Louisiana-based Provider Relations team members verify all demographic, contact, and practice-related information each time they visit local hospitals and network provider locations. These representatives partner with our PDM team to regularly monitor data for accuracy through the following:

- **Monthly audits of a random sample of providers.** We telephone the sample providers to validate their information.
- **Weekly quality reports that help to analyze data** for gaps/ inconsistencies, and compliance with Louisiana-specific business rules. Employees also research the State's website, master file, and provider address errors, like returned mail or incorrect fax numbers.
- **Quarterly Provider Directory review.** Our Louisiana-based Provider Relations representatives review the provider directory to verify accuracy before production.
- **Monthly evaluation of our data against recommendations from third party vendor, Enclarity.** Enclarity specializes in data accuracy and uses advanced analytics to mine their repository of more than 140 million records compiled from their clients, public sources, subscriptions, and outbound provider calls. They evaluate our provider data against their repository and return suggested changes to our data. Each suggested change is accompanied by an Enclarity confidence level. We update our system when suggested changes have an Enclarity confidence level of 90 percent or greater.
- **Validation of roster-based updates for delegated subcontractors.** Each month, our delegated subcontractors submit monthly rosters that include additions, terminations, and demographic updates. We validate these changes for accuracy and update our system accordingly. If the changes appear to be unusual or inaccurate, we research and resolve the issue with the subcontractor before updating our system.

Leveraging End-user Feedback

We encourage members, providers, and Amerigroup employees to identify and report incorrect or outdated provider directory information. We produce our ADA- and language-compliant provider directories in hard copy and online search formats. Each provider listing includes:

- Provider name
- Provider specialty, including identification of PCPs, specialists, and hospital PCP groups; clinic settings; Federally Qualified Health Centers; and Rural Health Clinics
- Location
- Office hours, including identification of providers with non-traditional office hours
- Telephone number
- Non-English languages spoken
- Indicator if not accepting new patients
- Indicator if provides EPSDT services
- Indicator of treatment for patient age categories (for example, treats patients ages 18 and under)

All directories instruct members to telephone our member call center or visit our member website for the most current information. Updated nightly, the online directory includes all of the information included in the quarterly hard copy directory and does not require a user login.

We accept reports of changes or inaccuracies from a variety of sources, including:

- Providers who call to report changes or use our online, self-service tools to update their information (we often use our provider newsletters and fax blast updates on other topics to remind providers to call or report changes to demographics using our online tools).
- Member Disruption Program: When a member contacts us because he or she was not able to reach a provider or obtain care due to an incorrect address or phone number, the provider panel being full, or the provider not accepting new patients, we forward the information to our provider outreach team. The outreach team contacts the provider to verify demographic data in our system, and action is immediately taken to correct any incorrect data identified during the call. The Member Services team also helps the member arrange for care with another network provider when panels are full or new patients are not currently accepted.