5.1 VENDOR INFORMATION

5.1.1 Company Profile

Vendors must provide a company profile in the table format below.

Table 5.1.1-1. Profile of Amerigroup Nevada, Inc.

Question	Response
Company name:	AMERIGROUP Nevada, Inc.
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	Nevada
Date of incorporation:	August 11, 2005
# of years in business:	4 years
List of top officers:	Eric Lloyd, President and CEO Scott W. Anglin, VP and Treasurer Nicholas J. Pace, VP and Secretary Dr. Richard Roberts, VP and Medical Director
Location of company headquarters:	7251 West Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128
Location(s) of the company offices:	7251 West Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128
Location(s) of the office that will provide the services described in this RFP:	7251 West Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128
Number of employees locally with the expertise to support the requirements identified in this RFP:	47
Number of employees nationally with the expertise to support the requirements in this RFP:	76.75
Location(s) from which employees will be assigned for this project:	7251 West Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128

5.1.2 NRS 80.010

Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

N/A: AMERIGROUP Nevada, Inc. is not a foreign corporation.

5.1.3 Appropriate Licensure

The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Table 5.1.3-1. Nevada Business of Amerigroup Nevada, Inc.

Question	Response
Nevada Business License Number:	NV20051537996
Legal Entity Name:	AMERIGROUP Nevada, Inc.

Is "Legal Entity Name" the same name as vendor is doing business as?

If "No", provide explanation.

Yes		No	√

Amerigroup Nevada, Inc. also does business as "Amerigroup Community Care." Amerigroup Nevada, Inc. has used an approved doing business as (DBA) name of Amerigroup Community Care on certain company materials and communications since 2009.

5.1.4 Verification of Licensing Requirements

Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

AMERIGROUP Nevada, Inc. holds a Certificate of Authority to operate as an HMO in the mandatory managed care counties issued by the Department of Insurance. The license was issued on March 30, 2006, and has been maintained continuously since its date of issue.

Additionally, based on our proposed corporate structure, AMERIGROUP Corporation also holds two licenses issued by the Nevada Division of Insurance in accordance with Nevada statutes and regulations governing utilization review and claims payment activities:

- ***Utilization Review Agent license issued February 8, 2006, and maintained continuously since its date of issue***
- ***Third Party Administrator license issued June 2, 2009, and maintained continuously since its date of issue***

5.1.5 Contracts with State of Nevada Agencies

Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes	√	No	

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Amerigroup Nevada, Inc. holds a contract with Nevada Department of Health and Human Services, Division of Health Care Financing and Policy.

Table 5.1.5-1. Amerigroup Nevada, Inc. Currently Holds Contracts with the State of Nevada

Question	Response
Name of State agency:	Nevada Department of Health and Human Services Division of Health Care Financing and Policy
State agency contact name:	John Whaley, Chief of Business Lines
Dates when services were performed:	February 1, 2009 – present
Type of duties performed:	RFP/Contract #1509: Provide risk-based capitated HMO services in support of the Title XIX (Medicaid) and Title XXI State Child Health Insurance Program (SCHIP) medical assistance programs.
Total dollar value of the contract:	$761,765,047.54

5.1.6 Employees of the State of Nevada

Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	√

5.1.7 Contract Failures, Breaches, and Litigation

Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed.

Does any of the above apply to your company?

Yes		No	√

5.1.8 Insurance Requirements

Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E.

Yes	√	No	

Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission.

Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Amerigroup Nevada acknowledges the requirement to provide the Certificates of Insurance upon contract award.

5.1.9 Company Background and Qualifications

Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.	
5.1.9.1	Corporate Background
A.	Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

AMERIGROUP Nevada, Inc. (Amerigroup Nevada) manages public sector health care programs in Nevada and is well qualified to provide health care services for more than 85,000 Medicaid, CHAP, and Nevada Check Up members. For nearly four (4) years, we have served Washoe and Clark County members—mainly mothers and children—the average age of which is 11, with 81 percent 18 years of age or younger. Amerigroup Corporation (our parent company) and our affiliates (collectively Amerigroup) have more than 16 years of experience providing managed care services to Medicaid, CHIP, the uninsured, and Medicare populations, including managing large-state Medicaid contracts. Today, Amerigroup serves approximately 2.7 million members through health plans in 13 states with the 14th going live in the first quarter of 2013. Our extensive track record includes managing services and populations across the continuum of care, including physical and behavioral health; LTC; home and community-based services (HCBS); foster care; Supplemental Security Income (SSI); aged, blind, and disabled (ABD); and rural populations.

B.	Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

Amerigroup Nevada, a wholly owned subsidiary of Amerigroup, was invited to participate in the program by DHCFP when another MCO exited the market. We stepped in February 1, 2009, and launched operations within 120 days of contract award. Amerigroup, our parent company, is an organization that focuses on meeting the healthcare needs of low-income and medically vulnerable Americans in the Medicaid and Medicare programs. Amerigroup Corporation owns 100 percent of the issued and outstanding shares of common stock of Amerigroup Nevada. As of production of this proposal, Amerigroup is aware that four entities own beneficially five percent or more of the outstanding shares of Amerigroup Corporation common stock. These entities are FMR, LLC; Artisan Partners Limited Partnership; Capital World Investors; Vanguard Group, and Institutional Investment Advisors.

C.	Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may

	be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

Amerigroup Nevada, Inc. is a resident of Nevada and was incorporated on August 11, 2005, as a Nevada-domiciled company.

D.	The location of disaster recovery back-up site.

The disaster recovery back-up site is located at the: DR Collocation Site, AT&T Internet Data Center, C/O Site 18396, 11830 Webb Chapel Rd., Dallas, TX 75234. There is a direct connection between the production data center in Virginia Beach, VA, and the Dallas, TX, hot site, which allows immediate backup Internet access for the entire enterprise if needed.

E.	The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Eric Lloyd, Chief Executive Officer, Amerigroup Nevada, Inc., 7251 West Lake Mead Blvd., Ste. 104, Las Vegas NV 89128; the phone number is (702) 228-1308.

F.	The size of organization in assets, revenue and people.

Table 5.1.9-1.Organization in Assets, Revenue and People

Amerigroup Nevada	Through 2nd quarter 2012
Assets	$44,482,676
Revenue	$91,682,411
Employees	47
Amerigroup Corporation (parent company)	**Through 2nd quarter 2012**
Assets	$2.9 billion
Revenue	$6.4 billion
Employees	6,600

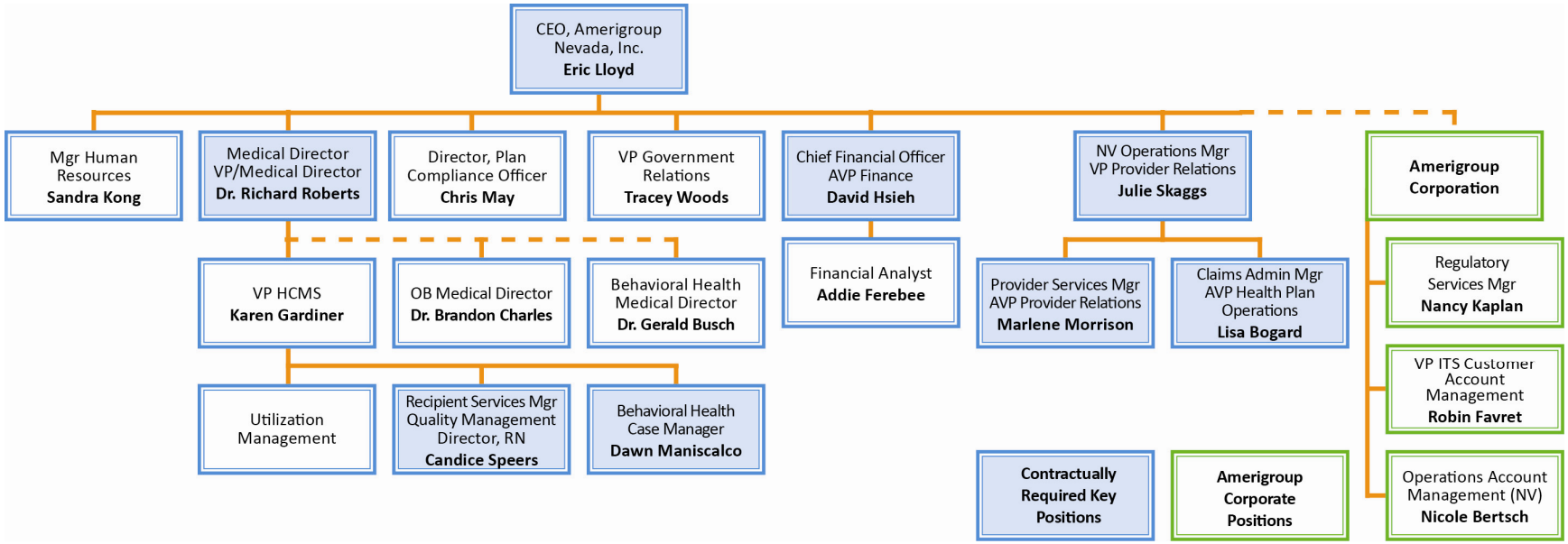
G.	The organizational chart of your senior management by function including key personnel.

Please see Figure 5.1.9-1 on the following page for an organizational chart of our senior management by function including key personnel.

H.	The areas of specialization.

Amerigroup specializes in Medicaid Managed Care and serves more than 2.7 million members through a variety of public programs, including Medicaid, Temporary Assistance for Needy Families (TANF—with more than 1.4 million mothers and babies), CHIP, uninsured adults, and people with disabilities/ Supplemental Security Income (SPD/SSI), as well as Medicare. Amerigroup drives value by focusing on the high-need, high-cost populations and innovating cost-effective solutions through integrated care management strategies. See Figure 5.1.9-2 on page 8.

Figure 5.1.9-1. Organizational Chart



I.	The company's main product/service lines and annual revenues for the two most recent years for which full data are available.

Table 5.1.9-2. Amerigroup Nevada's Revenue and Membership for Past Two Years

Amerigroup Nevada 2010	
Medicaid revenue	$12,867,925.85
Medicaid membership	67,027
CHIP revenue	$591,606.83
CHIP membership	5,805

Amerigroup Nevada 2011	
Medicaid revenue	$14,014,420.96
Medicaid membership	77,820
CHIP revenue	$674,287.28
CHIP membership	5,785

J.	The corporate philosophy and mission statement.

Corporate philosophy: We will be a different kind of health insurance company—a company that does well by doing good. Mission: To provide Real Solutions for members who need a little help by making the healthcare system work better while keeping it more affordable for taxpayers.

K.	A description of any plans for future growth and development of your organization.

Amerigroup and Amerigroup Nevada stand ready to continue partnering with DHCFP as new populations, services, and geographies are added. Our broad experience in Nevada and in our other 13 health plans enables us to scale new programs and solutions to address Nevada's healthcare needs. Additionally, we anticipate future growth and development to support an influx of members through expansions and opportunities offered by the Accountable Care Act (ACA). Here are some of the areas on which we are focusing:

Figure 5.1.9-2. Services Provided by Amerigroup

Market	Acute	Mental Health	Substance Use Disorder	Pharmacy	Vision	Dental	HCBS	NF	Total Members
Florida	✓	✓	✓	✓	✓	✓	✓	✓	266,000
Georgia	✓	✓	✓	✓	✓	✓			287,000
Kansas	✓	✓	✓	✓	✓	✓	✓	✓	Launches 1/1/13
Louisiana	✓			✓	✓				143,000
Maryland	✓		✓	✓	✓	✓			213,000
Nevada	✓	✓	✓	✓	✓	✓			85,000
New Jersey	✓	✓	✓	✓	✓	✓			154,000
New Mexico	✓			✓	✓	✓	✓	✓	24,000
New York	✓	✓	✓	✓	✓	✓	✓	✓	434,000
Ohio	✓	✓	✓	✓	✓	✓			57,000
Tennessee	✓	✓	✓		✓		✓	✓	205,000
Texas	✓	✓	✓	✓	✓		✓	✓	769,000
Virginia	✓	✓	✓	✓	✓				48,000
Washington	✓	✓	✓	✓	✓				16,400

Medicaid Expansion: ***leverage our depth of experience around providing cost-effective integrated benefits, services, care management, and transition plans***

Health insurance exchange: ***expand the frame work we have developed so far in order to meet future individual needs and State challenges and integrating member transition processes***

Health homes: ***support ACA guidelines to provide health homes to Medicaid members with chronic illnesses to achieve more accessible, cost-effective, high-quality primary care, and further support primary care practices in their effort to improve patient outcomes***

Health information exchange: ***deepen the links and training among the health information exchange, electronic health records, and the methods for provider collaboration***

Other populations: ***anticipate the changing needs for future populations such as the ABD, the children/adolescents in the juvenile justice system/foster care programs, and the approximately 70,000 potential members who are eligible but have not previously applied. We***

now serve more than 279,000 ABD/dual-eligible individuals and will continue to expand current benefits/services/transition plans to include these populations.

L.	Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

As the table illustrates, Amerigroup has welcomed new members across all products in all our states since January 2011. We have expanded products, including long-term care and the uninsured; services, ranging from physician/hospital and 24-hour institutional care to personal care services offered in the community; and geographic locations—all while controlling medical costs, improving quality, and saving taxpayer dollars beyond what is achieved through fee-for-service.

Table 5.1.9-2. More than 600,000 Members Added Since January 2011

Amerigroup Market Expansion/Business Line Additions Since January 2011	
TANF: new members	548,118
CHIP: new members	46,066
Long-term Care: new members	6,033
ABD: new members	5,805
Medicare: new members	1,178
Total:	***607,200***

Our methodology is to leverage our experience, fully engage our local leadership/administrative infrastructure, and build on strong relationships with state officials and established provider networks. Therefore, we have been able to help provide solutions during three recent implementations. Our health plans in Louisiana and Washington and a pending implementation in Kansas all reflect this—Louisiana transitioned most of their Medicaid population into managed care; Washington included Medicaid, plus the uninsured populations through an additional program; and Kansas, beginning January 1, 2013, will serve members statewide through a comprehensive patient-centered care coordination program. A natural extension of effort is the major opportunity to serve the dual eligible population—managed care is part of the organic solution for this high-cost population. Our implementation approach is an expertly managed process. From a highly trained, professional group of subject matter experts who are pulled from key functional areas to our Implementation Project Team, we adhere to a formal project management lifecycle, which includes:

- Formal engagement/documentation of resources dedicated to the project
- Meetings with the State's project/technical teams
- Formal communication plan/weekly reporting
- Risk management, mitigation, and contingency plans
- Internal readiness reviews
- Onsite go-live and post go-live support
- Full engagement for our local health plan operations

These qualities allow us to positively impact the health of members, sustain profits, and create a seamless system that spans acute medical care and long-term services and supports.

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5.1.10 Experience

Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

5.1.10.1 Experience

A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:

1. Managing a network of Medicaid Providers;
2. Managed care programs for Medicaid recipients;
3. Administering Medicaid utilization and case management programs;
4. Medicaid claims processing and adjudication
5. Project management; and
6. Qualifications of key personnel.

Experience Providing Services Requested in this RFP

Amerigroup is proud to have served Nevadans through the Medicaid MCO program since February, 2009. We now deliver healthcare services to approximately 85,000 members, including Temporary Assistance to Needy Families (TANF), Child Health Assurance Program (CHAP), and Nevada Check Up enrollees. Our local team includes 47 employees, including 33 Nevada residents and 18 doctors, nurses, behavioral health clinicians, and social workers. Amerigroup Nevada is the only Medicaid MCO in the State with NCQA accreditation.

In Nevada, Amerigroup annually covers more than:

- 508,000 physician visits
- 487,000 prescriptions
- 4,450 births
- 6,600 surgeries

Our operations now meet or exceed current DHCFP contract requirements, which mirror the vast majority of the new Contract requirements. Since our inception, Amerigroup Nevada has not been assessed any fines or monetary penalties directly related to any failure to meet standards as outlined in our contract. We have also cultivated excellent relationships with members, providers, consumer groups, community-based organizations, and State agencies throughout Washoe and Clark Counties to complete the continuum of care needed to promote healthy lives for our members.

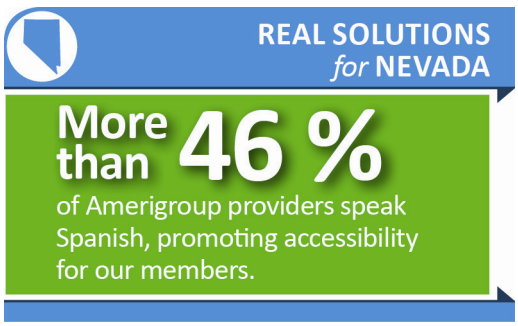
As described throughout this section, we have sought active collaboration with DHCFP to strengthen the Medicaid and Nevada Check Up programs and deliver results that align with the Agency's goals; we also have demonstrated our commitment to achieving improved health outcomes for all Nevadans, not just Amerigroup members. We are enthusiastically working with the State to plan for the future. Our CEO participates on the Silver State Health Insurance Exchange (SSHIX) Finance and Sustainability Advisory Committee and sits on the board of directors of the Nevada Health Information Exchange (NHIE). Our Medical Director is a member of the Plan Certification and Management Advisory subcommittee of the SSHIX. We engage with State leadership to share ideas and strategies to achieve the Governor's Healthy Nevada goals.

Augmenting our experience in the State, Amerigroup Nevada is a wholly owned subsidiary of Amerigroup Corporation, which has more than 16 years of experience managing publicly funded health programs. Amerigroup covers approximately 2.7 million members, including one out of every 23 Medicaid recipients and one out of every 24 children covered by CHIP nationwide. In addition to Nevada, Amerigroup operates health plans in 13 other states: Florida, Georgia, Kansas (launching January, 2013), Louisiana, Maryland, New Jersey, New Mexico, New York, Ohio, Tennessee, Texas, Virginia, and Washington.

Amerigroup's experience outside Nevada enables us to capitalize on innovations that are developed with similar populations in other states and bring to DHCFP expertise related to programs and services that now fall outside the current MCO program. We have deep experience serving seniors, people with disabilities, and dual eligibles; delivering long-term services and supports (LTSS) benefits for members enrolled in Home and Community-Based Service (HCBS) waivers; and innovating new solutions to fill care and service gaps.

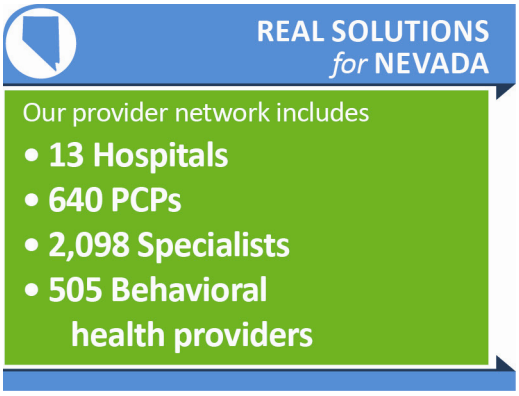
Medicaid Provider Network (5.1.10.1.A.1)

Amerigroup has extensive experience managing Medicaid provider networks in Nevada as well as across the country. As an organization immersed in Medicaid managed care, Amerigroup understands the factors that drive a successful network strategy. These factors include promoting access by contracting with providers located close to public transportation, strategically partnering with entities like schools and health departments, and maximizing access to services on evenings and weekends to accommodate working families. Outside Nevada, Amerigroup has managed Medicaid provider networks for 16 years and has established networks in 13 other states. Our response to Section 5.1.11.4 includes details on our specific network management strategies.



Our local team has forged trusting relationships with providers of all types in Clark and Washoe counties. This foundation of trust enables us to more rapidly respond to changing member needs. For example, we can expand our network by recruiting specialists to whom our contracted PCPs currently refer. We continually evaluate network access and capacity by monitoring GeoAccess® tools and member complaints. For example, we identified an uptick in member complaints about access in Washoe County, evaluated network gaps that drove the complaints, and recruited additional providers to resolve those gaps.

This experience positions Amerigroup Nevada as an optimal MCO partner as we bring a solid foundation on which to build and expand our network as DHCFP needs evolve in the future, including network expansions required for a Qualified Health Plan for the SSHIX. For example, an increase in the number of enrolled adult males will likely require increased capacity for PCPs who are internists. We stand prepared, based on extensive experience in other states, to expand our Nevada network capacity should DHCFP opt to add seniors and people with disabilities enrolled in the Medical Assistance for Aged Blind and Disabled (MAABD) eligibility category or dual eligibles. We also bring expertise to the State should it expand the covered services to include LTSS to promote independent living for members requiring Home and Community-Based Services.



Our experience spans the following areas:

- *Scope. Amerigroup Nevada has already developed a comprehensive and robust network in Clark and Washoe counties that includes 13 hospitals, 640 PCPs, 2,098 specialists, and more than 500 behavioral health providers. Our network meets all DHCFP requirements, including accessibility and appointment standards. We enjoy a network retention rate exceeding 99 percent. Additionally, due to the increased prevalence of mental illness and chemical dependency in low-income populations, we maintain a robust range of behavioral health providers who can address acute and rehabilitation services that promote sustained recovery for members who are Severely Emotionally Disturbed (SED) and Seriously Mentally Ill (SMI). This includes an innovative partnership with Harmony Healthcare in Clark County through which its Rapid Response Team provides onsite screening for members presenting to the emergency department (ED) for a mental health or substance abuse condition.*
- *Composition. We understand the unique needs of low-income populations, and our network facilitates optimal access to care and services, including providers with whom*

our members already have trusting relationships. All Essential Community Providers in our current service area are in our network, including both of Nevada's Federally Qualified Health Centers (FQHC), reflecting the unique cultural preferences of our members. Almost 20 percent of our current members speak Spanish as their primary language, and more than 46 percent of our network providers can accommodate that preference.

- *Physician Extenders.* ***In Amerigroup's experience, properly trained and supervised physician extenders—Physician Assistants (PA), Advanced Practice Registered Nurses (APRN), and midwives—are a practical solution to expand access to primary care and deliver the needed preventive services for our members. In Nevada, we contract with 42 Nurse Practitioners and 43 PAs.***

- *Provider Engagement.* ***In Nevada and across the country, Amerigroup has demonstrated success engaging providers through innovative programs such as our Real Solutions® Medical Home and provider quality incentive programs, which are detailed in our response to Section 5.1.10.1.B. Currently 8,800 Nevada members, representing more than 10 percent of our membership, are served through a Real Solutions® Medical Home, and more than 36,000 members (more than 42 percent) are connected to PCP practices that participate in quality-driven incentive programs. We are also assisting our Medical Homes to achieve NCQA certification as Patient Centered Medical Homes (Level 2). Nationally, Amerigroup operates the fifth largest Medical Home program in the country according to the latest Patient-Centered Primary Care Collaborative (PCPCC) report. We are also well positioned to support DHCFP as it plans for the future. Our affiliate health plans in Washington, Kansas, and other states are building Health Homes that are compliant with Patient Protection and Affordable Care Act requirements to enable our state partners to capitalize on increased Federal Medical Assistance Percentage (FMAP) funding and foster quality outcomes through patient-centered integrated care for our members with chronic conditions, including SED children and SMI adults.***

- *Satisfaction.* ***In our most recent provider satisfaction survey, 90 percent of Nevada providers would recommend us to other physicians (a 20 percent gain over the previous year). Eighty-six percent reported that they were satisfied overall with Amerigroup, also a 20 percent gain over 2010. We achieve these satisfaction rates through a carefully structured Provider Relations strategy that includes field-based***

representatives that nurture close relationships with providers and their employees through one-on-one education, engagement, and problem-solving. So far this year, our Provider Relations team has met with more than 700 providers. We also assign Provider Relations Representatives by provider type so each Representative is most familiar with the questions and issues most relevant for each provider area, fostering expertise and early identification of trends within provider types. For example, Representatives who support obstetricians are familiar with health plan procedures specific to maternal care, such as preauthorization requirements and claims coding best practices required to gather accurate HEDIS®-related information.

- ***Alignment with State Goals and Objectives.*** ***Our experience also includes engaging providers to advance the State's goals related to the Nevada Health Information Exchange (NHIE). We promote health information sharing with our PCPs and PCMHs, but we also collaborate with HealthInsight's Health Information Technology Regional Extension Center and the State's Quality Improvement Organization on educating providers about adopting electronic health records (EHR) and achieving meaningful use standards. (Our CEO is also a member of HealthInsight's Nevada Partnership for Value-driven Healthcare Steering Committee.) For providers not currently using EHRs, we educate them on how to move toward them, fostering the long-term success of the State's HIE initiative.***

Amerigroup also innovates to create sustainable solutions to network gaps in other states that we are prepared to bring to Nevada.

See the Confidential Technical Volume for proprietary information.

- ***Telehealth.*** ***Our Georgia affiliate contracted with the Georgia Partnership for TeleHealth to increase access to specialty care (both physical and behavioral health) through the innovative use of technology, including telemedicine, HIE, and telehealth. The program has reduced delays in receiving specialty consults and follow-up appointments in areas that have poor access to specialty care and also reduced transportation expenses and missed days from work. We will apply best practices and lessons learned to expand access to services as the MCO expands into Nevada's rural areas.***

Medicaid Managed Care Programs for Recipients (5.1.10.1.A.2)

In Nevada and across the country, Amerigroup brings widespread experience delivering Medicaid managed care programs for recipients. As detailed in our response to Section 5.1.10.1.C, Amerigroup has significantly invested in the development of our people, our systems, and our processes to establish best practices that deliver results. We continue to innovate and create new programs and services for our members that advance the goals and objectives of the State customers we serve, including DCHFP.

In this section, we describe our Medicaid managed care experience related to:

- ***Implementing solutions to optimize member health outcomes, including children and pregnant women who currently represent our largest membership in Nevada***
- ***Delivering services to diverse populations***
- ***Coordinating comprehensive benefits and services***
- ***Partnering with existing community programs to reach members and their families***

Implementing Solutions to Optimize Member Health Outcomes

With more than 16 years of experience serving Medicaid recipients, including four years in Nevada, Amerigroup has refined programs to optimize health outcomes.

Designation of a Medical Home

We maintain established procedures to connect each member to an appropriate medical home, including policies and procedures that guide assignment of PCPs to those who have not selected one and that enable Children with Special Health Care Needs to select a specialist as a PCP. Our comprehensive and culturally diverse network enables members to select a PCP that promotes positive relationships. (They are described in our response to Section 5.1.11.3.) We reinforce the importance of having a PCP with each interaction. Additionally, as described above, Amerigroup is pioneering the adoption of Real Solutions® Medical Homes to enhance the capabilities of PCPs in Nevada. More than 10 percent of our current members are served through these medical homes.

Health Promotion and EPSDT Services

Timely and age-appropriate preventive and well-care visits for all members, including periodic screenings, are vital to assisting members maintain their health. Well-care visits, age-appropriate screenings, and immunizations also enable us to identify and address any potential conditions before they escalate. Amerigroup has in place the tools and strategies

necessary to drive promotion of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), primary, and preventive health services, including:

- ***Tracking tools that enable us to monitor member receipt of services in accordance with evidence-based guidelines, including HEDIS-related services***
- ***Telephonic and mail outreach to members to remind them about the need for services and a new pilot to test texting reminders, which is being evaluated for adoption in Nevada***
- ***Provider outreach and reminders, including enhanced reporting for our Real Solutions® Medical Home providers***

Care Management Programs Developed for Low-Income Populations

Amerigroup has implemented and refined a continuum of care management services that enable us to calibrate the level of intervention to each individual's risk level, making efficient use of the health plan's resources by focusing the greatest efforts on individuals with the greatest needs or challenges. This includes NCQA-accredited disease management as well as comprehensive case management. Our maternal and child health program fully aligns with DHCFP's goal of reducing pre-term birth rates as it provides extensive supports to pregnant women and their newborns. All programs specifically address the unique characteristics and needs of low-income populations, and our proprietary predictive models prioritize outreach to members with the greatest risk levels.

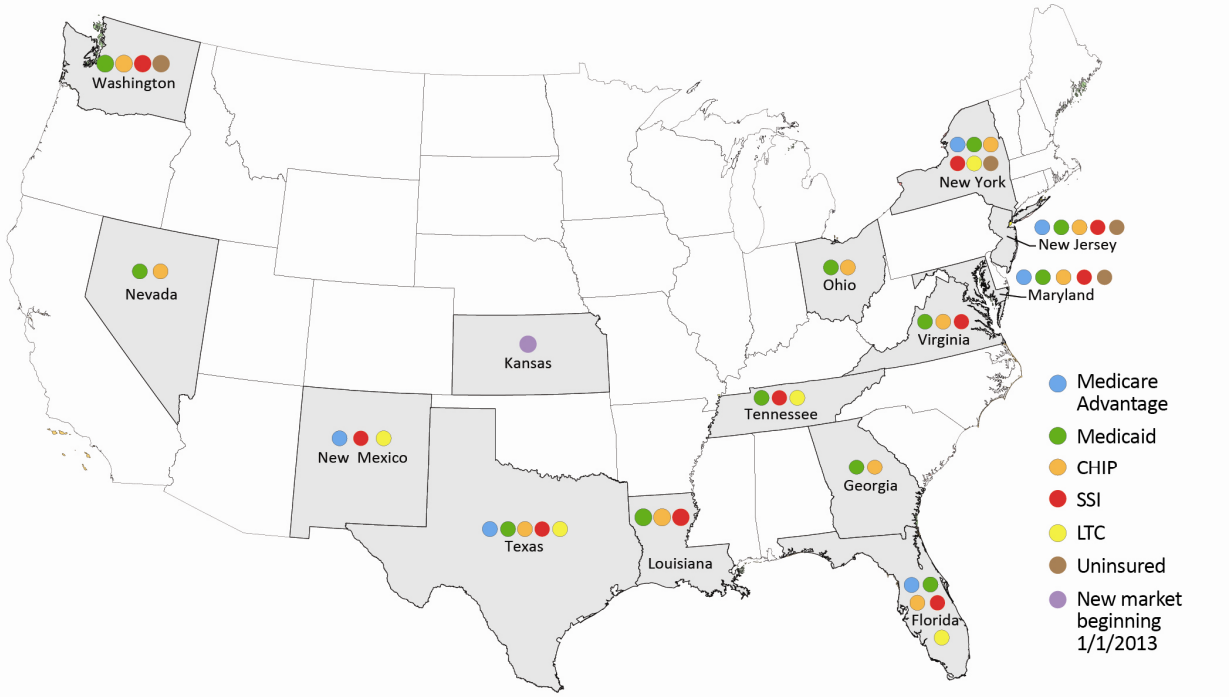
Delivering Services to Diverse Populations

Amerigroup Nevada has served Medicaid, CHAP, and Nevada Check Up enrollees since February, 2009. We understand the challenges and opportunities with this population, and we have achieved significant gains in clinical quality for our members.

We bring even greater value to DHCFP through our affiliate health plans, with which we share best practices, as the State considers expansion of the program to include eligibility categories now enrolled in the fee-for-service program. Our affiliate health plans are experienced at coordinating a wide-ranging array of services to a broader range of Medicaid recipients than we are currently contracted to do in Nevada.

Our programs serve the full continuum of members' health needs, from infants to seniors. Figure 5.1.10-1 illustrates our breadth of experience with various populations today.

Figure 5.1.10-1. Amerigroup Health Plans Serve Diverse Populations (through November 2012)



In Nevada we will adopt the best practices from our affiliates as DHCFP opts to expand the program. For example, other Amerigroup health plans cover individuals involved with the juvenile justice system and foster care. Amerigroup serves similar populations in other states and we are experienced at the unique challenges of serving these populations. For example, both groups experience elevated prevalence of significant behavioral health conditions and multiple co-morbid physical health diagnoses. Children in foster care are prescribed psychotropic medications at a rate far higher than other youth populations and also experience more fragmented care and require coordination with numerous state agencies. Youth in juvenile justice have higher rates of substance use and require extensive social supports. For both populations, Amerigroup will apply our lessons learned in other states to orchestrate effective care and services.

Member Mondays at high-volume PCP offices allow us to help members one-on-one.

Our deep understanding of the Medicaid and Nevada Check Up populations informs our operations. For example, community-based outreach and education offer the best opportunity to engage low-income populations in our experience. As a result, we have instituted our "Member Mondays" outreach program at high-volume and large PCP offices in Nevada. On those days, Amerigroup Provider Relations employees, cross-trained to interact with members, are available to answer Amerigroup member questions and provide hands-on assistance. With a

large presence of Mexican nationals in southern Nevada, we have also introduced "Member Mondays" at the Mexican consulate so that we can meet and engage members, encouraging them to access primary and preventive care services.

Amerigroup Corporation has committed extensive resources to developing Health Insurance Exchange (HIX) solutions that will be adapted to our Nevada operations. A designated team of experts has been collaborating with thought leaders nationwide to develop innovative and efficient solutions to a significant challenge facing our state customers across the country. These efforts complement our Nevada leadership's active engagement with local SSHIX efforts.

Coordinating Comprehensive Benefits and Services

Our team is skilled at coordinating the array of benefits and services available through Medicaid, CHAP, and Nevada Check Up as well as non-covered services available through other State programs or community agencies so that we can holistically address the physical, behavioral, social, and environmental needs of each individual member and his or her family. This expertise is particularly important as low-income families face unique challenges. Engaging them in care and services and coordinating access to community services is vital to achieving improved health outcomes.

Amerigroup has experience coordinating and delivering a wide range of benefits and services to diverse Medicaid populations in an integrated manner. Amerigroup offers industry-leading proficiency in delivering culturally competent Medicaid and CHIP managed care programs and coordinating a comprehensive array of benefits including physical and behavioral health, pharmacy, home and community-based services and supports, and nursing facility (NF) services. Table 5.1.10-1 summarizes the benefits offered through each of our 14 health plans to illustrate the depth of our expertise working with diverse benefits.

*Table 5.1.10-1. Delivering Integrated Benefits to 2.7 Million Members**

Market	Acute	Mental Health	Substance Use Disorder	Pharmacy	Vision	Dental	HCBS	NF	Total Members
Florida	✓	✓	✓	✓	✓	✓	✓	✓	266,000
Georgia	✓	✓	✓	✓	✓	✓			287,000
Kansas	✓	✓	✓	✓	✓	✓	✓	✓	Launches 1/1/13
Louisiana	✓			✓	✓				143,000
Maryland	✓		✓	✓	✓	✓			213,000
Nevada	✓	✓	✓	✓	✓	✓			85,000
New Jersey	✓	✓	✓	✓	✓	✓			154,000
New Mexico	✓			✓	✓	✓	✓	✓	24,000
New York	✓	✓	✓	✓	✓	✓	✓	✓	434,000
Ohio	✓	✓	✓	✓	✓	✓			57,000
Tennessee	✓	✓	✓		✓		✓	✓	205,000
Texas	✓	✓	✓	✓	✓		✓	✓	769,000
Virginia	✓	✓	✓	✓	✓				48,000
Washington	✓	✓	✓	✓	✓				16,400

**This table is representative of the services covered in the market. In some circumstances, the benefits may be provided for certain populations or as value added services.*

Our experience with diverse benefits has contributed to highly specialized services within our health plans. For example, we bring extensive national experience serving adults with SMI and children with SED, populations who currently may, and frequently do, opt out of the Nevada managed care program. Our recovery-focused programs provide the full range of benefits available to members and their families. We also identify and coordinate the extensive array of wraparound services that are often required to keep individuals with chronic mental health conditions on the path to sustained recovery, such as peer support and family-centered support programs.

Amerigroup's experience with members with SED and SMI includes recovery-focused care management programs and innovative provider partnerships, such as Health Homes and behavioral health medical homes.

This experience drives development of creative partnerships. For example, our Tennessee health plan partnered with local organizations to establish shared housing for adult men transitioning out of long-term stays at a state hospital to leverage the strong social ties among the men, an important factor in sustained recovery. It also contracted for supportive housing for women with co-occurring mental health and substance abuse disorders that accepts children, fostering family unity that

is vital to ongoing recovery. Additionally, as noted above, we have forged best practices by piloting unique medical home strategies for individuals with behavioral health diagnoses that we can to bring to Nevada. We are fully prepared to adopt valuable lessons learned to enhance quality of life and health for our Nevada members with SMI and SED.

Partnering with Community Programs to Reach Members and Families

In our experience in Nevada and across the country, it is difficult to engage Medicaid and CHIP members and their families through traditional outreach efforts. Therefore, a vital component of our Medicaid managed care program includes embedding the health plan and its leaders directly in the community we serve. In addition to reaching members and their families directly to build trust and credibility, maintaining a strong presence in the community builds a thorough understanding of the needs, challenges, and opportunities for low-income families that exist within Nevada today.

Amerigroup Nevada has grown deep roots in northern and southern Nevada and has established partnerships with many organizations with whom we share a mission. Our strategy is to link with community agencies, community, and faith-based organizations to extend the reach of the health plan and to coordinate existing social services that complement needed medical services. We also support these organizations through donations or grants from our foundation to achieve or continue their stated missions. We target efforts toward organizations that currently support children and young women and are known to and trusted by our Nevada members, most of whom are children and young women. We remain flexible and will expand the scope of partnerships should the State opt to include seniors and people with disabilities or recipients enrolled through juvenile justice or child welfare programs in the MCO program. We have many partnerships with such organizations in other states in which we serve this population, and we would adapt such partnerships in Nevada.

Many of our members hail from cultures in which trust must be slowly established over time. Our experience in Nevada and other states validates that faith-based organizations are important partners to help us build that trust. Amerigroup Nevada will continue to build on our current community efforts to nurture ties with faith-based community leaders through sponsorship of and participation in health fairs and education events. We will also leverage social services that faith-based organizations offer to help members obtain needed services from trusted organizations to achieve their health goals.

Just a few examples of our many Nevada partnerships include:

- ***Nevada Youth Alliance. Amerigroup is one of this organization's biggest sponsors. Most recently, we participated in their back-to-school event at College of Southern Nevada, at which we distributed backpacks full of school supplies.***

- ***After School All Stars (ASAS).*** ***We sponsored soccer teams at 10 schools in neighborhoods with a high concentration of Amerigroup members for this non-profit organization providing after-school programs for 6,000 at-risk youth in Clark County. Team sponsorship encourages a safe environment and encourages physical activity. Our CEO is a member of the board of ASAS Las Vegas.***
- ***Urban League.*** ***Amerigroup recently partnered with the Urban League to offer free dental and vision screenings for our members at their offices, inviting members as well as other community organizations who strive to reach the same population.***
- ***Southern Nevada Immunization and Health Coalition (SNIHC).*** ***Amerigroup partners with SNIHC to promote clinics that boost immunization rates for our members and the whole community. This is particularly important for our African-American members, who often experience lower immunization rates than those of other cultural groups. SNIHC is also leading efforts to advance women's health through improved prenatal care and reduced rates for unnecessary C-sections, which align with goals of both DHCFP and the health plan. In December, 2012, Amerigroup will receive SNIHC's Silver Syringe award for the third consecutive year as a community partner in childhood immunizations.***

Other community-based activities target specific populations. For example, we sponsor Baby Showers at community locations, such as shopping malls (in both northern and southern Nevada). We invite expectant mothers from our plan—and the community at large—to participate in Baby Showers both educate and celebrate soon-to-be moms. Games, prizes, and even a fashion show are combined with health screenings and important prenatal information. We distribute educational information such as relevant AmeriTips that focus on proper prenatal care. We can reach more than 1,000 individuals through these events.

David Osman, a prominent leader with established, long-term relationships with many of the community organizations in southern Nevada, recently joined Amerigroup to lead our open enrollment marketing and community outreach efforts. Our Health Education Advisory Committee, which includes representation from members and representatives of community-based organizations, guides the health plan toward member communication, health education, and health promotion activities that are meaningful and culturally relevant.

TESTIMONIAL

"Amerigroup exemplifies good corporate citizenship and commitment to advancing the mission and vision of Southern Nevada Immunization Coalition (SNIC) while providing invaluable guidance and support. They have set the bar high for community involvement and are leaders in promoting and improving children's health."

Pam J. Beal
SNIC Executive Director

The Amerigroup Foundation

Further supporting this goal, the Amerigroup Foundation, our philanthropic arm, fosters access to healthcare and supports and services, encouraging safe and healthy children and families, advocating independent living for seniors and people with disabilities, and promoting healthy neighborhoods. The focus is on helping grassroots organizations maintain viability in serving vulnerable populations. Specific Foundation awards include "Healthy Heroes" and "Champions for Children" to recognize individuals who have demonstrated a positive impact on their communities.

Nevada entities that have received Foundation grants include:

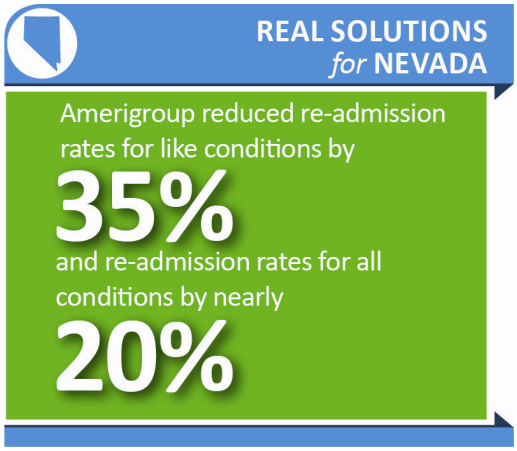
- ***American Red Cross, Northern Nevada***
- ***The Children's Cabinet***
- ***Clinics in Schools***
- ***Community Care Chest of Northern Nevada***
- ***Family TIES of Nevada***
- ***Food Bank of Northern Nevada***
- ***The Immunization Project***
- ***Legal Aid Center of Southern Nevada***
- ***March of Dimes***
- ***Nevada Health Centers, Inc.***
- ***Nevada Women's Fund***
- ***Northern Nevada Center for Independent Living***
- ***Opportunity Village***
- ***Rainbow Dreams Educational Foundation***
- ***UNLV Foundation—Prevent Child Abuse Nevada***
- ***United Way of Southern Nevada***

Utilization and Case Management Programs (5.1.10.1.A.3)

Amerigroup's integrated approach aligns with DHCFP's mission for continuity of care through integration.

Amerigroup's care management model, Real Solutions® Health Care Impact, has been honed over the past 16 years and offers a continuum of programs that support identification, engagement, and person-centered care coordination for our members, including Utilization and Case Management. It is specifically designed for low-income populations, who often have more acute healthcare needs that are exacerbated by the challenges of poverty or lack of social supports.

Real Solutions® Health Care Impact integrates physical and behavioral health and considers social and functional risk factors; calibrates the intensity of service coordination to each individual's risk factors; includes specialty programs for pregnant members and eight NCQA-accredited Disease Management programs; and delivers tailored, member-oriented case management plans that incorporate community-based services to encourage independence and sustained recovery.



Specific components of Real Solutions® Health Care Impact that demonstrate the value of our experience are summarized in Table 5.1.10-2 and described below.

Table 5.1.10-2. Comprehensive Care Management Programs Address Diverse Member Needs

Program	Goal
Utilization Management (UM)	Monitors that care and services are delivered in accordance with state-specific and nationally recognized medical necessity guidelines
Disease Management	Supports members with chronic conditions who have mild or moderate risk levels to coordinate care in accordance with evidence-based clinical practice guidelines
Healthy Families	Encourages health lifestyles and weights for Nevada's youth
Case Management	Provides hands-on support for members with elevated risk levels and coordination of care and services with PCPs, treating providers, and community agencies
Stabilization Case Management	Fosters safe transition between levels of care and reduces re-admissions
Taking Care of Baby and Me®	Promotes healthy moms and newborns

Our Real Solutions® Health Care Impact program undergoes continual scrutiny to assess the impact of our performance. Central to this effort is our Health Care Economics team, which includes biostatisticians and epidemiologists specializing in clinical outcomes, program evaluation, and predictive modeling. This team continually evaluates data across all Amerigroup health plans to identify opportunities to more precisely identify members with potential high risk and to guide development of new programs and refinement of existing ones.

Utilization Management

Amerigroup Nevada's UM efforts engage providers in productive dialogue regarding authorization of behavioral health and physical health services to promote access to the level of care that will drive the best health outcomes. We use UM to creatively address our members' health challenges rather than using it as a mechanism for authorization or denial of requested services.

In Nevada, our UM program leverages the medical necessity criteria in the Medicaid Services Manual, augmented by nationally recognized guidelines—InterQual® Level of Care guidelines and Aetna's Clinical Policy Bulletins (CPB). Between January and July of 2012, Amerigroup processed 16,007 inpatient authorization requests (compared to 28, 247 in all of 2011) and 13,844 outpatient authorization requests (20,497 in 2011) for our Nevada members.

We maintain provider-friendly processes that enable requests for pre-certification by telephone or by fax. In 2013, we will also be launching an online prior authorization tool for providers to obtain real-time authorizations through our provider website. We have significantly reduced the number of services that require prior authorization and continuously reassess our requirements to be consistent with recommended industry standards that are generally accepted by the provider community. Details on our UM program are located in Section 5.1.11.1.B.

Disease Management Programs that Promote Improved Education and Self-Care

Amerigroup's Disease Management (DM) program engages and supports members with chronic conditions and their families to enable them to learn more about their conditions and how best to manage them. Across all Amerigroup health plans, members who were enrolled in our DM program for asthma experienced a 14 percent decrease in inpatient admissions and an 11 percent decrease in ED visits compared to members enrolled the previous year. In 2011, asthma was in the top 10 diagnoses related to inpatient admissions for Nevada members under the age of 14, underscoring the need for disease management related to chronic conditions.

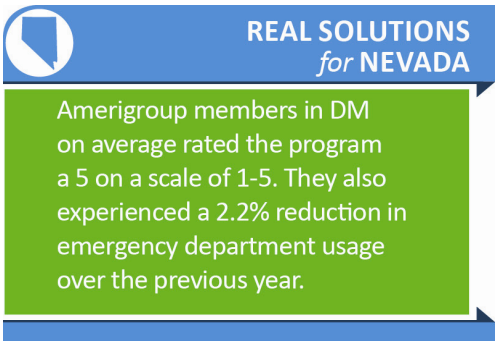
Amerigroup offers eight programs that have earned NCQA Patient and Practitioner-Oriented

Figure 5.1.10-2. Amerigroup's Eight NCQA Accredited Disease Management Programs Promote Optimal Health Outcomes

NCQA Accredited Programs

- Asthma
- Major Depressive Disorder
- Diabetes
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- HIV/AIDS
- Schizophrenia

Accreditation (Figure 5.1.10-2). This is NCQA's most comprehensive designation because it includes 32 standards related to engaging both members and their providers to improve outcomes. Complementing these programs, DM includes programs for bipolar disorder, hypertension, substance use disorder, and transplants. Our DM program also includes a smoking cessation support program for adults 18 and older. This program includes individual cessation counseling (including outbound follow-up calls to participants), coaching to quit, cessation planning and support, and follow-up.



Our Real Solutions® Health Care Insights suite of predictive models facilitates prospective identification and referral for specialized care coordination of members with elevated risks or ongoing medical or behavioral health conditions. We can then reach out and engage them in the level of care management that is commensurate with their needs, promoting efficient use of State healthcare dollars.

We invite members diagnosed with a chronic condition who are deemed to have mild or moderate risk to participate in DM. Our DM Case Managers educate and coach members and their families to take greater responsibility for their personal health status and empower them to adopt improved self-care skills—boosting access to primary and preventive care, enhancing health outcomes, and reducing preventable ED visits or inpatient admissions.

Our DM program centers on respect for and individualized engagement with members and their families in accordance with their beliefs, values, and readiness to change, supporting enhanced and sustainable results. Our DM Case Managers coordinate care in accordance with nationally-recognized evidence-based clinical practices guidelines.

Results

Nevada members who participated in DM during 2011 reported an average satisfaction score of 5 (on a scale from 1 to 5) when rating their satisfaction with overall elements of the program. Nevada DM participants also experienced a 2.2 percent decrease in ED visits compared to the prior year. More than 40 percent of participants in the smoking cessation program have successfully quit smoking compared to mid-single digit success rates for the unassisted general population.

Encouraging Healthy Weights for Children and Adolescents through Healthy Families

Healthy Families could support a Healthy Nevada initiative.

Reducing the rate of childhood obesity can reduce long-term risks for cardiovascular disease, diabetes, bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem. Amerigroup is introducing our Healthy Families program in Nevada under the new Contract that delivers healthy behavior and fitness coaching for kids. Healthy Families is a family-centered program that works with overweight children and teens and their families and coach them to adopt healthy lifestyles that contribute to healthy weights.

Figure 5.1.10-3. Healthy Families Delivers Results

RESULTS FOR HEALTHY FAMILIES PARTICIPANTS:

- 12 percent reduced their body-mass index percentile
- 60 percent increased servings of fruits and vegetables
- 58 percent increased their daily water intake
- 42 percent increased daily activity level
- 35 percent decreased the number of hours spent with the TV/computer/ video games

In the Healthy Families Program, Amerigroup initiates an outbound call to partner with parents of pre-teen children whom we identify as potentially overweight and to screen them for participation in the program. We then provide six months of fitness and healthy behavior coaching, including information about available community resources that complement the program. To reinforce the PCP as medical home, we share information on each participant's progress with his or her PCP.

Results

In other Amerigroup health plans in which Healthy Families has been implemented, we have demonstrated its effectiveness at changing behaviors. (Figure 5.1.10-3).

Case Management Holistically Addresses Members' Physical, Behavioral, and Social Support Needs

Once we identify members with elevated risk levels due to complex or co-morbid conditions, Amerigroup's Case Managers work closely with members, their families, PCPs, and treating providers to establish a results-oriented care treatment plan that integrates care across all domains and services—physical, behavioral health, and social support needs. Case Managers then monitor members' progress, working closely with the member, his or her PCP, and other treating providers as necessary to verify the member is on the path to optimal health and functional outcomes.

As Nevada launches the HIX, we will leverage our extensive experience in continuity of care. Designated Transitional Case Managers will facilitate transitions between health plans and benefits. During this process, the Case Manager will identify and address any potential gaps in care or benefits resulting from the change.

Amerigroup promotes effective case management through comprehensive training, boosting the skills of our case management team to best address the holistic needs of each individual. This includes our proprietary Case Management Certification program that boosts Case Managers' abilities to coordinate personalized care and services that encompass each individual's physical, behavioral, social, and environmental needs. The training is accredited for continuing education credits from several organizations, including the National Association of Social Workers, the Commission for Certified Case Managers, and the American Nurses Credentialing Center's Commission on Accreditation. It also includes our Recovery Innovations training in which Behavioral Health Case Managers undergo intensive training to enhance outcomes for members with chronic mental health and substance abuse diagnoses to build self-directed and recovery-oriented care treatment plans.

REAL STORIES

Karla, a 48 year-old Amerigroup Nevada member, was identified as a member with complex needs through our predictive model. For almost 15 years, Karla suffered from complications related to gall bladder surgery, including bile duct leakage that caused chronic pain and discomfort. She routinely required drainage of excess fluid from her abdomen, experiencing repeated infections that had a profoundly negative impact on her life.

Her Amerigroup Case Manager, Christy, realized more could be done for her. Christy accompanied Karla to her doctor's appointment to gain a clear understanding of her condition and coordinated a referral to a renowned liver and transplant specialist at Loma Linda University Medical Center in June, 2012. In July, Karla underwent surgery to repair the leakage and almost immediately her health improved.

She is now healthy and a happy mom to her two children. When Christy recently talked with Karla's dad, he told her "Thank you for giving us our daughter back."

Results

In a 2010 study of our high-risk members under case management, we found that after 90 days of management, members used healthcare resources more efficiently, required less emergent care, had reduced costs, and had improved health outcomes. One outcome was a significantly greater reduction in non-emergent visits to the ED and inpatient admissions through the ED. This indicates that members are receiving the right care at the right time. Overall, members enrolled in case management demonstrated a 39 percent reduction in non-emergent ED visits.

REAL STORIES

"Felicia," a 28-year-old Amerigroup Nevada member, was pregnant and had multiple health conditions that caused her to worry about the health of her baby. Previously, Felicia was admitted to the hospital six times with multiple kidney stones and a history of premature labor. She was diagnosed with hyperemesis, a severe form of morning sickness that prevents adequate intake of food and fluids. Amerigroup Case Manager Maria Guevara referred her to home health services where she received a continuous infusion of nausea medication and intravenous hydration.

Maria coordinated and managed Felicia's home health services and kept in contact with all of her physicians throughout her pregnancy. Maria also referred Felicia to a behavioral health case manager to help her cope throughout the process. Felicia was only admitted to the hospital once for symptoms related to premature labor. She delivered a healthy baby in week 37 of her pregnancy.

<u>Fostering Safe Transitions through Stabilization Case Management</u>

As part of the new Contract, Amerigroup Nevada will launch our advanced Stabilization Case Management program to promote safe transition between care settings. Members, who are at elevated risk for hospital re-admission, including those with behavioral health diagnoses, receive intensive outreach, support, care coordination, and individual coaching until they are stabilized at home or in a community setting.

Our innovative Stabilization Case Management program is based upon a nationally recognized model. The goal of stabilization case management is to reduce overall 30-day re-admission rates and to facilitate a smooth transition between inpatient settings and the home or other community settings by providing intensive, short-term support, such as monitoring follow-up appointments, conducting medication reconciliation, educating members and families about self-care and when to call the PCP, coordinating home care, and more.

Our new Stabilization Case Management initiative is based upon a nationally recognized model of transitional care.

Taking Care of Baby and Me®

In Nevada, three of the 10 most frequent inpatient diagnoses are related to pregnancy, delivery, and complications from delivery, representing 70 percent of inpatient admissions. Our experience confirms that maternal and child health offers a significant opportunity to improve outcomes.

Figure 5.1.10-5. Advocating for Healthy Moms and Babies through Taking Care of Baby and Me

In 2010, the National Minority Quality Forum (NMQF) awarded Amerigroup Corporation the first Health Promotion and Disease Awareness Award for our efforts in helping moms have healthy babies. This award recognizes an individual or organization for making an outstanding contribution to the promotion of wellness in minority communities.

Our Taking Care of Baby and Me program screens all pregnant women to identify their risk level, stratifies women by risk level, and applies personalized case management interventions that are commensurate with their risk level. Women at elevated risk are then paired with an OB Case Manager who works with them to identify and implement a care treatment plan that promotes a healthy pregnancy and baby. Financial incentives for achievement of key milestones (such as completing the screening and timely prenatal and postpartum visits) encourage member participation in the program. We also provide participants with educational materials on planning a healthy pregnancy and caring for newborns.

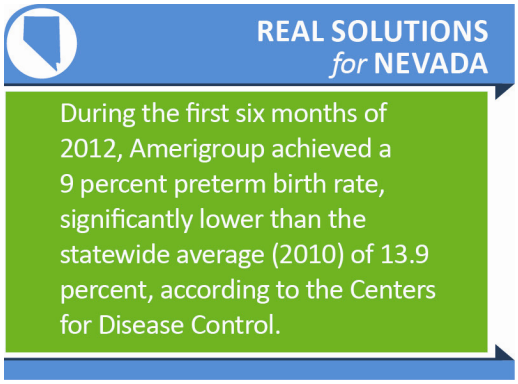
Complementing our OB Case Managers in Nevada, Amerigroup partners with an agency that specializes in community-based support for pregnant women. When appropriate for women with high-risk pregnancies, our OB Case Managers will coordinate home visits by clinicians to monitor their status or coordinate services. This includes administration of medications to prevent preterm birth or accompanying the member to the doctor's office. Alere is an agency that specializes in services for pregnant women. Alere nurses visit members in their homes or

accompany them to provider offices when appropriate to keep members on track with their care treatment plans.

Amerigroup has also collaborated with DHCFP to explore innovative strategies for improving maternal and child outcomes for all Nevadans. In our response to Section 5.1.10.1.D, we describe our role in supporting the State in development of a CMS Innovation Strong Start grant proposal.

Results

During the first six months of 2012, Amerigroup Nevada achieved a 9 percent preterm birth rate, significantly lower than the Nevada statewide average (2010) of 13.9 percent and lower than our 2011 rate of 9.2 percent, according to the Centers for Disease Control. Our response to Section 5.1.11.5 provides additional details on each of these programs.



Claims Processing and Adjudication (5.1.10.1.A.4)

Amerigroup has 16 of years of experience processing Medicaid claims, including almost four years in Nevada. In the 12-month period ending September 30, 2012, we processed more than 803,000 Nevada claims. Our average claims turnaround time was 4.7 calendar days. In Nevada, an average of 99.6 percent of claims was paid within 30 calendar days, with September, 2012, financial and payment rates of 99.94 percent and 99.21 percent, respectively.

We have effective technology and experienced employees in place to ensure prompt and accurate claims payment. Our employees and systems are also capable of administering any type of provider payment arrangement (for example, prospective payment, case rate, and per diem). Details on our specific claims processing and adjudication strategies are found in Section 5.1.11.6.

Amerigroup's claims management process offers significant advantages in Nevada:

- *Experienced Medicaid Claims Analysts. We use a designated claims processing team specialized in the Nevada program using Claims Analysts who are experienced with Medicaid managed care claims and are knowledgeable in the needs of the marketplace; they will collaborate to solve any problems that arise with minimal disruption to normal workflow.*
- *Multiple Methods of Submission. We accept paper claims and offer multiple methods of electronic claims submission to give our providers maximum flexibility in claims*

submission. Our claims formats are industry-standard and HIPAA compliant and include CMS 1500 and CMS 1450 (UB 04) formats.

- ***Efficient and Reliable Processing.*** ***We operate an efficient and reliable electronic claims processing system. By combining our core claims transaction platform with electronic imaging, a workflow management system, and electronic data interchange (EDI) claims solutions, we quickly capture and adjudicate claims with minimum manual intervention; this leads to faster, more accurate claims turnaround and provider payment.***
- ***Automated Clearinghouse Speeds Processing.*** ***Our Automated Clearinghouse (ACH) mechanism offers provider reimbursement using Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability; this leads to faster receipt of payment from Amerigroup and the ability to quickly and easily review claims and remittance details.***
- ***Designated Mental Health/Substance Abuse Services Team.*** ***Our Claims Department maintains a designated team that processes claims for mental health and substance abuse services and handles all related claims inquiries; this team has expertise regarding the unique aspects of behavioral health, including provider types and coding, as well as issues that require coordination between behavioral and physical health.***

Further demonstrating our experience, Amerigroup's Provider Experience Program has increased the quality of service delivered to our providers. The Provider Experience Program focuses on claims payment and issue resolution. A toll-free telephone number connects providers to a dedicated resource team to ensure:

- ***Availability of helpful, knowledgeable representatives***
- ***Increased first-contact issue resolution rates***
- ***Significantly improved turnaround time of inquiry resolution***
- ***Increased outreach communication to deliver inquiry status updates***

Amerigroup will continue to leverage best practices in claims submission, provider education, and outreach programs for our Nevada providers.

Project Management (5.1.10.1.A.5)

Amerigroup brings discipline and rigor to project management across the organization. Whether it is program implementation, business process improvement, or a Quality Management Performance Improvement Project, we rely on leaders and employees with the training and skills required to achieve our goals and objectives efficiently. We describe our project management experience for each of these project types below.

<u>Rigorous Project Management and Dedicated Staff Deliver On-time Implementations</u>

Amerigroup has extensive experience implementing and expanding programs in Nevada. In fact, the implementation of our initial Nevada contract demonstrates the value of our approach. In September 2008, DHCFP asked Amerigroup to serve people enrolled in the State's Medicaid and Nevada Check Up programs on February 1, 2009 in the Reno and Las Vegas areas. Expediting our structured implementation protocols, our team rapidly built a provider network and established local operations. Our network development in Nevada began in early October 2008, soon after we received notice of the Contract award from DHCFP and was completed within 120 days. By February, 2009, Amerigroup had recruited and credentialed nine hospitals, 497 PCPs at 713 locations, and 838 specialists at 1,595 locations.

Upon contract award, we immediately designated a Transition Officer who ultimately moved into the CEO role and is still in that position today, proving the value of continuity and consistency throughout the implementation. We also rapidly recruited and hired local employees and paired them with corporate and health plan employees from other states who were onsite in Nevada throughout the implementation. This enabled us to conduct hands-on training and streamlined knowledge transfer. This approach also fostered ongoing mentoring as each new employee had a designated expert with whom he or she could work beyond the initial implementation.

This approach, which proved so valuable during the Nevada implementation, has become our standardized model for start-up. Designating corporate experts to support health plan employees fosters a depth of knowledge for each implementation and consistency in program start up. In other states in which we have expanded existing service areas, added new populations, or launched new products (every state in which Amerigroup operates except Nevada), we have continued this best practice.

Our success in implementing the Medicaid Managed Care program in Nevada derives from one of our core competencies—the ability to successfully implement new business while seamlessly transitioning new members and providers into its operations. Amerigroup has never missed a contract implementation deadline in its experience of conducting 92 program implementations and expansions.

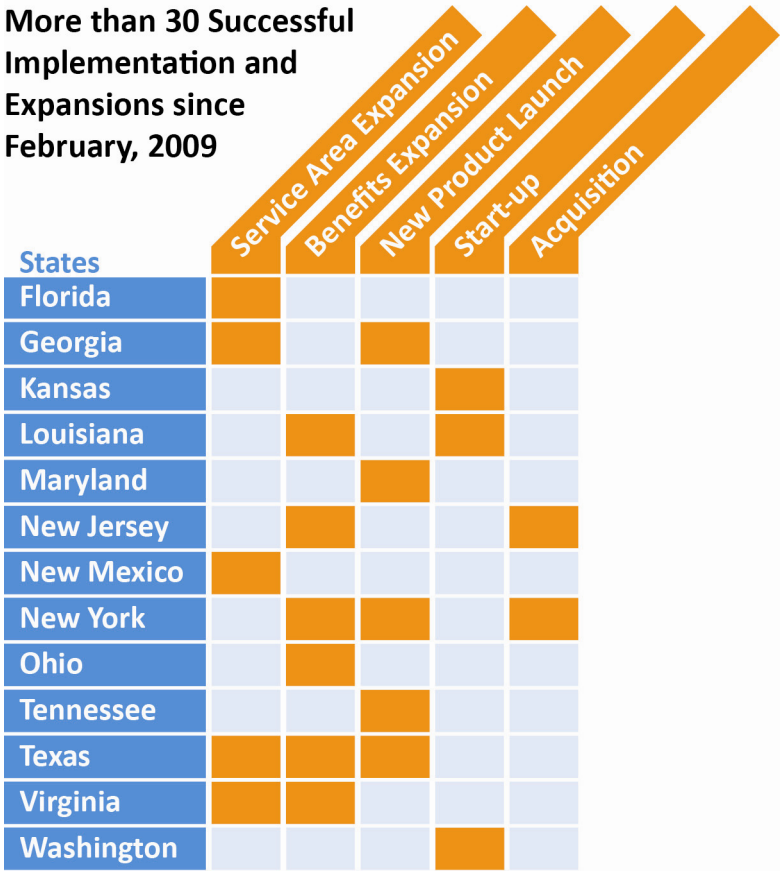
Designated Implementation Experts

Amerigroup's full-time Implementation Management Office (IMO), led by a certified Project Management Professional with more than 20 years of health insurance industry experience, has worked closely with Amerigroup to plan and execute implementations across our corporate family. IMO employees, with nearly 100 combined years of project management experience, manage all aspects of implementations in accordance with the Project Management Institute's (PMI) global standards for project management methodology.

As the State launches the SSHIX, Amerigroup will rely on our team of experts and structured methodologies and tools to architect and manage its implementation. Our team is fully prepared to plan and execute a SSHIX implementation that promotes the best possible launch of this valuable initiative.

Since our Nevada implementation, Amerigroup has led more than 30 successful implementations and expansions, summarized in Figure 5.1.10-6. Health plans in some states have experienced multiple implementations of the same type (for example, service area expansion).

Figure 5.1.10-6. Amerigroup Successfully Completes Implementation and Expansion Projects



Structured Project Management Methodologies across Amerigroup

Amerigroup embraces the use of structured project management methodologies. Project management professionals across the organization follow PMI and Agile methodologies to guide a variety of projects that drive our business – from technology projects like software implementation to setting up new office space. Our seasoned project managers select and deploy the tools and techniques they need to successfully manage a project through completion. For example, Amerigroup recently implemented a system to streamline the efficiency of our call center operations. The project management team used an Agile project management methodology to effectively manage the project as its evolving requirements necessitated frequent check-ins along the development continuum, ultimately facilitating successful implementation with minimal risks.

Further demonstrating our commitment to the business value of project management, we host monthly lunch and learn webinars, led by certified Project Management Professionals and open to all Amerigroup employees. During the webinars, moderators educate participants about project management skills, such as managing risks, conducting virtual meetings, and gathering business requirements for a project. Employees with project management certification can earn continuing education credits for these webinars. In addition, our intranet includes a host of project management resources accessible to all employees who may be leading projects within their functional areas. All employees can access tools and information on project management techniques to build their project management skills.

Structured Process Improvement Methodologies Drive Continual Business Enhancements

Amerigroup strives to achieve improved business performance through the use of structured process improvement techniques. This underscores our dedication to operational excellence. To achieve this goal, we integrate Six Sigma and Lean Six Sigma methodologies into all parts of the organization because we value the disciplined approach and focus on measurable improvements inherent in the process. Employees at all levels and in almost all functional areas have been trained and certified as Six Sigma Black Belts and Six Sigma Green Belts. Lisa Bogard, Amerigroup's Associate VP of Health Plan Operations for Nevada, is a certified Six Sigma Black Belt, fostering a structured approach to process improvements at the health plan level.

Lisa Bogard, Amerigroup's AVP Health Plan Operations in Nevada, is a certified Six Sigma Black Belt, fostering a structured approach to process improvements at the health plan level.

In addition, Amerigroup's corporate Business Improvement team consults with business owners and, using Six Sigma methodologies, works with them to define the problem, identify root causes, and develop a solution. The team focuses on achieving desired outcomes that are

compliant, measurable, sustainable, scalable, and cost effective. For example, the Business Improvement team, in partnership with Amerigroup's clinical leadership, is now implementing UM operational refinements after almost a year of detailed analysis of processes across all health plans.

Current Six Sigma projects that will benefit from this rigorous methodology are listed below:

- ***Improving Respiratory Care for Nevada Members. As a part of our clinical quality improvement initiative, described in more detail later in this section, a team of Nevada health plan employees (led by Ms. Bogard) is applying Six Sigma methodologies to drive gains in HEDIS measures related to respiratory care for our Nevada members. The project is still in its early stages, but we anticipate a significant boost in our HEDIS 2013 scores.***
- ***Improving Successful Transmission of 837 Encounter Data. Although we do not yet submit 837 encounter data in Nevada, the Agency will ultimately benefit from the efforts of this project, led by Six Sigma experts in our Encounters Department. Their goal is to increase the rate of successful submission of 837 data in states where we have identified opportunity for improvement. When the State migrates toward transmission of 837 data, Amerigroup will already have the optimized process in place.***

Performance Improvement Projects

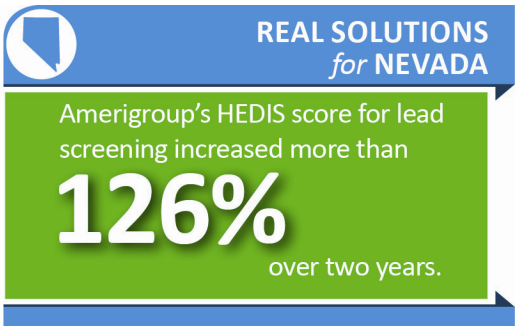
Amerigroup works with DHCFP and its External Quality Review Organization (EQRO) to identify opportunities for quality gains and applies highly structured processes to achieve the targeted results. Our Quality Management (QM) team brings rigorous project management expertise to each Performance Improvement Project (PIP).

Amerigroup uses the Plan Do Study Act (PDSA) process to manage clinical and non-clinical PIPs. The QM Leader creates a multi-departmental team with representation from various stakeholders representing their functional areas to participate in the project. The process follows NCQA protocols: developing a baseline measurement, identifying barriers, building appropriate interventions to address those barriers, gathering the resources needed to conduct interventions, and establishing specific targets/benchmarks and timeframes to measure our performance as they relate to the established benchmarks and overall stated performance goals. The team identifies the means for measuring the results of new/enhanced interventions and reports the results of the data analysis monthly.

Amerigroup's Integrated Analytical Platform and HEDIS Datamart tools enable our quality team to capture and evaluate data and to monitor cost and utilization trends across our membership base in real time. With these tools, Amerigroup can quickly identify and address negative quality indicators and select or modify PIPs accordingly. If the PIP progress is slower

than anticipated within the timeline of the PDSA, we employ the Rapid Cycle Learning (RCL) process to make mid-course corrections based on the data received. This RCL continues throughout the year as QM department employees and other functional area representatives of the health plan collect and use real-time data.

Our PIP process has delivered results. Our HEDIS score for lead screening increased from a low of 14.71 percent in 2009 to 33.33 percent in 2011, an increase over two years of 126 percent. We attribute this increase to our concerted effort and collaboration with DHCFP to find workable solutions to the barriers identified during the PDSA process. Once new processes were implemented, the number of children receiving lead screening significantly increased.



In 2012, Amerigroup has refined our PIP project management protocols based on recommendations provide by the State's EQRO, including mid-year analysis of HEDIS measures to assess progress toward the PIP targeted performance goal. As a result, we continue to refine our current PIPs and continue to see positive results.

Our response to Section 5.1.11.5, Quality Assurance, includes detail on our Quality Management program and PIPs.

Qualifications of Key Personnel (5.1.10.1.A.6)

Amerigroup Nevada brings a seasoned team to the Medicaid MCO. Many have been with Amerigroup since the program launch in February 2009, and all Key Personnel are actively engaged in focusing the health plan on achieving DHCFP goals and objectives.

Amerigroup Nevada's leadership maintains positive and collaborative relationships with Agency employees at all levels. As detailed in our response to Section 5.1.10.1.D, we have established highly collaborative relationships within DHCFP. With almost four years' experience serving Nevada members and the 16 years' experience of our affiliate health plans in 13 other states serving low-income populations, our leadership team offers DHCFP expertise, resources, and passion to helping DHCFP develop long-term and sustainable solutions to the complex healthcare problems that influence the health of all Nevadans and the State's budget.

As noted in their biographies, our leadership team is also actively engaged with the Nevada provider community and community agencies to remain attuned to local member and provider needs. Through intensive and ongoing interaction with stakeholders, we cultivate a deep

understanding of the opportunities and challenges to improving health outcomes for our members and for all Nevada citizens.

The community roots of our Key Personnel are augmented by a dedicated and passionate team of local health plan employees who work with members, providers, and DHCFP. This team is well positioned to identify local needs and evaluate programs that have proven successful in other states to determine if and how they can be adapted within Nevada. Our Nevada team designated as Key Personnel, as defined in Section 4.13.2.3, is summarized in Table 5.1.10-3 on the following page. Resumes for Key Personnel are located in Tab VIII.

Table 5.1.10-3. Amerigroup's Experienced and Highly Qualified Team of Key Personnel Delivers Results

DHCFP Position Title	Amerigroup Name and Title	Qualifications and Experience
Administrator	Eric Lloyd Chief Executive Officer	With more than 20 years of experience in the healthcare field, Mr. Lloyd led Amerigroup's Nevada start-up operations and has directed our local team since 2008. Under his leadership, the health plan has delivered strong results for DHCFP. He also held leadership positions with several other managed care plans. His expertise includes business development, sales, new program start-up, operations, and network development. Mr. Lloyd holds a bachelor's degree in kinesiology from the University of Colorado Boulder and a master's degree in health administration from Loma Linda University School of Public Health. Mr. Lloyd plays a leadership role within the community. He participates on the SSHIX Finance and Sustainability Advisory Committee, sits on the board of directors of the NHIE, is a member of HealthInsight's Nevada Partnership for Value-driven Healthcare Steering Committee, and is on the board of directors for After School All Stars Las Vegas. He also sits on the board of the United Way of Southern Nevada and co-chairs their Access to Healthcare committee.
Chief Financial Officer	David Hsieh AVP, Finance	For almost four years, since the health plan's inception, Mr. Hsieh has overseen the health plan's financial operations. He brings more than 10 years' experience in healthcare finance to the Medicaid and Nevada Check Up programs and is experienced at analyzing health plan financials to identify opportunities for performance improvement that benefit DHCFP. Prior to joining Amerigroup, Mr. Hsieh held senior positions in the fields of health data analytics, financial operations, and multi-site specialty provider operations. Mr. Hsieh earned both bachelor's degree in industrial engineering and a master's degree in business administration from Rutgers University. Mr. Hsieh is an active member of the local Nevada chapter of Healthcare Financial Management Association.

DHCFP Position Title	Amerigroup Name and Title	Qualifications and Experience
Medical Director	Richard Roberts, MD, MSHA, CPE Medical Director	Dr. Roberts brings more than 30 years' experience in managed care, working with providers and insurers in Medicaid, Medicare, commercial, for-profit, and not-for-profit settings, including almost four years' experience with the Medicaid and Nevada Check Up managed care programs. A board-certified pediatrician, Dr. Roberts has served as the Medical Director for Amerigroup's Nevada health plan since January 2009. He is licensed in Nevada, California, Arizona, and Arkansas. Dr. Roberts received a bachelor's degree from Loyola University in Chicago, a doctorate of medicine from the University of Illinois College of Medicine, and a master's degree in healthcare administration from the University of Arkansas. Dr. Roberts is a member of the Nevada Association of Managed Care Physicians and the Plan Certification and Management Advisory Committee of the SSHIX.
Recipient Services Manager	Candice Speers, RN Quality Management Director	Ms. Speers is an experienced health professional with extensive experience in the acute clinical setting as well as managed care organizations. She has eight years of experience in HMOs/MCOs as Director of Quality Management with responsibility for URAC® and NCQA accreditation, compliance with QM functions as contracted by the state or HMO, appeals, and grievances. She has been with Amerigroup since June, 2010 and is a key contributor to the quality gains achieved by the health plan. In her current role, Ms. Speers oversees the recipient services delivered to Amerigroup Nevada members through monitoring of the QM program and annual work plan. Ms. Speers earned a bachelor's degree in nursing from San Jose State University and a master's degree in public administration–health services from the College of Notre Dame.
Provider Services Manager	Marlene Morrison AVP, Provider Relations	Ms. Morrison joined Amerigroup Nevada in 2012 with more than 22 years of experience in health care. She has worked with hospitals, provider groups, and health plans to develop comprehensive networks, establish innovative partnerships that enhance access to care and services such as telemedicine, and strengthen collaborative relationships between payers and providers. Ms. Morrison has held executive-level positions with Integrated Marketing Technologies, HealthNet, Inc.,

DHCFP Position Title	Amerigroup Name and Title	Qualifications and Experience
		and the US Department of Defense. Ms. Morrison is trained in and experienced working with Lean Six Sigma projects, fostering a focus in continuous quality improvement with our Nevada network. Ms. Morrison earned a bachelor of science degree in medical technology at Western Kentucky University and a master of science in hospital and health services administration from The Ohio State University.
Grievance and Appeals Coordinator	Dena Sargent, RN Quality Management Coordinator	Ms. Sargent, who has been with Amerigroup for three years, has more than 20 years' experience in healthcare, including 12 in managed care. She oversees the grievance and appeal program for the health plan. Additionally, she is one of our quality-of-care reviewers, back-up HEDIS subject matter expert, and the business owner on several QM regulatory reports, which she reviews for accuracy. Prior to joining Amerigroup, Ms. Sargent held several positions at MCOs in medical management and quality management, including member outreach and education, disease management, utilization review with discharge planning, and quality compliance. Ms. Sargent holds a bachelor's degree in information systems from the University of Phoenix and an associate's degree in nursing from St. Clair College.
Claims Administrator	Lisa Bogard AVP, Health Plan Operations	Ms. Bogard has more than 18 years' experience in quality assurance, production, systems, and project management in healthcare management operations, including six years with Amerigroup. Before joining the Nevada health plan in January, 2012, Ms. Bogard held several managerial positions on our corporate Quality Management team. In this role, she led numerous quality improvement projects that resulted in significant gains in health plan operations efficiency, including quality gains related to claims and provider data management. This experience positions her well in her role in Nevada. Prior to joining Amerigroup, Ms. Bogard led a multi-disciplinary process improvement team consisting of information technology testing, quality assurance, training, and policy and procedures focused on improving claims and contact center operations.

DHCFP Position Title	Amerigroup Name and Title	Qualifications and Experience
		Ms. Bogard is certified as a Six Sigma Black Belt with a history of successful process improvements. She is also a Certified Professional Coder. Ms. Bogard attended the University of Oregon studying psychology.
Nevada Operations Manager	Julie Skaggs VP, Provider Services	With more than 24 years of healthcare experience including more than 10 years with Amerigroup, Ms. Skaggs has particular expertise at managing comprehensive provider networks and implementing innovative programs that transform healthcare delivery. She has been with the Nevada health plan for three years and has been instrumental in collaborating with the Medical Director to launch innovative delivery systems enhancements, such as PCMHs and quality-based incentive programs. Prior to joining Amerigroup, Ms. Skaggs held managerial positions with other managed care health plans in which she had responsibility for development and management of provider networks. Ms. Skaggs is a member of the board for the Southern Nevada Immunization and Health Coalition. She is also an active volunteer with several community agencies, including the March of Dimes, Nevada Youth Alliance, the American Lung Association, and The Shade Tree Women's Shelter.

B.	Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.

Experience with Performance Measures and Incentives

Amerigroup Nevada supports the use of performance measures and incentives based upon targeted health outcomes. When effectively designed and implemented, performance incentives better align payment and quality to improve the quality and delivery of healthcare to our members.

Experience in Nevada

Amerigroup Nevada uses performance measures to positively affect the quality of services and healthcare that our Medicaid and Nevada Check Up members receive. Although we do not have incentives explicitly tied to performance measures in our current Contract with the State, several of our affiliated Amerigroup health plans do have performance incentives in their respective state contracts, described later in this section.

We do, however, have experience with provider incentive programs in Nevada for our Medicaid and Nevada Check Up members, also described later in this section.

Reporting Performance to the State of Nevada

Amerigroup Nevada currently delivers performance measurements to the State of Nevada. We report performance measures to the State of Nevada related to:

- ***Quality of care***
- ***Utilization of services***
- ***Member satisfaction, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, grievances, and appeals***
- ***Access to care, including out-of-network usage***
- ***HEDIS and HEDIS-like measures***
- ***Performance Improvement Projects (PIPs)***

Amerigroup Nevada currently reports HEDIS measures and PIPs to the Nevada External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG). We will continue working collaboratively with DHCFP and HSAG to implement new performance

measures and monitor the continuous improvement in the level of care and services delivered to our members.

Amerigroup Nevada Provider Incentive Programs

Amerigroup Nevada has designed and implemented provider incentive programs that promote efficiency in the service delivery system, improve the quality and delivery of services, and help reduce costs for our providers. Our provider incentive programs include:

See the Confidential Technical Volume for proprietary information.

Experience with Performance Incentive Programs in Affiliated Health Plans

Amerigroup Nevada's affiliated health plans in other states operate under performance incentive programs that reward the health plan for achievement of targeted performance levels—both administrative and targeted health outcome standards. These incentive programs have been developed in other states where Amerigroup operates full-risk managed care programs for Medicaid and CHIP populations similar to Nevada. When a performance incentive is tied to a targeted health outcome, measures are consistent with HEDIS or other measures that are evidence-based and carefully vetted. This experience includes:

- ***Georgia.*** ***We implemented performance incentives that are based on HEDIS effectiveness of care measures.***
- ***Maryland.*** ***Performance incentives are based on HEDIS measures for child and adolescent well-care visits, appropriate medications for asthma, cervical cancer screening, diabetic eye examinations, lead screening, postpartum care, and access to care for children and adults.***
- ***Tennessee.*** ***Performance incentives were implemented in 2007 based on HEDIS measures for diabetic screening, breast cancer screening, adolescent well-care visits, controlling high blood pressure, anti-depressant medication management, follow-up care for children prescribed ADHD medication, and follow-up after hospitalization for mental illness.***

We will draw upon the experience and best practices of our affiliated health plans should the State choose to implement performance incentives as part of DHCFP's contract with managed care plans. We will collaborate with the State in the development of the program using experience and knowledge of the population.

Recommended Performance Measures

To provide the most meaningful measure of healthcare service delivery performance, we recommend the following performance measures:

- ***Asthma Care: Use of Appropriate Medications***
- ***Diabetes Care: HbA1c Test, LDL-C Test, and Nephropathy***
- ***Immunization Rate: Childhood Immunizations***
- ***Prenatal and Postpartum Care***
- ***Preterm Birth Rate and/or Low Birth Weight (<2,500 grams)***

Managing Ambulatory Care Sensitive Condition ED Visits

Amerigroup Nevada will work collaboratively with DHCFP to develop performance measures that are based on realistic goals for improvement. We recommend that performance measures be consistent with HEDIS or other externally based, reliable, and valid measures or measurement sets.

Addressing Healthcare Disparities in the Hispanic Population

One of our goals is to reduce and/or eliminate healthcare disparities for Medicaid and Nevada Check Up recipients. A proposed study is the reduction of healthcare disparities in the Hispanic population. This reflects the population we serve as almost 20 percent of our current Nevada members speak Spanish as their primary language.

Possible outcome measures tied to the population could include:

- ***Asthma Management***
- ***Obesity***
- ***Teen Pregnancy***

We are especially interested in promoting the health and well-being of the Hispanic population. We are working closely with the Mexican Consulate and the Latin Chamber of Commerce to develop a comprehensive Hispanic Outreach and Education program. The program will be offered to our Hispanic member communities and include outreach by Promotoras. This program is scheduled to roll out by the end of the year. We will focus on reducing cultural barriers—seen as stigmas—to having a diagnosis of asthma or diabetes. Because of these barriers, many Hispanics do not seek appropriate care for their conditions in a timely fashion.

C.	Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

Investing in Improvement of Services, Treatment Protocols, and Development of Best Practices

In Nevada and across the country, Amerigroup has invested in our employees, our systems, and our strategies to continually innovate new solutions to address the complexities facing DHCFP and other state customers. We know that there is no single answer to the challenge of lowering healthcare costs in Medicaid programs, so we developed a disciplined process to identify a range of new opportunities for healthcare cost savings that are implemented by leaders in each of our health plans based on local conditions.

Amerigroup Nevada embraces quality management and improvement as a workplace culture, not as a separate function within the health plan. Our Culture of Quality is embedded in everything we do, in every employee, in every decision. We continually measure our performance against established benchmarks to identify and promote best practices and improvement opportunities. Since program launch in 2009, Amerigroup has achieved substantial year-over-year quality-of-care gains for our Nevada members. These gains have been validated through external audits and operational review. The State's External Quality Review Organization validated Amerigroup Nevada's performance in our first State Quality Assessment and Performance Improvement Program audit. Further, we have demonstrated our commitment to quality and transparency through achievement of NCQA accreditation as a New Health Plan through December, 2014, and we are the only Medicaid MCO in Nevada to achieve accreditation.

In addition to working with our corporate experts who have piloted innovations across the country to identify those that will work in Nevada, our local Quality Management (QM) program centers on delivering high quality of care and medical services to our members, administrative support to our providers, and accuracy of data management to the DHCFP. The QM program drives health plan investment priorities that link to DHCFP goals and objectives.

We highlight below those investments that we believe are the most significant and that will demonstrate our commitment to achieving results for DHCFP.

Improvement of Services

Since 2009, Amerigroup Nevada continually strives to improve our service to members, providers, and DHCFP. Examples of specific investments are highlighted below.

Expansion of our Nevada Staff

We have doubled the number of our Nevada-based employees across all functional areas over the past two years. As the health plan has grown, we have developed a local team that understands the needs of our stakeholders, and we have refined our staffing strategies to improve overall performance. For example, we added two more Provider Relations employees (increasing the size of the team by more than 30 percent) and assigned them by provider type so that each Representative is most familiar with the questions and issues most relevant for each provider area, fostering expertise and early identification of trends within provider types. As noted below, we have also doubled our QM team in Nevada, allowing us to keep pace with an expanding membership while also continuing to achieve gains in quality outcomes measures that are a key DHCFP objective and to the Governor's Healthy Nevada initiative.

Amerigroup Nevada has doubled our local staff in the past two years to drive quality services for members, providers, and DHCFP.

Prompt Enrollment of Newborns and Pregnant Women

Amerigroup Nevada recognized from the outset that the enrollment process for Nevada newborns was often delayed, limiting our ability to rapidly intervene to coordinate necessary healthcare services to foster a healthy start for Nevada newborns. We diligently worked with DHCFP and Division of Welfare and Support Services (DWSS) to shed light on the impact of delayed newborn enrollment, especially the lost opportunity to promote care for newborns. The resulting modified newborn enrollment process has expedited enrollment and our ability to begin planning for a healthy start.

We will continue to partner with the State to identify additional opportunities to expedite enrollment of newborns and pregnant women to accelerate risk screening and case management for those at high-risk. For example, we look forward to working with the State to evaluate new options under the Patient Protection and Affordable Care Act (PPACA). Beginning January 1, 2014, states can allow Medicaid-participating hospitals to conduct presumptive eligibility determinations for any Medicaid-eligible populations regardless of whether the State is using presumptive eligibility in any other setting or for any other populations in the state (PPACA Section 2201). This may offer an opportunity to expedite enrollment for pregnant women, allowing us to initiate risk screening and care coordination even more rapidly. This process also promotes timely enrollment for newborns and enables coordination of prompt preventive care. We applaud the State's interest in more rapid

enrollment of recipients into managed care, as outlined in the Section 1115 Demonstration Waiver Concept Paper from early 2012, as it will also promote early access to care for pregnant women.

See the Confidential Technical Volume for proprietary information.

Development of Innovative Case Manager Training

35% of our Nevada members with the highest risk levels have co-morbid medical and behavioral health diagnoses.

Medicaid enrollees typically experience elevated acuity levels and higher rates of co-morbid conditions, including increased rates of co-morbid medical and behavioral health diagnoses. Amerigroup's proprietary case management training programs enhance our Case Managers' skills to accomplish the best results for our members and their families. Our innovative Case Management Certification program, accredited by several professional organizations for continuing education credits, builds and reinforces the core competencies required to address the diverse physical, behavioral, and social support needs of each individual and the skills to facilitate communication among providers. Recovery Innovations, which is specialized two-day training for Behavioral Health Case Managers, centers on collaborating with members with Serious Mental Illness (SMI) to create recovery-oriented care treatment plans that build on each individual's strengths and foster self-determination. It also boosts Case Managers' coaching skills to promote sustained member recovery. These skill sets will be of even greater value should DHCFP opt to expand Medicaid Managed Care to include the MAABD, juvenile justice, and foster care populations whose enrollees tend to have more intensive needs and a greater prevalence of SMI and co-morbid conditions.

Stabilization Case Management to Promote Safe Transitions between Care Settings

As described in our response to Section 5.1.10.1.A.3, Amerigroup Nevada will launch our Stabilization Case Management program in Nevada under our new Contract. The goal of this program, which is based on the nationally recognized Coleman model, is to reduce overall 30-day re-admission rates and to facilitate a smooth transition between inpatient settings and the home or other community settings by providing intensive, short-term support such as monitoring follow-up appointments; conducting medication reconciliation; educating members and families about self-care and when to call the PCP; coordinating home care; and more.

Integrated Customer Service Desktop Drives Customer Satisfaction and Efficiency

Amerigroup successfully rolled out an Integrated Customer Service Desktop application for more than 700 customer care employees and nurses located across four sites for member and

provider services, authorizations, claims research, and issue resolution. The Integrated Desktop consolidates information from multiple systems, allowing representatives to spend more time listening and responding to customers and less time searching for information. Role-based screens and dialog scripts guide representatives through common questions and requests, reinforcing best-practice behaviors, reducing training time, and standardizing processes. The desktop automatically applies Nevada-specific regulations for members and providers.

See the Confidential Technical Volume for proprietary information.

Improvement of Treatment Protocols

To boost health outcomes, Amerigroup Nevada adopts evidence-based treatment practice guidelines and educates our network providers on their application.

Reducing Premature Births by Educating Providers about 17P

Three of Amerigroup Nevada's 10 most frequent diagnoses are pregnancy-related, and we cover more than 4,400 births each year. The CDC ranks Nevada's preterm birth rate 44th in the country. Amerigroup is committed to improving the rate of premature births, which will improve quality of life for all Nevadans and substantially reduce the State's financial burden. Our OB Medical Director has conducted extensive outreach to OB providers in Nevada to educate them about the effectiveness of 17α hydroxyprogesterone caproate (17P), which recent studies have validated as effective at preventing preterm contractions and premature delivery.

Amerigroup Nevada screens all pregnant women for their risk of preterm birth and engages members with significant risks of delivering a premature baby or having an adverse outcome and their providers to discuss appropriate use of 17P, and our OB Medical Director consults directly with treating OBs when appropriate to educate one-on-one about its efficacy at reducing preterm births. Preventing preterm births fosters a healthy start for babies, improved quality of life for moms and families, and reduced costs for the State related to medical costs and long-term costs resulting from possible developmental delays.

Verifying Safe and Effective Medications for Members

Amerigroup's Medication Therapy Management (MTM) program leverages specially trained clinical pharmacists who work directly with members and prescribers to ensure that all medications prescribed are appropriate, effective, and safe for the member and will improve clinical outcomes. Through our Real Solutions® Health Care Insights tools, we identify and prioritize members who are likely to benefit most from our MTM outreach. These include members who are prescribed multiple medications or medications for chronic conditions. Our

clinical pharmacists work with the PCP team to ensure that all medications are appropriate; effective for their medical condition; safe with respect to co-morbidities and other medications being taken; and able to be taken by the member as prescribed.

Our pharmacy team also continually monitors prescription drug utilization patterns to verify that members are receiving safe and effective medications and to prospectively identify any utilization patterns that may suggest the need to reach out to prescribers to improve outcomes for our members. Monthly and quarterly retrospective drug utilization review (RDUR) of pharmacy claims data identifies potential cases of under- and over-utilization, coordination of care issues, and drug abuse or misuse. Amerigroup clinical pharmacists evaluate RDUR reports to identify providers and members for targeted review and intervention. For example, when we identify prescribers with low formulary compliance rates, we send letters to encourage formulary compliance and generic dispensing. Should we note inappropriate utilization patterns for a member, we may initiate MTM services or, for cases in which the RDUR suggests complex medical or behavioral health issues, we may refer them for case management.

Development of Best Practices

Amerigroup Nevada has aligned development of best practices with DHCFP's priorities and objectives. Some of our most significant investments are described below, including:

- ***Improving maternal and child outcomes***
- ***Achieving measurable clinical quality gains***
- ***Implementing innovative provider collaboration strategies***
- ***Enhancing care for members in the hospital through a hospitalist program***
- ***Text messaging reminders to close gaps in care***
- ***Streamlining administration and fostering safety and quality with Personal Health Records***
- ***Establishing an urgent services network to reduce preventable emergency department (ED) visits***
- ***Identifying high-risk members through predictive models***
- ***Participating in a public-private partnership to prevent healthcare fraud***
- ***Promoting safety by restricting payment for Provider Preventable Conditions***

Improving Maternal and Child Health Outcomes

Improving outcomes for our pregnant members and their babies remains a priority for Amerigroup Nevada. As a result of our investment in this area, we have achieved a preterm birth rate of nine percent, which is well below the Nevada statewide average of 13.9 percent (2010). Specific best practices implemented to improve maternal and child outcomes are summarized below.

- ***Investing in Specialized Clinical Leadership for Taking Care of Baby and Me®.*** ***Amerigroup Nevada has invested in specialized resources, including an OB Medical Director supporting the health plan. Our OB Medical Director has spent significant time building relationships with Nevada providers both in-person and over the phone and is available to consult with OB Case Managers about members with complex needs or to talk directly with providers to discuss treatment plans.***
- ***Referring all Women with High-Risk Pregnancies to Maternal Fetal Medicine Specialists.*** ***For women with high-risk pregnancies, our OB Case Managers, working with the OB Medical Director as necessary, incorporate a maternal fetal medicine specialist into the member's care treatment plan to encourage optimal outcomes for mom and baby. OB Case Managers also coordinate home visits through our partner, Alere, which specializes in community-based support for high-risk pregnancies. This includes clinicians who conduct home monitoring or accompany women to their doctor's visits to keep them on track with their care treatment plan.***
- ***Incenting Providers for Achieving Quality Goals in the Obstetrical Pay-for-Performance Incentive.*** ***As detailed in our response to Section 5.1.10.1.B, Amerigroup has engaged obstetricians to focus on quality outcomes, including reducing the rate of unnecessary C-sections. So far this year, we estimate this initiative has provided approximately $100,000 in savings. This is based on estimated savings of approximately $2,000 per case based on the average inpatient length of stay. Data also shows a three percent reduction in the rate of C-sections.***
- ***Investing in Strong Starts for Families through our You and Your Baby in the NICU Program.*** ***The program eases the stress caused by the birth of a premature baby by providing educational material that is culturally and linguistically targeted for low-income populations and onsite support and coaching by an Amerigroup clinician; it further***

REAL SOLUTIONS *for* NEVADA

During the first six months of 2012, Amerigroup achieved a 9 percent preterm birth rate, significantly lower than the statewide average (2010) of 13.9 percent, according to the Centers for Disease Control.

prepares the family for the transition to home, including coordination of follow-up care when necessary. We connect newborns with a PCP from the outset, a priority for DHCFP. Amerigroup also identifies and coordinates other support needs, such as the need for a car seat or diapers and coordinates with the appropriate community agencies to holistically promote a smooth transition home.

- ***Investing in Community Activities to Engage Pregnant Women.*** Community-based outreach activities, such as Baby Showers, engage pregnant members in prenatal care and screen them for risk factors. Games, prizes, and even a fashion show are combined with health screenings and important prenatal information. We also distribute educational materials, called AmeriTips, which offer educational information to help moms take care of themselves and seek appropriate care. (Figure 5.1.10-8). We can reach more than 1,000 individuals through these events.

Figure 5.1.10-8. AmeriTips Deliver Educational Information to Members and Promote Appropriate Care

See the Confidential Technical Volume for proprietary information.

Achieving Measurable Clinical Quality Gains

Between HEDIS 2010 and 2012, Amerigroup Nevada has achieved significant increases in Medicaid scores for the measures summarized in Table 5.1.10-4.

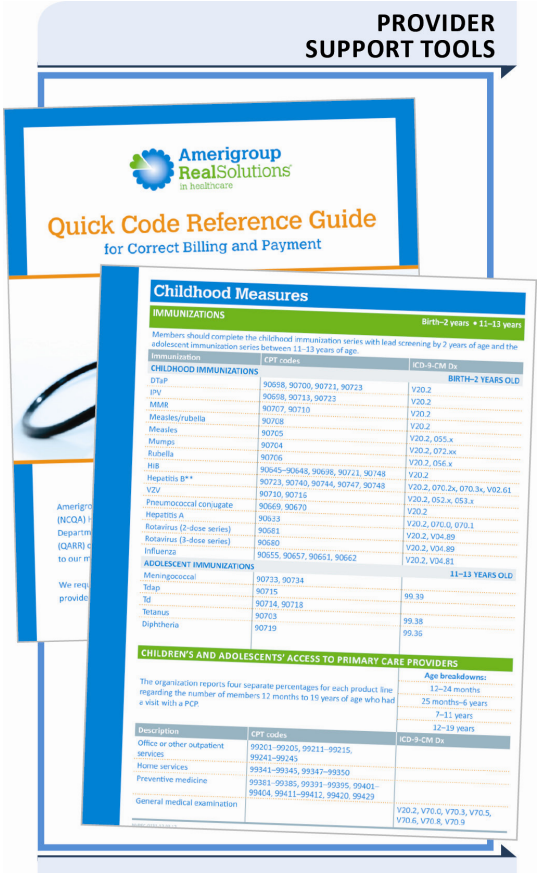
Table 5.1.10-4. Amerigroup Has Driven Gains in Medicaid Quality Performance since Program Implementation

HEDIS Measure	Increase between HEDIS 2010 and 2012
Follow -up after Hospitalization for Mental Illness—7 Day	79.77%
Diabetes Care: Retinal Eye Exams	36.38%
Timeliness of Prenatal Care	46.01%
Frequency of Ongoing Prenatal Care (> 81 percent)	188.62%
Childhood Immunization Status (Combination 3)	24.57%
Lead Screening in Children	126%

To achieve these results, Amerigroup Nevada has invested in development of strategies that fuel quality gains. For example, our Provider Relations Representatives have diligently educated provider offices on appropriately coding their claims to document HEDIS-related services to enhance our data capture. We have also delivered reference tools to providers, illustrated in Figure 5.1.10-9, to assist them. In another example, we changed lead screening protocols to enable PCP office-based gathering of screening samples, making lead screening more convenient for members.

We remain committed to continuing our history of quality gains. In June, 2012, we launched our Investing in Quality initiative, chaired by our Nevada CEO. This initiative places quality at the center of the health plan and immerses the entire health plan, led by the senior executive team, in a culture of continuous quality improvement. This approach effectively engages every employee in every department in organizational performance improvement activities that ensure that Amerigroup exceeds quality standards as measured by HEDIS.

Figure 5.1.10-9. Reference Tools Encourage Proper Coding of HEDIS-related Services

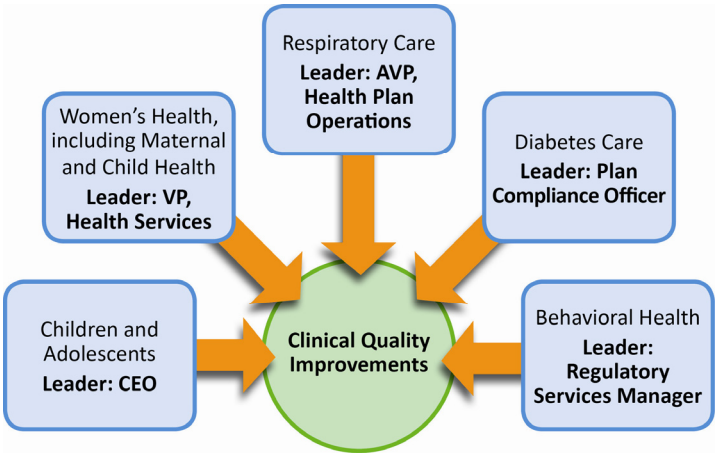


Five teams, each led by a member of the health plan leadership team, have been challenged to brainstorm and evaluate ideas, interventions, and solutions to improve relevant HEDIS scores in the areas illustrated in Figure 5.1.10-10. Every health plan employee is assigned to one of the teams.

Each team has a budget and is developing a comprehensive plan to achieve the desired results. They also have the latitude to make decisions to change course or design a new intervention. Health plan leadership is encouraging new and innovative ideas that inspire creativity to reach our shared goals with DHCFP. To monitor our progress, we produce monthly interim HEDIS scores to assess our overall progress and further refine our strategies.

In addition, in the last two years, we have added highly qualified experts at all levels of the department to continue our quality gains. For example, we added a bilingual outreach associate to directly and personally engage members and their families to obtain age-appropriate care and services, including HEDIS-related services, using tracking tools that enable viewing of all outstanding HEDIS services for each individual and household. We have also engaged our network providers and community-based organizations to team up to improve HEDIS performance, such as partnering with the Southern Nevada Immunization and Health Coalition to promote their back-to-school immunization events to our member families.

Figure 5.1.10-10. Investing in Quality Initiatives Focuses the Health Plan on Quality Improvements



Our Nevada team is fully supported by our corporate QM experts who aggregate experience across all 14 Amerigroup health plans and identify and share best practices. This facilitates the identification of areas for investment and treatment and practice protocols to be applied to Nevada. This team provides support related to HEDIS data management, clinical quality performance outcomes, and research and development.

Implementing Innovative Provider Collaboration Strategies

As described in our response to Section 5.1.10.1.B, Amerigroup Nevada has implemented innovative and quality-oriented incentive strategies with our providers, which is the first important step in our provider collaboration strategy. Complementing those initiatives, our investment in other provider collaboration strategies includes:

- ***Real Solutions® Medical Homes.*** ***For larger provider sites, Amerigroup has invested in helping Nevada primary care sites to transform their practices to adopt population health management strategies. Real Solutions® Medical Homes enhance care for the entire community as providers develop population management capabilities that they apply to all their patients, including enhanced coordination for member with co-morbid physical and behavioral health conditions. Amerigroup's local health plan team includes a full-time Medical Practice Consultant augmented by resources in our corporate offices that exclusively support our Real Solutions® Medical Homes program. We also assist those practices to achieve NCQA accreditation as Patient Centered Medical Homes (Level 2), improving quality of care for all patients, not just our members.***

  Real Solutions® Medical Homes improve quality of care for all Nevadans, not just Amerigroup members, as PCPs enhance their care delivery and tracking protocols for all patients.

- ***Enhancing Medical Homes for Members with Behavioral Health Diagnoses.*** ***Amerigroup has piloted innovative provider practice transformation specifically for members with behavioral health diagnoses that may be adapted for Nevada. For example, we integrated primary care capabilities into a behavioral health provider in Maryland to integrate service delivery for members with substance use disorders.***

- ***Building Affordable Care Act–compliant Health Homes.*** ***In Washington, Kansas, and other states, we are establishing patient-centered multidisciplinary provider teams to deliver care for members with chronic conditions (both medical and behavioral health). We are enthusiastic about developing industry-leading capabilities related to***

  Amerigroup's experience with Patient Centered Medical Homes and Health Homes reinforces our commitment to a medical home for members, a DHCFP mission.

Health Homes and to apply best practices learned in other states to apply to Nevada should the State opt to pursue such programs as a means to enhance quality of care.

See the Confidential Technical Volume for proprietary information.

Identifying High-Risk Members through Predictive Models

Our Real Solutions® Health Care Insights suite of predictive models facilitates prospective identification and referral for specialized care coordination of members with elevated risks or ongoing medical or behavioral health conditions. Predictive modeling allows us to identify members with healthcare needs that may lead to high-intensity intervention, making the most efficient use of DHCFP dollars. Members with high-risk scores are prioritized for enrollment in clinical programs.

Predictive models identify members at risk for:

- Complex needs
- Imminent hospitalization
- Hospital re-admission
- Future neonatal intensive care unit (NICU) services
- Inappropriate ED visits
- Nursing home admissions

Participating in a Public-Private Partnership to Prevent Healthcare Fraud

Amerigroup has built a robust Program Integrity function, and we continually seek opportunities to enhance performance. We recognize that organizations that administer public programs should work together to improve detection and prevent payment of fraudulent healthcare billings. Amerigroup is among the first to join HHS, CMS, the U.S. Department of Justice, and other industry leaders in an innovative public-private fraud prevention initiative. The initiative will focus on fraud prevention opportunities that are only possible through broad collaboration, including:

- ***Data sharing to pool Medicare and Medicaid claims data to allow federal investigators and private insurers to look for suspicious billing patterns and abnormalities.***
- ***Best practices and new methods to better detect suspicious activity and share approaches with the most potential to stop fraudulent billing.***
- ***Data analytics that uses sophisticated information technology and analytics on industry-wide healthcare data to predict healthcare fraud schemes before they happen.***

Promoting Safety by Restricting Payment for Provider Preventable Conditions

Protecting the safety of Amerigroup members is an Amerigroup hallmark. Amerigroup currently maintains a number of patient safety initiatives, including processes for reviewing

all potential Quality of Care events. Complementing these efforts, Amerigroup maintains a rigorous policy that prohibits payment for Provider Preventable Conditions (PPCs) and Never Events. We require that providers report such incidents to Amerigroup, and our UM Nurses monitor all admissions to identify potential cases. Amerigroup thoroughly investigates all potential Quality of Care issues, including those associated with PPCs and Never Events. Our claims system monitors claims to identify those associated with a PPC and restricts payment accordingly. With this strategy, we continually reinforce to our network providers that member safety is of paramount importance.

D.	Describe the experience your organization has had working with state government and or experience in specifically related services.

Experience Working with State Governments

For almost four years, Amerigroup Nevada has cultivated positive and productive relationships with DHCFP and other state agencies connected to the Medicaid, CHAP, and Nevada Check Up programs. We have emphasized a collaborative approach to identifying and implementing cost-effective program enhancements that foster sustained improvements to the healthcare of Nevadans.

Amerigroup recognizes that, like most states, Nevada faces significant challenges in the future. As Medicaid costs continue to rise and enrollment grows, DHCFP will continue to confront difficult choices. Over the past 16 years, Amerigroup has cultivated trusting relationships with many state governments, including Nevada. As an organization with extensive data on public health programs, well-respected thought leaders in the healthcare field, and substantial capital resources to invest, Amerigroup remains committed to working with state partners to create innovative solutions to stabilize public health programs. We have a long history of partnering with states to help achieve the goal of improving health outcomes, streamlining administration, and optimizing the cost-effectiveness of public health programs in general. It is this commitment that separates Amerigroup from our competition. We believe that our role is not limited to that of an MCO vendor, but it is to anticipate the challenges facing the State, share program data and information, and collaboratively develop sustainable solutions with DHCFP.

Amerigroup brings to DHCFP extensive data on public health programs, well-respected thought leaders in the health care field, and substantial capital resources to invest in developing real solutions to the public health program challenges facing DHCFP.

In addition, we interface with various State agencies in Nevada in the course of managing our business. This includes DWSS for eligibility, the Division of Insurance for regulatory oversight. Our case management team is well-versed in the diverse array of services available

to members and coordinate referrals to other State agencies based on each individual's needs. This includes DWSS' Supplemental Nutrition Assistance Program for members needing food stamps and its energy assistance program, the Nevada Supplemental Nutrition Program for Women, Infants & Children (WIC), and the Food Stamp Employment and Training program.

Highlights of our experience working with the State government in Nevada, each of which is described below, include:

- *Partnership for strategic initiatives*
- *Collaboration to achieve program improvements*
- *Planning for the future*
- *Coordination with other State agencies*
- *Partnership and transparency*

We also highlight our experience with other states, which gives Amerigroup a broader range of experience with programs, services, and challenges beyond those of Amerigroup Nevada.

Partnership for Strategic Initiatives

As a true partner, Amerigroup Nevada has contributed ideas and resources to support the State's overall health improvement efforts. We supported DHCFP in the development of a successful grant submission for CMS' Medicaid Incentive Program for Chronic Diseases (MIPCD) demonstration. Beginning in December, 2012, through the MIPCD, members who are at risk of or diagnosed with diabetes will be rewarded for participating in our diabetes disease management program to boost their self-management skills. We look forward to monitoring the success of the project and are committed to collaborating with the other grant partners to deliver results in the demonstration.

We also continue to seek sustainable improvements to maternal and child outcomes for Nevadans. Amerigroup actively collaborated with HealthInsight (a non-profit organization that served as convener), Nevada State Health Division, and DHCFP, the other Medicaid managed care plan, and the three largest obstetrical practices in Nevada to develop a CMS Innovation Strong Start grant proposal.

CenteringPregnancy is an evidence-based model for delivery system reform adopted in several states by Amerigroup to improve outcomes for maternal and child health.

The proposal incorporates adoption of a small-group intervention model of care that supports information sharing and understanding through shared experience. The proposal is based on

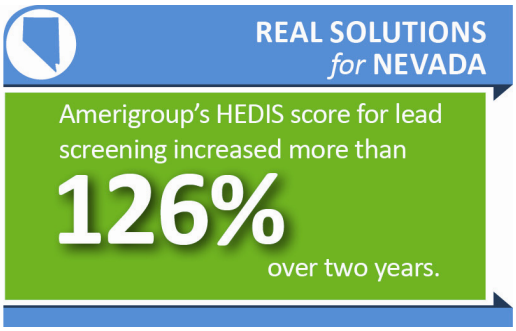
CenteringPregnancy, an evidence-based model for delivery system reform adopted in several states by Amerigroup to improve outcomes for maternal and child health. CenteringPregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support. The model uses a group setting to maximize the opportunity to educate women and to help them learn from each other and their shared experience. Small groups of eight to twelve women with similar gestational ages meet with the provider, learn care skills, and participate in facilitated discussions. The group learning model has proven to improve health outcomes, facilitate broader learning opportunities for participants, and create a support network for the woman with other group members.

Amerigroup recognized the value of this approach early on. In March 2011, the Amerigroup Foundation awarded the Centering Healthcare Institute (CHI) with a $125,000 grant to implement CenteringPregnancy at three clinical practices. Amerigroup's Public Policy Institute continues to work with CHI on several projects, including a program evaluation of the CenteringPregnancy model.

This initiative underscores our commitment to the pursuit of innovative evidence-based care models, our collaboration with providers to develop sustainable solutions, and our willingness to partner with the State and other entities to achieve the State's goals.

We look forward to working with State and other stakeholders to identify and pursue other opportunities that align with DHCFP goals and objectives.

<u>Collaboration to Achieve Program Improvements</u>



Amerigroup Nevada enjoys excellent relationships throughout DHCFP, and we continually collaborate with the Agency to drive program improvements. Our commitment to collaboration with DHCFP is evident in our efforts related to the Nevada Medicaid Services Manual (MSM). Amerigroup Nevada's Medical Director, Richard Roberts, MD, MHSA, CPE, works closely with DHCFP employees with whom he regularly consults regarding clarification of the MSM. He has been recognized across the Agency as an expert in its interpretation. Dr. Roberts' collegial relationships with each of the DHCFP employees who are accountable for the various MSM chapters foster a deep understanding of the MSM rules and rapid response when the need for clarifications or interpretations arise. His expertise with the MSM and productive relationships with key employees enable us to identify and rapidly resolve inconsistencies within the MSM, which has supported refinement of the fee-for-service program.

Amerigroup appreciates that DHCFP seeks a performance-based program, and our leadership team has actively engaged the Agency to develop solutions when Medicaid rules or processes seem to impede optimal performance. For example:

- ***Lead Screening. HEDIS rates related to lead screening for children were unusually low. Upon analysis of potential barriers, Amerigroup identified that the State requirement that samples be collected at labs, rather than in provider offices, placed additional burden on families who often chose not to visit another provider to have their child tested. We worked with the Agency to enable provider office collection of samples, and our HEDIS rates increased by 126 percent over a two-year period.***
- ***Newborn Enrollment. As noted in our response to Section 5.1.10.1.C, Amerigroup worked with the Agency and DWSS to modify the process for verifying Medicaid eligibility for newborns as delays inherent in the initial process had created barriers to early intervention to coordinate necessary care for newborns, especially those with high-risk factors. We strongly support pursuit of the presumptive eligibility waiver, which will further expedite interventions for newborns.***

Planning for the Future

The State faces significant challenges in the future, including increasing budgetary pressures and implementation of the SSHIX and Health Information Exchange (HIE) initiatives. Amerigroup is experienced in supporting the State to vet options and identify and implement solutions that will guide the State toward achievement of its goals and objectives. We also stand prepared to work with the State on new policy initiatives that influence Medicaid and Nevada Check Up.

We remain committed to engaging with State leadership to share ideas and strategies to align the health plan's operations toward achievement of the Governor's Healthy Nevada goals. Amerigroup strives to improve the health of all Nevadans, not just those enrolled in our health plan. We support and collaborate with community-based organizations on health promotion and education, and we incorporate value-added services into our Medicaid MCO program that contribute to improved health outcomes for our members. Our employees at all levels of the organization are actively involved in the community, including participating in many volunteer events.

Other future planning support experience in Nevada and other states is related to:

- ***Health Insurance Exchange.*** ***Amerigroup's leadership has committed to being a part of the solution. Our CEO participates in the SSHIX Finance and Sustainability Advisory Committee. Our Medical Director is a member of the Plan Certification and Management Advisory Committee of the SSHIX. Our team has been actively preparing for launch of SSHIX. Amerigroup Nevada also receives extensive support from Amerigroup corporate resources. Since 2010, we have cultivated a team of employees dedicated to research and thought leadership concerning Health Care Reform issues. The Health Reform Integration Team strives to be the thought leaders for analysis, education, and communication on the changes and opportunities of health reform for our stakeholders and partners. We have dedicated resources to track HIX trends and strategies across the country and develop solutions that deliver value to all our state customers, further strengthening our expertise.***
- ***Health Information Exchange.*** ***Our CEO is also on the Board of Directors of the Nevada Health Information Exchange (NHIE). We currently work with HealthInsight's Health Information Technology Regional Extension Center and the State's Quality Improvement Organization to boost adoption of its community-based NHIE. Recognizing the value of provider information sharing as a tool toward improved quality and efficiency, Amerigroup assists them by educating providers about how to use electronic medical records (EMRs) effectively to achieve meaningful use standards. We also educate providers who do not yet have EMRs on how they can move toward that goal. Our efforts educating providers about EMRs will positively influence the overall effectiveness of the NHIE as more providers opt to participate and share larger volumes of data.***
- ***Program Expansions to Add New Populations.*** ***In many other states, Amerigroup has worked closely with state governments to add new populations to their Medicaid–managed care programs. We currently service members enrolled in the ABD/SSI category in 10 states and almost 92,000 dual eligibles in eight states. We understand the issues that states face serving these members, whose needs differ vastly from TANF and CHIP recipients, and have consulted and worked with state governments to develop real solutions.***
- ***Benefit Expansions.*** ***Many states have begun to integrate long-term services and supports (LTSS) into their Medicaid managed care program. Amerigroup has consulted with many state entities to design and develop successful strategies and to engage stakeholders in a collaborative effort. Across the country, Amerigroup has extensive experience coordinating LTSS for more than 145,000 members in five states. Amerigroup is supported by our National Advisory Board (NAB) on Improving Health***

Care Services for Seniors and People with Disabilities, which recently celebrated its fifth anniversary. The NAB advocates for changes in public policies that both recognize and foster individual preferences for independent living through better integrated community-based services.

Coordination with Other State Agencies

Grounded in the State of Nevada, Amerigroup Nevada has nurtured relationships with other agencies that have oversight responsibility for aspects of the Medicaid, CHAP, and Nevada Check Up programs. Examples include:

- ***Supporting Program Integrity.*** ***As detailed in our response to Section 5.1.11.6.C, Amerigroup maintains employees, systems, and processes to support identification of potential fraud, waste, and abuse, and we fully cooperate with State authorities in their investigation. As required, Amerigroup Nevada reports instances of all suspected fraud and/or abuse to the Surveillance and Utilization Review Section (SURS) at the DHCFP. In addition to reporting suspected cases, our investigation team actively partners with SURS as necessary to deliver data and documentation that supports the SURS investigation. Our Corporate Investigation Department (CID) employees meet quarterly by telephone with SURS personnel to discuss open investigations and share trends. In addition, members of the CID team participate on the US Attorney's Heath Care Task Force, which is another venue for sharing and receiving information regarding active health care investigations.***
- ***Sharing Relevant Data.*** ***We recognize that the health plan's data provides important public health information to the State. In addition to regular reports, Amerigroup Nevada regularly receives requests for data from DHCFP and other State agencies or departments, and we will continue to share relevant data that advances the mission of other agencies. For example, we recently received a request from DHCFP to produce a report for the Nevada State Health Division with data on our PCPs and dentists. In 2012, we also shared data that DHCFP has requested through ad hoc reports related to EPSDT services, dental services, maternal and child health block grant data, and organ transplants.***
- ***Coordinating Referrals for State Investigations.*** ***As an MCO, Amerigroup Nevada gathers relevant data about provider practice patterns and potential quality of care concerns, and we refer cases for investigation to the State Board of Medical Examiners. For example, we recently referred a provider to the State Board of Medical Examiners after receiving complaints from members about his narcotic prescribing patterns. We also referred a network pain management provider who prescribed a powerful narcotic for home use in an amount our Medical Director felt was dangerous***

for the patient. He filed a formal complaint with the Board regarding that provider as well.

<u>Partnership and Transparency in Communication</u>

The Amerigroup leadership team meets with DHCFP quarterly to review the status of the Medicaid Managed Care program, discuss opportunities for improvement, and strategize on new initiatives. We emphasize open communication that builds trust and centers on shared goals and objectives. For example, during our quarterly meetings, Amerigroup shares our progress on quality improvement programs, an important priority for DHCFP.

This trusting relationship builds on a shared vision for a successful program. Amerigroup has a proven record of open communication with DHCFP, including prompt communication in cases when issues arise. Amerigroup recognizes that a rapid, detailed, and transparent response is our responsibility to the State. We are committed to and accountable for fully supporting DHCFP in program administration.

E.	Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

Key Personnel

Amerigroup Nevada's experience operating as a Medicaid and Nevada Check Up MCO has allowed us to develop a skilled management team with the expertise needed to operate an efficient health plan. Our key personnel are committed to providing quality, accessible care to our members, and dedicated to working with the State to create a more efficient healthcare system. Our talented employees have gained knowledge through personal experience in managed healthcare and through the support of Amerigroup Corporation, which has experience caring for approximately 2.7 million members in 13 states. As we blend local key personnel with the highly skilled leaders of Amerigroup Corporation, we ensure that the Nevada health plan and our members have a smooth and positive experience, with the best health outcomes possible.

The key personnel will perform and be responsible for the duties defined in any Contract resulting from this RFP. These local leaders bring regional relationships and understanding of unique, local healthcare challenges to ensure DHCFP the right combination of personnel to meet the needs of the State and our Nevada members.

Collectively, this local team of key employees has more than 144 years of managed care experience and 25 years of experience in operating the Nevada health plan. Table 5.1.10-5 lists the key personnel of the Amerigroup Nevada team dedicated to the Medicaid and Nevada Check Up Contract. We present resumes of the key personnel identified in RFP 4.13.2.3 in Section 5.4 Vendor Staff Resumes.

Table 5.1.10-5. Key Personnel

DHCFP Position Title	Amerigroup Associate	Amerigroup Title	Years of Managed Health Care Experience
Administrator	Eric Lloyd	Chief Executive Officer	20
Chief Financial Officer	David Hsieh	Associate Vice President, Finance	10
Medical Director	Richard Roberts, MD	Medical Director	30
Recipient Services Manager	Candice Speers, RN	Director, Quality Management	8
Provider Services Manager	Marlene Morrison	Associate Vice President, Provider Relations	22
Grievance and Appeals Coordinator	Dena Sargent, RN	Quality Management Coordinator	12
Claims Administrator	Lisa Bogard	Associate Vice President, Health Plan Operations	18
Nevada Operations Manager	Julie Skaggs	Vice President, Provider Relations	24
		Total	144

Tables 5.1.10-6 through 5.1.10-13, starting on the following page, provide information on specific responsibilities for RFP-identified key personnel. Employees listed will manage all oversight and performance requirements for any Contract resulting from this RFP.

Table 5.1.10-6. Administrator Contract Responsibilities

Name	Eric Lloyd
Amerigroup Title	Chief Executive Officer
RFP Title	Administrator
Responsibilities	▪ Manage the overall operations Nevada health plan ▪ Represent Amerigroup Nevada in all matters related to the Medicaid and Nevada Check Up Programs ▪ Oversee DHCFP contract negotiations and ensure that policies and programs achieve results in compliance with the contract ▪ Receive and respond to DHCFP inquiries and requests and resolve contract issues ▪ Meet with DHCFP representatives to review performance and resolve contract issues ▪ Oversee, direct, and manage health plan operations in Nevada ▪ Develop policy and programs to achieve results through effective financial management ▪ Lead the rate development process and oversee the health plan budgeting process ▪ Certify financial statements, encounter reports, and other required regulatory reports ▪ Oversee fraud and abuse program compliance and reporting responsibility ▪ Maintain regulatory and Contract compliance, including securing and coordinating resources necessary for such compliance and monthly reporting ▪ Ensure implementation and integration of cultural competency programs and training for all Amerigroup Nevada employees ▪ Work collaboratively with Amerigroup senior leadership to achieve overall company goals of growth, financial performance, and service to the community ▪ Manage key regulatory and legislative relationships ▪ Oversee Contract negotiations ▪ Oversee key hospital and provider contractual relationships

Table 5.1.10-7. Chief Financial Officer Contract Responsibilities

Name	David Hsieh
Amerigroup Title	Associate Vice President, Finance
RFP Title	Chief Financial Officer
Responsibilities	▪ Own topline, medical expense, and local Selling, General and Administrative (SGA) portions of annual budget process and quarterly forecasts ▪ Conduct and coordinate all analysis required for membership, premium yield, and medical expense ▪ On a quarterly basis, analyze, interpret, and communicate financial statement and medical accrual results to plan leadership ▪ Develop, maintain, and enhance mechanisms to track, report, and provide feedback on company financial performance ▪ Monitor monthly claims production, including investigation and resolution of adverse changes in production statistics and their impact on medical accrual estimates ▪ Control profit planning, forecast, expense budgets, accounts receivable, cost standards, and administrative savings ▪ Administer a risk management program to minimize the exposure to business disruption ▪ Monitor, analyze, and report any variances for local and direct administration expenses ▪ Identify and drive opportunities for savings with plan leadership on a monthly basis ▪ Identify and monitor the assumptions and issues in the rate methodology that drive financial success including trend, populations covered, benefits covered, unit cost assumptions, risk adjustments, birth rates, newborn enrollment rules, special populations, utilization assumptions, and program changes

Table 5.1.10-8. Medical Director Contract Responsibilities

Name	Richard Roberts, MD
Amerigroup Title	Medical Director
RFP Title	Medical Director
Responsibilities	▪ Oversee all medical management services for the Nevada health plan in coordination with the Amerigroup integrated Medical Management Model ▪ Lead the development and implementation of programs that assure that members receive appropriate and timely access to healthcare services ▪ Lead the development and implementation of medical management programs that assure our physicians and hospitals deliver appropriate and timely medical services to our members ▪ Lead the development and implementation of medical quality management programs that assure members fulfill their healthcare needs and have appropriate health maintenance and preventive services ▪ Establish and implement the company's medical management policies ▪ Co-chair the Utilization Management and Quality Assurance Plan committee ▪ Direct the development and implementation of our internal quality assurance plan and utilization management activities and monitoring the quality of care Amerigroup members receive ▪ Oversee the development and revision of our clinical care standards and practice guidelines and protocols ▪ Review all potential quality of care problems, and oversee the development, implementation, and adherence to plans of correction ▪ Oversee referral process for specialty and out-of-network services ▪ Serve as a liaison between Amerigroup Nevada and its providers, communicating regularly with providers, including oversight of provider education, in-service training, and orientation ▪ Serve as consultant to medical staff with regard to referrals, denials, grievances, and problems ▪ Ensure coordination of out-of-network services ▪ Serve as liaison to work with DHCFP regarding utilization review and quality assurance issues

Table 5.1.10-9. Recipient Services Manager Contract Responsibilities

Name	Candice Speers
Amerigroup Title	Director, Quality Management
RFP Title	Recipient Services Manager
Responsibilities	▪ Establish quality management objectives and annual goals in conjunction with the Medical Director ▪ Direct implementation of the comprehensive Quality Management Program to meet the demographic and epidemiological needs of the population served ▪ Promote plan wide understanding, communication, and coordination of the quality management program ▪ Develop quality management reports ▪ Analyze validity of quality management data from a clinical perspective ▪ Coordinate reporting of all quality initiatives to all appropriate committees on a quarterly basis ▪ Develop, design, implement and evaluate continuous quality improvement action plans for the quality improvement activities ▪ Participate in the reporting of the HEDIS® data and coordinate the improvement action plans ▪ Coordinate the state regulatory quality reporting for the health plan ▪ Support plan leadership to meet NCQA standards ▪ Support provider re-credentialing in the areas of medical reviews and quality indicators ▪ Assure compliance with State and Federal quality improvement/assurance requirements ▪ Evaluate and make recommendations for oversight of delegated services ▪ Develop the annual operating and capital budgets to sufficiently meet departmental needs and ensure that the department stays within budget ▪ Set goals, establish measurements, quality standards and tracking mechanisms ▪ Work with plan and corporate team to prioritize work requirements, balance competing priorities for resources, and develop plans to address those needs having the greatest impact

Table 5.1.10-10. Provider Services Manager Contract Responsibilities

Name	Marlene Morrison
Amerigroup Title	Associate Vice President, Provider Relations
RFP Title	Provider Services Manager
Responsibilities	▪ Support network contracting efforts within Nevada, including active involvement in significant provider contracting efforts such as hospitals and organized physician groups ▪ Ensure the appropriateness of the health plan's programs for provider credentialing, orientation, education, and services as defined by the organization and the State ▪ Ensure the provider network successfully integrates with the medical management function ▪ Lead and manage all aspects of provider implementation, including understanding, communication, and accurate administration of unique arrangements ▪ Maintain provider service standards and facilitate marketing programs that involve providers ▪ Manage all aspects of provider profiling programs, including educating health plan employees on using provider profiling information to engage the provider network in improving quality ▪ Develop and maintain all provider services policies and procedures ▪ Monitor provider concerns and issues, communicate those issues to other functional areas of the health plan, participate in ongoing processes to obtain feedback to the health plan, and coordinate and assist in the appropriate response of the health plan for provider issues ▪ Support strategic network composition and design initiatives that are consistent with the objectives of the health plan

Table 5.1.10-11. Grievance and Appeals Coordinator Contract Responsibilities

Name	Dena Sargent, RN
Amerigroup Title	Quality Management Coordinator
RFP Title	Grievance and Appeals Coordinator
Responsibilities	▪ Process medical appeals according to the state Medicaid contract and regulatory requirements ▪ Process and monitor medical appeals and Member Fair Hearings ▪ Maintain internal medical appeals policies according to the state Medicaid contract and state regulatory requirements ▪ Maintain database inventory of medical appeals by source, type, data received, and outcome ▪ Manage medical appeals process to meet timeliness and accuracy standards ▪ Analyze data and prepare quality management reports in accordance with plan procedures ▪ Participate in intradepartmental quality management improvement teams ▪ Perform medical record review and data collection for medical appeal processing ▪ Discuss medical appeals with reviewing Medical Director, or designee, to facilitate decision making ▪ Schedule and present medical appeals to appeal committee members for decision ▪ Submit required documents to reviewing agency and monitor medical appeals ▪ Coordinate with Medical Management, Provider Relations, and other internal Amerigroup Nevada departments as necessary to collect data to process the medical appeal ▪ Communicate process and appeal determinations as necessary with external customers, such as, Members, physicians and hospitals ▪ Assist in educating providers about the medical appeals process ▪ Identify research and acts on areas requiring process improvement ▪ Participate and contribute to the Quality Management, Medical Advisory, and Community Advisory Committee Meetings ▪ Support regulatory audits and accreditation status and efforts ▪ Maintain complaint documentation ▪ Conduct regular audits of the core operations systems to track misrouted complaints

Table 5.1.10-12. Claims Administrator Contract Responsibilities

Name	Lisa Bogard
Amerigroup Title	Associate Vice President, Health Plan Operations
RFP Title	Claims Administrator
Responsibilities	▪ Manage and improve all health plan operations to achieve or exceed performance standards and budget ▪ Maintain all required regulatory compliance and serve as the liaison to all health plan support services, such as Medical Management, Claims, Provider Relations, and Information Technology Services ▪ Develop and manage provider contracts and partnerships to achieve quality, cost management, and strategic business development objectives; develop and negotiate strategic provider contracts on behalf of the health plan ▪ Lead the health plan's performance management and earning improvement activities; assist in developing policy and programs to achieve business results through effective financial management ▪ Assist CEO with development of plan's annual administrative, medical, and capital budgets ▪ Assist CEO with management of monthly reporting and review of financials and accruals ▪ Assist the CEO with aspects of local and state government relationships, including dealing with regulators as necessary, to establish and continue effective working relationships ▪ Manage the plan's complaint, appeals, pended claims, and claims research functions ▪ Manage the hiring, developing, training, and retention of high-quality, productive employees ▪ Oversee and direct the claims administration operation – hard copy claims and claims received in automated format ▪ Prepare periodic claim volume and status reports for management ▪ Investigate third party liability and subrogation cases using information supplied by Claims, Medical Management, reports, and phone calls ▪ Communicate with attorneys, insurance carriers, members, providers, and state Medicaid agencies to achieve recovery using verbal and written correspondence ▪ Work with Legal Department to resolve difficult recovery cases and to obtain legal advice ▪ Identify and recover overpayments related to tort or subrogation

Table 5.1.10-13. Nevada Operations Manager Contract Responsibilities

Name	Julie Skaggs
Amerigroup Title	Vice President, Provider Services
RFP Title	Nevada Operations Manager
Responsibilities	▪ Collaborate with plan CEO and other senior management to determine the plan's provider contracting needs ▪ Lead the development of provider network business plans, strategies and goals as they relate to network expansion and provider contracting, education, communication, policies, procedures and servicing ▪ Develop and manage provider contracts and partnerships to achieve quality, cost management, and strategic business development objectives ▪ Lead the strategic analysis and negotiation of all types of complex provider contracts ▪ Review financial information and, in collaboration with Medical Finance and other corporate departments, develop effective reimbursement methodologies and strategies to achieve specific contracting and budgetary objectives which are operational and efficient ▪ Monitor local market trends relative to provider contracting, reimbursement and service, make recommendations to modify current processes and assist implementing changes when necessary ▪ Educate Provider Relations staff on the concepts and practice of provider marketing ▪ Assume responsibility for development, implementation, operation and oversight of provider marketing efforts in collaboration with Sales and Marketing leader ▪ Work with staff to identify operational issues and implement projects to promote payment of claims on first submission ▪ Supervise the provider network and operations staff to ensure proficiency and efficiency in meeting all health plan strategic and operational goals, major job objectives and planning goals ▪ Develop and implement strategies to recruit and retain the highest quality staff members

F.	Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:
1.	Information Systems
2.	Utilization/Case Management
3.	Claims Payment
4.	Quality Improvement and Reporting (e.g., HEDIS, CMS 416)
5.	Health Education
6.	Data Coding
7.	Contract Negotiation Specialists/Network Recruiters
8.	Encounter Data
9.	Other staff as needed for project

Additional Employees with Contract Responsibilities

In addition to the key personnel, Amerigroup Nevada designates additional full-time employees who supervise each of the following functional areas required by this RFP. The Nevada employees receive support from Amerigroup Corporation's specialized departments, which complement these employees in strategically determined functional areas to create both better value and results for our members. Table 5.1.10-14 provides a summary of the name(s) of the responsible Amerigroup Nevada employees and the supporting Amerigroup Corporate department(s) for all employees responsible for each of the functional areas. We describe each staff member listed and their supporting department(s) in detail following the table.

Table 5.1.10-14. Additional Full-time Personnel and Project Supervisors

Functional Area	Staff	Amerigroup Supporting Department(s)
Information Systems	Shaun Wayne	Technology Services
Utilization/Case Management	Karen Gardiner	Behavioral Health Clinical Operations
Claims Payment	Stephen Williams Richard Marucut Denise Ward	Reimbursement Policy Management Claims
Quality Improvement and Reporting	Addie Ferebee	Quality Management
Health Education	David Osman	Disease Management

Functional Area	Staff	Amerigroup Supporting Department(s)
	Michelle Washington	
Data Coding	Robin Favret	Provider Life Cycle Information Technology Services
Contract Negotiation Specialists/Network Recruiters	Shaneka Wiley Stephen Ford	National Provider Services Provider Collaboration
Encounter Data	Robin Favret	
Other personnel, as needed	Brandon Charles, MD Gerald Busch, MD Nancy Kaplan Chris May	

Information Systems

Staff and Contract Responsibilities

Shaun Wayne, Information Technology Service Field Service Technician III, supports Amerigroup Nevada's Information Systems. Shaun has almost 10 years of experience with Amerigroup and more than 15 years of experience working with Information Technology Services. Under the Contract, Shawn:

- ***Provides technical support and direction for Amerigroup Nevada staff members***
- ***Contributes advanced, top-level technical knowledge and experience in the areas of software and hardware testing, change control, configuration management, test plan development, and systems documentation***
- ***Provides information to internal and external customers and vendors***
- ***Provides and implement innovative ideas and solutions for complex problems***
- ***Ensures system security is maintained and strengthened through implementation of current technologies***

Supporting Department

Shaun Wayne and Amerigroup Nevada receive support from Amerigroup Corporation's Technology Services (TS) Department, which consists of more than 380 highly skilled and experienced technology professionals. In order to best support the Nevada Health Plan, the management of our TS Department is fully integrated across operations, allowing us to focus on serving our members. Integrating the management of all functions creates a collaborative

environment that focuses on implementing technology tools to strengthen customer relationships and drive operational improvements.

Utilization and Case Management

Staff and Contract Responsibilities

Karen Gardiner, Vice President of Health Care Management Services, is part of the Nevada health plan Clinical Leadership team, and leads the Utilization and Case Management responsibilities, including those resulting from this RFP. Under the Contract, Karen:

- ***Directs and provides leadership for designing and developing the Nevada health plan's medical management program to meet the unique needs of the population***
- ***Directs Healthcare Management Programs including disease management, case management, and utilization management***
- ***Promotes understanding, communication, and coordination of the Integrated Medical Management Program***
- ***Works with Provider Relations, Quality Management, and Health Promotions to develop and implement effective provider communications, quality assurance, and member outreach programs***
- ***Ensures support for compliance with NCQA and assure compliance with the State and federal program requirements***

Supporting Departments

Amerigroup's Behavioral Health Department works to leverage centralized behavioral health utilization management and disease management employees who handle complex cases with the lowest acuity level. These teams, designated by region to build local market knowledge, collaborate closely with local health plan employees. Amerigroup also deploys locally based complex case management experts to provide high-touch services for our most vulnerable members and to make best use of extensive local knowledge of community resources. This approach matches the intensity of service required for each individual member.

Amerigroup's Clinical Operations Department ensures that Amerigroup's policy and operations support the national medical model by promoting collaboration, accountability, and teamwork, which aids the removal of barriers to operational success. The core functional responsibilities of Clinical Operations includes Clinical and Utilization Management (UM) procedures and workflows, NCQA UM standards, medical program management, Case Management and UM training, and integration of Case Management and UM certification programs.

Claims Payment

Staff and Contract Responsibilities

Stephen Williams, Vice President of West Regional Services Center Operations, has been with Amerigroup for almost six years. Under the Contract, Stephen leads operations for the Regional Service Center, which is responsible for customer services and claims processing.

Richard Marucut, Director of Service Operations, is a leader in the West Regional Service Center. As director, he helps manage the claims team responsible for supporting Amerigroup Nevada. Under the Contract, Richard:

- ***Monitors claims quality reporting and ensure fulfillment of all State requirements***
- ***Analyzes reports to identify areas of concern, trends, and issues across entities that impede customer service***
- ***Collaborates with internal partners to develop process improvement initiatives to reduce defects, improve overall operating efficiencies, and maximize dollar recovery through cost containment***
- ***Ensures appropriate scheduling of employees to manage claims volume***
- ***Works with the Nevada health plan to resolve operational issues including enrollment, benefit configuration, call metrics, authorizations, high dollar claims, pending claims, appeals, adjustments, customer service, and policy issues***

Denise Ward, Claims Manager, directly manages claims for the Nevada market. With more than 21 years of experience in healthcare, she has the expertise necessary to manage an efficient claims team. Under the Contract, Denise:

- ***Manages the Nevada claims inventory***
- ***Provides updated claims training as required***
- ***Ensures that all market Performance Guarantees are met***
- ***Partners with cross-functional areas to ensure all claim errors are resolved timely***
- ***Processes high dollar, complex and adjustment claims***

Supporting Departments

Amerigroup Corporation's Claims Department works to ensure the satisfaction of our providers, members, and state partners by striving to provide the most accurate, cost effective, and responsive claims processing system. This extensive corporate department provides vital support to the Nevada health plan's claims payment team.

Amerigroup Corporation's Reimbursement Policy Management Team supports the claims payment employees. The Reimbursement Policy Management team creates consistent and industry-standard reimbursement policies and medical coding logic, taking into consideration our member's unique needs. The Claims Payment functional area collaborates with local Nevada employees to ensure claims payment understanding, communication with providers, and claims processing efficiencies.

Quality Improvement and Reporting

Staff and Contract Responsibilities

Addie Ferebee, Nevada Health Plan Financial Analyst, supports the data and quality needs of the Quality Improvement and Reporting functional area. Under the Contract, Addie:

- ***Produces, analyzes, and maintains reports used to measure, monitor, and manage quality of care and services***
- ***Employs knowledge of databases, information systems, statistical tools, and analytical principles to analyze outcomes that support strategies for managing health plan performance***
- ***Compiles and analyzes data including quality indicators, performance scorecard, and quality improvement activities***
- ***Develops, standardizes, maintains, and enhances reports for State quality reporting***

Supporting Department

Amerigroup Corporation's Quality Management Department fully supports our Nevada team. The department's experts have aggregate experience across all 13 Amerigroup health plans and identify and share best practices. The Amerigroup Quality Management Department leads national efforts related to development and implementation of quality metrics and identification of effective interventions in affiliate health plans for inclusion in performance improvement initiatives. This facilitates the identification of areas for investment and treatment and practice protocols to be applied to Nevada. This team provides support related to HEDIS data management, clinical quality performance outcomes, and research and development.

Health Education

Staff and Contract Responsibilities

David Osman and Michelle Washington, Nevada Health Plan Marketing Representatives, provide field-based marketing and health education to promote a healthier community. Under the Contract, Dave and Michelle:

- ***Converse with and educate the general public on the importance of healthcare and the services a managed care organization provides***
- ***Provide outreach and guidance to members of the community regarding enrollment questions and social services needs***
- ***Conduct presentations, create exhibits, and perform other educational activities in an effort to inform the community and establish positive relationships with providers and community organizations***

Supporting Department

Amerigroup Corporation's Disease Management Team also supports the Nevada health plan with targeted disease management programs tailored to the needs of members and caregivers. Our DM team is supervised by our National Medical Director and consists of licensed nurses and social workers assigned to state-specific teams. This builds familiarity with local programs and resources and incorporates a deeper support system for individual members.

Data Coding

Staff and Contract Responsibilities

Robin Favret, Associate Vice President of Information Technology Services Customer Account Management, has more than 28 years of healthcare experience and 14 years with Medicaid and CHIP programs. Robin's experience has provided her the opportunity to work extensively with DHCFP on integration challenges and her expertise supports Amerigroup Nevada's Data Coding functional area. Under the Contract, Robin:

- ***Leverages industry, corporate, and health plan knowledge to partner with the state in developing solutions to operational or system issues***
- ***Ensures the communication of key service and performance measures to the health plan and its customers***

Supporting Departments

Amerigroup Corporation's Provider Lifecycle Management Department focuses on the operational leadership of systems that administer our provider network and member benefits. Department experts manage provider data management and provide reimbursement and provider data quality initiatives. The Provider Lifecycle program is an enterprise-wide initiative to improve the timeliness of bringing providers into our network and the quality of the provider data in our systems.

Contract Negotiations and Network Recruiting

Staff and Contract Responsibilities

Shaneka Wiley, Nevada Health Plan Manager of Provider Services, manages and coaches Amerigroup Nevada's Provider Services team daily. Shaneka promotes provider satisfaction and provides an extensive provider network for our members. Under the Contract, Shaneka:

- ***Evaluates the provider network to ensure appropriate access for membership and develop and execute recruitment plans***
- ***Promotes positive relationships with the provider community and other Amerigroup departments***
- ***Develops and implements action plans regarding provider satisfaction***

Stephen Ford, Associate Vice President Senior Counsel, supports the health plan by providing legal expertise. In this role, Stephen:

- ***Serves as counsel for the Nevada plan***
- ***Handles intake and resolution of legal issues related to regulatory compliance, provider network development and maintenance, provider disputes, agency disputes, product development and plan extension, and risk management***
- ***Participates with merger and acquisition activity and new market development***
- ***Participates with negotiations and process improvement***
- ***Manages paralegal and administrative staff***

Supporting Departments

Amerigroup Corporation's National Provider Services Department and Provider Collaboration Team both understand the importance of working with our providers to ensure the best care for our members. National Provider Services supplies the support necessary to develop an extensive provider network that promotes positive relationships and facilitates

provider communication. The Provider Collaboration team develops and maintains programs that support providers initiatives including patient-centered medical homes; incentive, risk, and shared savings; provider information sharing; and innovative reimbursement.

Encounter Data

Staff and Contract Responsibilities

Robin Favret, Associate Vice President of Information Technology Services Customer Account Management, in addition to her role described above, supports the health plan's encounter data process. She:

- ***Systematically reviews operational performance, including service level agreements and regulatory mandated performance guarantees in order to address issues and maintain alignment with business goals***
- ***Monitors operational and system trends across the health plan to determine potential solutions to operational or system issues***

Additional Employees

Staff and Contract Responsibilities

Brandon Charles, MD, OB Medical Director, provides complimentary clinical expertise to our Medical Director. Dr. Charles works with Amerigroup Nevada leadership to promote care treatment plans that improve our members' health outcomes. Under the Contract, Dr. Charles:

- ***Promotes optimal maternal and child health outcomes***
- ***Coordinates and manages Amerigroup Nevada peer reviews, education and physician relations***

Gerald Busch, MD, Behavioral Health Medical Director, provides additional clinical support to the health plan. Dr. Busch is a board-certified psychiatrist and has the experience necessary to provide exceptional insight and guidance to improve the care of our members. Under the Contract, Dr. Busch:

- ***Assists in the management of complex behavioral health conditions***
- ***Provides leadership and guides providers in developing recovery-oriented care treatment plans for members with behavioral health diagnoses***

Nancy Kaplan, Manager of Regulatory Services, is a valuable part of the Nevada health plan. Nancy is involved with several functional areas resulting from the Contract, including state

contracts, reporting resources, regulatory tasks, collateral material, and performance standards. Under the Contract, Nancy:

- ***Researches and provides guidance to the Nevada health plan and corporate departments regarding compliance with the requirements of the Nevada managed care contract, as well as state and federal statutes and regulations***
- ***Serves as representative for the Nevada health plan and the corporate departments with state regulatory agencies***
- ***Assesses proposed and final legislation with potential impacts on business activity and operations***

Chris May, Director, Amerigroup Nevada's Compliance Officer, plays a key role in the successful management of the health plan. Chris educates the Amerigroup Nevada employees to ensure compliance with corporate and state policies. Under the Contract, Chris:

- ***Leads and assures compliance training activities***
- ***Monitors health plan performance standards for compliance with contractual and regulatory requirements***
- ***Reviews policies and procedures and health plan activities to ensure adherence to business associate requirements and physical and electronic security under HIPAA***

G.	Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.

Current Licenses and Certifications

The following documents are evidence of Amerigroup Nevada's authority to serve members and operate as proposed in Nevada; We have included copies of our current licenses and certifications in Tab IX – Other Informational Material, behind Tab VII Attachments as Attachments 5.1.10.1-1, 5.1.10.1-2, and 5.1.10.1-3.

- ***Certificate of Authority.*** ***Amerigroup Nevada maintains a license to operate as a Health Maintenance Organization (HMO) in the Service Areas of Clark and Washoe counties, issued by the Nevada Division of Insurance on March 30, 2006.***
- ***NCQA New Health Plan (NHP) Accreditation.*** ***Amerigroup Nevada currently is operating under a three-year accreditation that we received in December 2011; the accreditation is valid through December 2014.***

- *Nevada State Business License.* ***Amerigroup Nevada holds a State Business License through the Nevada Department of Taxation. The license has been maintained continuously with the State annually since its date of issue on April 26, 2006; the license is valid through August 13, 2013.***

Through our accreditation efforts, we seek to demonstrate our commitment to quality of care for all members.

H.	List any bilingual staff, the area to which they are assigned and the languages spoken.

Bilingual Employees

Amerigroup Nevada representatives reflect the cultural and linguistic needs of our members. We work with the State to provide services to unique populations, as well as a large Hispanic community, and we are proud to supply the necessary resources to accommodate our members who do not speak English as a first language.

Amerigroup Nevada has several bilingual associates. Table 5.1.10-15 lists our bilingual employees, their departments, and the language(s) spoken.

Table 5.1.10-15. Amerigroup Nevada Bilingual Employees

Name	Title - Department	Language Spoken
Lynette Glasco	Member Advocate – Quality Management Department	Spanish
Socorro Carrasco	Outreach Associate – Quality Management Department	Spanish
Eric Ortiz	Claims Resolution Analyst – Provider Relations Department	Spanish
Laura Deya-Orona	Senior Claims Resolution Analyst – Provider Relations Department	Spanish
Luzy-Ann Yanson	Quality Management Representative – Quality Management Department	Tagalog

In addition to the Amerigroup Nevada bilingual resources, Amerigroup Corporation has several translation and bilingual resources to support the health plan.

Amerigroup's National Contact Center (NCC) is well equipped to handle large volumes of calls from members who do not speak English as a first language. The National Contact Center currently has 135 employees that are fluent in both English and Spanish. In 2012, NCC employees have directly handled more than 326,000 calls for our Spanish-speaking members.

In addition to in-house resources, Amerigroup contracts with a professional over-the-phone interpreter (OPI) service vendor to provide interpretation services for languages other than Spanish. Our OPI vendor can quickly provide translators 24 hours a day, seven days a week for 170 languages, using language-appropriate, healthcare-aware translators. We train our Amerigroup employees to offer translation services whenever this service can enhance the communication between the employee and the member. Generally, within an estimated 45 seconds, we connect a healthcare-aware translator, the member, and the representative in a three-way conversation. In 2012, NCC employees have utilized our OPI translator for other languages for 124,887 calls.

Between January, 2012 and September, 2012, Amerigroup's OPI Services Vendor received 2,036 calls from Amerigroup Nevada members. While 90 percent of these calls were from members who spoke Spanish as a first language, they were able to address the minority of Amerigroup Nevada members who required Vietnamese, Korean, and Nepali translation services.

The bilingual support from Amerigroup Corporation's National Contact Center, matched with translation services provided by experienced vendors, gives Amerigroup Nevada the ability to communicate effectively with members for whom English is not a primary language.

I.	List any associations or organizations to which the organization belongs.

Associations and Organizations

Amerigroup Nevada is deeply rooted in Clark and Washoe Counties and partners with many associations and organizations that share our mission. We link with community and government agencies, as well as schools and faith-based organizations to help broaden our ability to bring social services and community support. We currently belong to the Las Vegas Chamber of Commerce, the North Las Vegas Chamber, the Reno Chamber of Commerce, the March of Dimes, and the American Heart Association.

Amerigroup Nevada CEO Eric Lloyd is a participating member of several community association boards, including:

- ***The United Way of Southern Nevada and co-chairs the Access to Healthcare committee***
- ***After-School All-Stars Board of Directors-Las Vegas***
- ***Nevada Health Insurance Exchange Board of Directors***

- ***Silver State Health Insurance Exchange (SSHIX) Finance and Sustainability Advisory Committee***
- ***HealthInsight Nevada Partnership for Value-driven Healthcare Steering Committee***

David Osman, our Marketing Manager in southern Nevada (who is also a registered nurse), also has very strong ties to the community. He has lived in the community for many years and most recently served as president of the Nevada Youth Alliance and past president of the Southern Nevada Continuity of Care Association. Because of his training and experience, he brings a unique perspective to the community and the organizations he serves.

We have participated in health fairs, walks, and countless back-to-school immunization and health fairs with our partner organizations.

We are continuing to grow our community outreach and are in the process of finalizing our school-based program in partnership with the University of Nevada School of Medicine. Our goal is to support healthy outcomes for children in Nevada and increase access to preventive care.

TESTIMONIAL

"The American Lung Association considers our colleagues at Amerigroup to be strong and loyal supporters and partners of our public health work; and we greatly value our relationship with them. Over the past several years, we have regularly turned to them for support and they have always been generous with their time, attention and resources. Financially, Amerigroup has provided funding for our children's asthma camp, and regularly provides sponsorships for our special events that raise money for our overhead and operating expenses. Amerigroup has also provided participants for our programs – for example, we have trained their quality assurance nurses to conduct "Brief Intervention" interviews with their members to determine smokers' readiness to quit and advise them on resources available to them to quit. Similarly, we have been happy to participate in Amerigroup's member and employee health fairs. Amerigroup has also provided us with letters of support, which we have submitted with applications for grant funding as we seek supporters for our goal of reducing smoking rates among Medicaid recipients."

Allison Newlon Moser,
Executive Director,
American Lung Association
in Nevada

5.1.11 Plan of Operation

The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

Medical Services (§5.1.11.1)

A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

Providing Services beyond the Required Covered Services

Services beyond those required in Section 4.2.2, Vendor Covered Services, include two categories, and we describe both determination processes below. These are:

- ***Non-covered services that are approved by the Medical Director and coordinated through the health plan because they will ultimately improve health outcomes for members or reduce the need for more costly services***
- ***Value-added services that we have incorporated into the Nevada Medicaid Managed Care benefit package to enhance overall gains in health outcomes for members.***

Facilitating Access to Non-Covered Services that Drive Gains in Health Outcomes

Amerigroup Nevada incorporates non-covered services into member care treatment plans when such services offer medically appropriate and cost-effective alternatives to covered services. Examples include extension of outpatient benefits to avert an inpatient admission or to reduce the need for future services or coverage of rehabilitation facilities if they expedite discharge from an inpatient facility when appropriate. In another example, we coordinate medically necessary services for Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) services for children enrolled in Medicaid, regardless of whether they are covered under the State plan.

Facilitating access to non-covered services when medically appropriate and cost-effective reinforces our commitment to promoting the right care in the right place at the right time for each Amerigroup member in Nevada.

We maintain clear protocols to guide review and authorization of such services. Since 2009, we've remained committed to coordinating the right care in the right place at the right time for Nevada members with a keen focus on improving quality and health outcomes.

Either a treating provider or an Amerigroup employee (such as a Case Manager or Utilization Management (UM) Nurse) may determine that non-covered services may offer the most effective treatment alternative for a member. In our experience, Case Managers, who are familiar with member needs, most frequently identify the opportunity to incorporate non-covered alternatives into a member's care treatment plan. When identified, the UM Nurse or Case Manager requests appropriate medical records and other documentation and shares them with the Medical Director.

The Medical Director then reviews the records and other supporting documentation, such as relevant clinical studies. When appropriate, the Medical Director may engage Amerigroup's National Medical Director or Chief Medical Officer to gather additional clinical expertise. The Medical Director issues a determination about non-covered services after careful consideration of the member's needs, medical necessity guidelines, and a cost-benefit analysis, documenting the decision in the claims system.

REAL STORIES

Recently Anna, a Nevada member was hospitalized with a suspected rare blood disorder. An Amerigroup UM Nurse arranged transportation for the child and her family to a California facility because Nevada hospitals lacked the testing equipment needed to properly diagnose the condition. Doctors confirmed the diagnosis and presented an experimental gene therapy as the child's best option for a positive health outcome.

Because the procedure is experimental, our Medical Director, collaborating with the treating providers throughout the testing and treatment planning phase, reviewed the supporting documentation and confirmed that gene therapy offered the best alternative. He contacted DHCFP which granted approval which was required because covered services do not include experimental procedures.

The child is currently in the hospital for the treatment. In the meantime, an Amerigroup Case Manager has developed a care treatment plan to coordinate the complex array of services required for the child and her family, obtaining necessary medications (available in only four pharmacies in the country), coordinating transportation and accommodations for the family, and linking treating providers in California with the child's PCP and other providers in Nevada to promote a safe transition back home.

Although experimental gene therapy is not a covered benefit, Amerigroup covered and coordinated the treatment because it offered the best chance for this member's optimal health outcomes.

Value-Added Services

Amerigroup has operated in Nevada for almost four years. Working closely with DHCFP, our members, providers, and community-based organizations, we have developed a keen understanding of the greatest needs of the community's various stakeholders and created innovative sustainable solutions to drive positive outcomes where results are needed most. By providing certain benefits above and beyond the required core services, we believe we can achieve lasting and measurable

improvements in the behavioral and physical health and welfare of our Nevada members.

In determining the value-added services for our members, we consider member demographics, utilization trends, benefit gaps, and the healthcare goals of the State. For example, we recognize that DHCFP has prioritized reduction of preterm birth rates in Nevada, so we have incorporated value-added services that encourage pregnant women to participate in risk screenings as well as prenatal and postpartum care. Our most recent analysis validates that:

- ***More than 81 percent of our Nevada members are under the age of 19, and the average age is 11.***
- ***Three of the 10 most frequent diagnoses are pregnancy-related, and we cover more than 4,400 births each year.***
- ***Asthma is one of the top 10 diagnoses related to inpatient admissions.***

We also consider the goals of the State, the Governor, and DHCFP when we determine potential value-added services. For example, Nevada ranks 49th in the country for adequacy of prenatal care, and our incentives to participate in Taking Care of Baby and Me® encourage pregnant women to seek care as soon as possible. We will continue to work with State leadership to share ideas and strategies to align the health plan's operations toward achievement of the Governor's Healthy Nevada goals. Our proposed services reflect a strong commitment to enhancing health outcomes for our members.

In addition, Amerigroup Nevada routinely engages with our community-based partners and stakeholders, such as our Health Education Advisory Committee, to vet ideas for value-added services, gather additional insight into potential benefit or service gaps, and solicit ideas for increasing interest in value-added services. For example, our analysis suggested that Boys and Girls Club memberships were somewhat lower than expected, so we worked with that organization to create promotional fliers and distributed them to members and providers to boost use of this important benefit.

Accordingly, we propose to offer the expanded benefits summarized in Table 5.1.11.1-1 to qualified members to enhance care, promote healthier outcomes, and increase member satisfaction. Under the new Contract, Amerigroup Nevada is proposing a number of new value-added services that have been implemented, tested, and validated in other states with similar populations. We believe that the new programs align with DHCFP's overall goals and support the Healthy Nevada initiative overall.

Table 5.1.11.1-1. Value-Added Services Foster Improved Health Outcomes for Nevada Citizens

Current Value-Added Services		
Benefit	**Value**	**Description**
Annual free sports physicals	Promotes increased participation in exercise, encouraging healthy lifestyles and reduced rates of obesity	Amerigroup Nevada covers one sports physical every twelve months for children between the ages of 6 and 18.
Memberships in Boys and Girls Clubs	Offers a safe place for children to learn and grow, encourages healthy behaviors through sports and exercise programs, encourages kids to stay in school, and builds skills to address substance abuse and domestic violence	Amerigroup Nevada covers annual membership fees for children ages 6 to 11. Members can re-enroll each year for free.
Asthma Camp for children with asthma	Promotes medically supervised activities and educational sessions in which children learn to understand and manage their condition	Amerigroup Nevada pays for one visit to Asthma Camp annually for children between the ages of 8 and 12 who have been diagnosed with severe asthma. Amerigroup will pay for eligible members to attend camp once a year for as long as they are a member.
Targeted text message reminders and free additional mobile minutes for no-cost mobile phone service	Enhances the SafeLink Phone Service Program, maximizes our ability to maintain contact with members—especially high-risk members—and offers ongoing educational opportunities through targeted text messages	Amerigroup Nevada promotes the SafeLink Phone Service Program to members, which is funded by the Universal Service Fund Lifeline program and includes a free cell phone and plans of up to 250 minutes per month at no cost. Through a partnership with Amerigroup Nevada, our members receive an additional 200 bonus lifetime minutes of cell phone time and free health information text messages from Amerigroup Nevada.
Circumcision for newborns	Improves health outcomes by reducing the risk of urinary tract infections in the first year of life and lowering the long-term risk of acquiring other sexually transmitted conditions, such as HIV, genital herpes, human papilloma virus, and syphilis	Amerigroup Nevada will cover elective circumcision for newborn boys up to one month of age.

Additional Value-Added Services Proposed for the *New* Contract		
Benefit	**Value**	**Description**
Hypoallergenic bedding	Creates healthier sleeping environments and helps reduce the rate of ED visits for members with asthma, allergies, or any chronic respiratory or pulmonary diagnosis	Amerigroup Nevada will offer up to $100 toward the purchase of hypoallergenic bedding such as pillowcases, box spring covers, mattress covers, and blankets for members with asthma, allergies, or any chronic respiratory or pulmonary diagnosis. Amerigroup Nevada's Case Manager will authorize and order the bedding on behalf of the member in the appropriate bed size. This benefit is a one-time lifetime benefit.
Career Development Educational DVDs	Enhances our members' ability to achieve sustainable employment in the state with the highest unemployment rate in the country	Providing members with career development tools will improve member engagement in their own professional development. Improvements in education and professional development have been linked to improved sense of purpose, life outlook, and mental and physical well-being. To help members better understand and cultivate their interests, strengths, skills, and attitudes and to become more effective in the workplace, Amerigroup Nevada offers members ages 18 and older a free 4-pack of career development educational DVDs. Topics include education on basic developments in career-building skills such as personal finance, interview preparation, cover letters, and resume writing. T his benefit is a one-time lifetime benefit.

Amerigroup Nevada is committed to coordinating the array of benefits and services necessary to achieve DHCFP's goal for improved health outcomes for Medicaid and Nevada Check Up participants. We are confident that facilitating access to non-covered services when appropriate and delivering value-added services that complement covered services supports that goal. Our determination processes for both types of services encourage improved health outcomes for members and cost-effectiveness for DHCFP.

B.	Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.

Determining Medical Necessity of Service Authorization Requests

Amerigroup Nevada leverages both Nevada-specific and nationally recognized guidelines to determine the medical necessity of service authorization requests. We also maintain efficient procedures to streamline program administration for providers. Our process for medical review of claims promotes prompt evaluation of claims pended for medical necessity determination. Each of these is described in detail below.

THE SSHIX CONNECTION

Amerigroup will apply consistent medical necessity guidelines to develop a Transition Plan for our MCO Transition QHP members with ongoing treatment needs.

Amerigroup Nevada's UM efforts engage providers in productive dialogue regarding authorization of behavioral health and physical health services to promote access to the level of care that will drive the best health outcomes. We use UM to creatively address our members' health challenges rather than using it as a mechanism for authorization or denial of requested service.

Clinical Guidelines Promote Clinical Integrity in Decision-making

As a participant in Nevada's Medicaid Managed Care program since 2009, Amerigroup Nevada has fully integrated our clinical criteria for medical necessity and service utilization requests with DHCFP's Medicaid Services Manual (MSM). MSM criteria, which define medical necessity for Medicaid and Nevada Check Up, are augmented by nationally recognized clinical criteria to guide our UM decisions.

Amerigroup has fully integrated the Nevada Medicaid Service Manual guidelines into our operations, including our system.

Our primary guidelines for medical necessity are those outlined in the MSM. All Amerigroup employees who conduct UM for Nevada members have undergone extensive training on the application of the MSM criteria, and we have incorporated the criteria into our system to support efficiency and consistency. The system facilitates primary use of the MSM criteria in UM decisions in Nevada. We work closely with DHCFP to accurately integrate the MSM criteria, guidelines, and procedures into our operations, and our Medical Director regularly interacts with DHCFP employees to clarify and refine MSM requirements. This collaborative relationship fosters accuracy in applying MSM guidelines, which benefits members and providers.

Augmenting the MSM, Amerigroup will use InterQual® Level of Care and Behavioral Health guidelines as well as Aetna's Clinical Policy Bulletins to review medical necessity and appropriateness of health services. These objective criteria and guidelines are industry standard for medical necessity review and widely used by health plans, hospitals, and government agencies. They provide a rules-based system for screening proposed medical care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

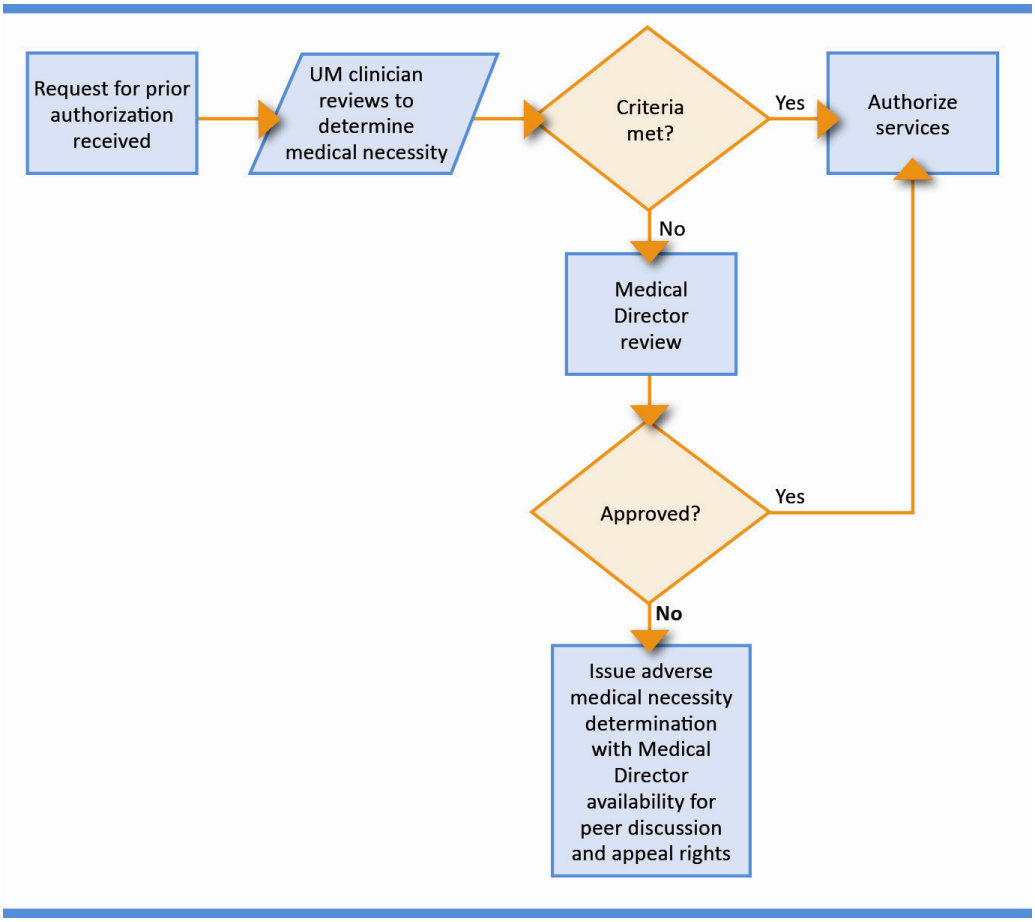
The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities as well as episode-specific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

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

Streamlined Procedures Foster Provider Convenience

Figure 5.1.11.1-1 depicts Amerigroup Nevada's service authorization process, and our response describes it in more detail.

Figure 5.1.11.1-1. Amerigroup Nevada's Streamlined, Provider-Friendly Authorization Process



Efficiency, accountability, and results drive our UM program design and operations. Amerigroup Nevada identifies and implements industry best practices to positively impact our members, providers, and customers. Our Business Improvement team, in partnership with Amerigroup's clinical leadership, implemented UM operational refinements after almost a year of detailed analysis of processes across all health plans. The result is a finely tuned UM program that blends clinical integrity with operational efficiency and customer compliance, demonstrating our strong commitment to accountability for DHCFP's budget dollars.

Our UM process is modeled after NCQA standards and compliant with DHCFP requirements. We maintain a user-friendly and efficient alternative to frequently cumbersome, time-consuming, and labor-intensive UM processes. Our process eliminates the need for providers to mail or fax hard copy forms and does not require pre-authorization for all covered services. Our process saves valuable time for providers and members and is cost-effective for DHCFP. It is also scalable for growth and flexible to meet Nevada requirements while producing measurable outcomes. Providers may submit authorization requests online, by fax, or by phone. In addition, in 2013 we will launch a real-time, online automated approval process

based on specific business rules, offering an additional convenient resource for providers. Our voice portal technology and provider website are available 24 hours a day/7 days a week to assist providers with questions and concerns. Using these tools, a provider can conveniently check the status of an authorization at any time.

With a continued focus on customer service, we achieve high performance levels in delivering UM services in Nevada, as illustrated in Table 5.1.11.1-2.

Table 5.1.11.1-2. Excellence in Customer Service for Provider Calls, including UM Calls Services in 2012 (January through September)

Amerigroup Performance Goal	Goal	2012 Performance
Average speed of answer	30 seconds	12 seconds ***Exceeded goal by 60%***
Abandonment rate	<5%	0.75% ***Exceeded goal by 85%***
Overall service level	>80%	91% ***Exceeded goal by 14%***

Amerigroup Nevada has demonstrated excellent results in promptly handling UM calls for all types of services. In 2011 and in 2012 year-to-date, we have met DHCFP performance standards for a UM turnaround time within 14 days.

Our Nevada employees, with clinical and administrative experience in behavioral and physical healthcare and detailed knowledge of available community resources, are available to assist providers in the authorization of services that require additional information or consultative services and provide a high level of local knowledge to providers. This expertise makes the authorization process more efficient and can help to ensure that members are receiving the services they require. Additionally, providers can connect with local Amerigroup Nevada employees for ongoing review of higher-level services.

TESTIMONIAL

"Our two companies have resolved all claims issues that hindered our business relationship in the beginning and now have a very cohesive working relationship. They are a professional company and conduct themselves in an excellent manner."

Howard Dorsky
System Director
The Valley Health System
Consolidated Business Office

In addition, we actively engage with our Nevada providers to identify and resolve any service issues or concerns, further strengthening trusting relationships throughout the provider community. For example, each quarter, our Provider Relations and Health Services employees conduct Joint Operations Committee meetings with large-volume hospitals in which we discuss facility-specific

provider issues or unusual utilization trends, focusing on identifying root causes and brainstorming solutions. Implementing these Joint Operations Committee meetings allowed us to create a formal forum for communicating about issues. For example, when Valley Health System issued a termination notice for Amerigroup Nevada, we partnered with them to identify the issues and implemented formal action plans to resolve those issues promptly. We also instituted an issue resolution process for rapid resolution of future issues or concerns. Valley Health System was pleased with our commitment and rescinded the termination notice. We are proud that we now have a strong working partnership with all Valley facilities.

Pre-service (Prospective) Review Decisions

Amerigroup Nevada requires pre-certification on selected services to ensure timeliness and appropriateness of care, including:

- ***Planned inpatient admissions***
- ***Certain outpatient surgeries, procedures, and services and programs***
- ***Non-emergent, out-of-network services (with the exception of covered EPSDT, family planning, and women's preventive health services)***
- ***Home health services***
- ***Certain durable medical equipment***
- ***Rehabilitation services (physical therapy, occupational therapy, speech therapy)***
- ***Certain medications***
- ***High cost radiology procedures***
- ***Certain diagnostic procedures***

On our provider website, we publish a list of services requiring pre-certification, facilitating convenient access for providers and their staff. At a glance, they can ascertain which services require pre-certification, expediting the process and keeping it as transparent as possible.

Amerigroup Nevada UM Nurses (licensed clinicians) located in Nevada and in our call center perform our pre-certification. Amerigroup Nevada UM Nurses are Nevada-licensed professionals with training and experience in UM for the members they serve and are familiar with the providers, services, and members in Nevada, including the diverse cultural groups to which they belong. UM clinicians assigned to pre-certify behavioral health services have experience with this type of care and can offer their expertise in consultation to providers.

Amerigroup UM Nurses in our call center are licensed professionals in the state in which they practice. They receive extensive training and are familiar with the local provider network, services, and needs of the Nevada membership. These clinicians verify eligibility and benefits in the claim payment system and apply the Nevada-specific guidelines to determine medical necessity. UM Nurses approve services for situations that meet medical necessity.

When medical necessity is in question, the UM clinician will refer the case to one of the Medical Directors for review. The Medical Director performs a review against the appropriate criteria. Often the Medical Director will request additional information from the treating provider to support clinical decision-making. Based on the information available and the Medical Director's clinical judgment, he makes a determination and documents the results of the medical necessity review. A peer-to-peer review may also take place at this time. We notify providers about the availability of the Amerigroup Nevada Medical Director (or appropriate practitioner reviewer) and how to make contact to discuss any UM denial decisions. Notification also includes information regarding how to submit appeals of UM decisions.

Concurrent Review Decisions and Innovative Inpatient Support Strategies

In performing concurrent review, our clinicians assess member progress and needs during the episode of care. They coordinate such needs before discharge to help facilitate a smooth transition for the member between levels of care or home and to avoid delays in discharge due to unanticipated care needs.

If a stay does not meet standard criteria, the Medical Director or designee reviews the case and makes the determination. Upon notification of an admission, the appropriate Amerigroup Nevada UM Nurse obtains as much clinical information as possible to review. We make these decisions in accordance with currently accepted medical or healthcare practices, accounting for special circumstances that require deviation from the norm.

Upon discharge of the member, the UM Nurse enters documentation in the authorization database following Amerigroup Nevada documentation guidelines. If at any time we identify a potential quality issue, we make an appropriate referral to the QM Department.

Amerigroup works with hospitalists who monitor and organize care for all adult members admitted to a hospital for non-obstetrical services.

To enhance our ability to promote optimal outcomes for members in the hospital, Amerigroup Nevada UM Nurses coordinate with Amerigroup Nevada-contracted hospitalists at all network hospitals in southern Nevada. These individuals monitor and organize care and services for all adult, non-obstetrical admissions. Throughout a member's stay, the hospitalist and UM Nurse regularly communicate to verify that a clear and clinically appropriate treatment plan is in place and to coordinate discharge

planning that centers on a safe transition home for each member. Reinforcing the importance of the medical home, our hospitalists deliver admission and discharge summaries to each member's PCP. This hands-on approach facilitates an appropriate inpatient length of stay and a safe transition from the hospital to enhance each member's experience.

We also adapt our protocols to address the specific issues that drive inpatient utilization for members. For example, asthma is one of the top 10 diagnoses for Amerigroup Nevada inpatient admissions. As part of discharge planning for members admitted with asthma-related conditions, UM Nurses in Nevada work with treating physicians to coordinate provision of a peak flow meter to each member while they are in the hospital. The UM Nurse also works with the treating provider to coordinate a visit by a respiratory therapist who meets with the member and family, as appropriate, to educate them about proper use of the device and how to best manage their condition, promoting improved self-care that reduces the risk of future admissions.

Post-service (Retrospective) Review Decisions

A post-service or retrospective review evaluates a service authorization request for care or services that have already been rendered by the provider. Amerigroup Nevada follows established procedures and timelines for retrospective review based on individual member medical necessity; inpatient or outpatient status; elective, urgent, or emergent status; timeliness of the request or notification; and precertification requirements.

Structured Processes for Medical Review of Claims Promote Program Integrity

Amerigroup Nevada continues to verify the clinical appropriateness of services delivered to members through automated claims edits, which detect potential authorization conflicts or coding irregularities that may suggest inappropriate services. We describe our processes for two types of medical claim reviews below.

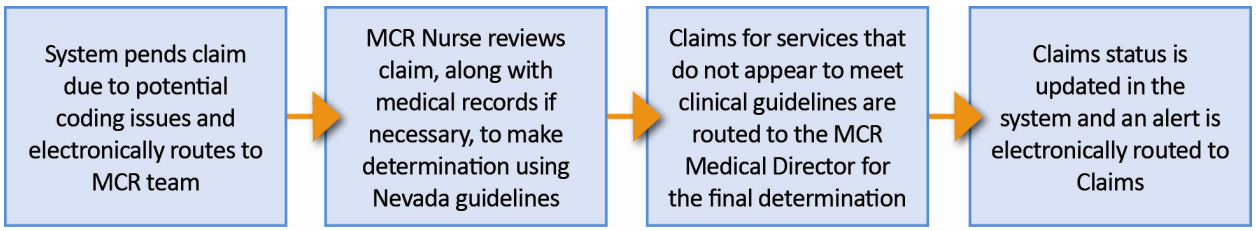
Our claims system may pend claims for medical review because authorization and claims data conflicts or appears incorrect. For example, the system pends claims that appear to have mismatched authorizations, a number of billed visits that exceeds the authorization, or claims coding inconsistent with the authorization (such as an authorization for home health visits by an LPN and claim coded to indicate RN visits). Our protocols support prompt resolution of such claims, and we illustrate our resolution process in Figure 5.1.11.1-2.

Figure 5.1.11.1-2. Efficient Resolution of Claims Pended for Review of Authorizations

Amerigroup also maintains a Medical Claims Review (MCR) team under our Reimbursement Policy Management (RPM) department, which evaluates the medical necessity of claims that are pended due to potential coding issues. The team includes Registered Nurses who are also certified professional coders, balancing their clinical and coding expertise to uphold optimal decision making.

Examples of claims that may be pended include claims that are coded with modifiers to denote additional practitioner time, unbundling of procedures that are usually billed as one procedure, or repeat procedures by different providers on the same day. The MCR Nurse reviews the claims information, requesting medical records when necessary, and determines a medical necessity determination based on our clinical guidelines. Figure 5.1.11.1-3 illustrates the process for the MCR team.

Figure 5.1.11.1-3. Medical Claims Review Verifies that Claims are Consistent with Clinical Guidelines



To address the root causes of inappropriate billing and coding, our Provider Billing Integrity team within RPM identifies and reaches out to providers with aberrant billing patterns to educate them about correct billing practices and to monitor targeted providers until their billing patterns return to a consistently normal level. This promotes good customer service with our providers by establishing clear expectations and also underscores our commitment to being a responsible steward of DHCFP funds.

C.	Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.

Monitoring and Evaluating Medical Necessity Guidelines and Procedures

Amerigroup maintains processes to monitor and evaluate our guidelines and procedures to determine the medical necessity of service authorization requests, which are described below. These include:

- ***Formal review of the medical necessity criteria and guidelines at least annually or more frequently if new criteria are published prior to the annual review date***
- ***Annual inter-rater reliability (IRR) reviews that evaluate the consistency and accuracy of UM decisions***

Annual Review Verifies Clinical Appropriateness of Guidelines

Amerigroup's Medical Policy Committee serves as the official medical/clinical policy-making body and leads the development of clinical standards or the evaluation and approval of nationally recognized standards. Each year, the MPC reviews and approves all medical necessity criteria and guidelines and updates them when appropriate. The MPC may review the criteria more frequently if a new version of the criteria is published before the annual review date, such as updates to the MSM. The MPC identifies:

- ***Regulatory and contractual barriers to implementation***
- ***Concerns regarding the medical accuracy, validity, or scope of the criteria***
- ***Statewide or supplemental guidelines that may be used for medical necessity determination when the nationally adopted criteria do not address pertinent issues***
- ***The need for an Ad Hoc committee to provide professional knowledge or clinical expertise on the development or adoption of criteria***

Local Nevada providers review and approve clinical guidelines through our Medical Advisory Committee.

Locally, the Nevada Medical Advisory Committee (MAC), part of the Quality Management governance structure, serves as an ongoing forum for provider feedback regarding our policies and procedures governing UM, including medical necessity criteria and guidelines. Once the MPC approves medical necessity guidelines, the MAC reviews them, requests changes, and approves them. To date, the Nevada MAC has not requested any changes to medical necessity guidelines approved by the MPC.

The Nevada MAC, under the leadership of our Medical Director, currently includes two pediatricians, two obstetricians, two family practitioners, and a behavioral health practitioner. MAC participants include providers from both Clark and Washoe counties and reflect the cultural diversity of our members. In addition, two participants currently serve as leads in our Real Solutions® Medical Home program. In the event that DHCFP expands the Medicaid MCO program to include the Medical Assistance for Aged Blind and Disabled (MAABD) population or dual eligibles, we will adjust MAC participation to reflect participation from providers who are most vital to those members, such as geriatricians.

Inter-Rater Reliability Reviews Monitor Consistency in Guidelines Use

We annually evaluate the consistency with which healthcare professionals apply medical necessity criteria in decision-making by assessing physician and non-physician reviewers' application of medical necessity criteria. All licensed clinical UM staff who apply medical necessity criteria participate in the IRR evaluation process.

The goals of our IRR program are to:

- *Measure knowledge of criteria*
- *Minimize variation in the application of criteria*
- *Enhance employee recognition of potentially avoidable or inappropriate utilization*
- *Identify employees who need additional training*
- *Identify potential risks resulting from inconsistent application of guidelines*

Upon completion of the IRR assessment, we review the results and take corrective actions as indicated. For those UM employees whose scores fall below the threshold, the Clinical Operations team institutes individual action plans that include specific remedial tasks such as individual counseling by the employee's manager, formal retraining on criteria, or retesting through the IRR audit as well as a timeline for these activities.

Our 2012 IRR assessment, the most recent available, validated that 100 percent of IRR scores for the Nevada health plan exceeded our compliance threshold. No follow up action was indicated by the audit.

All Nevada UM staff exceeded the 80 percent compliance threshold in 2012.

We report our IRR results to the Nevada Quality Management Committee, the Amerigroup Quality Improvement Council, and other relevant stakeholders. The IRR report incorporates action plans that address opportunities for improvement.

D.	Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.

Providing, Monitoring, and Coordinating Out-of-Network Services

Amerigroup Nevada is committed to facilitating access to medically appropriate care for our members. Clear protocols that meet all DHCFP requirements guide handling of cases in which out-of-network services are necessary. Our comprehensive Nevada provider network offers an array of accessible and convenient options for members. Due to limited availability of some specialties within Nevada, including pediatric subspecialty providers and transplant services, as well as limited provider capacity in parts of Washoe County, Amerigroup Nevada has refined our procedures to foster timely access to non-network providers so that our members can access the full range of services quickly, regardless of network capacity.

When an Amerigroup Nevada network provider is not available to meet a member's non-emergency needs, we refer that member to an out-of-network provider through a single case agreement. All members can access medically necessary emergency care at any provider regardless of the provider's participation in our network.

Our UM Nurses verify member eligibility upon receipt of a request for authorization for non-emergent services from a PCP or an out-of-network provider. We also verify provider licensure and confirm that the provider does not appear on any governmental exclusion lists. If sanctions exist or if we identify an issue regarding appropriate licensure, we inform the requestor that we cannot approve the out-of-network service, and we locate an alternative provider.

Upon verification of eligibility, licensure, and lack of sanctions, UM Nurses forward the case to our Out-of-Network Coordination Nurse, part of the UM team, to review and discuss with our Medical Director. We have designated the Out-of-Network Coordination Nurse as the single point of contact for this role to foster consistency in single case agreement processing, streamline and expedite the process, and encourage relationship-building with non-network office employees to ease the process.

Negotiating and Executing Single Case Agreements

If the Medical Director deems that the non-emergent service from the out-of-network provider is medically necessary, we negotiate and execute a single case agreement. We take the following actions:

- ***We approve the authorization for services by an out-of-network provider and update the case in the system. If the course of treatment will require services over an extended***

period, the treating provider includes this information in the initial request for authorization. If approved, we may extend the authorization for a longer period.

- *Our Out-of-Network Coordination Nurse negotiates a single case agreement with the provider that specifies provider payment as well as prior authorization and case management requirements.*
- *During the initial contact with the out-of-network provider, our Out-of-Network Coordination Nurse may encourage the provider to join our provider network.*

To ensure timeliness of single case agreements, our Out-of-Network Coordination Nurse daily reviews reports that track aging of open cases to set priorities and focuses on those that require immediate action. The nurse also reviews system-generated logs to identify and resolve potential barriers to timely case closure. Finally, we monitor data in weekly or monthly reports to identify trends that might indicate problems with current processes or workload distribution.

In our experience, out-of-network referrals are most common for pediatric subspecialty services which are not available within the State of Nevada and for members seeking services in rural and remote areas of Washoe County that have limited provider capacity. Existing providers in those areas have been unwilling to join the network because their practices are often at capacity. Amerigroup Nevada's Provider Relations employees in Reno and our Out-of-Network Coordination Nurse have cultivated strong relationships with office employees at these practices that enable us to rapidly coordinate single case agreements when necessary. Provider office employees are already familiar with our agreements, case management practices, and claims submission protocols, expediting execution of single case agreements and member appointment availability.

Established relationships with non-network providers facilitate rapid execution of single case agreements and expedite access to care in members in under-served areas of Nevada.

In addition, our Out-of-Network Coordination Nurse maintains relationships with out-of-state hospitals, including several of the Children's Hospitals in California and several large hospital systems that serve as Centers of Excellence, such as UCLA. This facilitates access to services not available within Nevada, such as most transplants. These relationships enable prompt access to such services for members.

Monitoring Services Provided by Out-of-Network Providers

Our multi-faceted approach to monitoring providers, both network and out-of-network, includes:

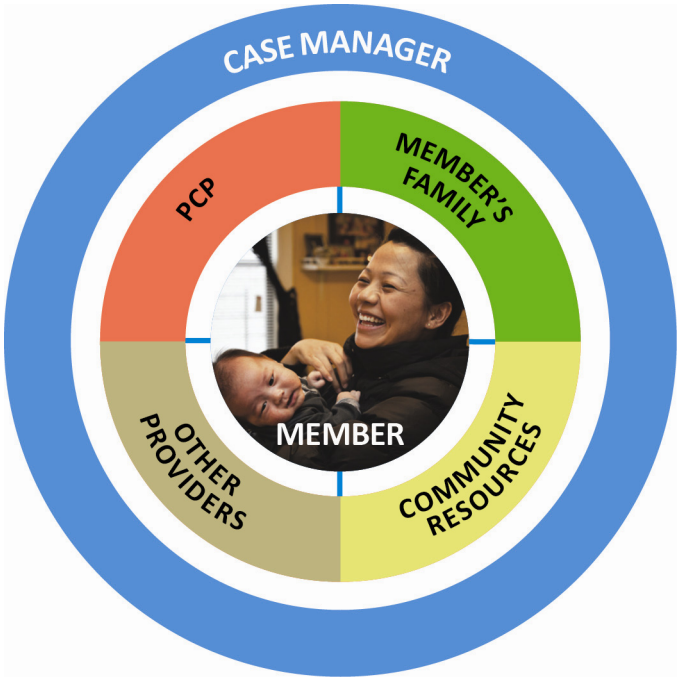
- ***Monitoring of services by UM Nurses and Case Managers, to which we educate out-of-network providers through the single case agreement, to verify that care is appropriate and meets medical necessity criteria and guidelines***
- ***Monitoring and investigating any potential quality of care concerns through Quality Management***
- ***Automated claims processes that verify that submitted claims reflect the authorized services***
- ***Medical review process through which Registered Nurses, who are also certified professional coders, review claims with potential coding irregularities to validate the medical necessity of billed services***

E.	Describe the roll and responsibilities of your case managers.

Role and Responsibilities of Case Managers

All Case Managers coordinate care with each member's PCP and treating providers, assist members in accessing community-based resources, provide disease-specific education, and facilitate a broad range of interventions designed to improve the quality of life and functional abilities of members and to make more efficient use of limited healthcare and community-based resources. Case Managers function as patient advocates and work with members and providers to identify member and family goals and design and achieve personalized care treatment plans that address identified problems, challenges, barriers, and goals. (Figure 5.1.11.1-4)

Figure 5.1.11.1-4. Case Managers Coordinate Member-centric Care and Services among All Providers and Stakeholders



All Case Managers are responsible for:

- ***Conducting thorough member assessments (guided by online tools in our care management system) that identify each individual's physical,***

behavioral, social support, and functional needs

- ***Gathering information on member preferences, goals, and priorities, including race and ethnicity and how these factors influence the member's preferences***
- ***Reinforcing the medical home for each member by engaging the PCP and other treating providers, including behavioral health practitioners, as necessary to gather information and input into the care treatment plan***
- ***Developing comprehensive care treatment plans that align with PCP and other treating provider recommendations, member and family goals; address all conditions (consistent with evidence-based clinical practice guidelines when available); include member and family health education and coaching (such as our smoking cessation and healthy behavior and fitness coaching programs for adults and pre-teens, respectively); and incorporate age- and gender-specific primary and preventive care***
- ***Coordinating non-covered services available through community agencies and supports to foster optimal health outcomes, such as connecting members with food pantries, faith-based support programs, and other services***
- ***Coordinating communication among treating providers, including the PCP and any behavioral health providers, to foster continuity and minimize fragmentation of care***
- ***Monitoring each member's progress in relation to his or her care treatment plan and coaching and supporting members as necessary to remain on track toward improved health***
- ***Assisting members during transitions between care settings, such as returning home after a hospital admission, to verify that members have scheduled follow-up appointments, reconcile medication lists, and educate members and family about red flags that should trigger a call to their PCPs***

Our Case Managers explore each member and family's capabilities with respect to readiness to change, values, and the capacity to take responsibility for change to develop an achievable set of goals.

Amerigroup Nevada Case Managers include Nevada health plan clinicians who provide support and assistance for members with complex needs. Our local team comprises Nevada-licensed professionals who work closely with members, families, PCPs, other providers, and community-based organizations to coordinate care and services for our current Medicaid MCO members. Our team also includes a social worker who supports Case Managers by developing relationships with community organizations, government agencies, and other social support service providers throughout Clark and Washoe counties. These relationships strengthen our Case Managers' ability to incorporate non-covered services and social supports into each

member's care treatment plan. Our most frequently accessed agencies include Family TIES, Family Resource Centers, and the Nurse Family Partnership.

Complementing our local team is a team of Nevada-designated Disease Management (DM) Case Managers in our Integrated DM Center, which leads all DM efforts for all Amerigroup health plans, promoting consistency, expert service delivery, and quality. Supervised by our National Medical Director, our DM team consists of licensed nurses and social workers that we assign to state-specific teams to build familiarity with local programs and resources to incorporate into support for each individual member.

As the Health Insurance Exchange (HIX) launches, Case Managers will also support members with complex needs through transitions between programs to promote continuity of care and services. This includes developing a formal transition plan for members when appropriate and identifying any potential gaps in benefits as the member transitions between the Medicaid MCO and a Qualified Health Plan on the HIX.

THE SSHIX CONNECTION

Amerigroup will assign Transition Case Managers to members moving into our MCO Transition QHP to evaluate and address continuity of care issues.

Amerigroup Nevada's case management program focuses squarely on the member. That is, in a truly member-directed approach, our case management team assesses each individual to gauge their willingness to change and identify their individual preferences and values and tailors a plan that includes achievable goals for that individual. Further, our Case Managers apply motivational interviewing techniques to engage members. Through motivational interviewing, Case Managers establish relationships with members, solicit their involvement in the case management planning process, and keep them focused on making the changes necessary to achieve sustainable health gains. Motivational interviewing is a member-centered, directive method for facilitating change by helping people to explore and work through ambivalence.

Specialized Expertise

The expertise of our local Case Management team directly reflects the specific needs of the members we serve. We have clinicians who specialize in obstetrics, pediatrics and adults, and behavioral health. As the Medicaid Managed Care program expands to include other populations, such as seniors and people with disabilities, our team will expand to reflect a commensurate range of expertise.

For example, should DHCFP opt to enroll individuals in the juvenile justice system or those in foster care in the MCO, we will adapt our expertise to reflect the unique needs of these populations. Amerigroup serves similar populations in other states and we are experienced at the unique challenges serving this population. For example, both groups experience elevated prevalence of significant behavioral health conditions and multiple co-morbid physical health diagnoses. Children in foster care are prescribed psychotropic medications at a rate far higher than other youth populations and also experience more fragmented care and require coordination with numerous state agencies. Youth in juvenile justice have higher rates of substance use and require extensive social supports. For both populations, Amerigroup will apply our lessons learned in other states to orchestrate effective case management.

OB Case Managers

Our OB Case Managers focus on assisting members with high-risk pregnancies, supporting them throughout their pregnancies to promote healthier mothers and healthy newborn Nevadans, which benefits our members and the State. OB cases historically represent more than half of members enrolled in case management. OB Case Managers interact with and engage our OB Medical Director when appropriate to collaboratively work with the member and her treating providers to promote a healthy outcome.

Behavioral Health Case Managers

Our Behavioral Health Case Manager spends a substantial amount of time in the community. Families of Severely Emotionally Disturbed (SED) children often benefit from hands-on assistance and support. While Seriously Mentally Ill (SMI) adults experience the typical challenges of low-income members such as lack of or intermittent phone access and changes in

REAL STORIES

Sylvia is a 24-year-old Amerigroup member with a history that includes a liver transplant at age 11 and a previous high-risk pregnancy due to her transplant. Her first baby was premature and small for her gestational age.

Tawana, Sylvia's Amerigroup OB Case Manager, had difficulty engaging Sylvia. The coordinator for the liver transplant team in California was not connecting Sylvia with the care and services she needed, and Sylvia was not compliant with prenatal care and lacked trust. Tawana slowly gained her trust by demonstrating reliability and accessibility and confirming that Sylvia had what she needed. Tawana arranged transportation and communicated with Sylvia regularly. Tawana connected Sylvia with an out-of-state liver transplant specialist who maintained part-time hours in the Las Vegas area.

By coordinating care, sharing information, and providing regular progress reports among Sylvia's obstetrician, California-based transplant team, and the local specialist, Tawana kept Sylvia on track with her prenatal care while reducing her risks associated with the transplant. In addition to having a full-term healthy baby, Sylvia is now on the path to sustained healthy living which is vital to her own long-term health and the well-being of her children. Tawana, in collaboration with our social worker, continues to support Sylvia to verify that her and her baby's postpartum needs are met.

living situations, they also experience increased episodes of homelessness, challenges in providing accurate information due to illness-caused cognitive difficulties, and reluctance to engage in treatment or treatment programs due to lack of insight into the illness and symptoms of the illness itself. As a result, our Behavioral Health Case Manager visits members with complex needs in their communities when necessary and meets directly with providers when necessary to promote greater success.

Pediatric and Adult Case Managers

Pediatric/Adult Case Managers focus on non-obstetric case management for children and adults. They are skilled at linking together the disparate resources that are available to Nevada families. For example, Case Managers coordinate follow-up services necessary for a child discharged from the newborn intensive care unit (NICU) to home, including private-duty nursing when clinically appropriate. In a 2010 study, members (across Amerigroup health plans) enrolled in case management for 90 days or more demonstrated a 39 percent reduction in non-emergent ED visits.

39%
reduction in non-emergent ED visits by managed members.

Escalating Complex Cases

Case Managers are also responsible for escalating complex cases for review by the health plan's multidisciplinary team. The health plan conducts complex case rounds in which our physical, behavioral, and OB Medical Directors lead a multidisciplinary team of nurses, behavioral health clinicians, and social workers to strategize on meeting the holistic needs of members with complicated co-morbid needs. For example, in support of a member with uncontrolled diabetes who is being discharged from a behavioral health facility, the team would collaborate on an appropriate care treatment plan that brings diabetes under control while concurrently promoting sustained recovery for the behavioral health condition.

Additionally, when clinical rounds suggest that the member's care treatment plan may benefit, a Medical Director may call the treating providers to discuss referral or care coordination strategies. This outreach, which is well-received by providers, ensures that cases in which members have complex medical and behavioral health components have appropriate clinical oversight.

Innovative Training Enhances the Effectiveness of Case Managers

Amerigroup has invested significantly in developing unique skills required for Case Managers to optimize their effectiveness. Because co-morbid behavioral and physical health challenges are common within Medicaid populations (including 35 percent of members with the highest risk levels in Nevada), Amerigroup developed an innovative Case Management Certification

REAL SOLUTIONS *mean* **REAL RESULTS**

Our formal Case Management Certification program equips our employees with the skills and expertise necessary to manage complex co-morbid cases.

program that ensures that all Case Managers master the core competencies required to address the diverse physical, behavioral, and social support needs of each individual and the skill to facilitate communication among their providers. This skill set will be of even greater value should DHCFP opt to expand Medicaid Managed Care to include the MAABD, juvenile justice, and foster care populations whose enrollees tend to have more intensive needs and a greater prevalence of co-morbid conditions.

Over a period of several months, Amerigroup conducts formal training and confirms that all Case Managers meet measurable competency standards. The structured course curriculum includes a series of training modules that educate Case Managers across any array of topics, including:

- ***Evidence-based best practices for managing specific disease conditions, both medical and behavioral***
- ***Care coordination skills such as motivational interviewing strategies or coaching members to build self-care and medication-adherence strengths***
- ***Technology tools and resources that are available to support the Case Management process***

All Case Managers must demonstrate competence in managing co-occurring physical, behavioral, and social issues. We test their skills annually. The training is accredited for continuing education credits from several organizations, including The National Association of Social Workers, the Commission for Certified Case Managers, and the American Nurses Credentialing Center's Commission on Accreditation.

Furthermore, Amerigroup is strengthening our Case Managers' skills to support transformation in the lives of our members with mental illness through recovery. We have implemented an intensive two-day training for our Behavioral Health Case Managers. The training centers on teaching and practicing techniques to collaborate with members with SMI to create recovery-oriented care treatment plans that build on each individual's strengths and foster self-determination. It also includes exercises to boost Case Managers' coaching skills to promote sustained recovery. This training program teaches techniques and provides a theoretical background that links members with the skills and services they need to keep them on their recovery path. Our Behavioral Health team serving Nevada members will participate in this training, enhancing our service to members with behavioral health diagnoses.

F.	Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.

Working with DHCFP's DO Care Coordination Staff on Behalf of High Risk Pregnant Women

As a Medicaid and Nevada Check Up MCO for almost four years, Amerigroup Nevada is familiar with DHCFP's District Offices (DOs) in Clark and Washoe Counties. During the course of our current Contract, DHCFP removed the requirement that MCOs coordinate with their DOs, so our OB Case Managers have directly coordinated non-covered services and community education and supports for women with high risk pregnancies. Under the new Contract, Amerigroup is fully prepared to coordinate with the DOs to ensure that a full array of supports and services are provided to high risk pregnant women. Well-choreographed interaction with the DOs will encourage optimal health outcomes for members, minimize fragmentation of services, and promote cost efficiency for the State.

Our plan to coordinate and communicate includes:

- ***Orientation meetings with all DO supervisory and care coordination staff in Clark and Washoe counties led by our Nevada clinical leadership***
- ***Documentation of care coordination protocols that outline criteria that trigger care coordination activities, the responsibilities of each entity, the methodologies for coordinating activities (such as telephone calls and e-mails), and the frequency of coordination and information sharing***
- ***Development of a comprehensive resource list of non-covered services, carved-out services, and community health information to be shared with our case management team and DO care coordination staff to promote consistency between the two programs***

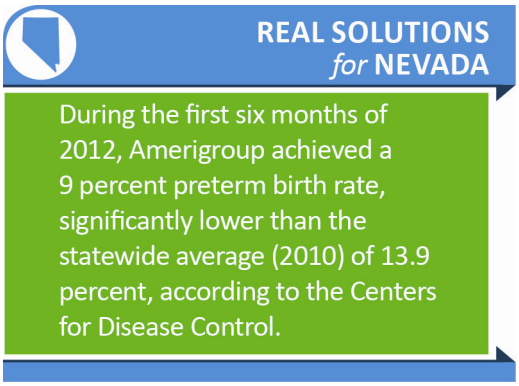
Promoting continuous quality improvement, Amerigroup Nevada's clinical leadership will contact each DO's supervisory staff regularly to assess performance, identify opportunities for improvement, and strategize on solutions to enhance the value we provide to members and to the State. This includes a review of case referral processes, communication protocols, and operational processes.

Under our current Contract, Amerigroup Nevada's OB Case Managers have been effective at screening for risk and coordinating care and services that are commensurate with each individual's risk level and physical, behavioral, and social support needs. This includes coordination of non-covered services that may be available through community or faith-based organizations to complement services available through the health plan. Under the new Contract, they will identify and work directly with DO care coordination staff as required by

DHCFP for each member with a high risk pregnancy. Below, we describe our specialized case management program, Taking Care of Baby and Me®.

An Award-winning Program for Women with High Risk Pregnancies

Amerigroup Nevada has achieved a preterm birth rate that is well below the Nevada statewide average through proactive care coordination for our members who are pregnant. Taking Care of Baby and Me builds an array of services for the pregnant woman and her newborn to provide the best opportunity to have a healthy baby and to be a successful mom. From identification through the birth of the child and the postpartum period, Amerigroup Nevada supports the patient in each major stage, helping her achieve a healthy outcome. We address each case individually, one mom at a time, using innovative and proven strategies to identify, assess, inform, engage, and support our members.



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

Through Taking Care of Baby and Me, Amerigroup Nevada identifies our pregnant members as early as possible, either as noted on the eligibility file or confirmed during the initial member welcome call, and refers them to a specialized OB Case Manager who conducts a thorough clinical assessment to determine her risk level and develops individualized care treatment plans that correspond to each patient's risk level, including linkage to our smoking cessation program for individual counseling, coaching to quit, cessation planning and support, and follow-up..

In addition, Amerigroup Nevada's case management team includes a social worker who cultivates relationships with community agencies and social services organizations throughout the service area and maintains a referral guide for Case Managers. The social worker has established strong partnerships with many agencies that provide support for pregnant women, including women with high-risk pregnancies. These include:

- ***Nevada Supplemental Nutrition Program for Women, Infants & Children.***
- ***Nurse Family Partnership of Nevada, which provides support, including weekly home visits, for first-time moms and their babies through pregnancy and the first two years of life, particularly valuable for our teen moms.***

- ***Women's Resource Centers, which provide care seats, diapers, and formula, promoting security and safety for infants.***
- ***Baby's Bounty, which fosters a healthy start and safe sleeping for babies by providing new car seats, Pack 'n Play, and other supplies to help moms. Our social worker personally delivers these items to new moms, offering an opportunity to assess the home environment and identify other needs.***

G.	Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?

Assessing Enrollees Identified as Children with Special Health Care Needs (CSHCN)

Amerigroup Nevada leverages industry best practices to identify, assess, and develop holistic care plans for Children with Special Health Care Needs (CSHCN) in Nevada. Our services:

In the first six months of 2012, Amerigroup served more than 110 CSHCN (Medicaid and Nevada Check Up).

- ***Empower children with special healthcare needs and their families to lead independent and healthy lives***
- ***Help caregivers and family members support the child***
- ***Designate a single point of contact to help members and family navigate an often complex healthcare system***
- ***Identify all care and service needs early, thus preventing acute conditions and hospitalizations***
- ***Ensure that members and families have access to both PCP and specialty physicians as needed***

Assessing CSHCN to Understand All their Needs

Amerigroup Nevada is compliant with all State requirements related to CSHCN, and we maintain policies and procedures that guide our employees in linking each CSHCN with case management services as required in Nevada. Whether DHCFP notifies us that a child has specialized healthcare needs or when Amerigroup Nevada identifies the child directly (through, for example, predictive modeling, claims triggers based on diagnoses, a preauthorization request that indicates that the child meets criteria, or a request by the PCP or family), we thoroughly assess each child to identify the range and scope of services necessary to promote optimal health outcomes.

Amerigroup Nevada gathers the most complete and accurate information possible. We conduct assessments that are sensitive to the needs and preferences of the child and his or her family, including performing assessments in the family's preferred language. Assessment data forms the foundation of all care planning and future healthcare interventions.

Using structured online tools, our Case Managers conduct an in-depth clinical assessment in which they gather information about the child's:

- ***General health status, including possible pregnancy (age appropriate)***
- ***Behavioral health status***
- ***Emergency department (ED) usage***
- ***Hospital admissions***
- ***Medications***
- ***Healthcare utilization history***
- ***Functional capacity and the need for supportive services***
- ***Preventive healthcare history***
- ***Delays in child development***
- ***Family supports and other natural supports available to the family***

REAL STORIES

Robert, an Amerigroup Nevada member, was born prematurely (at 24 weeks) in May of 2011 with a host of medical issues, including brain bleeding, respiratory problems, and corneal scarring that are common in preemies. He was deemed eligible for benefits as a Child with Special Health Care Needs.

When Robert left the NICU after almost four months, Amerigroup coordinated follow-up care at home, which included oxygen therapy and private duty nursing to support his mom, who had four older children as well. Our UM team worked with Robert's mom to coordinate referrals to Children's Hospital in Los Angeles since the pediatric specialties required to treat his eye problems were unavailable in Nevada.

Robert was hospitalized several times after his NICU discharge, and we helped his mother each time, for example arranging transportation through LogistiCare. His Case Manager, Christy, also coordinated referrals to Family Resource Centers and Clark County Social Services for rent and energy assistance since the family was close to losing their home, and she negotiated single case agreements for non-network providers in Clark County for follow-up and ongoing care.

Robert received a corneal transplant in May, 2012, and we are pleased to report that his health is now stabilized, offering the opportunity for a healthy future. Christy continues to follow Robert and his mom.

The assessment uses branching logic to probe into more than 20 potential clinical areas for risk factors. For example, if the assessment suggests a history of depression, the Case Manager will initiate additional questioning to gather details on the acuity level for that condition. This information helps determine the child and family's need for case management services based on complexity, severity, intensity, and risk, along with a gap analysis of service needs.

The Case Manager's goal is to fully understand the nature and scope of the child's condition, current healthcare practices including nutrition and exercise, availability of accessible transportation, family supports, and the child's ability to engage in self-management activities. Additionally, the Case Manager evaluates significant factors including age, race, culture, and personal preferences and values that can impact the child and family's involvement in treatment.

At the conclusion of the assessment, the Case Manager assigns the member to one of five acuity levels to further define the level of case management needed and frequency of follow-up, summarized in Table 5.1.11.1-3.

Table 5.1.11.1-3. Acuity/Risk Levels Align Care Management with Member and Family Needs

Acuity Levels	Criteria	Frequency of Contact
Complex/ Catastrophic	The member's medical, psychosocial, safety, and/or functional status is extremely unstable; uncontrolled utilization of acute care; lack of Care Plan progress and/or adherence due to instability; requires intensive trans-disciplinary interventions and monitoring.	Weekly
Severe Risk	The member's medical, psychosocial, safety, and/or functional status is severely unstable; frequent admissions or re-admissions; lack of Care Plan progress; requires very frequent interventions, adjustment, and monitoring of the Care Plan to increase the likelihood of adherence and goals achievement.	Every one to two weeks
High Risk	The member's medical, psychosocial, and/or functional status is unstable, requiring more frequent interventions and monitoring; exhibits a significant risk for admission or re-admission to an acute care setting or safety risk.	Every three to four weeks
Medium Risk	Services are well coordinated; however, the member still requires support and follow-up to ensure compliance.	Every one to two months
Low Risk	Stable, safe environment, and following an established Care Plan. Care management focuses on continued stability and increased likelihood of positive outcomes.	Every two to three months

For all CSHCN, Amerigroup continues to conduct at least quarterly outreach throughout their enrollment with the health plan to monitor the child and family's status and identify any changes or evolving needs.

Developing a Treatment Plan that is Responsive to Each Need

To deliver these services in an exceptional and timely manner, we will use our Real Solutions® Health Care Impact model. This model promotes the child's wellness, member and family preferences, and empowerment through a coordinated program of advocacy, communication, education, identification of service resources, and service facilitation. Members and families remain at the helm of our care planning process. Case Managers promote positive outcomes (optimal health status, quality of life) when working with children and families to ensure that they are directing the array of meaningful services in concert with their goals and preferences. This model ensures that we apply the intensity and personalization of services and supports at a level commensurate with the child's health status, abilities, predicted future risks, and preferences. This is particularly important for children with special healthcare needs who typically face intense, chronic health disorders, frequently deal with co-morbid health issues, and require additional services and supports in the community and at home to maintain their quality of life.

Following identification, stratification, and assessment processes, our Case Manager engages the member and their family, the PCP, and any other treating professionals involved in the member's care to develop a personalized care treatment plan. The Case Manager's goal is to support the child's medical home by linking the PCP into the planning process and sharing the ultimate care plan.

If the member's PCP has not developed a treatment plan, we work with them to develop one that meets DHCFP requirements. If there is an established treatment plan in place, the Case Manager gathers relevant information on the plan and incorporates into the broader care treatment plan that includes other care plan components, such as a full range of supportive services and resources required to meet the child and family's needs, including coordination with community agencies and schools, health promotion and education, and family supports. Ultimately, the goal of a care treatment plan is to ensure that all medical, behavioral, and social service needs are defined and addressed, as we summarize in Table 5.1.11.1-4. The Case Manager faxes the resulting plan to the PCP and relevant treating providers.

Table 5.1.11.1-4. Personalized Care Treatment Plans Focus on Coordinating All Care and Services

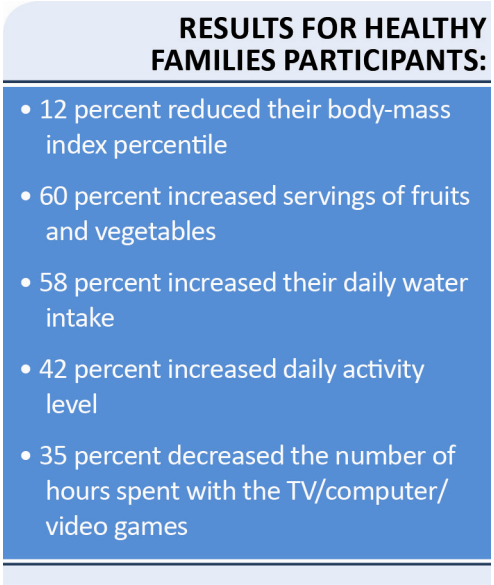
Type of Component	Description
Treatment Intervention/Goals	Short-term treatment goals
	Long-term treatment goals
	Identification of barriers to meeting treatment goals
	Clinical service provision
	Treatment follow-up/communication
Health Promotion/Education	Child and family self-management goals

Type of Component	Description
Activities	Health promotion activities, including scheduling for primary and preventive care
	Identification of barriers to self-management goals
Supportive Services/Resources	Non-clinical services required, including Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and occupational, speech, and physical therapies
	Natural supports
Care Treatment Plan Development and Progress	Participation of the child (when appropriate) and family in development of the plan
	Progress, or lack thereof, in meeting goals
	Care plan updates and modifications
	Care plan approval
Case Management Activities	Integration and coordination of clinical and non-clinical services
	Communication with all providers

The Case Manager verifies that treatment plans are developed in accordance with applicable State quality assurance and utilization review standards, as required by DHCFP.

The care treatment plan serves as the blueprint for care coordination and service delivery for all involved in the child's care. The Case Manager will work continually with the PCP, other providers, child, family, and other stakeholders to address any challenges in accessing treatment services, address any gaps in care, assist with identifying and referring the member for additional specialized services, provide member and family education, and ensure that we provide all services within the highest standards of quality and based on evidence-based practices in the field. This includes coordinating enrollment in our Health Families program, when appropriate through which we provide six months of fitness and healthy behavior coaching for pre-teens who are overweight and their families.

Figure 5.1.11.1-5. Healthy Families Delivers Results



Our role is to integrate, not replace, the breadth and full array of existing supports that the State of Nevada provides for children with special healthcare needs. We work closely with these entities such as school-based services, which are familiar to and trusted by Nevada families. This includes linking parents and families with Nevada resources that augment those

delivered through the health plan, such as Parents Encouraging Parents, which helps parents learn how to advocate for their child and provides ongoing peer support. It also includes referrals for family support services from local agencies such as Give Me A Break, which provides monthly respite services, and Rebuilding All Goals Efficiently, which assists families with disabilities in maintaining independence in the community with adaptive equipment or home modifications.

The Amerigroup Nevada Case Manager coordinates service delivery for children covered under the Federal Individuals with Disabilities Education Act through an individual education plan (IEP) with the school or local education authority. This includes obtaining a copy of the IEP, with the parent or guardian's consent, which details all services the child requires.

During care planning, the Case Manager verifies that we incorporate all medically necessary services that augment school-based services included in the IEP into the personalized care treatment plan to promote the highest functional abilities. Case Managers also confirm the scope of the IEP to identify and address any potential gaps in care, such as extended school absences resulting from an inpatient stay, school breaks, or after school hours.

Facilitating Convenient Access to Specialists

Amerigroup Nevada values the role of the PCP as medical home. We encourage members to establish positive, trusting relationships with their PCPs, who are often best able to identify the need for and facilitate access to specialty care, promoting optimal continuity and integration of care. We verify that each child has a PCP and that the PCP is appropriate for their needs.

Our experience confirms that efficient and cost-effective care does not always require PCP referrals for specialty services. Therefore, Amerigroup Nevada provides all members with direct access to specialists without referrals from PCPs. This is especially important for children with special healthcare needs who often have multiple needs that cannot be addressed by one single physician. Our Case Managers assist children with special healthcare needs access the appropriate specialists within their geographic area. In such cases, the Case Manager will work with the member and family to determine and identify the most appropriate specialist (based on the member's medical or other needs) within the child's geographic area who could meet the family's cultural and other requirements. The Case Manager can assist the child and family in the referral process.

Specialist services do not need to be limited to basic healthcare services. For example, children with limited mobility may need providers who will visit their homes. Children with co-morbid physical and behavioral health conditions may need referrals to a behavioral health practice where they can be treated by specially trained providers.

There are occasions where children with special healthcare needs would be best served by a specialist as their primary care provider. For example, a child with hemophilia may best be served by a PCP who is a hematologist. Amerigroup Nevada will assist the child in setting up this type of a relationship when it is considered to be in the best interest of the child. In such cases, the specialist must have previously provided care to the child or must have significant experience treating the relevant condition. The specialist must also agree to and take responsibility for acting as the child's PCP.

H.	Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.

Providing Services to Severely Emotionally Disturbed (SED) Children and Seriously Mentally Ill (SMI) Adults

Amerigroup Nevada promotes integrated and person-centered care for our members with primarily mental health or substance abuse diagnoses through care coordination by a Behavioral Health Case Manager, a licensed clinician. We maintain a comprehensive network of providers to support these members. Our robust network currently includes 178 behavioral health practitioners and 18 facilities in Clark and Washoe counties.

According to our most recent network adequacy report, our behavioral health network meets DHCFP requirements, as summarized in Table 5.1.11.1-5, promoting prompt access to care for our SED children and SMI adults.

Table 5.1.11.1-5. A comprehensive Network to Serve SED and SMI Members

Provider Type	DHCFP Access Standard	Clark County	Washoe County
Behavioral Health Providers	One behavioral health provider within 25 miles of member's residence	98 behavioral health providers Members with access within 25 miles = 100%	80 behavioral health providers Members with access within 25 miles = 99.9%
Behavioral Health Facilities	One inpatient behavioral health facility within 25 miles of member's residence	15 behavioral health facilities Members with access within 25 miles = 99.9%	3 behavioral health facilities Members with access within 25 miles = 99.7%

Amerigroup Nevada recently executed an agreement with Harmony Healthcare, one of the largest behavioral health networks in southern Nevada, to deliver mental health and substance abuse services for our members in Clark County. We selected Harmony for the breadth and

depth of their affiliated providers. We also selected them because their experience spans Medicaid and commercial health plans. Their reach into the southern Nevada community fosters continuity of care for members who may join Amerigroup Nevada as a part of the Medicaid expansion or through the HIX.

Further, we will leverage Harmony's Rapid Response Team, which deploys to hospital EDs to immediately assess and coordinate referrals for members who present at the ED for mental health or substance abuse issues. This enables us to avoid inappropriate hospitalization by swiftly facilitating access to an appropriate level of care, such as crisis stabilization with follow-up outpatient visits.

Our network includes almost every provider type included in Section 4.2.14, including University of Nevada School of Medicine's Mojave Mental Health Clinics, which are Essential Community Providers. We actively recruited Southern Nevada Adult Mental Health Services and Northern Nevada Adult Mental Health Services, and they are fully contracted and credentialed in our network. Our network composition for both Clark and Washoe counties is summarized in Table 5.1.11.1-6, including providers joining our network later this year through Harmony Health.

Table 5.1.11.1-6. Amerigroup Nevada Delivers an Accessible and Comprehensive Behavioral Health Provider Network

Provider Type	Clark County	Washoe County	Total
Inpatient Psychiatric Hospital	7	1	8
Mental Health Outpatient Clinic	33	17	50
Mental Health Rehabilitative Treatment Services	200	45	245
Psychologist	67	10	77
Outpatient Psychiatric	33	30	63
Residential Treatment Center (RTC)	0	1	1
Case Management	0	0	0
Habitation Services: Instrumental Activities of Daily Living/ Activities of Daily Living (IADL/ADL)	61	0	61
Methadone Treatment	3	1	4
Alcohol and Substance Abuse Treatment, including Intensive Outpatient Treatment	1	3	4
TOTAL	405	108	513

Amerigroup is actively engaged in identifying our current providers delivering case management services and will credential them into our network for the new Contract.

As DHCFP expands the scope of the Medicaid Managed Care program, such as removing the option to disenroll for members with SED or SMI, adding new counties to the service area, or including new populations, such as seniors and people with disabilities and individuals in the juvenile justice and foster care programs (all of whom tend to have a higher prevalence of serious behavioral health conditions), Amerigroup Nevada will continue to build upon our existing network for SED and SMI members to reflect the State's evolving needs.

Focus on SED Children

In our experience, the vast majority of members with serious behavioral health diagnoses have been children, and our network reflects the unique expertise required to support the needs of these children as well as their families. Further, our Behavioral Health Medical Director is a Board Certified Child Psychiatrist, fostering appropriate clinical oversight of cases.

Amerigroup Nevada has sought behavioral health providers who understand the broad needs of SED children, including the need for social and family supports and rehabilitation services that foster the best possible health and functional outcomes. Sixty percent of providers in the Harmony network treat children. Our network includes many providers who deliver supportive and rehabilitative services such as tutoring, peer support groups for children and teens, and programs that build children's skills related to activities of daily living that are vital to building functional skills. Our network providers also recognize the importance of the needs of the family with respect to peer supports, respite services, education, and advocacy. Linking SED children and their families to these wraparound supports fosters improved health outcomes and enables children to thrive at home, at school, and in the community. Our Behavioral Health Case Manager connects children and families with the behavioral health providers that are best able to deliver the range of services incorporated into each child's care treatment plan.

Comprehensive Support for SMI Adults

SMI adults generally require care in community-based treatment settings that offer a full range of recovery-based, culturally and linguistically competent services, and interventions with varying levels of intensity. These include individual, group, and family therapy; medication management; case management; and psychosocial rehabilitation services, as well as individualized wraparound services that complement treatment, such as housing, family support services, supported employment, and peer support resources.

Our behavioral health network reflects systems of care and providers who are skilled at developing comprehensive treatment plans, including Northern and Southern Nevada Adult

Mental Health Services. Working collaboratively with our Behavioral Health Case Manager, network providers arrange for necessary treatments but also facilitate access to those wraparound services that encourage improved health outcomes and independent living for SMI adults.

Creating Innovative Medical Homes for SED and SMI Members

Amerigroup is experienced at building unique medical homes for SED and SMI members that may be adapted for Nevada. Since March 2010, Amerigroup has collaborated with a behavioral health provider in Maryland to integrate service delivery for members with substance use disorders, a population that historically lacked PCP involvement. We incorporate primary care capabilities into an established outpatient behavioral health provider site with integrated medical charts and care teams. The care site includes a PCP and an Advanced Practice Nurse who are credentialed and contracted as PCPs in our network, along with an Amerigroup Case Manager who visits the provider office at least weekly. Amerigroup provides our quality reports detailing care gaps, ED visits, inpatient census, and risk ranking (based on predictive modeling), all of which further strengthens the health home.

Amerigroup Nevada is prepared to blend lessons learned in other states with our experience developing Real Solutions® Medical Homes in Nevada to create more integrated behavioral health medical homes in Nevada, a core mission of DHCFP in this procurement. Based on our experience over the past four years, we have already identified specific providers who have the capabilities to act as behavioral health medical homes and are interested in pursuing similar innovations in Nevada.

Amerigroup is also building Affordable Care Act-compliant Health Homes in Washington, Kansas, and other states in which we create patient-centered multidisciplinary provider teams to deliver care for members with chronic conditions, including SED and SMI. We are enthusiastic about developing industry-leading capabilities related to Health Homes. We are prepared to bring together the best practices learned with our Real Solutions® Medical Homes in Nevada with that of Health Homes in other states should the State opt to pursue such programs as a means to enhance quality of care.

Network Providers Trained to Comply with SED and SMI Determination Processes

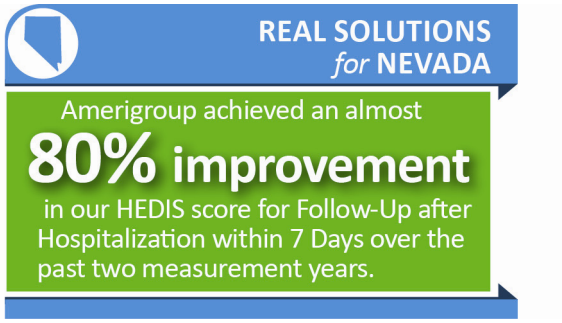
Amerigroup Nevada protocols for SED/SMI determination currently align with DHCFP requirements, and our network providers are already trained on the process. Between January and August of 2012, we identified 449 SED children and 168 SMI adults. Our protocols are consistent with the Nevada MSM.

Amerigroup Nevada behavioral health providers are familiar with and required to apply the State's process to determine whether individuals are SED or SMI in accordance with MSM

mandated processes and forms. Amerigroup Nevada coordinates annual re-determinations for members who remain enrolled in the health plan.

Strong Quality Gains

A comprehensive network is vital to achieve quality gains for our members, and Amerigroup Nevada has demonstrated strong quality improvements related to behavioral health. The HEDIS score for Follow-Up after Hospitalization for Mental Illness within 7 Days of Discharge has improved almost 80 percent over the past two measurement years. Our HEDIS 2012 score reflects the Quality Compass 50th percentile. This follow-up is particularly vital for members with SED and SMI to foster continued recovery and a safe transition between care settings. In addition, our Investing in Quality initiative includes a team that is developing innovative member and provider interventions to achieve targeted behavioral health HEDIS measures.



Strengthening PCP Skills Related to Behavioral Health

As a member's medical home, PCPs are often the first providers to recognize the signs of a mental health or substance abuse issue. In addition, in areas with limited behavioral health providers, they are often the treating provider for such conditions. Amerigroup Nevada is working closely with our Real Solutions® Medical Home practices to enhance care coordination efforts for members with behavioral health diagnoses to improve outcomes and reduce fragmentation of care. Amerigroup Nevada is helping practices build policies and procedures that foster coordination. This includes tracking referrals, improving follow-up activities with inpatient and outpatient providers, establishing memoranda of understanding with frequently used specialists that detail care coordination expectations, and delivering relevant reports (such as a report showing members with inpatient admissions). Our goal is to strengthen the role of the medical home and more fully integrate physical and behavioral care and service delivery.

In addition, in 2013, we will launch an annual webinar training for all PCPs, eligible for Continuing Medical Education credits, to further strengthen PCP skills related to screening, treatment, and referral to specialists for members with behavioral health conditions.

The training educates PCPs on:

- *Behavioral health conditions typically treated in a primary care setting*
- *Screening of mental health conditions*
- *Screening of substance use disorders*
- *Communication with behavioral health providers*
- *Referral to behavioral health specialists*
  - *When to refer*
  - *How to identify behavioral health providers*

We also provide them with depression screening guidelines and sample screening tools to facilitate the process.

I.	Provide your policies and procedures for emergency and post stabilization services.

Providing Emergency and Post-Stabilization Services

Amerigroup Nevada policies and procedures related to emergency and post-stabilization services promote convenient and hassle-free access to services. Attachments 5.1.11.1-A and 5.1.11.1-B includes two policy documents ("Emergency Services—Core Process" and "Coverage for Post Stabilization Care Services"), which outline our policies and procedures. Our policies and procedures currently comply with all Nevada and federal requirements. A summary of those policies is below.

Emergency Services

Amerigroup Nevada covers and pays for emergency services delivered by any provider (network or non-network) without the need for authorization and applies the prudent layperson definition of an emergency. Amerigroup Nevada works directly with the facility to obtain documentation and adjudicate claims. We do require hospitals to attempt to notify the member's PCP to promote the member's medical home.

Post-Stabilization Services

Amerigroup Nevada covers and pays for post-stabilization services in accordance with Nevada requirements. We do not require any prior authorization for post-stabilization services delivered by network or non-network providers.

Encouraging Appropriate Use of Emergency Services

Amerigroup Nevada deploys multiple strategies to foster appropriate use of emergency services by our members. These include:

- ***Educating members about our Nurse HelpLine through new member welcome calls and distribution of related Ameritips throughout the community***
- ***Applying our innovative and proprietary predictive model to identify members with the greatest risk for inappropriate ED use and to connect them with case management and disease management programs to mitigate that risk***
- ***Developing an after-hours network and educating members about providers with after-hours availability and urgent care facilities as an alternative to the ED***

See the Confidential Technical Volume for proprietary information.

Our innovative Amerigroup on Call program has demonstrated success in other states, and we are enthusiastic about launching it in Nevada as part of the new contract. We provide more detail on our efforts to promote effective use of ED services, including Amerigroup On Call, in Sections 5.1.11.4 and 5.1.11.5.B.

Enrollment (§5.1.11.2)

Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.

Transitioning Members into Amerigroup Nevada

To ensure continuity of care and services for our members and their providers in all populations, we work to understand the care and services that they currently receive, know the providers of services, and work with them through the transition.

The criteria for transferring members to or from the fee-for-service (FFS) program, Amerigroup Nevada, or another health plan are outlined in our written Enrollment Policies and Procedures that are subject to DHCFP review and approval. Please see Attachment 5.1.11.2: Nevada Continuity of Care Policy and Procedure.

Anytime there is an exchange of private patient information, all personnel associated with us, including employees and contractors, follow stringent policies regarding patient confidentiality and privacy. All Amerigroup and Amerigroup Nevada employees receive extensive training in our security/privacy policies and procedures and HIPAA regulation regarding patient health information.

Transition Planning

Every day, we successfully transition Medicaid and Nevada Check Up recipients into Amerigroup Nevada. Comprehensive written policies and procedures guide our care management and business processes to ensure that each member receives the right care in the right place at the right time.

When Amerigroup receives the eligibility file from the State, new members are referred to our Outreach department where they place calls to all new members. When we reach the members, they are asked a series of questions that help us assess their needs while answering any of their questions. There are three diagnosis-driven questions that we ask: Do you have asthma? Do you have diabetes? and Are you pregnant? If they answer "Yes" to the pregnancy question, the member automatically moves to the pregnancy triage questions. If the member answers "Yes" to either the diabetes or asthma question, then we make a referral to the Disease Management Centralized Care Unit (DMCCU) for additional screening. The DMCUU nurse contacts the member to find out if the member has the condition-specific equipment needed, such as a peak flow meter or a glucometer. Educational material is sent to the member on an ongoing basis, and the member will either be enrolled into Disease Management or referred to Case Management, if needed.

To expand the information gathered during this new member call process, we are currently working on additional questions that will identify:

- ***Any immediate medical needs or ongoing services such as durable medical equipment or home health services***
- ***Any scheduled surgeries or procedures***
- ***Any behavioral health needs or ongoing services***

We are also augmenting the new member packet to include a questionnaire to help identify needs and gather additional contact information like cell phone numbers and e-mail addresses. We are also identifying considerations on how to incent members to respond to the questionnaire. We will also add information on how to navigate the healthcare system (a helpful reminder for those who have had insurance and essential for those who have not). From the provider's perspective, we are identifying ways to highlight new member information on our monthly PCP reports and researching possible incentives for PCPs who gain new members.

Data is reviewed on a monthly basis to identify members who:

- ***Have medical conditions such as:***
  - ***Pregnancy (especially if high risk)***
  - ***Major organ or tissue transplantation services in process***
  - ***Terminal illness***
  - ***Intractable pain***
- ***Are receiving:***
  - ***Chemotherapy and/or radiation therapy***
  - ***Significant outpatient treatment or dialysis***
  - ***Prescription medications or durable medical equipment***
  - ***Other services not included in the State plan but are covered by Medicaid under EPSDT requirements for children***
- ***Are:***
  - ***Scheduled for inpatient surgery(ies)***
  - ***Currently in the hospital***

- ***Have:***
  - ***Prior authorization for procedures and/or therapies***
  - ***Post-surgical follow-up visits scheduled after their enrollment***

We ensure that all members who meet the above criteria continue in their course of treatment, without interruption, during their transition to Amerigroup Nevada. The claims reports are integrated into our health plan reports and are reviewed by the case managers for appropriate interventions.

Continuity of Care Transition Plans

We honor the care management plans and authorizations that new members already have in place when they join Amerigroup Nevada until we complete a comprehensive assessment with the member to create a new care management plan. Our care plan will include appropriate and coordinated physical, behavioral, social, functional, and environmental services as needed. CareCompass, our unique clinical support tool, facilitates the transition planning process for Case Managers. CareCompass gives Case Managers easy access to new member information, information on treating providers, and ancillary and pharmacy data. Because the information drives automated functions such as prioritization of duties, service authorizations, and benefits calculations, this tool enhances our Case Managers' ability to work with members during the transition and care planning process.

If the member's existing provider is not in our network, we will try to contract with that provider. If we are not able to contract, we will work with the member to choose another provider and transition the member to a network provider; or if necessary, we work with the provider to establish a single case agreement. New members who are pregnant can continue to receive care from their existing OB/GYN, regardless of the physician's status in our network.

Transitioning Medications

Ensuring continuity of care and access to necessary medications is a primary objective of the pharmacy management program. A discontinuation of drug therapy can lead to reduced member medication compliance and increase the risk of medication-related adverse outcomes. To mitigate potential lapses in care, Amerigroup has a transition process to provide coverage for members who are stabilized on drugs that are not included in the formulary or Preferred Drug List (PDL). This transition process applies to new members transitioning from FFS programs or another health plan who are stabilized on drugs not on the Amerigroup formulary/PDL; it also applies to current members affected by formulary/PDL changes.

The transition process covers non-formulary/non-PDL drugs for the first 60 days of enrollment or until the member's physician or other prescriber has completed the prior

authorization process. All members who receive non-formulary/non-PDL drugs are identified weekly on a claims system–generated report. Letters are sent to both the member and prescriber to inform them that a transition supply of medication has been approved but that continued use will require prior authorization. The notification to the prescriber advises them of the need for prior authorization for the member to continue on the non-formulary/non-PDL drug, or if clinically appropriate, to transition the member to a preferred alternative on the formulary/PDL. At the same time, the Pharmacy Department works with the prescriber to initiate a prior authorization on the member's behalf and communicates directly with them to determine the medical necessity for the non-formulary/non-PDL drugs.

Transitioning Members FROM Amerigroup Nevada

When we transfer a member to another managed care plan or to the FFS program, our responsibility to the member does not stop with the notification of transfer. We work with the provider and health plan to coordinate the transfer of medical records, patient information, and other materials relevant to the member's care. We continue to provide a multidisciplinary approach that encompasses nursing, quality management, case management, social services, and pharmacy services, where appropriate.

The receiving health plan or provider must be aware of certain conditions that require continued care for our members. When we know a member is transferring, we work with their provider(s) or health plan and notify the member's new care team of that member's healthcare needs, concerns and current status. Our nurses can verbally hand-off or fax the clinical the information.

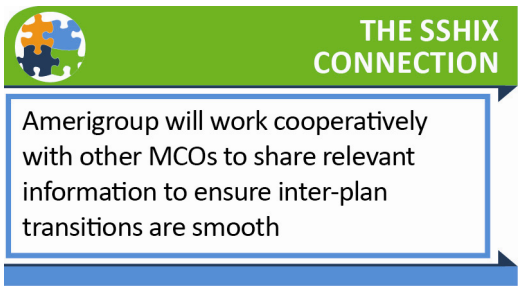
Specifically, we inform the new health plan and provider whether the member is:

- *Hospitalized*
- *Pregnant*
- *Receiving dialysis*
- *Chronically ill*
- *Receiving significant outpatient treatment and/or medications, and/or pending a payment authorization request for evaluation or treatment*
- *Using an apnea monitor*
- *Receiving behavioral health services*
- *Receiving early intervention services in accordance with an individualized Family Service Plan*

- ***Involved in, or pending authorization for, major organ or tissue transplants***
- ***Scheduled for surgery or post-surgical follow-up***
- ***Scheduled for prior authorized procedures or therapies***
- ***Referred to a specialist(s)***
- ***Receiving substance abuse treatment***
- ***Receiving prescription medications***
- ***Receiving DME or currently using rental equipment***
- ***Receiving case management (including the Case Manager's name and telephone number)***

We also include all contact information including the name and telephone number of the member's PCP and specialist, if referred.

When transferring a member who is hospitalized to another health plan, we notify the receiving health plan, the receiving provider, or the DHCFP Quality Improvement Organization, as appropriate, of the change within five business days.



Supporting HIE Efforts and Transitioning Members between Amerigroup Nevada and the State HIX

Amerigroup Nevada is currently working on ways to support the Health Information Exchange (HIE) by deepening our links and training between the HIE, electronic health records, and methods for provider collaboration. We will also develop written policies and procedures for transferring/receiving relevant member information and other pertinent materials to/from the Health Insurance Exchange. Our policies and procedures will be in compliance with HIPAA and other privacy laws.

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Recipient Services (§5.1.11.3)

A.	Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.

Amerigroup Nevada's member handbook (please see Attachment 5.1.11.3-1: Nevada Member Handbook) is included in a welcome package that we mail to new Medicaid and Nevada Check Up members within five business days of our receipt of notice of enrollment. The handbook, along with all other member communications, conforms with the State's eighth grade reading level requirements. Sometimes materials are written to a fourth-through-sixth grade level depending on the audience receiving the information. The handbook is printed in English and Spanish, and is available for translation into any other prevalent languages, as well as Braille and large print. Amerigroup also makes the handbook available on the member website, and members can ask for a copy of the handbook to be mailed to them at any time. We mail the member ID card separately and it contains our contact information, the member's PCP information, and other required data.

See the Confidential Technical Volume for proprietary information.

Members can ask for new cards anytime their cards are lost, there are changes in name, PCP change, or other information. We automatically generate a new card anytime a PCP change occurs.

Sample Copy of Proposed Enrollee Handbook and ID Card

Please see Attachments 5.1.11.3-1 and 5.1.11.3-2 for a sample enrollee handbook and ID card.

B.	Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.

Process to Assign or Change PCP or PCS

Amerigroup Nevada enrolls all members into the health plan according to State requirements, and afforded them the freedom to choose from our participating PCPs or Primary Care Sites (PCS), in addition to the flexibility to request PCP or PCS changes within DHCFP guidelines. We ensure that within five business days of the effective date of enrollment, each new member is assigned to/has chosen a PCP/PCS, who acts as his or her medical home and facilitates coordination of care. If a member does not select a PCP or PCS at enrollment or makes a PCP or PCS selection that is not valid (such as an adult accidentally choosing a pediatrician), we auto-select a PCP or PCS for the member. Members may remain with an existing PCP or PCS, if the provider is part of our primary care network. We base PCP and PCS assignments on:

- ***PCP or PCS is a provider from whom the member has previously received services***
- ***All children in one family are assigned to the same PCP or PCS***

If the member has not had a prior PCP or PCS relationship, the auto-assignment logic uses the family case number to evaluate whether an immediate or other family member has a historical provider relationship with a PCP or PCS within the geographic requirement. If the first two criteria do not apply, we evaluate all eligible PCPs and PCSs and from this subset of providers, we auto-assign an appropriate PCP or PCS. We also ensure all new members receive information about where they can receive care during the time period between enrollment and when they select a PCP or PCP assignment occurs. We send notification to our members of their PCP or PCS assignment in writing within five business days, and we also notify all PCPs and PCSs with a monthly online roster update (we mail a monthly hard copy notification to all providers who request one).

100 percent of our members have access to a PCP within 25 miles of their residence and the average distance is 1.3 miles.

Requests for PCP and PCS changes can be generated by the member, Amerigroup Nevada, or, sometimes, by the provider or the State. Our members can make a change for any reason. Procedures for changing the PCP or PCS assignment are outlined in the member handbook. Members can change their PCP or PCS on the member website or by calling the Member Services number. After the member finalizes his or her new PCP or PCS selection, the member database in our core operations system is updated to reflect the change. Members can also change PCPs or PCSs if they relocate.

When Amerigroup Nevada generates a PCP or PCS change, it can happen for many reasons and when it does, we notify all members in the provider's panel of the action. We send written notification, in English and Spanish, within 15 business days of the termination effective date to the member clearly stating how the termination affects him or her. We also invite our members to call us if they need a translator for this or any other information we provide to them. We provide instruction for the selection of a new PCP or PCS and information about how to receive urgent care until the new PCP or PCS selection/assignment occurs. We may also generate a PCP or PCS change for the member if he or she requires specialized care for an acute or chronic condition. Once we consult with the member, we assign him or her to a provider that can offer more specific, appropriate care.

Finally, there are times when a PCP or PCS asks for a member to be changed to another PCP or PCS if the PCP or PCS does not have the right experience to treat the member, the assignment was made in error (such as an adult assigned to a child's PCP or PCS), a member consistently fails to keep appointments/does not follow medical advice, or the PCP or PCS agrees that a change is best for the member. Again, we assign a new PCP or PCS based on criteria listed above. All PCP and PCS change requests are made on the day requested and are effective the same day if the member calls into Member Services to make the change or they are effective the next day if requested via the member website. The member receives a new ID card in the mail within five business days after the PCP or PCS has been changed, or the member may access a mobile ID card from our website. If the State requests a PCP or PCS change, Amerigroup handles it in the same way as any other request, making it effective the day after the request.

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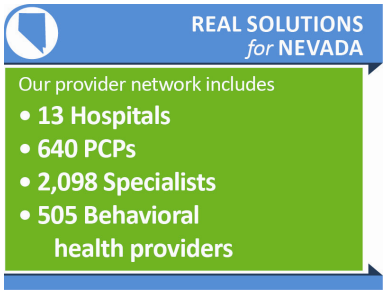
Network (§5.1.11.4)

Amerigroup Nevada has been managing a provider network for Nevada's Medicaid and Nevada Check Up recipients since 2009. Our network management ensures that our members have access to healthcare services through a comprehensive, coordinated, and integrated delivery system.



In September, 2008, when one of the State's Medicaid MCOs left the program, DHCFP approached Amerigroup Nevada to serve certain recipients enrolled in Medicaid and Nevada Check-Up. Amerigroup worked diligently under an accelerated implementation timeline to meet the State's needs. We began network development immediately after contract award and met network adequacy requirements within 120 days.

Our Clark and Washoe County provider network currently stands at 13 acute care hospitals, 640 Primary Care Physicians (PCPs), 2,098 specialists, and 505 behavioral health providers.

A.	What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?

Developing and Maintaining an Adequate Network for Clark and Washoe Counties

Amerigroup Nevada has a comprehensive network of providers in place in Clark and Washoe counties to serve Medicaid and Nevada Check Up members. And, we are the only NCQA Medicaid-Accredited Health Plan in Nevada, and follow NCQA quality, utilization management, credentialing, and compliance standards for all NCQA components and domains.

Our network currently meets, and often exceeds, requirements for access and availability; therefore, we do not have to build a network to meet the requirements of the RFP. We are, however, actively recruiting additional provider types for the newly covered services.

Amerigroup Nevada takes the following steps to develop our provider network and will take these steps to meet any future DHCFP expansion requirements:

- ***Assess the market and requirements for network development/expansion***
- ***Identify the provider types required and establish network capacity level based on Nevada requirements***

- ***Prepare and mail recruitment packages to providers including introductory postcards, invitation letters, information on Amerigroup Nevada, and application materials***
- ***Contact providers by telephone and in-person meetings to explain Amerigroup Nevada and the Medicaid and Nevada Check Up managed care program, answer any questions, and provide assistance completing application materials***
- ***Facilitate the execution of provider contracts***
- ***Credential providers***
- ***Conduct initial provider orientation***

Maintaining our Provider Network

Once contracted, we work to ensure that our network and management program meets the needs of our members and providers. Our Real Solutions® Provider Collaboration Model engages providers to deliver sustainable improvements in health quality and service delivery. This, coupled with our Nevada team-based approach, emphasizes open communication and shared responsibility with network providers.

We focus our management activities to ensure positive provider relations. Our provider hotline, education and outreach, communications, and contracting and compensation strategies, among other elements, work to ensure an optimal level of provider satisfaction and member health outcomes. See Section 5.1.11.4.E for more information on our provider maintenance and management approach.

Amerigroup Nevada enjoys a high level of provider retention; in the last year, only one percent of our providers chose to terminate their participation in our network. This helps ensure continuity of care for our members.

We attribute our network development and retention success to the following highly effective practices:

- ***Sound reimbursement practices, including prompt and accurate claims payment***
- ***Streamlined utilization management practices, including electronic submission of authorization requests***
- ***Provider incentive programs structured to reward physicians who deliver measurably better care and achieve more positive patient outcomes***
- ***Collaborative relationships, including extensive, one-on-one outreach***

- ***Proactive, comprehensive provider education***
- ***Practices to simplify and minimize administrative burdens, including use of the Nevada Division of Insurance Form 901 for credentialing providers***

We will continue these practices to maintain the geographic adequacy of our network and our high level of provider satisfaction. We will expand our network as indicated to meet future State requirements.

Expanding our Provider Network to Meet Future DHCFP Requirements

TESTIMONIAL

Health Access Washoe County (HAWC), a Federally Qualified Health Center, has enjoyed a beneficial collaboration with Amerigroup for several years in multiple areas including credentialing new providers with our recent merger with St. Mary's former Division of Mission and Outreach and our efforts to be recognized as a patient centered medical home. They have always been of assistance in helping us achieve our mission to serve the underserved.

Dan Ahearn M.D., MBA, FACP
CEO, HAWC Inc.

Our existing relationships with Nevada providers positions us at the forefront of the provider contracting process and will serve us well to promote increased provider recruiting should we need to expand our network. In recruiting additional providers, we focus on providers who traditionally serve our members. We seek these key providers, such as Essential Community Providers, because they maintain the appropriate geographic presence, the established trust of our members, a keen awareness of the diverse needs of the population, and access to key local resources available within their communities.

We are prepared to expand our network to meet any future changes in covered services, geographic service area, covered population, and/or legislative requirements. In fact, we have already begun the steps to expand our provider network statewide.

Covered Services

Amerigroup Nevada is prepared to cover additional Vendor-covered services as required. Home and community-based waiver services and non-emergency transportation services, for example, are already managed successfully by several of our affiliated health plans, including New Mexico. We will draw upon the experience and best practices at affiliated plans to develop protocols and standards for these services should we cover them.

Should the State require Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) members to remain in a managed care plan, we will leverage existing relationships to provide members a seamless transition from fee-for-service. We have solid, collaborative relationships with key providers including Harmony Healthcare, Nevada behavioral health clinics, and

community-based organizations that ensure quality outcomes for these members through a holistic approach, including behavioral health medical homes.

Geographic Service Area

Should the State expand the program beyond Clark and Washoe counties, we will leverage our existing resources and knowledge of the region to contract with additional providers. Amerigroup has already established relationships with rural providers in Nevada; in fact, some are already under contract. Our network includes both of Nevada's Federally Qualified Health Centers (FQHCs) that provide services in rural areas. We also have a successful, collaborative relationship with Nevada Health Centers, which also participates as a site in our Patient Centered Medical Home (PCMH) program and with network providers in neighboring areas such as Carson City.

We have gained a valuable understanding of Nevada's provider community, its complexity, and its vast differences such as limited sub-specialty providers. We understand the challenges faced by rural area physicians in solo practices with limited resources, technology, and support. We will tailor our approach to meet their needs should we expand into rural areas. For instance, rural physicians unfamiliar with managed care will be provided one-on-one training to help them ease through the transition.

We will also pursue, explore, and secure alternative delivery systems such as telehealth and additional physician extenders to develop a network in rural Nevada and ensure appropriate access to state-of-the-art healthcare services. We will work with our existing providers, such as Nevada Health Centers, who offer telehealth services. Our affiliated Amerigroup health plans have already successfully implemented telehealth in other markets, including Georgia and Texas.

Covered Population

We are prepared to cover additional populations, such as Medicaid Aged, Blind, and Disabled recipients or children and adolescents under the juvenile justice and foster care programs. Amerigroup currently serves members enrolled in the Aged, Blind, and Disabled/Supplemental Security Income category in 10 states and almost 92,000 dual eligibles in eight states through our affiliated plans, and we would draw upon this knowledge and experience base to serve this populations' specialized service and care coordination requirements.

THE SSHIX CONNECTION

We have also identified and begun outreach with providers that will supplement our SSHIX network.

We have already forged relationships with agencies within DHHS, the juvenile justice system, and Clark and Washoe County agencies as part of our existing

managed care program for Medicaid and Nevada Check Up members. And our partners offer immense additional value should this population be covered under our contract in the future. For example, Harmony Healthcare, our behavioral healthcare partner, currently serves children and adolescents from the juvenile justice and foster care programs and provides valuable services to ensure that troubled youth receive prompt and appropriate services. Harmony performs onsite assessments at facilities and foster care homes to develop a plan of treatment. In addition, they have three staff-based centers that are conveniently located and offer immediate onsite crisis intervention, including rapid assessment and coordination of appropriate services to avert a visit to the emergency department (ED) or an inpatient admission, such as an appointment with an outpatient clinician to stabilize the crisis.

Legislative Requirements

As Nevada continues toward full implementation of Health Care Reform and the Patient Protection and Affordable Care Act (ACA) of 2010, Amerigroup will expand our provider network to meet future needs, such as the addition of childless adults should the State choose to cover this population. We closely track legislative initiatives at the local, Nevada level as well as through our corporate Amerigroup Office of Health Reform Integration. The Office of Health Reform Integration focuses solely upon the integration of health reform and its impact upon our state customers and Amerigroup health plans.

Regardless of the impetus for expansion of our provider network, Amerigroup Nevada is prepared to further meet the changes ahead in Nevada and will offer provider networks that are accessible, highly qualified, motivated, and fully able to meet the needs of Nevadans.

Amerigroup Nevada's Current Provider Network

Our network includes credentialed providers to provide covered services detailed in RFP Section 4.2.2, Vendor Covered Services, including hospitals, PCPs, PCSs, specialists, and ancillary providers. We also have contracts with all Essential Community Providers in our service area, including both of Nevada's FQHCs. We are actively recruiting additional provider types for the newly covered services.

Our network reflects the unique cultural preferences of our members. We educate and train providers and Amerigroup employees on cultural competency and provide support to members with linguistic barriers or physical disabilities. Almost 20 percent of our current members speak Spanish as their primary language, and more than 46 percent of our network providers can accommodate that preference.

We regularly provide DHCFP with supporting documentation of our network's capacity to serve our enrollment. Table 5.1.11.4-1 provides a summary of our current provider network and satisfaction of DHCFP's access standards.

Table 5.1.11.4-1. Amerigroup Nevada's Network Frequently Exceeds DHCFP Access Standards

Provider Type	DHCFP Access Standard	Amerigroup Network	Amerigroup Compliance with Access Standard
Clark County			
Hospitals	1 hospital within 25 miles of member's residence	10 hospitals	Members with access within 25 miles = 100%
PCPs	1 full time equivalent (FTE) PCP for every 1,500 members. Or, if PCP practices in conjunction with a healthcare professional, the ratio is 1 FTE PCP for every 1,800 members. 1 PCP within 25 miles of member's residence	792 PCPs	15.81 PCPs per 1,500 members Members with access within 25 miles = 100%
Specialists	1 specialist for every 1,500 members	3,895 specialists	77.13 specialists per 1,500 members
Behavioral Health Providers	1 behavioral health provider within 25 miles of member's residence	398 behavioral health providers	Members with access within 25 miles = 100%
Behavioral Health Facilities	1 inpatient behavioral health facility within 25 miles of member's residence	7 behavioral health facilities	Members with access within 25 miles = 99.9%
Dentists	1 FTE dentist per 1,500 members. The dental provider network must also include at a minimum 1	168 general dentists 29 pediatric dentists 70 dental hygienists	3.35 dentists per 1,500 members

Provider Type	DHCFP Access Standard	Amerigroup Network	Amerigroup Compliance with Access Standard
	pediatric dentist, 1 dental hygienist, and 1 oral surgeon.	8 oral surgeons 7 orthodontists	
Washoe County			
Hospitals	1 hospital within 25 miles of member's residence	3 hospitals	Members with access within 25 miles = 99.8%
PCPs	1 full time equivalent (FTE) PCP for every 1,500 members. Or, if PCP practices in conjunction with a healthcare professional, the ratio is 1 FTE PCP for every 1,800 members. 1 PCP within 25 miles of member's residence	121 PCPs	18.42 PCPs per 1,500 members Members with access within 25 miles = 99.9%
Specialists	1 specialist for every 1,500 members	818 specialists	124.53 specialists per 1,500 members
Behavioral Health Providers	1 behavioral health provider within 25 miles of member's residence	107 behavioral health providers	Members with access within 25 miles = 99.9%
Behavioral Health Facilities	1 inpatient behavioral health facility within 25 miles of member's residence	1 behavioral health facility	Members with access within 25 miles = 99.7%
Dentists	1 FTE dentist per 1,500 members. The dental provider network must also include at a minimum 1 pediatric dentist, 1 dental hygienist, and 1 oral surgeon.	36 general dentists 1 pediatric dentist 6 dental hygienists 4 oral surgeons 2 orthodontists	5.48 dentists per 1,500 members

We have the full range of medical and surgical specialties to meet the needs of our members, including key specialties such as:

- ***156 OB/GYNs: 2.85 per 1,500 members in Clark County and 1.98 per 1,500 members in Washoe County***
- ***86 pediatric subspecialists: 1.48 per 1,500 members in Clark County and 1.83 per 1,500 members in Washoe County***

B.	Provide a sample of all base network provider contracts.

Sample of All Base Network Provider Contracts

See Attachments 5.1.11.4-1 – 5.1.11.4-3 for copies of the following base network provider contracts:

- ***Facility***
- ***Provider***
- ***Ancillary***

Amerigroup Nevada's written provider contract templates have been submitted to DHCFP and the most recent contracts were approved for use in August 2012. We believe our current base contracts are fully compliant with the RFP; however, we will make any revisions necessary to comply with future DHCFP requirements.

Prior to distributing or executing any substantive changes or amendments to our base contracts, we will submit a draft of standard language to DHCFP for review. Amerigroup Nevada's provider contracts currently meet all State and federal requirements.

C.	What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?

Involving Essential Community Providers in Our Network

Essential Community Providers are at the core of the Amerigroup Nevada network development strategy due to our like-minded focus on serving low-income and underserved populations. We collaborate with Essential Community Providers because we actively support their roles in caring for these most vulnerable members of the population—and because this support is so keenly linked to improving the health outcomes of our members.

All Essential Community Providers in our current service area already participate in our network. In fact, both of Nevada's FQHCs participate in our network, with more than 5,300 of our members assigned to them. They also participate in our provider incentive programs that use a results-driven reward system to provide an incentive to physicians to meet quality and other healthcare access targets. We hold monthly Joint Operating Committee meetings with our network hospitals, including the University Medical Center where we are pleased to report that more than 1,000 deliveries have taken place for Amerigroup Nevada members. Table 5.1.11.4-2 provides the status of Essential Community Provider participation in our network.

Table 5.1.11.4-2. Amerigroup Nevada's Provider Network Includes Many Essential Community Providers

Essential Community Provider	Participation in Amerigroup Nevada Network	
	Clark County	Washoe County
FQHCs	✓	✓
University Medical Center of Southern Nevada	✓	Provider does not exist in Washoe County
University of Nevada School of Medicine	✓	✓
Mojave Mental Health Clinics	✓	✓
University of Nevada, Las Vegas, School of Dentistry	✓	✓
Health Division (Health Districts)	✓	✓
Mental Health and Developmental Services Division	✓	✓

Amerigroup fully supports the mission of school-based health services in Nevada. We are actively working to sponsor a school-based healthcare center and anticipate finalizing our agreement by the end of 2012. This includes weekly meetings with one of our Amerigroup Real Solutions® Medical Home, an Essential Community Provider, with whom we are working to sponsor a school-based healthcare center.

THE SSHIX CONNECTION

Essential Community Providers are central to Amerigroup's SSHIX network strategy and will be the axis of provider continuity for our members.

We reach out to ALL Essential Community Providers and make a good faith effort to gain their participation in our network. As DHCFP notifies us of newly identified Essential Community Providers, we contact them in-person or by telephone to introduce Amerigroup Nevada, answer any questions they might have, and begin the contracting process. And, although Rural Health Clinics (RHC) and Tribal Clinics are not in our service area at this time, our leadership has met with RHCs and Tribal leaders to better understand the services they offer and how our organizations can work together in the future.

D.	How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?

Monitoring and Evaluating Performance and Correcting Deficiencies

Amerigroup Nevada diligently monitors the access to and availability of our provider network. At the network level, we monitor for geographic access to verify that our members have adequate 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 DHCFP, to ensure that our network meets the needs of the members we serve.

Our Provider Relations team develops an action plan to address any identified deficiencies in our provider network. The action plan identifies 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 all standards.

Comprehensive, written policies and procedures guide our activities to monitor, evaluate, and correct our network to ensure full compliance with access requirements. We formally review policies and procedures at least every two years. We conduct annual review of certain policies and procedures to conform to contract or accreditation requirements, guidelines, and Amerigroup business decisions.

Below, we present our response to Sections 4.5.5.1 through 4.5.5.9 of the SOW.

Ensuring Adequate Physical and Geographic Access to Covered Services (§4.5.5.1)

Amerigroup uses GeoAccess® reporting features to evaluate network adequacy for physical and geographic access:

- ***Geographic Overview Maps.*** ***Displays the provider locations by geographic area.***
- ***Provider and Member Location Maps.*** ***Plots 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.***
- ***Access Comparison.*** ***Provides a comparison 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. The detail provides the total number of members, providers, and a member-to-provider ratio for the specified demographic or geographic area. There is also a detailed analysis of a member's choice of up to five providers and the average distance to achieve that access.***

We also monitor access for members with disabilities. We capture physical access for each provider location and use this to map access for members with disabilities and expand our network as indicated.

All Amerigroup Nevada network providers are required to meet State and federal accessibility standards and those defined by the Americans with Disabilities Act of 1990. This is reinforced through training and our provider manual. We monitor compliance through our onsite Office Site Evaluation that is conducted by Provider Relations Representatives and review of member grievances. Providers are required to take actions to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- ***Street-level access***
- ***Elevator or accessible ramp into facilities***
- ***Access to a lavatory that accommodates a wheelchair***
- ***Access to an examination room that accommodates a wheelchair***
- ***Handicapped-accessible parking clearly marked unless there is street-side parking***

We perform GeoAccess analyses on a quarterly basis to verify that our existing network includes sufficient numbers of providers with adequate capacity to provide timely access to care in accordance with DHCFP requirements. We provide DHCFP supporting documentation of our capacity to serve expected enrollment in accordance with State standards.

We also continually monitor information obtained through our Provider Relations, Medical Management, Quality Management, and Member Services areas to identify opportunities to improve the network and address any deficiencies. For example, any member grievances about physical access or travel time are promptly routed to our Provider Relations Department for investigation and follow-up.

If we identify an issue regarding physical or geographic access, 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:

- ***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 per the single case agreement*

After we have launched 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.

SECTION 4 S.O.W. **Using Geo-access Mapping and Data-driven Analyses to Ensure Compliance with Access Standards and Taking Appropriate Corrective Action (§4.5.5.2)**

As described in the previous section, Amerigroup Nevada generates quarterly GeoAccess reports to ensure compliance with access standards. We promptly develop and implement corrective action plans when a deficiency is identified, and monitor the plan until the access standard is met.

SECTION 4 S.O.W. **Partnering with DHCFP, Community Providers, and Stakeholders to Identify and Address Issues and Opportunities to Improve Healthcare Access and Availability (§4.5.5.3)**

We value the roles and contributions provided by DHCFP, community providers, and stakeholders to ensure healthcare access and availability. We encourage, invite, and welcome feedback from DHCFP, community providers, stakeholders, and our Health Education Advisory Committee (HEAC) to monitor and evaluate access issues.

Our HEAC meets quarterly and includes representatives from the provider community, advocacy groups, and community-based organizations such as local representatives from the Northern Nevada Immunization Coalition and Southern Nevada Immunization Coalition. Our Vice President of Provider Relations is a member of our HEAC and actively seeks out input on our provider network to ensure that it meets standards for access and availability.

Any issues are routed to our Provider Relations Department, which will research the issue and develop, as indicated, an action plan to address the deficiency.

SECTION 4 S.O.W. **Assuring Access to Health Screenings, Reproductive Services, and Immunizations through County and State Public Health Clinics (§4.5.5.4)**

Amerigroup Nevada covers and will continue to cover health screenings, reproductive services, and immunizations provided by county and State public health clinics.

We employ various methods to ensure member access to these services. We work closely with county and State clinics so that we fully understand the services they provide and to keep apprised of upcoming events. Some of our efforts include:

- *Health Screenings. We promote health screenings through a variety of forums. For example, we work closely with the local Boys & Girls Clubs and recently sponsored an event that provided our members dental and vision screenings.*
- *Reproductive Services. We promote the availability of reproductive and family planning services to our members, as well as the availability of services through Health Districts. We partner with Special Supplemental Food Program for Women, Infants, and Children (WIC). We refer members for WIC services through our Taking Care of Baby and Me® program, which coordinates specialized maternal and child health services for members who are pregnant and new mothers. We host Baby Showers at community locations such as shopping malls (in both northern and southern Nevada). We invite expectant mothers from Amerigroup Nevada and the community at large to attend these baby showers that educate and celebrate soon-to-be moms. Games, prizes, and even a fashion show are combined with health screenings and important pre-natal information for expectant and new mothers. We can reach more than 1,000 individuals through these events.*
- *Immunizations. We continually reinforce the need for members to stay up-to-date on immunizations, and promote the availability of immunizations through Health Districts. We include an immunization chart in our member handbook. In August of each year, we mail reminders to our members about the upcoming Back-to-School Vaccine Clinics, including a schedule of locations, dates, and times. We also are closely involved with the Northern Nevada Immunization Coalition and Southern Nevada Immunization and Health Coalition (SNIHC); in fact, Amerigroup Nevada employees sit on the board of each organization. In December 2012, Amerigroup Nevada will receive SNIHC's Silver Syringe award as a community partner in childhood immunizations for the third consecutive year.*

> We continually promote the use of county and public healthcare resources. In August, we mailed reminders to our members about upcoming Back-to-School Vaccine Clinics.

We will continue to identify and promote the use of local resources. We will monitor and evaluate access using internal and external resources including our HEAC; Provider Relations, Medical Management, Quality Management, and Member Services areas; DHCFP; community providers; and stakeholders. Any deficiencies are relayed to our Provider Relations Department who develops and implement corrective action plans, and monitors the plans until the access standard is met.

SECTION 4 S.O.W.

Promotion of Care Management and Early Intervention Services (§4.5.5.5)

New members receive a welcome call upon enrolling in Amerigroup Nevada. The welcome call introduces the member to Amerigroup Nevada; orients the member to our services; reviews PCP selection and change procedures; and identifies any member-specific issues and needs for Disease Management, Case Management, and early intervention. If a potential need is identified during the welcome call, the member is triaged by our Management team to assess their needs. After assessment, the member's case will either be managed by the Disease Management team or, if identified as high risk, forwarded to our Case Management team. Amerigroup Nevada Case Managers include Nevada health plan clinicians who provide support and assistance for members with complex needs. Our local team comprises Nevada-licensed professionals who work closely with members, families, providers, and community-based organizations to coordinate care and services for our Medicaid and Nevada Check Up members. The expertise of our local Case Management team directly reflects the specific needs of the members we serve. We have clinicians who specialize in obstetrics, pediatrics and adults, and behavioral health.

Amerigroup Nevada makes a good-faith effort to screen Title XIX and XXI pregnant women for high-risk factors. We identify pregnant members through analysis of the DHCFP eligibility file, claims data, laboratory reports, and hospital census reports. We also identify members through our initial new member welcome calls, provider referrals, and member self-referrals.

When we identify a member who is pregnant, we conduct a risk assessment to determine her level of risk for pre-term birth using our Statistical Obstetrical Risk Score (STORK) tool. This tool incorporates screening for specific statistically validated predictors of the future need for neonatal intensive care unit (NICU) services, including history of pre-term labor or birth, prior baby with low birth weight, or diagnosis of hypertension or diabetes mellitus. Members receive a risk score (COR score) and are categorized into one of four groups: urgent, high, medium, or low. All members, including the low risk category group, receive informational materials. We refer those with risk factors and high COR scores to our specialized Obstetrical Case Manager who conducts a thorough clinical assessment to further refine risk and develop individualized care treatment plans that correspond to each member's risk level.

Members can change PCPs at any time and for any reason. PCP changes are effective no later than the next business day of the change. For additional information on PCP selection and change, please see Section 5.1.11.3.B.

If a member qualifies for case management, our Case Managers engage the member, the PCP/, and any other treating professionals involved in the member's care to develop a personalized care treatment plan.

For those members who require more in-depth health screening, we coordinate with PCPs to schedule these visits as quickly as possible.

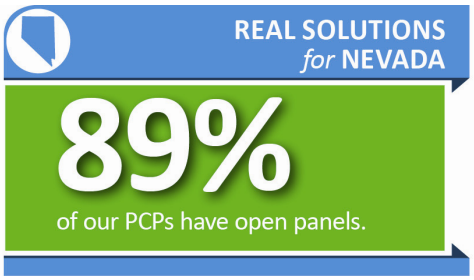
SECTION 4 S.O.W.

Maintaining an Adequate Network (§4.5.5.6)

Amerigroup Nevada has a comprehensive process to assess and monitor the adequacy of our network, anticipate future needs, and readily identify network gaps to ensure that our members have access and that we continue to meet DHCFP standards. We review multiple data sources to identify patterns, trends, and service demands:

- *Review of GeoAccess reports to determine any network gaps relative to travel distance*
- *Analysis of network changes, including additions, deletions, and PCP capacity changes*
- *Monitoring of network access, appointment availability, and provider compliance with after-hours coverage*
- *Annual audits of a random, statistically valid sampling of PCPs and designated specialists to assess appointment availability and after-hours coverage*
- *Analysis of member and provider grievance data*
- *Analysis of member retention rates*
- *Review of results of member and provider satisfaction surveys*
- *Feedback from providers, members/families, community-based organizations, and our HEAC*

Amerigroup Nevada takes several steps to monitor and evaluate our network to ensure that it continues to meet DHCFP and Amerigroup Nevada standards.



- *PCP-To-Recipient Ratios (§4.5.5.6.A). We generate and evaluate GeoAccess reports on a quarterly basis. One of the reports, Accessibility Detail, shows counts of members with and without access to care under the DHCFP access standard. The detail provides the total number of members, providers, and a member-to-provider ratio for the specified demographic or geographic area. We monitor patient load for PCPs and physician extenders in accordance with DHCFP standards. We also routinely monitor provider adherence to the standard through site visits and review of member grievances. We also place limits on the number of members assigned to a PCP's practice to ensure that we do not exceed patient load standards through our PCP assignment process.*

- *PCP Network Requirements (§4.5.5.6.B).* ***We use the GeoAccess Accessibility Detail report to evaluate the capacity of our PCP network in meeting FTE requirements.***
- *Primary Care Provider Participation (§4.5.5.6.C).* ***We monitor compliance with DHCFP's PCP access requirement through quarterly GeoAccess reports. One hundred percent of our members have access to a PCP within 25 miles of their residence in Clark County and 99.9 percent in Washoe County. Amerigroup Nevada has contracts with both of Nevada's FQHCs and the University of Nevada School of Medicine, University Health System, which satisfies DHCFP's 50 percent participation and 50 percent acceptance requirement. We comply and will continue to comply with any audit that DHCFP or its designee conducts to monitor our compliance. We also have a high rate of open PCP panels at 89 percent.***
- *Physician Specialists (§4.5.5.6.D).* ***Amerigroup Nevada's network of specialists in Clark and Washoe counties is 100 percent compliant with DHCFP access standards. Today, our Nevada members have access to a specialist within a 0.9-mile radius, and at least two specialists within a 1.2- mile radius, on average. We monitor compliance with DHCFP's specialist access requirement through quarterly GeoAccess reports. We have the full range of medical and surgical specialties to meet the needs of our members, including key specialties including 156 OB/GYNs and 86 pediatric subspecialists.***

REAL SOLUTIONS *for* NEVADA

On average, our members have access to an Amerigroup Nevada specialist within a 0.9 mile radius, and at least two specialists within a 1.2 mile radius.

When we identify a deficiency in our provider network, 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. Once launched, we monitor the progress and effectiveness of the plan until we meet or exceed all standards.

SECTION 4 S.O.W.

Ensuring Enrolled Recipients' Access to Covered Services is Consistent with the Degree of Urgency (§4.5.5.7)

Amerigroup Nevada routinely monitors and evaluates provider adherence to appointment standards through:

- *Annual Audits of a Random, Statistically Valid Sampling of PCPs and Designated Specialists to Assess Appointment Availability.* ***In our last audit of PCP appointment availability, 99.1 percent were compliant with appointment availability for urgent care and 95.8 percent were compliant for appointment availability for routine care.***

Amerigroup Nevada enjoys a very low member grievance rate concerning appointment access.

- *Reviews of Member Grievances.* ***In our annual review of member grievances concerning appointment access, the rate was less than 0.04 per 1,000 members.***
- *Results of Member Satisfaction Surveys.* ***We evaluate satisfaction with clinical care and access to services using the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey to compare performance against national benchmarks and State performance goals to identify improvement opportunities.***

By recent example in June 2012, our appointment availability audit call to a Family Medicine provider in North Las Vegas showed that the provider failed to meet standards for availability of routine appointments. Our Provider Relations Manager telephoned the practice's office manager and discussed the results, appointment availability requirements, and actions to achieve compliance. The Manager communicated to the provider that a follow-up, unannounced survey would be conducted within 90 days. The next audit call in September 2012 revealed that the provider was meeting the contractual requirements for access and availability.

THE SSHIX CONNECTION

Anticipating the continuity needed for our Nevada members, Amerigroup is already making progress with our providers regarding SSHIX participation.

We develop annual Quality Improvement Activity Reports (provider satisfaction surveys) to assess compliance with access standards and identify ways to improve. These reports are the result of surveys that are developed each fall by Amerigroup Nevada Provider Relations employees. The surveys are administered by an outside vendor who holds the internationally recognized ISO 9001:2000 certification for quality management systems. The reports reveal access deficiencies, as well as provider concerns, relating to the specialty network, reimbursement, customer service, our technology services, and the supporting operations department.

Amerigroup Nevada ensures that members have access to these covered services:

- *Emergency Services (§4.5.5.7.A).* ***Members have access to emergency services 24 hours a day, 7 days a week (24/7). We do not require referral or prior authorization for emergency services.***

  For non-emergency services, members have access to urgent care centers in our network including the University Medical Center Quick Care centers. Our Member Handbook provides information on how and where to access emergency and urgent care services. Members also have 24/7 access to our Nurse HelpLine.

See the Confidential Technical Volume for proprietary information.

- *PCP Appointment (§4.5.5.7.B). Our provider contract and provider manual stipulates that PCPs provide appointment availability in accordance with the standards set by DHCFP. We conduct random calls to check appointment availability for same day, urgent, and routine care appointments.*
- *Specialist Appointments (§4.5.5.7.C). Specialists are contractually bound to meet DHCFP appointment availability standards. Amerigroup Nevada makes random calls to check appointment availability for same day, urgent, and routine care appointments at specialists, including OB/GYNs.*
- *Prenatal Care Appointments (§4.5.5.7.D). Appointment availability standards are included in our provider agreement. We conduct random calls to check appointment availability for initial pre-natal care appointments: first trimester, second trimester, third trimester, and high-risk pregnancies.*
- *Dental Appointments (§4.5.5.7.E). Appointment availability standards are included in the provider agreement, and surveys are conducted on a quarterly basis to ensure access.*

When we identify providers who are out of compliance with appointment standards, our Provider Relations Representatives visit them in-person and present a letter requesting corrective action plans. The Provider Relations team continues to monitor compliance and then re-surveys the providers after 90 days to verify that they are in compliance. Ultimately, we remove providers from our network if they do not meet access standards or do not take action to meet the standards.

SECTION 4 S.O.W.

Appointment Standards (§4.5.5.8)

Comprehensive written policies and procedures guide our monitoring activities to ensure compliance with access requirements. These policies and procedures reflect the individual requirements contained within our current contract with DHCFP. Policies and procedures address:

- *Access to Care Standards*
- *Appointment, After-hours, and Telephone Accessibility*
- *Provider Network Accessibility Analysis*
- *PCP Panel Capacity Review and Access and Availability*

All Amerigroup Nevada network providers are required through provider agreement to abide by all DHCFP appointment standards. Providers are educated on these standards through initial and recurring provider training and the Provider Policy and Procedure Manual

(provider manual), incorporated by reference as part of the provider agreement. Amerigroup Nevada's provider newsletters supplement providers' initial orientation training and serve as recurring reminders for timely scheduling of routine appointments and triage requirement standards.

We use various mechanisms to monitor compliance with appointment standards. The method and frequency is presented in Table 5.1.11.4-3.

Table 5.1.11.4-3. We Employ Various Measures to Ensure Member Access to Appointments

Mechanism	Description	Results
Audits of Appointment Availability	Annual audits of a random, statistically valid sampling of PCPs and designated specialists to assess appointment availability and after-hours coverage.	In our last audit of PCP appointment availability: ▪ 99.1% were compliant with appointment availability for urgent care ▪ 95.8% were compliant for appointment availability for routine care ▪ 100% were compliant for after-hours access
Review of Member Grievances	Member grievances are routed to our Provider Relations Department for review and follow-up.	In our annual review of member grievances concerning appointment access, the rate was less than 0.04 per 1,000 members.
Member Satisfaction Surveys	Annual CAHPS member satisfaction surveys query on member access to care.	In our last member satisfaction survey, 91% of members reported they could get care for their child as soon as needed.
Onsite Visits to Provider Offices	Provider Relations Representatives conduct site visits to PCPs and high-volume specialists.	There were no compliance or quality of care issues found for the reporting period.
Review of PCP Panel Reports	We review PCP panel status to ensure that an adequate number of PCP practices are open to new members. Provider Relations Representatives monitor PCPs with closed panels to identify opportunities for re-opening.	89% of our PCP have open panels.

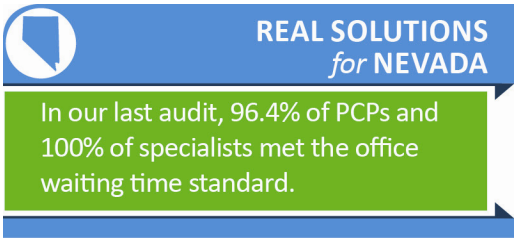
Our Vice President of Provider Relations is responsible for ensuring compliance with standards.

SECTION 4 S.O.W.

Office Waiting Times (§4.5.5.9)

Office waiting time standards are included in our provider agreement and provider manual, and providers are educated about maintaining office waiting times of less than one hour. We routinely monitor and evaluate provider adherence to standards through onsite visits and reviews of member grievances. In our last audit of office waiting times, 96.4 percent of PCPs and 100 percent of specialists met the office waiting time standard.

When we identify providers who are out of compliance with the one-hour standard, our Provider Relations employees request a corrective action plan. The Provider Relations team continues to monitor compliance and then re-surveys the provider to verify that they are in compliance. Ultimately, we remove providers from our network if they do not meet access standards or do not take action to meet the standards.



E.	How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.

In this section, we will address Amerigroup Nevada's activities to:

- ***Monitor our network providers to ensure compliance with Amerigroup Nevada requirements and DHCFP requirements in RFP Section 4.5.3, Network Management.***
- ***Plan of action to ensure positive provider relations through our provider relations and management program, including our Very Important Provider (VIP) program, provider hotline, provider disputes, provider education and outreach, provider communications, and provider contracting and compensation. A description of this program is discussed in the Section below entitled: Plan of Action to Ensure Positive Provider Relations.***

Monitoring Providers to Ensure Compliance with DHCFP Requirements

SECTION 4 S.O.W.

PCP and PCS Responsibilities (§4.5.3.1)

We closely and continually monitor PCPs to ensure that they offer timely access to care for our members. We use information from our Provider Relations, Medical Management, Quality Management, and Member Services areas to identify opportunities to improve the network and address deficiencies. We carefully review the results of our annual member satisfaction surveys, and any grievances about PCPs or access to services are routed to our Provider Relations Department for investigation and follow-up.

Amerigroup conducts annual audits of a random, statistically valid sampling of PCPs to assess appointment availability and after-hours coverage.

When we identify PCPs who are out of compliance with DHCFP and Amerigroup Nevada standards, our Provider Relations Representatives visit the PCP in person and presents a letter requesting a corrective action plan. Provider Relations Representatives continue to monitor compliance and re-survey the PCP to verify that the PCP is in compliance. If the provider remains non-compliant, another survey is conducted within 90 days. At that point, if the provider is still non-compliant, we present the findings to our Medical Advisory Committee. To date, we have not had to refer a case. Ultimately, we will remove providers from our network if they do not take action to meet the access and after-hours requirements in their contracts and outlined in the provider manual.

Table 5.1.11.4-4 details the PCP responsibilities contained in Section 4.5.3.1, items A-F; the tools and resources we use to support PCPs meeting the requirement; and our activities to monitor PCP compliance.

Table 5.1.11.4-4. We Employ Various Measures to Support PCPs in Meeting their Responsibilities

TOOLS AND RESOURCES TO SUPPORT PCP	AMERIGROUP NEVADA MONITORING ACTIVITIES
PCP Responsibility: A Delivery of covered medically necessary, primary care services and preventive services, including Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) screening services	
• Our provider contracts require that PCPs provide covered services within the scope of their licensure, expertise, and usual and customary range of services. • We supply providers with reports of members who are overdue for EPSDT services. • Our provider incentive programs include incentives for achieving preventive health and well-care visit targets • Outreach Coordinators telephone members who are overdue for EPSDT services. • We include preventive and wellness care information in our provider and member communications, including newsletters and websites. • Members can self-refer to any qualified provider for Healthy Kids visits and immunizations.	• Annual appointment availability telephone surveys • Review of member grievances • Medical record reviews to confirm delivery of EPSDT services • Provider profiling for under-utilization
PCP Responsibility B Provision of 24/7 per week coverage	
• PCPs are contractually required to provide members access to 24/7 urgent and emergency services. • We educate PCPs on this through our provider education efforts and provider manual. • Members have 24/7 access to our *Nurse HelpLine*. • Beginning with the new Contract, members will have 24/7 access to tele-consults with board-certified, licensed doctors. • We offer PCPs additional reimbursement for providing care after-hours.	• Annual after-hours access telephone surveys • Review of member grievances
PCP Responsibility: C Referrals for specialty care and other covered medically necessary services in the managed care benefit package	
• Our provider contract, provider manual, and provider education inform the PCP that they are responsible for coordinating referrals of members to specialists and to services that may be available through fee-for-service Medicaid. • Our provider manual and member handbook both explain that members can self-refer to any qualified provider for behavioral healthcare, family planning services, Healthy Kids visits, immunizations, prenatal care, annual women's wellness exams, and routine dental care. • Our experience confirms that efficient and cost-effective care does not always require PCP referrals for specialty services. Therefore, Amerigroup Nevada provides all members with direct access to specialists without referrals from PCPs.	• Review of member grievances • Review of provider complaints • Medical record reviews • Provider profiling

PCP Responsibility: (D) Members shall be allowed to self-refer for family planning, obstetrical, gynecological, and mental health and substance abuse services within the Vendor's network	
• Our provider manual and member handbook both explain that members can self-refer to any network provider for family planning, obstetrical, annual women's wellness exams, mental health, and substance abuse services. • Our provider manual and member handbook explain that women can self refer to any provider, including out-of-network, for family planning services	• Review of member grievances • Review of provider complaints
PCP Responsibility: (E) Continuity and coordination of the enrolled recipient's healthcare	
• Our provider manual and provider education explain that PCPs are responsible for the complete care of their patients including, but not limited to, providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the continuity of care. • Our Case Managers engage the PCP to develop a personalized care treatment plan.	• Review of member grievances • Review of provider complaints • Feedback from Case Managers and disease management employees
PCP Responsibility: (F) Maintenance of a current medical record for the enrolled recipient, including documentation of all services provided by the PCP, and specialty or referral services, or out-of-network services such as family planning and emergency services	
• Our provider manual and provider education explain medical record standards • Provider training on medical record standards	• Credentialing and re-credentialing activities • Medical record reviews to confirm that providers are maintaining current and appropriate medical records

SECTION 4 S.O.W.

Laboratory Service Providers (§4.5.3.2)

Amerigroup requires that all laboratory testing sites have valid Clinical Laboratory Improvement Amendments (CLIA) certificates and CLIA identification numbers and comply with CLIA regulations per 42 CFR Part 493. Our systems are configured to comply with these requirements and verify correct CLIA identification numbers when claims are processed. We monitor compliance through provider credentialing, claims reviews, and provider site visits. We will provide DHCFP copies of certificates upon request.

SECTION 4 S.O.W.

Essential Community Providers (§4.5.3.3)

Amerigroup Nevada has all Essential Community Providers that are in our service area participating in our current network, including:

- ***Nevada Health Centers (FQHC)***
- ***Health Access Washoe County (FQHC)***

- ***University Medical Center of Southern Nevada and its affiliated primary care and urgent care centers (Quick Care)***
- ***University of Nevada School of Medicine, University Health System***
- ***University of Nevada School of Medicine, Mojave Mental Health Clinics***
- ***University of Nevada, Las Vegas, School of Dentistry***
- ***Southern Nevada Health District***
- ***Washoe County District Health***
- ***Northern Nevada Adult Mental Health Services***
- ***Southern Nevada Adult Mental Health Services***

Essential Community Providers are a critical part of our provider network; in fact, more than 5,300 of our members are assigned to the FQHCs that are in our network. We collaborate with Essential Community Providers to maximize the health and well-being of our members. For example, both of Nevada's FQHCs participate in our physician incentive programs, described in the next section.

More detail about Essential Community Providers is in subsection C, Involving Essential Community Providers In Our Network.

Plan of Action to Ensure Positive Provider Relations

As an existing MCO in Nevada, Amerigroup Nevada has strong, positive relationships with providers who serve Medicaid and Nevada Check Up recipients. Our 2011 provider satisfaction survey indicated an 86 percent satisfaction rating with Amerigroup Nevada, and 9 of 10 providers indicated they would "recommend Amerigroup to other physicians." Several areas stood out as specific strengths of Amerigroup Nevada; one, in particular, was provider satisfaction with the local services we offer.

We have developed strong, collaborative relationships with providers in Clark and Washoe counties, 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 that we meet their needs and answer their questions. Our approach offers:

- ***Strong, Local Leadership. We have a highly qualified leadership team who is physically located in Nevada. Our CEO, Eric Lloyd, has more than 20 years of healthcare experience. Mr. Lloyd is actively involved in the community and working***

with underprivileged children and is a board member of After-School All-Stars Las Vegas, a non-profit organization providing after-school programs. Our Medical Director, Dr. Richard Roberts, is board-certified in pediatrics and has more than 30 years of healthcare experience. Dr. Roberts is an active member of the Nevada Association of Managed Care Physicians, a group of physician thought leaders, public health departments, and Nevada's Medicare PRO. Dr. Roberts is also a member of the Health Plan Certification and benefits subcommittee of the Nevada Silver State Health Insurance Exchange. And, Julie Skaggs, our Vice President of Provider Relations, is also very involved in the local community and sits on the board of the Southern Nevada Immunization Coalition.

- *On-the-Ground, Personal Outreach. We believe that to best serve our network providers, our health plan representatives must be out in the community, meeting face-to-face with providers. Accordingly, we meet providers where they practice; so far this year, our Provider Relations Representatives have visited more than 700 physician practices. Our CEO, Medical Director, and Case Managers also regularly visit providers to better understand their needs and concerns and how we can best serve them and our members. We hold "Member Mondays" in select, high-member volume PCP and OB/GYN provider offices. During these, our Provider Relations Representatives, cross-trained in member services, spend 2.5 to 3 hours in the provider's office to answer any questions members may have and promote preventive services, health education, and health promotional resources such as Taking Care of Baby and Me, our prenatal program that coordinates specialized maternal and child health services for pregnant members and new moms. We also hold monthly Joint Operating Committee meeting with our network hospitals and hold Provider Workshop sessions at least twice per year.*

- *Reduced Administrative Burdens. 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. For example, we have a local Internal Resolution Unit at our Las Vegas office to expedite the process for receiving and responding to provider inquiries, grievances, and requests for information. We work one-on-one with providers to help manage administrative issues. To illustrate, when an obstetrician in Henderson faced claims issues because his billing manager had recently resigned and left things in disarray, our Provider Relations Representative spent several hours providing hands-on training to the new office staff. The staff can now enter claims directly into our website and is able to avoid any further payment delays.*

- *Innovative Strategies. We continually seek to improve the level of service we provide our network providers and members. Our provider incentive programs promote efficiency in the service delivery system, improve the quality and delivery of services, and decrease costs for providers. We also help key primary care practices transform into PCMHs through our Real Solutions® Medical Home model. Amerigroup operates one of the largest medical home programs in the country, ranking fifth for the number of providers participating in the program according to the latest Patient Centered Primary Care Collaborative report.*

Amerigroup Nevada has the personnel, systems, and processes in place to ensure positive provider relations. In the remainder of this subsection E, we will describe elements of our provider management program, including:

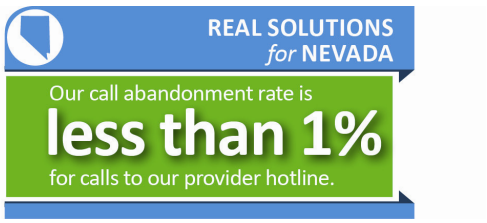
- *Provider Relations, including our Nevada VIP program, PCMH model, member health record card, practice supports, provider hotline, and provider disputes*
- *Provider Education and Outreach, including initial and ongoing training*
- *Provider Communications, including our provider website, manual, and newsletter*
- *Provider Contracting and Compensation, including our contracting approach and provider reimbursement*

Provider Relations

Our provider relations program is based upon Amerigroup's Real Solutions® provider collaboration model. This innovative model engages providers to deliver sustainable improvements in health quality and service delivery. We meet the needs of Nevada's provider community and equip them with tools and resources to positively impact the health and well-being of Medicaid and Nevada Check Up members.

See the Confidential Technical Volume for proprietary information.

Provider Hotline



In Nevada, we offer providers centralized service through our provider call center. Physical and behavioral health providers can access a menu of both automated and live agent services at the call center. Our provider call center is available from 8:00 a.m. to 5:00 p.m. Pacific Time, Monday through Friday, except for federal holidays. Our call center clinical employees are available 24/7. Our voice self-service technology and provider website are also available 24/7 to help providers and their employees answer questions and concerns such as verifying eligibility and checking the status of claims.

Amerigroup has a successful record of provider customer service. From January through August 2012, we received more than 49,300 calls from Nevada provider offices. For these calls, our average speed of answer was 11 seconds and our call abandonment rate was less than one percent.

We use Impact 360 Workforce Management, a workload-balancing application, to predict provider call volumes and arrival patterns. This application enables us to schedule employees to meet forecasted needs at the most effective times. It also allows real-time monitoring so that we can quickly and efficiently allocate employees to meet demand.

Provider Disputes

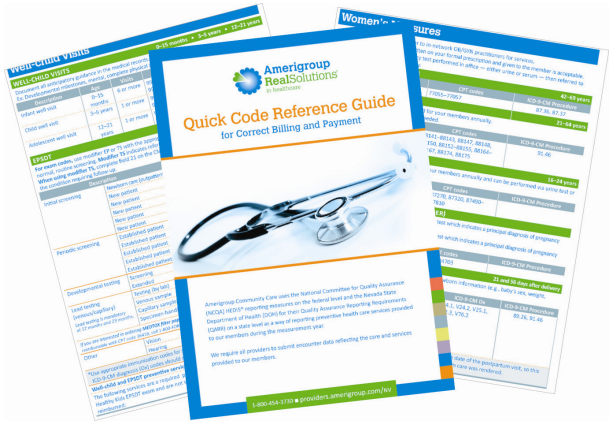
We have documented policies and procedures for handling provider disputes, grievances, and appeals. Our provider training and provider manual also include information on the procedure to dispute adverse payment and contract decisions. See Section 4.11.7 for information on our processes for handling provider disputes, grievances, and appeals.

Provider Education and Outreach

We offer formal group training to all of our providers. For providers within large health systems, Provider Relations Representatives schedule formal, onsite orientation sessions in the providers' offices or at off-site locations. For providers whose schedules preclude attending these orientations, we provide in-person seminars, conference calls, and online training through the use of WebEx online conferencing. We also conduct in-person provider forums and webinar training sessions during lunch periods as a convenient and economical way to keep providers informed.

We post all training session materials, our provider manual, quick reference cards, announcements, and provider alerts to our provider website. Figure 5.1.11.4-2 provides an illustration of our popular coding reference guide. This tool is offered to provider offices to assist them in appropriately coding their claims.

Figure 5.1.11.4-2. We Offer Providers Important, Readily Available Information



To continually supplement initial provider orientation, Amerigroup Nevada offers providers ongoing educational sessions across a variety of topics and venues. We hold Provider Workshops at least twice a year to provide specialized forums for providers to receive information and answer questions. Representatives from Provider Relations, Operations, Case Management, and Quality Management attend these Town Hall meetings to personally address provider questions. Topics may include the claims submission procedures, cultural competency, HEDIS, EPSDT, eligibility verification, and tools on the provider website.

Initial Provider Training

Newly contracted providers complete initial training within 30 days of becoming active. All providers are invited to attend an initial orientation session to ensure their understanding of the managed care program and Amerigroup Nevada's policies and procedures. We conduct ongoing training (described later in this response) with providers to facilitate the sharing of best practices, to communicate new and updated policies and procedures, and to reinforce education.

We offer formal group training for all providers. We offer training using various modes and venues to maximize participation. We offer multiple dates at convenient times and locations for each training session and serve food to encourage attendance. We take attendance at every training session and track individual provider participation. When a provider does not attend scheduled training sessions, our Provider Relations associates contact the provider and schedule training, including the option of a one-on-one or webinar session.

At initial training, we distribute copies of our provider manual and member benefit collaterals. Updates and distribution of the provider manual are in accordance with the requirements contained in Section 4.5.8.1 of the RFP.

We present instructions on how to use our provider website, which contains key provider education information. We also offer a question-and-answer session that fosters an environment where providers and associates can address specific provider questions. When providers do not attend scheduled training, we follow up with them to reschedule training sessions.

For hospitals, we provide a comprehensive orientation session that includes policies, procedures, and formal agreements to communicate between our Medical Management team and the hospital. We also conduct monthly Joint Operating Committee meetings with hospitals to provide further education and work through any operational issues.

Ongoing Training and Provider Workshops

Amerigroup Nevada offers additional training sessions to all providers who request it. We also use blast faxes, provider newsletters, and our provider website, to disseminate educational information to our network providers.

We tailor our provider training programs to meet the unique needs of the local provider community. Amerigroup Nevada typically conducts Provider Workshops twice per year. Our last one was November 7, 2012 where we reviewed cultural competency, pre-certification requirements, eligibility verification, HEDIS measures, and electronic medical records.

See the Confidential Technical Volume for proprietary information.

Cultural Competency Training

Amerigroup Nevada delivers cultural competency training for our network providers through the provider orientation and tools available on our provider website. We also plan to add a link to the Cultural Competency training sponsored through the U.S. Department of Health and Human Services' website, for which they can earn free Continuing Medical Education credits.

Provider Communications

Our provider communications and outreach strategies reflect the needs of the local Nevada provider community. Our role as an active partner in the provider community gives us valuable insight into what works and what matters. Our written materials have been approved by DHCFP and reflect Nevada and federal laws and regulations.

Provider Website

We maintain a comprehensive website for network providers. Amerigroup's website is an important tool to enhance provider communication, deliver actionable information, and streamline plan administration. Our provider website features tools that promote convenience and transparency for providers. With the provider-focused goal of delivering the tools that simplify practice management and provide information needed to engage members, our website will enable real-time messaging and alerts to providers that support provision of care related to HEDIS, real-time panel listing updates, and delivery of financial reports.

On the website, Nevada providers can view or obtain:

- ***The Amerigroup Nevada provider manual***
- ***Online eligibility verification, including coverage dates***
- ***Information on upcoming provider trainings***
- ***Provider training materials***
- ***Practice guidelines***
- ***Information on the provider grievance system***
- ***Information on obtaining prior authorization and referrals***
- ***Information on how to contact Amerigroup Provider Relations***
- ***PCP panel listings***
- ***Online updating of office information (such as changes in address, telephone number, or language capabilities)***
- ***Online network provider searches***
- ***Claims dispute submission information***

Today, 67.5 percent of our network providers in Nevada are registered users on our website.

Additional Supporting Communications

In addition to the provider hotline and provider website, we offer providers various other materials to support program activities. This includes:

Figure 5.1.11.4-3. Provider Communications Includes Newsletters, Quick Reference Card, and More

- ***Quick Reference Card.*** ***Our Quick Reference Card summarizes critical process information from the Provider Manual, including eligibility verification and reference information.***
- ***Provider Manual.*** ***Amerigroup Nevada has a Provider Policy and Procedure Manual (Provider Manual) that is approved by DHCFP for our current contract. It includes all of the requirements detailed in Section 4.5.8.1 of the RFP. Our Nevada Provider Manual is developed by our Nevada Provider Relations team in consultation with our Nevada Medical Director, Nevada Medical Management team, Nevada Compliance Officer, Nevada Regulatory Services Manager, and other subject matter experts within our local Nevada health plan and our corporate office. We will obtain written approval from DHCFP prior to distributing any new or materially revised Nevada Provider Manual.***
- ***Provider Newsletter.*** ***Our quarterly provider newsletter offers providers relevant and helpful information. Recent topics include the newly updated immunization schedule, benefits of prescribing generic prescription drugs, and the benefits of shared decision making. Our provider newsletter is distributed to providers through our provider website. We submit our newsletters to DHCFP for review and approval prior to publication and distribution in accordance with RFP Section 4.5.8.2.***
- ***Provider Alerts and Updates.*** ***To convey important information or updates to providers, we fax an Amerigroup Alert to provider offices. For example, last year we faxed an alert to providers who did not appear in our provider eligibility file from DHCFP. The***

alert was to notify them of the process to secure enrollment with DHCFP as an eligible provider.

We post communications to our provider website.

Provider Contracting and Compensation

We have an open network and encourage participation of all eligible providers who meet our credentialing standards. We reach out to all Essential Community Providers and make a good-faith effort to gain their participation in our network. As DHCFP notifies us of newly identified Essential Community Providers, we contact them in person or by telephone to introduce Amerigroup Nevada, answer any questions they might have, and begin the contracting process.

We understand Nevada provider billing patterns and structure provider compensation to reflect the local community. For example, we understand DHCFP's guidelines around EPSDT services, coding, and reimbursement, including what services, such as hearing and dental screenings, are not payable separately.

We are committed to adjudicating provider claims in a timely, accurate, and provider-friendly manner. Our practices are in accordance with the requirements of the RFP, including Section 4.10.5, Timely Payment of Claims. Amerigroup Nevada reimburses providers for medically necessary, covered services based on Nevada Medicaid rates, when available. We processed more than 1.6 million claims under our Nevada Medicaid contract since beginning our operations. September 2012 quality results showed financial accuracy of 99.94 percent and payment accuracy of 99.21 percent. On average, we pay our Nevada Medicaid and Check Up claims in 4.7 days.

For additional information on claims and reimbursement, please see Section 5.1.11.6.

F.	Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.

See the Confidential Technical Volume for proprietary information.

G.	Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.

Sole Source Subcontracts

We do not have any sole source subcontracts that are exclusive to any particular providers and effectively freeze other providers as explained in Question 61 in Amendment 1 to the RFP. Amerigroup Nevada understands this is an ongoing requirement and we do not intend to have any sole source subcontracts in the future. Should we anticipate having any sole source subcontracts in the future, we will notify DHCFP of the service and sole source subcontract.

H.	The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transaction. Vendor(s) should acknowledge their understanding that NPI's must be used.

Using the National Provider Identifier (NPI)

Amerigroup Nevada currently complies with this requirement and will continue to do so under the new Contract.

Amerigroup's information systems and practices are fully compliant with National Provider Identifier (NPI) requirements. Our credentialing, single case agreement, and claims-processing processes verify that the provider has a valid NPI.

We worked closely with DHCFP in 2010 to ensure that providers, including atypical providers, were complying with NPI requirements and we are committed to continuing this practice and ensuring compliance.

Quality Assurance (§5.1.11.5)

In Section 5.1.11.5, Amerigroup Nevada describes our approach to Quality Assurance. Our responses to the questions from RFP Section 5.1.11.A through C include our response to the Scope of Work requirements for RFP Sections 4.7 through 4.9. Section 5.1.11.5 is organized as follows:

- ***Introduction***
- ***Section 5.1.11.5.A and Scope of Work Sections 4.8—Internal Quality Assurance Program (IQAP) and Standards***
- ***Section 5.1.11.5.B and Scope of Work Section 4.9 and 4.7—Quality Assessment and Performance Improvement Strategy***
- ***Section 5.1.11.5.C—HEDIS Measure Diversity of Medicaid membership Data Collection***

Amerigroup—Established Nevada Medicaid Quality

Successful HSAG Initial Program Audit - 96 %

Over the past four years, Amerigroup built and implemented our Nevada Quality Assurance Program to deliver quality care and services by establishing strong relationships with our providers and DHCFP. We successfully completed our initial audit by Health Services Advisory Group (HSAG); the State's External Quality Review Organization (EQRO), with a 96 percent score and achieved NCQA Medicaid Accreditation as a New Health Plan. We are the only NCQA Medicaid-Accredited Health Plan in Nevada, and follow NCQA quality, utilization management, credentialing, and compliance standards for all NCQA components and domains. We achieved this distinction in 2011 with a 98.28 percent compliance score for New Health Plan accreditation.

Achieved NCQA Medicaid Accreditation as a New Health Plan with a 98.28% compliance score.

In September 2012, Amerigroup obtained NCQA re-accreditation for Disease Management (DM) with the status of Accredited with Performance Reporting. This distinction is awarded only to organizations that meet or exceed its standards for DM accreditation and report results for a specified number of DM Performance Measures. Our Performance Improvement Projects (PIPs) are well designed and have progressed well past baseline measurements. An MCO new to the State will need to start the process of developing relationships with the providers, members, and the State from the beginning, losing the gains we have achieved over the past four years.

Amerigroup Culture of Quality

Amerigoup Nevada embraces quality assurance and improvement as a workplace culture, not simply as a separate function within the health plan. We identify and adopt Nevada's local and community best practices and remain nimble in responding to changing market conditions. By continually directing our employees and resources toward achieving quality goals, we ultimately improve the quality of life for our members while delivering value to DHCFP.

Every employee is a quality advocate, and in every functional area of the organization, quality is the number one priority. Our Amerigroup Nevada "Investing in Quality" Team, led by the CEO, includes input from every Nevada health plan employee in all operational areas. We address a broad spectrum of care and service concerns, including internal health plan education, outreach and incentives to members and providers, and educational services and materials.

A.	Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.

SECTION 4 S.O.W

Amerigroup Nevada IQAP Description (§4.8)

The following response addresses the Scope of Work requirements from Section 4.8. We have added the subsection reference in parentheses in each related heading.

We annually develop or update the IQAP descriptions for Quality Management, the Utilization Management Program, the IQAP Work Plan, and the IQAP Evaluation Report. They are four separate but integrated program documents to document program details and accomplishments. We capture relevant processes within appropriate individual policies and procedures, and we identify quality improvement initiatives annually and throughout the year. The IQAP Work Plan captures all of our improvement initiatives, interventions, and monitoring of IQAP activities. Periodically and annually, we evaluate and analyze the IQAP and UM Programs are to assess the effectiveness of process improvement changes and to identify additional opportunities. We capture these analyses in the IQAP annual evaluation report.

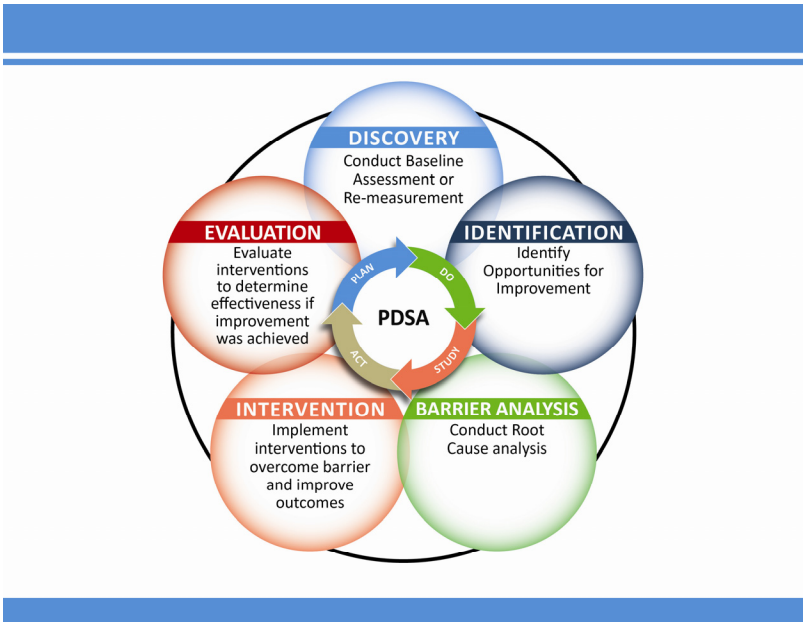
SECTION 4 S.O.W

Performance Improvement Projects (PIPs) (§4.8.1.)

Since 2009, we have worked closely with DHCFP and HSAG and have incorporated their recommendations into our Plan, Do, Study, Act/Assess (PDSA) and our Rapid Cycle Learning performance improvement plan (PIP) development and monitoring process (Figure 5.1.11.5-1). We use the PDSA process, also referred to as the Deming cycle, to identify and evaluate a possible clinical or non-clinical PIP opportunity. We derived our PIP

development and monitoring process from recommendations for planning and action published by CMS, HSAG, and from pioneering work in quality by Dr. W. Edwards Deming.

Figure 5.1.11.5.-1. Our PDSA and HSAG PIP Process Hybrid Diagram



To begin, the IQAP leader creates a multidepartmental team with representation from affected functional areas to participate in the project. The team develops an action plan to bring our performance up to the desired goal using the PDSA cycle. The process includes the following NCQA-recommended processes:

- ***Developing a baseline measurement***
- ***Identifying barriers (using Ishikawa (fishbone) diagramming)***
- ***Building appropriate interventions to address those barriers***
- ***Gathering the resources needed to conduct interventions***
- ***Establishing specific targets/benchmarks and timeframes***

The corporate quality department supports our work by sharing best practices from the other affiliate. We more fully describe corporate quality support in Standard III: Accountability to the Governing Body (§4.8.7.1-5) in this section of our response. The team identifies the means for measuring the results of new/enhanced interventions. We report results of the data analysis monthly or quarterly. We present quarterly results to the Medical Advisory Committee (MAC) and the Quality Management Committee (QMC), and we refine interventions based on

actual results. We repeat the process until the desired results are achieved. The team then monitors results for sustained improvement.

<u>Rapid Cycle Learning</u>

To support our Continuous Quality Improvement (CQI) efforts, we use our Integrated Analytical Platform (IAP)—a tool that enables our experts to capture and evaluate data and monitor cost and utilization trends across our membership base in real time. The IAP provides a powerful assist to analyzing population variables such as age, disease, risk factors, and members with special needs. With this tool, Amerigroup can identify and address potentially negative quality indicators. This process allows us to select and implement PIPs that are most responsive to the changing needs of the health plan by producing interim analysis of provider performance data related to the key measures and interventions.

Once we initiate a PIP, the design of the PIP is transformed into data collection processes that trigger the collection and tracking of interventions, incentive payments, encounters associated with the PIP, and other data points. These are analyzed in real time to provide our IQAP employees ongoing insight into the progress of the PIP, based on the initial interventions. If the progress is slower than anticipated within the timeline of the PDSA, then the Rapid Cycle Learning (RCL) process is employed to make mid-course corrections based on the data received. This RCL continues throughout the year as IQAP employees and other functional area representatives of the health plan obtain and use real-time data.

<u>Baseline Data Collection and Identification of PIP—(PLAN) (§4.8.1.1)</u>

Data analysis points us to potential quality concerns for further evaluation. We identify the appropriate quality indicator to measure and establish the baseline data collection timeframe. Once we identify a PIP, we perform a barrier analysis to determine root causes.

<u>Root Cause Analysis and Selection of Interventions—(DO) (§4.8.1.2)</u>

Our IQAP employees analyze that data quarterly to obtain insight into the quality of care delivered to members for a specific study parameter. We use the standard four-step root cause analysis process: data collection, causal factor charting, root cause (barrier) identification, and recommendation of actions, most often using Ishikawa diagramming. We implement the interventions as designed by the process which also address cultural differences in accessing care for the identified performance measure.

<u>Data Collection and Re-measurement—(STUDY) (§4.8.1.3)</u>

We compare subsequent data to the baseline data to determine if the interventions are correct. IQAP employees monitor all data results in comparison to the goals and benchmarks

established by DHCFP and the design of the PIP, whether State-mandated or internal, and identify areas exceeding or not meeting goals.

Our IQAP employees analyze data related to a PIP quarterly to obtain ongoing insight into the interventions' successes with the targeted members. We develop specific data collection processes that track interventions, incentive payments, encounters associated with the PIP, and other data points. IQAP employees evaluate race, ethnicity, language, and geographic sub-groups for specific community or cultural interventions to better reach them. In this way, we transform the design of the PIP based on ongoing data.

Evaluation and Adjustment of Strategies—(ACT and ASSESS) (§4.8.1.4)

When we exceed targeted performance, we share interventions with other Amerigroup health plans to promote organization-wide adoption of best practices. When data points do not meet goals, we conduct root cause analysis and discuss results at relevant workgroup meetings to identify barriers for members, providers, and the health plan. We implement new interventions and actions through the RCL process to address the identified barriers and then re-measure.

Upon request, we will offer our findings for PIPs not mandated by the State to DCHFP in support of continued collaboration.

SECTION 4 S.O.W.

State-Mandated Performance Improvement Activities (§4.8.2.1-3)

In 2011 and again in 2012, HSAG evaluated our Performance Improvement Projects. All three of our State-mandated PIPs received an overall "Met" validation status, which, HSAG reported, represented an area of strength for us and provided confidence in the technical aspects of the studies for HSAG and DHCFP. DHCFP identified three PIPs for Nevada Medicaid in 2012-2013 that we have implemented or are actively implementing: Childhood immunization Status-Combo 2, 3, and 10; Improving Diabetes Screening and Control; and Decreasing Avoidable Emergency Department (ED) Visits. We implemented Childhood Immunization Status-Combo 2, 3, and 10 and Decreasing Avoidable ED Visits for Nevada Check-up. The Lead Screening in Children PIP was validated in 2011 for both Medicaid and Nevada Check Up members and was retired in 2012 with ongoing monitoring of rates to demonstrated continued performance.

NEVADA CHECK UP

"Amerigroup also had a 17 out of 19 reportable HEDIS rates above the 50th percentile, including 11 rates above the 90th percentile."

HSAG 2011- 2012 External Quality Review Technical Report for Managed Care Organizations (MCOs)

The most recent HSAG Technical Report released in October 2012 gave Amerigroup an overall IQAP score of 95 percent. We scored over 90 percent compliance on 10 of the 13 standards with our performance on six of those standards earning a 100 percent score.

The 2011 Amerigroup IQAP evaluation noted that our DHCFP-reported HEDIS rates improved in 11 out of 12 comparable rates. Eight out of 12 rates achieved 10 percent improvement to meet DHCFP goals. The HSAG Technical 2011 Report noted that "Amerigroup Nevada had a remarkable 15 out of 18 rates above the 50th percentile, including nine rates above the 90th percentile", and we improved in all 22 comparable Medicaid rates over the previous period. As evidence of our continued performance with Nevada Check Up HEDIS rates, the 2012 HSAG report stated: "Amerigroup also had a remarkable 17 out of 19 rates at or above the 50th percentile, including 11 rates at or above the 90th percentile. The October, 2012 report noted that 31 out of the 35 trended Medicaid HEDIS measures showed improvement since the baseline rates. A detailed analysis of our DHCFP mandated PIPs is presented in our response in Section 5.1.11.5.B—(§4.9.2.3-4).

NEVADA MEDICAID

"Amerigroup improved in all 22 comparable Medicaid rates over the previous period."
HSAG 2010-2011 External Quality Review Technical Report for Managed Care Organizations (MCOs)

In addition, in 2011, we conducted measurement of quality improvement activities according to NCQA HEDIS 2011 Technical Specifications in accordance with DHCFP Contract requirements for Medicaid MCOs. Both HSAG and Amerigroup, (through Attest Health Care Advisors a HEDIS auditor), audited our performance for receiving and integrating HEDIS data for reporting. We sumitted the HEDIS 2012 data to DHCFP, HSAG audited it, and DHCFP accepted it.

We will continue to report annual HEDIS measures specified by DHCFP on a calendar-year basis, which may overlap Contract periods. We value the collaboratively relationship built with DHCFP and the EQRO contracted for the Nevada HSAG. Our goal is to continue to nurture and grow the relationships, and we welcome onsite validation visits as we did with the DHCFP 2011-12 IQAP Audit and the HSAG annual submission.

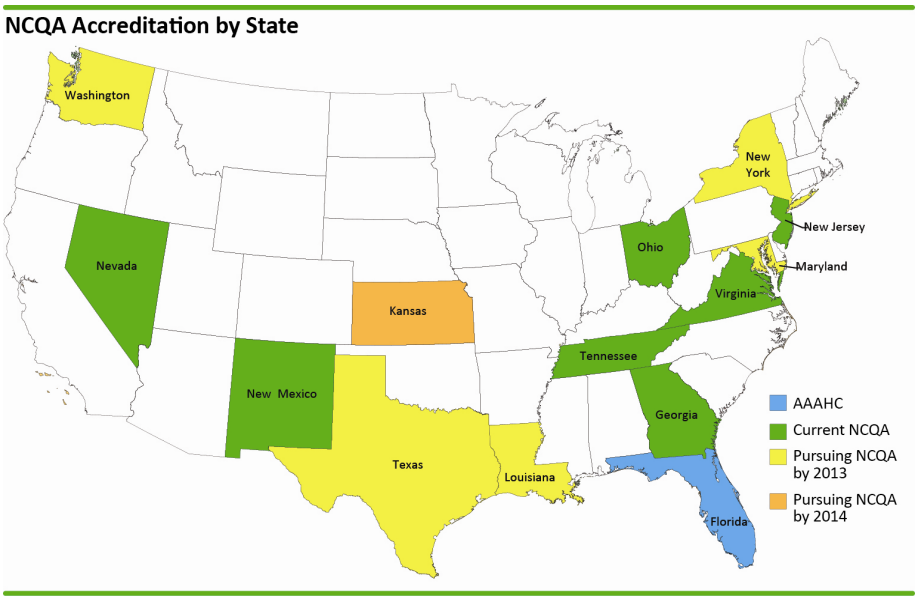
SECTION 4 S.O.W.

Current Sources for the IQAP guidelines and the most current NCQA Standards and Guidelines (§4.8.3)

Amerigroup Nevada holds NCQA Medicaid accreditation of New Health Plan effective from 2011 through 2014, which attests to the effective use of NCQA Standards and Guidelines as part of our IQAP. In addition, we use recognized clinical practice guidelines of professional associations such as the American Heart Association, American College of Obstetricians and Gynecologist, and the Community Preventive Service Task Force recommendations. We use the Nevada Medicaid Services Manual, InterQual Criteria, and Aetna Clinical Policy Bulletins to guide our UM decisions ensuring quality provision of care.

Our newest health plan in Kansas will begin operations in 2013 and already started the process to prepare for NCQA accreditation (Figure 5.1.11.5-2).

Figure 5.1.11.5-2. NCQA Accreditation Shows Amerigroup's Commitment to Quality



SECTION 4 S.O.W.

Health Information System (§4.8.4)

Amerigroup devotes significant corporate resources to ensure that system availability meets business needs. For many systems, such as our core operations system and telecommunications infrastructure, we maintain availability 24 hours a day, 7 days a week (24/7). We have positioned our management information system (MIS) and technology architecture to maintain the highest level of systems reliability and availability. We are committed to internal monthly systems availability of 98.5 percent and in 2011 performed at an average of 99.95 percent.

A detailed HSAG review of our 2011 Performance Reports determined that we prepared our reports according to the HEDIS 2011 Technical Specifications for all of the audited measures. Audits of information system capabilities for accurate HEDIS reporting found that we were compliant with all standards assessed. A review by Catalyst, an NCQA-Certified software program, found us in compliance with IS 1.0-.0. The medical record vendor Inovalon conducts our medical record pursuit and data collection.

We employ a health information system to collect, analyze, integrate, and report data in accordance with 42 CFR 438.242. We maintain data in standardized systems and databases in a confidential, accurate, timely, and comprehensive manner. We receive and process external data according to structured processes and timeframes. We verify internal and external data by rigorous quality checks for integrity. We make all collected data available to DHCPF and

CMS upon request. We use many IQAP data sources for analysis, tracking, and trending, including:

- ***Enrollment, disenrollment, and member demographic information***
- ***Claims and encounter data, with an emphasis on over- and under-utilization***
- ***Utilization and case management (CM) authorizations, assessments, and notes***
- ***Medical record audit results with follow-up taken on recommended actions***
- ***Grievances and appeals summary with pattern analysis***
- ***Adverse incident results focused on critical incidents***
- ***Member satisfaction survey***
- ***PIP interim results to identify progress or a need to modify interventions***

Core Operations System (§4.8.4.1-3)

Our core operations system is the system of record for all provider, member (including enrollment and eligibility), claims, and authorization data. We update this information through the user interface or through application-specific data loads such as enrollment files received from state partners. All other Amerigroup applications interface the core operations system map to its data structures to enable consistency in naming, formatting, and validation and drive data quality and reliability.

Care Management System

CareCompass is our clinical care management solution that integrates seamlessly with our core operations system. CareCompass gathers and organizes information from sources such as claims and authorizations, pharmacy data, and lab data to enable proactive identification and management of member health and to facilitate communications among all participants of the member's care team. We describe our CareCompass system in more detail in this response under Standard XIV: Continuity of Care System (§4.8.18).

Provider Data Verification (§4.8.4.2)

Our core operations system is the system of record for our provider data, including demographic data, provider type, specialty codes, payment information, provider contract status, license number, credentialing information and status, affiliations, and PCP panel capacity. We use an integrated workflow and imaging application to support the provider intake and information management process and to ensure accuracy and completeness of the data.

The application stores our provider contracts and credentialing application, aiding compliance management by tracking the credentialing details. On a quarterly basis, employees pull a random selection of provider files to review the data entered into the database as a means of verifying the accuracy and timeliness of data entered for all provider and credentialing data elements. Additional information on the credentialing/re-credentialing process is found in this response under Standard IX: Credentialing and Re-credentialing (§4.8.13).

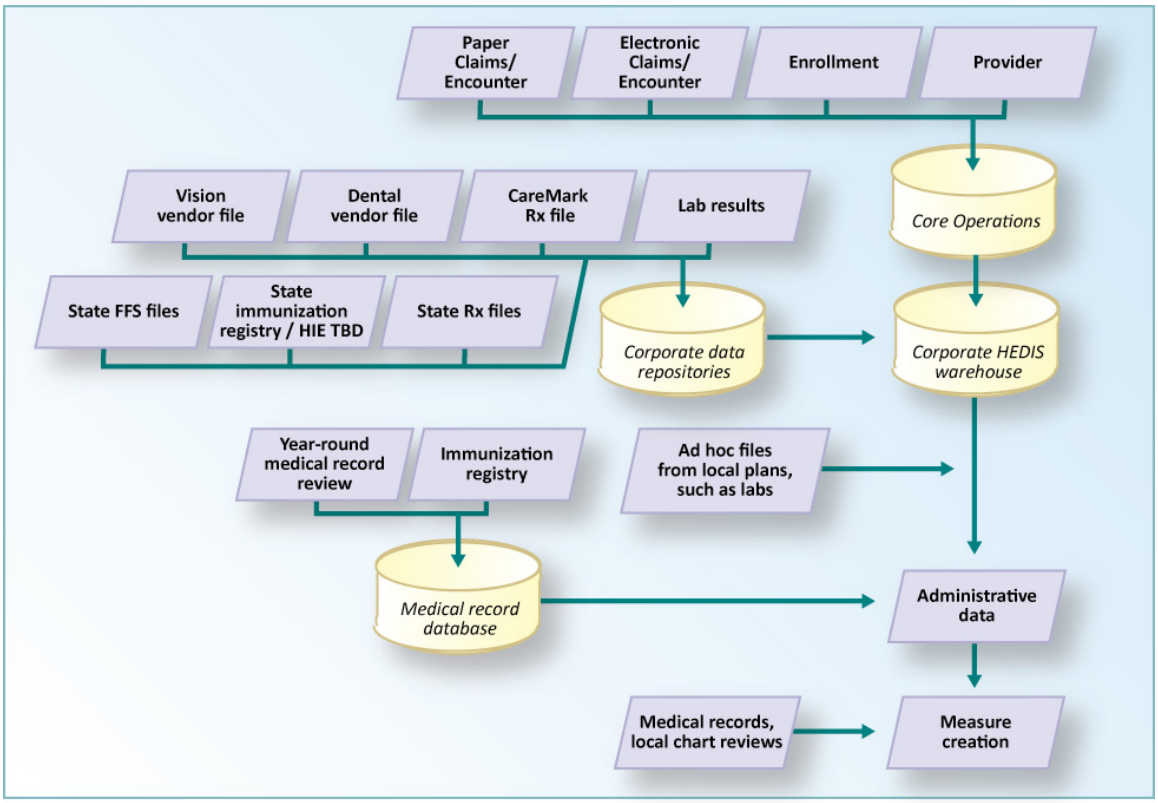
Supplemental Applications

Our MIS includes additional integrated applications that support the overall functionality of Medicaid and Medicare operations, including provider profiling, EPSDT, HEDIS, Member ID cards, PCP assignment, credentialing, imaging and workflow, and workforce management. Dashboards/business intelligence analytical reporting and other supplemental applications maximize functionality, efficiency, security, and data analytics.

Data Warehouse

Amerigroup's data warehouse is an integrated repository fed directly from the core operations system to ensure data quality, control, and consistency (Figure 5.1.11.5-3). The data warehouse maximizes our capacity for data analytics and affords us the flexibility to produce targeted reporting to support our state customers, business processes, providers, and members. Additional information on our HEDIS data warehouse is provided under HEDIS MIS below.

Figure 5.1.11.5-3. Amerigroup's HEDIS Data Warehouse Provides Validated Data Management



HEDIS MIS

Our HEDIS MIS system provides the structure to support the Amerigroup dedicated team of data experts. This team applies rigorous quality control tools to validate HEDIS, HEDIS-like, and health plan data used to measure outcomes for many quality activities. Managing all the data sources, formats, and elements required for HEDIS demands a comprehensive solution to capture and report data and information to support the process. Amerigroup's solution exists in a HEDIS data warehouse that stores data from multiple sources beyond the information stored in our transaction processing systems.

Amerigroup employs analytical professionals who support health plan performance improvement activities and our strategy to leverage clinical analysis, research, and development to drive quality improvements. Our biostatisticians and analysts provide expertise to our Quality team using multiple resources and programs for IQAP reporting.

Amerigroup's team of 14 HEDIS dedicated employees provide extensive support to our Nevada health plan. These five analytical professionals/HEDIS project managers, three performance project staff, and six local health plan management and QI coordinators:

- ***Mine, map, and extract data, and then report, review and analyze all HEDIS data to track performance and interpret trends; meet with our IQAP employees weekly to identify improvement opportunities***
- ***Synthesize data that links IQAP interventions such as member and provider outreach with data improvements and identify interventions that have the greatest impact at the plan level***
- ***Validate 100 percent of data, ensure accuracy and data efficiency, utilize knowledge of local providers, train personnel, and implement member and provider interventions***

TESTIMONIAL

"Amerigroup Nevada demonstrated strong policies and procedures for collecting, processing, and reporting HEDIS data and was in full compliance with the HEDIS 2012 Technical Specifications. The claims and encounter data systems employed used sophisticated scanning processes and advanced software to ensure accurate data processing. The audit showed that we used certified HEDIS software for reporting the HEDIS rates, which ensured accurate programming and reporting of the rates."

HSAG 2011-2012
External Quality Review
Technical Report

Amerigroup's information systems collect and integrate health information to support quality activities. We collect various kinds of data from internal/external data sources: claims; pre-season medical record review; laboratory results; pharmacy; dental/vision vendor encounters; state historical file and FFS information; and Nevada State immunization information.

We maintain data in standardized systems and databases in a confidential, accurate, timely, and comprehensive manner.

To create our HEDIS warehouse, we divided all encounter data sources into three categories: claims, pharmacy, and laboratory results, following our HEDIS-certified software vendor's (Inovalon) data category and layout. We map data into standard formats within the three categories of claims, pharmacy, and laboratory findings to capture a comprehensive clinical history of our members. A national auditor (Attest Inc) audits all data in this warehouse before being submitted to NCQA for HEDIS reporting.

Amerigroup generates specific data mapping for Nevada for both HEDIS and HEDIS-like measures. Through our expertise with HEDIS data collection, we work with DHCFP to extrapolate data specific for Nevada into segregated data warehouse components. Data are loaded into Inovalon warehouses to produce final HEDIS rates.

Inovalon servers extract the information in our warehouse. Amerigroup uses current NCQA-certified HEDIS software Inovalon Quality Spectrum Insight (QSI) and Quality Spectrum Hybrid Reporter (QSHR) to collect HEDIS measures and follows the NCQA current HEDIS specifications as validated by an externally certified, NCQA-approved auditor (most recently Attest Healthcare Advisors, LLC).

Our HEDIS Data Management and Maintenance team oversees the HEDIS data processes to verify that our quality metrics accurately reflect our performance.

- *Amerigroup monitors and audits all vendor data sources; we also leverage and examine all readily available supplemental data sources (such as state immunization registries; historical Member databases; and year-round medical record review results) to ensure that we report the most accurate results. We also regularly assess the viability of seeking additional data resources such as local laboratory vendors who may not regularly submit data.*
- *Meticulous data management protocols validate that our HEDIS reports reflect all potential encounters. Data mapping and extraction protocols undergo stringent quality testing prior to actual production and verify that our results reflect all appropriate provider specialties, state-specific coding practices and NCQA updates. Our team regularly assesses data integrity and searches for reporting anomalies that may skew HEDIS results, such as improper claims coding.*
- *Benchmarking tools enable the team to identify potential data irregularities. Using internal benchmarks (such as previous annual results, state averages, or NCQA percentiles), the team continually searches for data reporting errors that may distort HEDIS results.*
- *Our processes fully support data disaggregation to evaluate health disparities and the quarterly files detailing gaps in care by member are exported to the member outreach portal for ongoing Member outreach.*

For example, we performed a deeper look into the data on well child visits and uncovered a significant difference in the results between the Reno and Las Vegas areas. Our IQAP team used the information to tailor interventions to increase well child visits in each area.

SECTION 4 S.O.W.

Standard I: Written IQAP Description (§4.8.5)

Our locally based IQAP, includes oversight of our Utilization Management (UM) and Case Management (CM) Programs. Our Nevada IQAP is mature and continuously addresses issues related to quality, utilization, case, and disease management; customer service; and provider credentialing/re-credentialing. Since 2009, we have achieved significant

gains in quality improvement such as improved lead screening in children and our DHCFP partnership for Diabetes Self-Management, which eliminates the delays and costs associated with a new start-up.

Our NQCA Accredited Disease Management Program, along with our Case Management and Health Promotion Programs, are integrated into our IQAP processes to facilitate the delivery of the most appropriate, medically necessary care to members in the most cost-effective, least-restrictive setting. Our programs are flexible and easily adapted to the needs of diverse populations, whether those needs involve attention to co-morbid conditions or cultural/linguistic preferences. In addition, they span a broad clinical spectrum including preventive and primary care, behavioral health treatment (mental health and substance use disorder), Children with Special Health Care Needs, medication management, vision, and dental services. Our IQAP systems and techniques improve our efficiency and our providers while promoting improved health outcomes and well-being for our members.

AMERIGROUP'S DISTINGUISHING FEATURES FOR QUALITY MANAGEMENT:

- Creatively reaching members through high-touch and high-tech tactics
- Leveraging technology to identify and prioritize those members at the greatest risk for poor outcomes
- Actively engaging providers in quality management
- Engaging members by understanding their capacity for change and coaching them to take charge

Amerigroup's IQAP has three written NCQA-compliant documents to guide our quality improvement efforts: IQAP Description, Work Plan, and Program Evaluation.

<u>Goals and Objectives (§4.8.5.1-2)</u>

A Nevada-specific IQAP Description details our program structure and governance, resources allocated to IQAP activities, goals and objectives, scope, and specific strategies to achieve desired outcomes in the performance measures. We clearly define the scope of the IQAP. The program description includes narrative on the Nevada quality committees' composition and activities that are described in Section 4.8.7 and 4.8.8, along with resources allocated to quality management.

The following are our IQAP Goals and Objectives for 2012 that we also detail within the IQAP Description:

- ***Develop and maintain IQAP resources, structure and processes that support the organization's commitment to quality healthcare for members***

- ***Collaborate with State, federal and regulatory agencies in the administration and coordination of care and services, development of policy and procedures and oversight process***
- ***Develop effective methods for measuring outcomes of care and services provided to members and intervene to achieve continuous measureable improvements using a CQI approach***
- ***Coordinate, monitor, and report IQAP activities to include progress with quality improvement goals***
- ***Ensure effective coordination/communication of IQAP activities with all appropriate functional areas***
- ***Provide oversight of all activities to ensure compliance with all State, federal and accrediting organizations***

Scope of Our Nevada IQAP (§4.8.5.3)

Amerigroup's IQAP encompasses the full spectrum of physical and behavioral health services provided to our members including monitoring and driving quality improvement processes that support their health and well-being.

The scope of the IQAP encompasses clinical and administrative services provided to external and internal customers. External and internal customers include not only our members and providers but also Amerigroup employees, DHCFP, HSAG, and other associated State and federal government entities. Internal customers include our customer service organization, utilization management, disease management, health promotions, provider relations/network management, credentialing, and quality improvement functions.

The IQAP integrates all functional areas in the decisions that affect the quality and safety of care and services provided to our members. The program reviews the entire scope of care for all demographic groups, races, ethnicities, special needs populations, care settings, and types of services. Our Nevada IQAP has the organizational infrastructure to provide effective monitoring, reporting, and analysis and to act on opportunities to improve clinical care and services. We collaborate with DHCFP, HSAG, and other associated State and federal government entities to coordinate and collaborate across all systems of care on behalf of our members, our providers, and the State.

Specific Activities (§4.8.5.4)

A key component of quality operations and an integral component of our IQAP description is the annual IQAP Work Plan, which is our road map for the upcoming year. It includes a detailed outline of activities for monitoring, analysis, and reporting to the Amerigroup

governing bodies throughout the year. The Work Plan includes reporting of the Nevada measurements, organizational quality of care, provider reviews, and service projects.

The Work Plan is the tool that guides us in systematically monitoring, evaluating, and taking effective action to identify and address all program improvements and measure our success in achieving targeted improvement goals. Amerigroup identifies opportunities for improvement or expansion of our current quality improvement initiatives by assessing our performance across key quality metrics. Our Work Plan is consistent with the DHCFP Quality Assessment and Performance Improvement Strategy (QAPIS) for each year and is further discussed below in Standard II: Systematic Process of Quality Assessment and Improvement (§4.8.6).

Continuous Activity (§4.8.5.5-6)

Our integrated IQAP encompasses the spectrum of physical and behavioral health, pharmacy services, and dental services that our members receive. Our monitoring and quality improvement processes support member health and independence. The IQAP integrates all functional areas in the decisions that affect the quality and safety of care and services we provide to our members. Our services span all demographic groups, races, ethnicities, care settings, types of services, and populations with language and other specialized needs.

Our IQAP focuses the entire health plan through our culture of quality and our "Investing in Quality" Team efforts on achieving sustainable improvements in the quality and coordination of care for all of our members. Our program reflects the demographic and epidemiological needs of our Medicaid members and incorporates key strategies outlined by DHCFP. Quality improvement is a dynamic process that extends well beyond our formal IQAP written plan and includes the following methodologies to expand quality services' impact across all functional areas while focusing on those activities that drive improved quality:

- *Member-Centric Focus. Supporting member decision-making and providing members with coordinated services and supports needed for self-management of their health conditions and independent living. We offer targeted wellness, outreach, and incentive programs to support members taking charge of their health.*
- *Provider Review and Collaboration (§4.8.5.7). Collaborating with network providers to achieve our quality goals through outreach, education, cultural competency training, our physician incentive program (Provider Quality Incentive Program (PQIP), Patient Centered Medical Homes (PCMH) support, provider satisfaction surveys, and through representation on the Medical Advisory Committee (MAC) and Credentialing Committee.*

- *Customer Satisfaction.* ***Measuring member and provider satisfaction and taking action to maximize performance through Consumer Assessment of Healthcare Providers and Systems (CAHPS®)survey and provider surveys.***
- *Patient Safety.* ***Promoting the safety of healthcare services delivered to members.***
- *Accreditation Recognition.* ***Validating performance through external accreditation such as NCQA New Health Plan Recognition and Disease Management.***
- *Outcomes Management.* ***Authenticating our achievements through standardized quality activities and measures such as HEDIS, PIPs, and DHCFP-specific performance measures.***
- *Culture of Quality.* ***Fostering a workplace culture that is grounded in quality through training and alignment of employee objectives with quality goals examples include our quality online training and our total and continuous quality improvement approach.***
- *Clinical Research and Development.* ***Leveraging credible clinical data, both internal and external, to inform quality initiatives.***
- *Network Excellence.* ***Facilitating access to a superior provider network through a rigorous credentialing and auditing process.***

Focus on Health Outcomes (§4.8.5.8)

We maintain the quality resources, technology infrastructure, and expertise needed to meet the State's QAPIS goals for integrated and coordinated care and to improve health outcomes and quality of life for all Medicaid members.

Each year, we perform an extensive IQAP evaluation to analyze our processes and outcomes. Our QMC and other specific quality committees review this, along with all quality guiding documents and ongoing analyses. These monitoring strategies drive improvements to our quality processes. The IQAP evaluation is discussed in further detail in Evaluation of Continuity and Effectiveness of the IQAP (§4.8.6.8) below.

Standard II: Systematic Process of Quality Assessment and Improvement (§4.8.6)

We document our systematic process of quality assessment and improvement in our IQAP. As an integral component of the IQAP, the IQAP Work Plan lists each activity planned, the objectives for each activity, the actions to be taken, target action dates, responsible parties, status of the activity, and the outcomes. The Work Plan provides an objective and systematic means to monitor and evaluate the quality and appropriateness of care and service provided to our members through care studies, surveys, PIPs, and other related activities.

The Work Plan includes the specification of clinical or health services delivery areas that we plan to monitor. For our Medicaid and Nevada Check Up members, the Work Plan documents the care and services in certain priority areas of concern selected by DHCFP. Our Work Plan is the basis for our establishment of PIPs in accordance with 42 CFR Section 438.358(b). We collaborate on the design and implementation of at least three mandated PIPs during each State fiscal year. During the design, review, and approval process for new PIPs, we work with DHCFP to establish timeframes for each PIP. Our systematic PIP development, implementation, and evaluation processes are outlined previously in PIPs (§4.8.1) and are detailed in the response to Section 5.1.11.5.B.

Our Work Plan documents the quality indicators to be used in our studies and related activities as well as the clinical care standards and practice guidelines specified for each area of concern being monitored. We include standards and guidelines that are based on reasonable scientific evidence and which our providers have developed or reviewed. We focus our standards on the process and outcomes of healthcare delivery, preventive services, and access to care. We tailor the standards to meet the varied member population that we serve and we publish them for use by our network of providers. Each year, our QMC reviews the standards and updates them, as appropriate.

Multidisciplinary teams perform the activities and analyze the results. Our teams include qualified clinicians who evaluate the quality of care and services through the individual case review and through studies that analyze patterns of clinical care and related services. Each year, our QMC approves the IQAP Work Plan. The Director of IQAP prepares and distributes a written report (the evaluation) to Amerigroup QIC and the Nevada Board of Directors and then to DHCFP.

The evaluation allows us to determine if the scope of the IQAP Work Plan or the content needs to be modified in any way. The IQAP report provides an overall evaluation of the effectiveness of the IQAP. The report provides a complete picture of the studies conducted and the trends of clinical and service indicators; documents improvements in quality; and presents areas of deficiency and the recommendations for corrective actions.

<u>Monitoring and Evaluation of Care (§4.8.6.1)</u>

We use a CQI process described in Performance Improvement Projects (PIPs) (§4.8.1.). Using data from IAP and our HEDIS datamart paired with clinical and service observations from our experienced staff, we identify potential areas of concern. These tools provide the IQAP team with data sorted on multiple variables such as age, disease or diagnosis, risk factors, and special needs of members. We use the performance improvement process flow described previously, drilling down with the Ishikawa method for defining barriers and employing data

analysis to further refine the opportunities for improvement. Once identified, we apply the PDSA methodology, which corresponds to the following NCQA protocols:

- ***Develop a baseline measurement***
- ***Identify barriers and root cause (Ishikawa diagramming)***
- ***Build appropriate interventions to address those barriers***
- ***Gather the resources needed to conduct interventions***
- ***Establish specific targets, benchmarks, and timeframes***

The team then monitors results for sustained improvement. If progress is slower than anticipated within the timeline of the PDSA cycle, we employ the Rapid Cycle Learning (RCL) process to make mid-course corrections.

The result of this analysis drives the development of the IQAP Work Plan and the IQAP activities for the year. Our 2012 Work Plan focuses on the following:

- ***Improving HEDIS rates and satisfaction with member care and services***
- ***Monitoring provider access and availability***
- ***Assessing continuity of care for physical and behavioral care delivery***
- ***Addressing member safety issues to include hospital re-admission rates and pharmacy measures such as drug/drug interaction, duplicate therapy treatment, and polypharmacy/polyphysician use***
- ***Managing utilization for over- and under-utilization and appeal rates***

As an example, our pharmacy vendor noticed an increase in new stimulant prescriptions for members with an attention deficit hyperactivity disorder (ADHD) diagnosis. We immediately implemented outreach and education of recommended follow-up visits to those members enrolled in Case Management. With MAC and QMC approval, we expanded the activity to all members with new prescriptions for ADHD and added provider notification. We currently receive a weekly report of new prescriptions and feed the information into the automated call system to continue member education of recommended follow-up visits within 30 days of the start of medication. As a result, the number of follow-up visits for children with newly prescribed ADHD medication has remained above the HEDIS 75th percentile with a 2011 measurement year rate of 45.09 percent. As the measurement is time sensitive, we continue weekly

The number of follow-up visits for children with newly prescribed ADHD medication has remained above the HEDIS 75th percentile with a 2011 measurement year rate of 45.09 percent.

interventions and monitor results monthly to ensure continued improvement.

<u>Quality Care and Services Focus and Use of Indicators (§4.8.6.2-3)</u>

We currently participate with DHCFP in monitoring each of the clinical areas of concern and areas of health service delivery through the submission of HEDIS measures and PIPs. We will continue working collaboratively with DHCFP and with the contracted external quality review organization, HSAG, to monitor the continuing improvement in care and services delivered to Medicaid members. In the 2010-2011 EQRO Technical Report from HSAG, all three Amerigroup PIPs, Steps I through VI, received an overall score of 100 percent, critical element score of 100 percent, and "Met" validation status.

The reviewers stated that this finding represented an area of strength for Amerigroup and demonstrated confidence in the technical aspects of the PIP studies.

We follow the same approach described in Performance Improvement Projects (§4.8.1) for the identification, development, and monitoring on all quality activities whether or not mandated by the State. Through the use of the IAP and HEDIS data mart, we analyze our data to identify patterns of over- and under-utilization for both members and providers as measured against norms defined to account for regional and local practice variations. A detailed analysis of PIPs and other DHCFP measures is found in Section 5.1.11.5.B.

<u>Use of Clinical Care Standards/Practice Guidelines (§4.8.6.4)</u>

Amerigroup adopts, disseminates, and uses clinical practice guidelines (CPG) for acute and chronic medical and behavioral health conditions. Through a collaborative review process, we involve board-certified providers from appropriate specialties in the development and approval of the guidelines at both our national and local health-plan level. Our CPGs are evidenced-based and known to be effective in improving health outcomes. Scientific evidence or, in the absence of scientific evidence, by professional standards or expert opinion determine the effectiveness of guidelines. Our CPGs address all areas of care provided to Medicaid and Nevada Check Up members including medical, behavioral, and preventive services for all ages and demographics. They cover the process of care delivery, anticipated outcomes against local and national benchmarks, and access to needed care and services.

The development and update process includes review of government research sources, clinical or technical literature, and involvement of board-certified providers from appropriate specialties or professional standards.

We reference the following recognized sources of evidenced-based guidelines:

- ***National organizations such as the Centers for Disease Control (CDC) and National Institutes of Health (NIH)***
- ***Professional medical specialty organizations such as the American Academy of Pediatrics (AAP), American Lung Association, U.S. Preventive Services Task Force (USPTF), American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Practice (AAFP)***
- ***Voluntary health organizations such as the American Diabetes Association (ADA) and American Cancer Society (ACS)***
- ***Behavioral health organizations such as the American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP)***
  - ***Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SAMSHA) and National Institute of Mental Health (NIMH).***
  - ***Whenever additional information from the behavioral health discipline may be referenced for optimal guidelines for medical diagnosis, we integrate both specialties in the review processes.***

CPG Review/Revision/Dissemination Processes

Amerigroup updates guidelines at least every two years or sooner if new information is identified or an update is required. We conduct a literature search to determine if changes are needed to keep the CPGs current. We review the updated guidelines following a similar collaborative local and national review process. The appropriate specialty provider reviews the guideline and makes evidenced-based recommendations for change prior to adoption and dissemination.

We adopt and disseminate CPGs through the QMC and MAC. The CPGs are made available within the case management documentation system for reference by health plan employees including Case Managers and our Medical Director. A full discussion of our CPGs is documented in the provider manual that includes our network providers' use of CPG's for each population we serve. Within 60 days of adoption, Provider Communications notifies providers that the new or updated CPGs are available on the provider website. Amerigroup updates our website annually or more frequently as needed to reduce unnecessary variation in care and help both members and providers in decision-making. We also communicate specific guideline elements and areas of focus through broadcast faxes and special mailings. All electronic transmissions to providers and our website incorporate CPG links to resources when possible. CPGs also are available to members, upon request.

The CPGs, once adopted or revised, acts as benchmarks for monitoring utilization and performance improvements and become a measurement or goal within our IQAP Work Plan, PIPs, and IQAP activities.

Analysis of Clinical Care and Related Services (§4.8.6.5)

The Amerigroup Quality Team described previously under HEDIS MIS also provides the skills and knowledge to analyze clinical care and services outside the HEDIS realm. Our five analytical professionals/HEDIS project managers, three performance project staff, and six local health plan management and QI coordinators identify and analyze patterns and trends in care delivery and review findings weekly.

From these joint sessions, we compare findings against clinical guidelines and standards to determine the most effective interventions for implementation. One aspect of every analysis is the distribution of findings across age, gender, race and ethnicity which is described more fully in the Cultural Competency (§4.9.2.2) discussion in Section 5.1.11.5.B. We will continue to work collaboratively with DHCFP and offer to share results of our analyses, in addition to our State mandated results.

Through an internal performance analysis on our HEDIS scores and as the result of the HSAG audit, we identified a number of opportunities where our experience and creative problem solving could improve the care and services delivered to Nevada. The best practice solution was the development of a cross-functional work group within the Nevada health plan. These individuals are not only experienced with clinical and non-clinical care and service delivery; they are also familiar with issues unique to the Nevada population including geographic, ethnic, social, and economic circumstances.

Our Amerigroup "Investing in Quality" Team, led by the CEO, includes every Nevada health plan employee who touches the member since all provide a unique perspective to identifying and addressing concerns.

In 2011 we standardized, refined, and carried forward in 2012 member and provider outreach interventions. These interventions are as follows:

- ***Member interventions included***
  - ***Telephone calls***
  - ***Outreach calls for education, case management, and appointments***
  - ***Mailings, reminders, and newsletters***
  - ***Health fairs, sponsored and co-sponsored with other organizations***
  - ***Distribution of AmeriTips***
  - ***Addition of bilingual quality employees***
  - ***Implementation of a comprehensive Hispanic outreach and education program through our Promotoras employees***
- ***Provider interventions included***
  - ***Distribution of Amerigroup newsletters, fax blast, CPGs, and overdue service reminders***
  - ***Provider profiling with identified care opportunities and data sharing reports***
  - ***Office audits, and medical record reviews with provider feedback and education***
  - ***Expansion of PQIP and PCMH designations to qualified providers***

Dental and Vision partners also participate in member and provider outreach efforts.

When we identify a member using multiple pharmacies through our drug utilization reports and with medical director approval, we limit access to a single pharmacy of the member's choice, called the Pharmacy Lock In program. We work with the pharmacist to evaluate the member's entire drug utilization and monitor for overuse (poly-pharmacy) similar prescriptions from different physicians (poly–physician) and drug interactions.

Monthly and quarterly interim reports are used to monitor improvements made by our interventions. Our evaluation showed continued improvement, and these interventions will be carried forward.

Implementation and Assessment of Effectiveness of Corrective Actions (§4.8.6.6-7)

Within our CQI methodology, we refer to corrective actions broadly, including a corrective action plan initiated with a provider issue, a PIP to overcome an identified gap in quality care and services delivery, or a plan of correction (POC) directed by the State. The Quality Management team follows DHCFP-approved policies and procedures for making a corrective action determination and for implementing an action plan as appropriate. Our policies and procedures, which we update and submit to DHCFP annually, include:

- ***Determination of when corrective action is appropriate***
- ***Specification of who is responsible for making the final determination regarding quality problems***
- ***Identification of actions to be taken***
- ***Outline of the schedule and accountability for implementing corrective actions***
- ***Method for modification of the corrective action if improvements are not observed***
- ***Procedures for terminating affiliation with a provider, if necessary***

As an example, DHCFP mandates disenrollment rules. We recognized that the underlying cause for members facing disenrollment was generally a correctable situation. As a result, we developed a disenrollment policy and procedure that directs employees to explore the underlying cause and implement a corrective action to ensure that members continue to receive care and services. Our Real Solution is illustrated in the story of the child needing dental sedation.

Once our IQAP implements a POC, the QMC monitors and evaluates the improvements. The QMC continues to monitor study results and individual cases are reviewed periodically to ensure that improvements have been effective.

REAL SOLUTIONS *for* NEVADA

A mother wrote in wanting to disenroll because her child was not able to have her dental work completed under anesthesia. Our employee recognized that while the situation did not qualify for disenrollment as defined by the State, the mother clearly had a concern about the dental procedures. Our Member Advocate researched the situation and found that the proposed procedure was authorized but the mother was not able to have the services performed before the child's birthday. The dental criteria do not allow children above a specific age to qualify for sedation. Through collaboration between the Dental vendor, Medical Management, and the mother, the previous authorization was extended and the services were performed. The mother and child remain satisfied members of Amerigroup Nevada.

State-Mandated Plan of Corrective Action (§4.8.6.6)

During our tenure in Nevada, we have had only one instance when a POC was requested; we followed the processes that we have in place to respond. To address the situation in which the

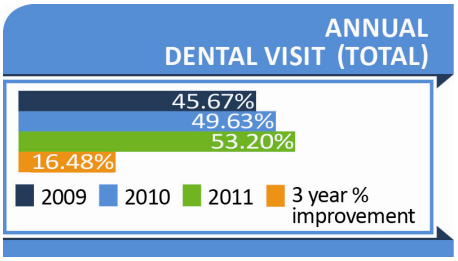
dental vendor that Amerigroup inherited from the previous MCO was under-performing, we invited DHCFP to collaborate with us and the dental vendor to identify steps for correction. Our POC addressed six areas of concern and included 17 different actions covering dental vendor employee education and process changes and Amerigroup-generated member and provider informational materials.

Amerigroup Nevada's 2012 Medicaid dental visit rate continues to improve to 53.2 percent, which exceeds the 50th percentile while our Nevada Check Up dental visit rate for 2012 exceeds the NCQA 90th percentile.

We continued to monitor the dental vendor's performance. When it became apparent that the situation was not significantly improved and the vendor relationship was seriously damaged, we focused on terminating the vendor's contract, and selected and engaged a new dental vendor.

As an example, monitoring and assessment of the dental visit rate improvement for the Nevada Check Up population from 2009 to 2011, showed a 23.26 percent improvement from 58.7 percent to 72.39 percent in two years. The issues with the dental vendor mentioned above contributed to low quality metrics, and the subsequent change to a different vendor showed the effectiveness of the corrective action taken.

As a result, our 2012 Medicaid dental visit rate continues to improve to 53.2 percent, which exceeds the 50th percentile while our Nevada Check Up rate for 2012 exceeds the NCQA 90th percentile. Over three years, our Medicaid results improved by 16.48 percent.



<u>Provider Corrective Action</u>

Amerigroup Nevada also has a structured process for requiring corrective action from providers where care or service does not meet quality standards for access, availability, member satisfaction, medical records, and over- or under-utilization. As part of the credentialing and re-credentialing process, we evaluate each of these elements and report as part of the annual IQAP evaluation. In 2011, we had no providers in corrective action.

<u>Evaluation of Continuity and Effectiveness of the IQAP (§4.8.6.8)</u>

Amerigroup conducts an annual IQAP evaluation, which is a formal assessment of the IQAP Work Plan. This evaluation is a comprehensive review of all functional activities and programs conducted throughout the year, and it occurs during the first quarter of the subsequent year. We use baseline data from our MCO experience and service delivery that allows us to build on the understanding of the population needs. Activities for subsequent years directly respond to known issues within the Nevada population served by the MCO. The Work Plan for the initial year of the new Contract will reflect a full scope of quality metrics

such as those specific to our chronic Case Management, HEDIS, preventive care measures, member outreach, and behavioral health programming. For all measures, we evaluate results as they compare to local and national benchmarks, including considerations for the population being served.

SECTION 4 S.O.W.

Standard III: Accountability to the Governing Body (§4.8.7.1-5)

Amerigroup Nevada's Board of Directors retains responsibility for overall health plan governance and in 2011 delegated oversight of the IQAP to the QMC. The QMC is co-chaired by the health plan CEO and the Medical Director. The CEO is charged with reporting IQAP successes and significant IQAP issues from QMC activities to the Board of Directors at each meeting. The Board develops and submits recommendations for action to the QMC for implementation. The Board of Directors reviews the IQAP Description, Work Plan, and Evaluation annually.

Amerigroup Nevada IQAP activities are also reported through the corporate structure to the corporate Quality Improvement Council (QIC) and the corporate Board of Directors. Their roles are to oversee all affiliate IQAP activities, monitor progress towards meeting corporate goals and benchmarks, and provide corporate guidance with shared best practices. The corporate IQAP structure includes the Vendor Selection and Oversight Committee, the Medical Policy Committee and the Pharmacy and Therapeutics Committee.

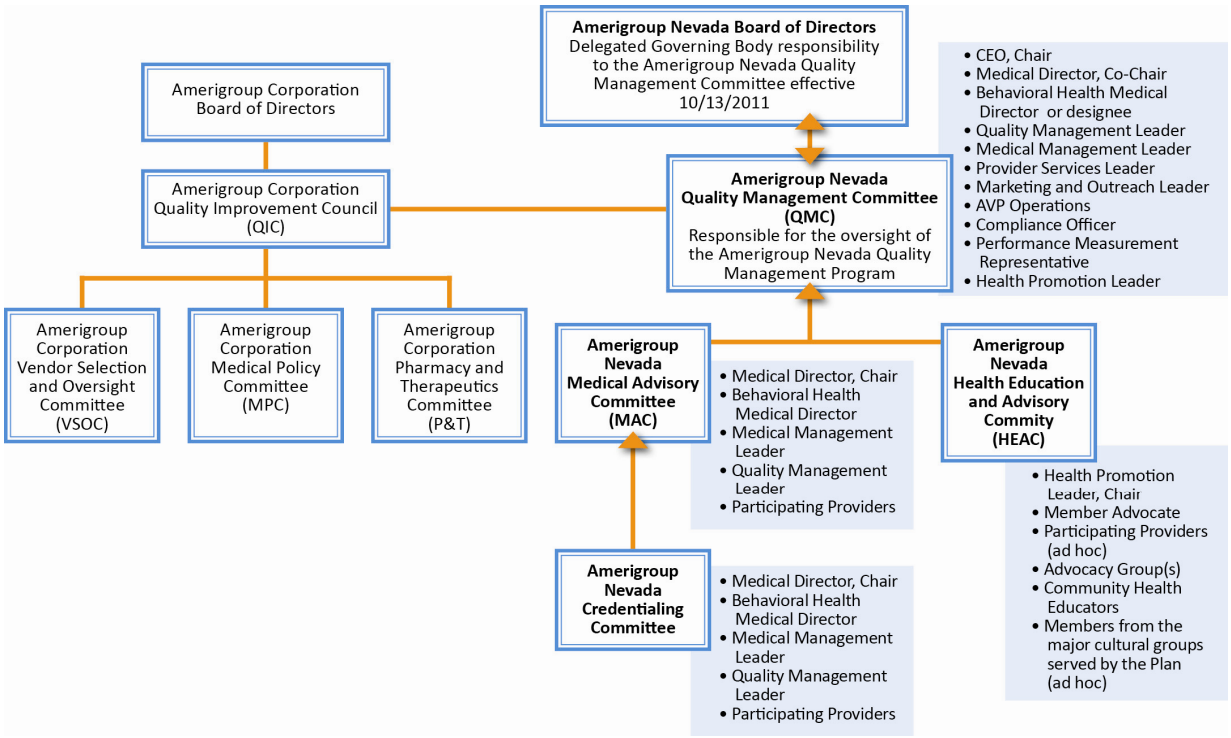
The structure of the IQAP's Governing Body is described as part of the QA Committee discussion below in Standard IV Active QA Committee (§4.8.8)

SECTION 4 S.O.W.

Standard IV: Active QA Committee (§4.8.8.1-5)

Figure 5.1.11.5-4 illustrates the quality committee structure for both Amerigroup Nevada and for Amerigroup corporate quality management which we discuss in the following response.

Figure 5.1.11.5-4. Amerigroup Nevada Quality Structure and Composition



The Amerigroup Nevada Board of Directors is the governing body of the Nevada IQAP. The Board delegates the QMC to oversee IQAP activities. The QMC is accountable to the Board through the CEO. The QMC annually approves the IQAP Work Plan, IQAP evaluation. Every Board agenda includes a routine quality reporting item.

Amerigroup Nevada's QMC develops, implements, and oversees the IQAP consistent with our approach of assuring local accountability and consideration of regional practices. The QMC is co-chaired by the CEO and Medical Director and includes leaders of Quality Management, Medical Management, Provider Relations, Marketing and Health Promotion, Operations, and Compliance. The QMC is a dynamic force in overseeing the health plan's quality performance for both clinical and non-clinical functions.

The Nevada QMC reviews and approves the activities of the QM Program, Work Plan, and Program Evaluation. The review and approval includes clinical and non-clinical issues related to regulatory compliance, fraud and abuse, over- and under-utilization, disease management, Case Management, PIPs, HEDIS, complaints and grievances, and outcomes of audits. The IQAP Director reports all quality activities to the QMC for assessment, development, implementation, and monitoring. The committee reviews activities, provides feedback and recommendations, and follows up on outstanding items from previous meetings.

The following health plan committees report to the QMC, and we maintain meeting minutes reflecting decisions, recommendations, and follow-up actions:

- ***Nevada MAC, which consists of local providers who review new medical technologies and requests for change to corporate-approved clinical practice guidelines based on the local demographic and epidemiologic needs of our members. The MAC uses ongoing peer review to assess levels of care and quality of care provided and monitors practice patterns and drug utilization to identify appropriateness of care and improvement/risk prevention activities, including review of clinical study design and results as well as development and approval of action plans/recommendations regarding quality improvement studies. Our Medical Director chairs the MAC ,which meets a minimum of six times each year.***
- ***Our Nevada Credentialing Committee consists of participating providers within our network and oversees credentialing and re-credentialing. The Credentialing Committee approved or denies participation, oversees credentialing relationships, and reports to the MAC. The Medical Director chairs the Credentialing Committee, which meets six times each year.***
- ***The Nevada Member Health Education Advisory Committee (HEAC) provides guidance to the plan about member needs and values, including education, cultural and outreach activities, grievance resolution, and member materials. HEAC is responsible for ensure plan materials meet cultural competency requirements and are understandable to the member. Our Health Promotion Leader chairs the Committee which includes member outreach employees and the QM Leader as well as members, advocates from the community, health community educators, and participating providers. This committee acts as the voice of the member.***

The Amerigroup Nevada QM Committee structure receives support from the corporate quality committee structure including the QIC for QM goals, benchmarks, and best practices; the Vender Selection and Oversight Committee (VSOC) for corporate-wide vender management; the Medical Policy Committee (MPC) for clinical practice guidelines; and the Pharmacy and Therapeutics Committee (P&T) for medication management guidance and criteria.

Please see Standard VII: Provider Participation in IQAP (§4.8.11) for additional details.

SECTION 4 S.O.W.

Standard V: IQAP Supervision (§4.8.9)

In October 2011, the Amerigroup Nevada Board of Directors delegated quality improvement oversight to the plan QMC. The Board action stipulates that our health plan CEO is the designated senior executive who is responsible for IQAP implementation. The CEO participates on the QMC and reports quality issues to the Board as needed.

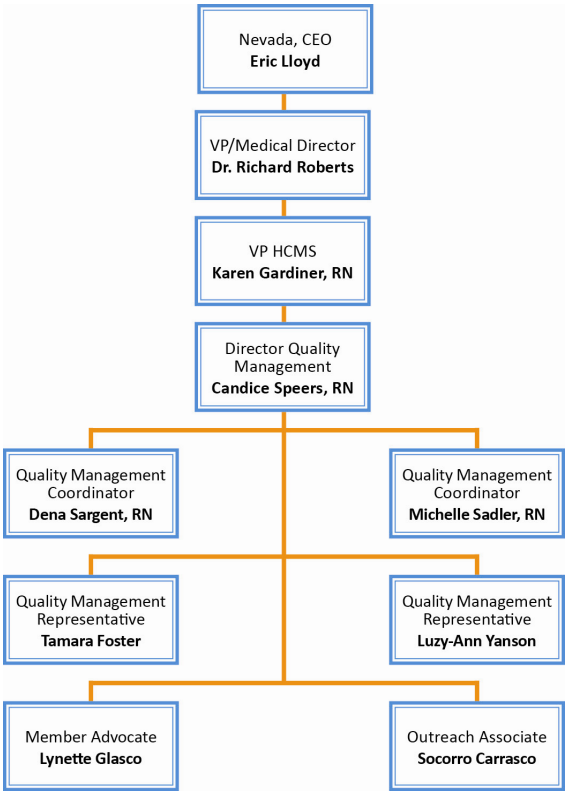
Standard VI: Adequate Resources (§4.8.10.1-3)

Our IQAP resources consist of the talented people we hire, the efficient processes we employ, and the versatile and evidence-based tools we use to manage quality of care and services delivered to Medicaid and Nevada Check Up Members. Amerigroup's IQAP has significant material resources and sufficient staff with the experience, education and training necessary to oversee, implement, manage, and evaluate all RFP specified quality tasks. Our IQAP staff and integrated material resources are integral to our successful quality performance and activities.

Our Nevada Quality Team

Our current staffing model provides exceptional service to our Nevada members. It also ensures that DHCFP has local and accountable IQAP leadership who ensure quality of care for our members and continue our collegial relationships. We recently doubled the size of our IQAP team, adding two bilingual employees. We will capitalize on our existing experience to ensure that the program has sufficient employees who have the correct skill sets, qualifications, cultural competency, and experience to support continued performance improvement (see Figure 5.1.11.5-5).

Figure 5.1.11.5-5. Quality Program Staff Organization Chart



Employees within our IQAP have knowledge and expertise in the concepts and processes of quality improvement and facilitate quality across all organizational departments. As part of their responsibilities, employees monitor and oversee activities to meet established timeframes of the IQAP Work Plan; conduct outreach to meet and exceed the goals of the PIPs; facilitate the review of reports related to HEDIS, grievances, and appeals; assess effectiveness of member outreach; and identify barriers to meeting goals and pursuing new opportunities. Throughout the year, our IQAP employees collect and submit required data and monitor and participate in the process to improve quality outcomes for Nevada Medicaid.

Our local employees receive support and mentoring from experienced corporate staff. A total of 350 quality employees across the Company, five analytical professionals/HEDIS project managers, and three performance project staff, are available to support Nevada plan operations and maintain accountability for the administration of the Nevada program. Our six dedicated local employees interface with both our corporate support functions and with the DHCFP to provide a seamless quality system. Our IQAP team includes the following Las Vegas-based IQAP personnel who have demonstrated expertise in quality assessment and continuous improvement.

- ***Eric Lloyd is the CEO and has 20 years of experience in managed care. He is experienced working in business development with nationwide health plan and employer partners, disease management client relationships; leading departmental design and performance; and developing strategic partnerships. He has four years of experience with Medicaid leading cross functional operational aspects of the health plan beginning with the operational launch of Medicaid and Nevada Check Up Contract for Nevada. Mr. Lloyd holds a master's degree in health administration from Loma Linda University. He plays a leadership role within the community and:***
  - ***Participates on the Silver State Health Insurance Exchange (SSHIX) Finance and Sustainability Advisory Committee***
  - ***Sits on the board of directors of the Nevada Health Information Exchange***
  - ***Participates as a member of HealthInsight's Nevada Partnership for Value-driven Healthcare Steering Committee***
  - ***Is on the board of directors for After School All Stars Las Vegas***
  - ***Sits on the board of the United Way of Southern Nevada and co-chairs their Access to Healthcare committee***
- ***Richard Roberts, MD, MSHA, CPE, is the Medical Director and has 30 years' experience in managed care, working with providers, and insurers, in Medicaid, Medicare, commercial, for-profit, and not-for-profit organizations. He has four years***

of experience with Medicaid and Nevada Check Up managed care programs and is licensed in Nevada, California, Arizona, and Arkansas. Dr. Roberts holds a bachelor's degree from Loyola University Chicago, a doctorate of medicine from University of Illinois College of Medicine, and a master's degree in healthcare administration from University of Arkansas. He is a member of the Nevada Association of Managed Care Physicians and a sits on the Plan Certification and Management Advisory Committee of the SSHIX.

- *Karen Gardiner, RN, is Vice President Health Care Management Services (HCMS) and has 13 years of managed care experience on the payer side for commercial, Medicare, and Medicaid products. She has 18 years of hospital experience and seven years of managed care experience with the Independent Physician Association/Medical Group and Physician Health Organizations. She holds a bachelor's degree in nursing from Oklahoma Baptist University and is licensed as a registered nurse in Nevada. Ms. Gardiner is a Certified Professional Coder with experienced in both Utilization Review Accreditation Commission (URAC) and NCQA accreditation preparation and execution. Her management experience includes utilization, quality, credentialing, case management, and health plan operations.*
- *Candice Speers, RN MPA, is the Director, Quality Management and has 20 years in clinical leadership and management with 10 years of current managed care experience in quality management, quality improvement, and utilization management. She holds bachelor's degree in nursing science and a masters of public administration on health administration. Ms. Speers is licensed as a registered nurse in Nevada and has experience with URAC and NCQA accreditation processes and HEDIS reporting. Her experience includes work with commercial, and Medicare HMOs.*
- *Dena Sargent, RN, is a Quality Management Coordinator and has seven years in quality management with five years UM experience. She holds an associate's degree in nursing, a bachelor's degree in computer information systems, and is licensed as a registered nurse in Nevada. Ms. Sargent has seven years' experience with HEDIS data collection and analysis and NCQA accreditation preparation.*
- *Michelle Sadler, RN, is a Quality Management Coordinator and has 12 years' experience conducting HEDIS projects, two years managing a vendor (MedAssurant [now Inovolan]), and 10 years performing medical record abstraction and focus reviews at provider office. She performed provider education during onsite review and as needed focusing on increasing HEDIS outcomes and rates. Ms. Sadler participates on two Community-based Organizations (CBOs) statewide: the Diabetic and Obesity Coalition and the Maternal Child and Health Coalition, She holds a Bachelor's degree*

in business administration, an associate's degree in nursing, and is licensed as a registered nurse in Nevada and California.

- *Tamara Foster is a Quality Management Representative and has 14 years in healthcare administration. She holds an Associate's degree in healthcare administration and informatics and is certified as a Nursing Assistant. Ms. Foster has knowledge of managed care (health maintenance organizations, point of service and preferred provider organization) policies, regulations, and operations. She brings 20 years of customer service experience for members, providers, and company partners to the IQAP team and conducts training for new employee process improvement. She has extensive training in Microsoft® Word, Excel®, Access®, and PowerPoint® for reporting, auditing, and training.*
- *Luzy-Ann Yanson is a Quality Management Representative and has 14 years' experience with managed care, independent physicians associations, and medical groups in the areas of grievance and appeals, credentialing and re-credentialing, and policies and procedures. She brings knowledge of Medicaid, federal and State guidelines and regulations, such as DHCFP, NCQA, URAC, and HEDIS. Her computer skills include: Microsoft Office® Suite, Crystal Reports, Macess®, Facets™, Sanovia for pharmacy appeals, and NIA for radiology appeals. She has excellent customer services skills including resolving complex issues such as member appeals, denials, and disenrollment and conducting member education.*
- *Lynette Glasco is a Member Advocate and has 20 years' experience in customer service. She is fluent in Spanish including reading, writing, and communication. She has demonstrated skill with: Microsoft Office including Word and Excel, Maximo, Primavera, SAP, Facets and Macess. She brings effective problem solving and strong analytical skills to the IQAP Team.*
- *Socorro Carrasco is the Outreach Associate and has 14 years of customer service, ICD-9, and CPT billing experience with multispecialty care medical office. She is fluent in Spanish including reading, writing, and communication. She holds an associate's degree in general studies and has a strong working knowledge of Microsoft Office, including Excel, Word, Publisher, PowerPoint and Access.*

Through our corporate and affiliate structures, each of these QM experts are available to support Amerigroup Nevada by sharing best practices and innovative ideas. Local QM employees receive support from the corporate Quality personnel in the following ways (Table 5.1.11.5-1):

Table 5.1.11.5-1. Amerigroup Corporate Staff Support Local State Efforts

Amerigroup Corporation Functions to Support Amerigroup Nevada, Inc.	
Senior Vice President, Clinical Quality Management	Clinical leader for Quality Management programs for all health plans
Vice President, Clinical Quality Management	Develops and implements QM Programs and initiatives for/with health plans
Director, Research and Development	Leads PIP development and Quality Improvement studies
Assistant Vice President, Clinical Quality Management-Data	Leads national QM data management team of analysts
Operations Business Analyst	Works with assigned health plan QM employees to support data management and reporting projects/activities
Assistant Vice President, Performance Outcomes	Works with health plans to develop/implement HEDIS reporting projects
HEDIS Medical Record Review, RN	Supports health plan Quality Assurance/HEDIS reporting projects and activities; collects/reviews data
Assistant Vice President, Clinical Quality Management-Accreditation	Leads plan/schedule for achieving accreditation status
Quality Improvement Coordinator	Support and monitor health plan compliance with quality management programs and annual work plans
Manager, EPSDT-Surveys	Maintains the EPSDT Data Mart; serves as subject matter expert for survey process, results, and other survey issues

Material Resources – IQAP Infrastructure and Tools

Amerigroup has a comprehensive quality infrastructure that is discussed throughout this section. Our integrated quality system tools include but are not limited to:

- ***Core Systems for documentation of claims and payment, appeals and grievance logging and tracking, case management, and utilization management – including real-time, online prior authorization capabilities***
- ***IAP Data Warehouse that captures, manages, verifies, and maintains all health plan data***
- ***HEDIS Datamart for HEDIS data collection, verification, analysis, and reporting capabilities with analytic expertise at the corporate and local levels***
- ***InterQual medical necessity criteria, and nationally recognized Clinical Practice Guidelines, in addition to the State Medicaid Services Manual***
- ***Provider quality improvement program reports, provider panel profiles, provider trainings, NCQA Patient Centered Medical Home practice transition technical support***

- ***Interactive website capabilities for member and providers that support quality activities such as provider notifications, provider panel reports, UM processes, provider updates, provider directories, member handbooks, provider manuals and educational materials***

Material Resources - IQAP Processes

Process reviews, updates and reports support all the tools outlined above, and we disseminate them to appropriate stakeholders and IQAP staff. Some key Amerigroup IQAP processes that support our implementation of national best practices, standardization of practices for consistent application across all Amerigroup health plans and cost-savings through economies of scale include:

- ***Weekly meetings between our Nevada local quality team and the corporate analysts and HEDIS project managers***
- ***Corporate (QIC) oversight and sharing of best practices developed across the 13 states where we provide services***
- ***Corporate Credentialing support of local responsibilities, an Amerigroup best practice that includes:***
  - ***Initial file and primary provider verification after our Nevada IQAP staff perform the initial data collection***
  - ***Initiate re-credentialing and verifications and file reviews including review of additional data specified in Section 4.8.13.6.C 1-6 to meet specified timelines***

Material Resources – Quality Training

Amerigroup's online education offerings provide a basic quality orientation for every employee as well as ongoing training on CQI. Amerigroup has measured, evaluated, and refined our data-driven quality approaches for the past 16 years. We continue to develop and implement innovative strategies that improve our members' outcomes and support our network providers; these strategies include new online and mobile tools and technology to enhance our ability to achieve the quality and financial goals of our State customers. Our IQAP guides the entire organization toward achievement of DHCFP's and Amerigroup's mutual goals.

SECTION 4 S.O.W.

Standard VII: Provider Participation in IQAP (§4.8.11.1-3)

We have active primary care and specialist participation through our Nevada MAC. Our Medical Director oversees recruitment of providers and has developed a list of providers to serve on the committee. The providers are representative of Nevada providers, reflecting both urban and rural providers, and their demographics mirror those of our

members. We rotate membership every two years. Participating providers do not receive incentives or gifts intended to improperly influence participation on health plan committees. Participating committee practitioners may be paid an honorarium for attendance and participation in committee meetings.

Our provider contract and provider manual outline the quality processes in place to secure providers' cooperation with our quality assurance oversight. We communicate specific quality information through our provider website, newsletters, broadcast faxes, and special mailings. We document the dissemination of all information to providers.

Sharing of Best Practices – Establishing Patient Centered Medical Homes and PQIPs

Another method for including providers in the ongoing improvement in quality of care is incentives for quality performance. Through our Medical Practice Consultant outreach, we are working with three PCP group practices who are implementing strategies toward becoming NCQA Accredited Patient Center Medical Homes and with seven PCP group practices through our PQIP who are striving for Amerigroup Quality Certification. These practices include Federally Qualified Health Centers (FQHCs) and large PCPs groups. Both medical home strategies promote incentives for well-performing provider practices based on key performance goals that affect positive health outcomes of our members.

Amerigroup recently recognized **Nevada Health Centers Inc.** for its commitment to improving access to healthcare in Nevada. Amerigroup ranked NVHC among the top 25 primary care practices for performance on quality indicators, as measured against peers and based on year-over-year improvement.

The PQIP Quality Certification Component rewards PCPs for their performance on the Quality Indicators measured against their Amerigroup plan peer PCPs (Quality Indicator Peer Comparative Score), as well as credit for year-over-year performance improvement (Quality Indicator Improvement Score). The total quality score equals the sum of the Quality Indicator Peer Comparative Score plus the Quality Indicator Improvement Score.

SECTION 4 S.O.W.

Standard VIII: Delegation of IQAP Activities (§4.8.12.1-3)

We retain full responsibility and authority for quality management. We do not delegate quality activities.

SECTION 4 S.O.W.

Standard IX: Credentialing and Re-credentialing (§4.8.13)

Amerigroup Nevada has successfully credentialed the following number of practitioners, ancillary providers, and facilities each year of operation: 2009 –857; 2010 – 573; 2011- 342. We have the systems, staff, and policies and procedures in place to continue to accurately and timely credential the full spectrum of physical and behavioral health providers required for Nevada's Medicaid and Check-Up managed care program.

Our credentialing and re-credentialing processes meet NCQA accreditation requirements. In our most recent health plan review, our credentialing program was found to be in full compliance. We regularly review and update our comprehensive credentialing policies and procedures in accordance with new NCQA standards and new federal or State requirements.

Written Policies and Procedures (§4.8.13.1)

Written policies and procedures outline our credentialing and re-credentialing requirements and processes for all contracted practitioners and organizational providers. Our written policies and procedures are in accordance with Nevada and federal laws and regulations including 42 CFR 438.214 and 42 CFR 1002.3.

Written policies and procedures describe the specific procedures for conducting credentialing, ongoing monitoring, and re-credentialing of all contracted providers. These written policies outline the scope, criteria, timeliness, and processes for credentialing and re-credentialing providers and meet industry standards, regulatory, and accreditation requirements. Our Credentialing Committee reviews these policies at least annually.

We fully support the use of standardized credentialing applications. We comply with NAC 679B.0405 and have adopted the Nevada Division of Insurance Form 901 for credentialing providers. We accept electronic versions of Form 901 via Council for Affordable Quality Healthcare (CAQH) and paper copies. Amerigroup has been participating with the CAQH Universal Provider Datasource® for several years to reduce the administrative burden that is placed on practitioners when multiple versions of credentialing applications are used.

We allow DHCFP and/or its contracted EQRO to inspect our credentialing and re-credentialing process and supporting documentation.

Oversight by Governing Body (§4.8.13.2)

The Amerigroup Nevada Board of Directors formally delegates responsibility for provider credentialing and re-credentialing to the Credentialing Committee according to federal and State regulations and guidelines, and NCQA accreditation standards. The Committee reviews, updates, and approves credentialing and re-credentialing policies and procedures. In addition, the Credentialing Committee:

- ***Conducts reviews for all providers who apply for participation in our provider network and approves or denies the provider for participation***
- ***Reviews all network providers for re-credentialing, including review of quality or utilization data/reports***

- ***Approves or denies for participation those providers submitted by credentialing activities***
- ***Reports to the Medical Advisory Committee physician corrective actions and sanctions imposed based upon re-credentialing activities***
- ***Oversees credentialing relationships***

The Credentialing Committee includes seven provider members in the following specialties: one Child Psychologist, two Internal Medicine physicians, two OB/GYNs, and two Pediatricians. Health plan representation includes our Behavioral Health Medical Director and the Health Plan Medical Director who chairs the committee.

Credentialing Entity (§4.8.13.3)

Amerigroup Nevada's Credentialing Committee makes decisions about credentialing and re-credentialing as directed by the Amerigroup Nevada Board of Directors.

Scope (§4.8.13.4)

Amerigroup Nevada credentials and re-credentialing practitioners (physicians, behavioral health providers, and allied health practitioners) and organizational providers. This includes all providers who are included in our literature for members. It also includes other providers (for example, adult day healthcare) whose services are excluded from the Contract but for whom Amerigroup is experienced in credentialing if DHCFP opts to expand the program to include long-term services and supports (LTSS).

Practitioners

The following practitioners are currently subject to credentialing and re-credentialing:

Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractics, Doctor of Podiatry, Doctor of Dental Science, Doctor of Medical Dentistry, and Doctor of Optometry

Behavioral Health Providers: Clinical Psychologist, Advance Practice Nurse in a psychiatric/mental health specialty, Licensed Professional Counselor, Licensed Clinical Social Worker, and Licensed Marriage and Family Therapist

Allied Health Practitioners: Physical Therapist, Occupational Therapist, Speech Language Pathologist, Certified Registered Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Acupuncturist, Licensed Midwife, Advanced Practice Nurse, and Audiologist

Organizational Providers

The following organizational providers are subject to approval by the Credentialing Committee to become part of the Amerigroup network:

Medical Facilities: inpatient hospitals, ambulatory surgery centers, home health agencies, skilled nursing facilities, and sleep laboratory/centers

Behavioral Health Facilities: inpatient psychiatric hospitals, community mental health centers, crisis intervention, ambulatory detoxification, inpatient substance abuse facility, intermediate care facility (ICF)/mentally retarded, intensive outpatient programs, residential treatment center

Ancillary Services: birthing centers, community health centers, dialysis centers, freestanding diagnostic centers, durable medical equipment providers, freestanding laboratory providers, FQHCs, Rural Health Clinics, hospice centers, rehabilitation facilities, urgent care centers

In the future, if the ABD Medicaid population is covered under the Contract, we are prepared to add the following to the list of providers subject to approval:

LTSS and Home and Community-based Service Providers: nursing facilities, adult day healthcare, assisted living services, personal care services, supported living services, transitional living services

Process (§4.8.13.5)

Our credentialing process uses the Nevada Uniform Credentialing Application (Form 901) through either paper copy or through the CAQH Universal Provider Datasource to capture all required data and is compliant with NCQA and State requirements. The Nevada Credentialing Committee and Amerigroup Nevada Provider Relations employees are supported by our corporate Credentialing Department, which conducts all verifications and credential file preparation specified in Section 4.8.13.5, items A-K. We conduct Primary Source Verification using the information submitted by the provider in accordance with NCQA standards. The process includes verification of all required information detailed in Section 4.8.13.5, items A-J. This includes assessment of the applicant's training and education against training requirements established by the Credentialing Committee. If a practitioner fails to meet these training requirements, we close the application and return it to the provider.

File Verification is performed in accordance with Section 4.8.13.5.K. We query and obtain information from:

- ***The National Practitioner Databank (NPDB) to determine if any disciplinary actions have been taken against the applicant in addition to any settled/closed malpractice cases***
- ***The Health and Human Services Office of Inspector General List of Excluded Entities/Individuals database***
- ***The General Services Administration's Excluded Parties List System***
- ***The Nevada Board of Medical Examiners***
- ***The State Board of Osteopathic Medicine***
- ***The Nevada Dental Board***
- ***Any equivalent licensing boards for out-of-state providers and any other applicable licensing entities***

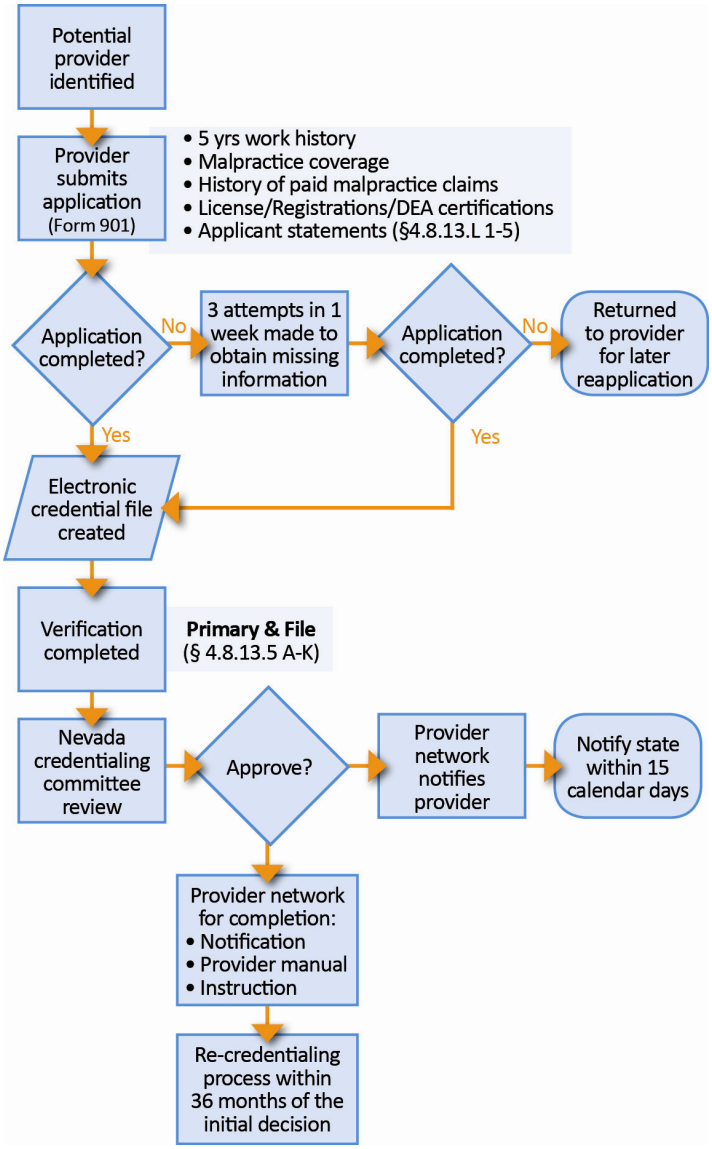
Our application process includes a statement by the provider in accordance with the requirements of Section 4.8.13.5.L.

Our credentialing and re-credentialing program complies with current NCQA standards. Therefore, we do not conduct site visits as part of our initial credentialing in accordance with Section 4.8.13.5.M.

Our policies and procedures are in accordance with Nevada and federal laws and regulations including 42 CFR 438.214 and 42 CFR 1002.3.

Figure 5.1.11.5-6 depicts our process, which is approved by DHCFP.

Figure 5.1.11.5-6 Our Credentialing Process Is Compliant and Efficient



In accordance with Sections 4.8.13.5.O and 4.8.13.5.P, Amerigroup notifies the State of Nevada within 15 calendar days of any provider denied credentialing or of our termination of a provider's contract for program integrity–related reasons including provider fraud, integrity, or quality.

<u>Re-credentialing (§4.8.13.6)</u>

Amerigroup requires that all practitioners and organizational providers are re-credentialed within 36 months of the previous credentialing decision in accordance with NCQA standards. Our re-credentialing program complies with the Code of Federal Regulations and NCQA standards and is approved by DHCFP.

This process includes re-verification of those elements contained in Sections 4.8.13.5.A through 4.8.13.5.M including re-verification of licensure(s), sanctions, certifications, clinical privileges, and competence, as reviewed by malpractice history and license history, and/or health status that could affect the practitioner's ability to serve our members. We also review information from:

- *Member grievances and appeals*
- *Member satisfaction surveys regarding provider experience*
- *Utilization management*
- *Quality improvement and medical management activities*
- *Re-verification of hospital privileges and current licensure, if applicable*

Amerigroup's Credentialing Department initiates the re-credentialing process , and they send a re-credentialing packet to the provider approximately eight months prior to the re-credentialing due date. This packet requests standard information and a copy of the provider's most current State licensure(s), professional liability insurance, and other applicable supporting information including an updated Disclosure of Ownership Form. We ask providers to respond to this written request within 30 days, and we make no fewer than three attempts to each provider asking for this information.

We then conduct primary-source verification in accordance with NCQA and Nevada requirements and provide the information to the Medical Director and/or Credentialing Committee. After reviewing the information and supporting documentation received from the re-credentialing applicant, the health plan includes an assessment of any available provider performance criteria. These criteria may include medical record audit results, accessibility of site, member satisfaction results and grievances, member grievances, quality improvement, and medical management activities. The elements we select for review may vary by provider type and the availability of information.

Reporting

In accordance with RFP Sections 4.8.13.6, Amerigroup notifies the State of Nevada within 15 calendar days of any provider denied re-credentialing or of our de-credentialing or termination of a provider's contract for program integrity–related reasons including provider fraud, integrity, or quality.

Oversight of Credentialing Activities (§4.8.13.7)

Amerigroup's Credentialing Department oversees credentialing, re-credentialing, recertification, and reappointment activities. There is a DHCFP-approved written description

of all oversight activities and accountability. We monitor to ensure that all credentialing and re-credentialing is done in accordance with Amerigroup, DHCFP, and NCQA standards.

Retention of Credentialing Authority (§4.8.13.8)

We have written policies and procedures for approving new practitioners and sites and for suspension, reduction, or termination of practitioner privileges.

Reporting Requirement (§4.8.13.9)

Written policies and procedures guide our process for reporting serious quality deficiencies resulting in suspension or termination of a practitioner to the appropriate Nevada and federal authorities, including the Secretary of Health and Human Services and the Inspector General of Health and Human Services.

Provider Dispute Process (§4.8.13.10)

We have written policies and procedures approved by DHCFP for the current MCO Contract that address when a provider disputes our decision to deny, reduce, suspend, or terminate a practitioner's privileges. These disputes are considered an appeal and are tracked and processed accordingly.

Providers, regardless of their State licensure or contract status with Amerigroup, are subject to all aspects of the IQAP, especially those elements such as office and medical records audits, quality reviews, and member satisfaction or grievance reports that indicate their continued qualification to perform services for Medicaid and Nevada Check Up members. When we discover poor provider performance or providers who are not qualified, we take the necessary and appropriate steps from establishing a corrective action plan with the provider up to termination from the network. The Annual Program Evaluation includes a summary of our mature credentialing activity.

SECTION 4 S.O.W.

Standard X: Recipient Rights and Responsibilities (§4.8.14)

We have met the member rights and responsibilities standard as part of our NCQA accreditation and continue to maintain a strong commitment and respect for our members including the following:

- *Members with chronic conditions may select a specialist within a medical home as a primary care physician.*
- *Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.*

- ***We have the latitude to include additional recipient responsibilities in our member communications.***
- ***We train our Member Services Representatives and Member Advocates and Outreach employees to respond to member questions, explaining their rights and responsibilities.***

<u>Member Rights and Responsibilities—Written Policies and Procedures (§4.8.14.1-2)</u>

We advise members about their Rights and Responsibilities through multiple means. First, when they enroll with us, members receive a New Member Packet in the mail with all pertinent information about our services. Included in this New Member Packet is a Member Handbook that outlines all the member's Rights and Responsibilities. We initiate new member mailings monthly that include each member's ID card, member handbook, provider directory, Advanced Directive regarding Living Wills, and other information.

<u>Communication of Policies to Providers (§4.8.14.3)</u>

Our provider manual educates providers about member Rights and Responsibilities and we send it to all new providers. Our provider website includes the rights and responsibilities information and also has a digital copy of the provider manual.

<u>Communication of Policies to Members (§4.8.14.4)</u>

Member Rights and Responsibilities are also available online at the member website in a digital version of the member handbook. We advise members that they can access this online information at any time to learn about their member Rights and Responsibilities.

We review the member handbook and provider manuals annually and as needed to ensure compliance with NCQA standards and DHCFP Contract requirements regarding member Rights and Responsibilities. We will add any new member rights and take advantage of the opportunity to include additional responsibilities when the member and provider handbooks are updated annually under the Nevada Contract.

Our member materials, approved by DHCFP, communicate expectations for member's to take responsibility for their own care. We supply members with condition or disease specific information to support this form of quality education and care management.

Recipient Grievance and Appeals (§4.8.14.5)

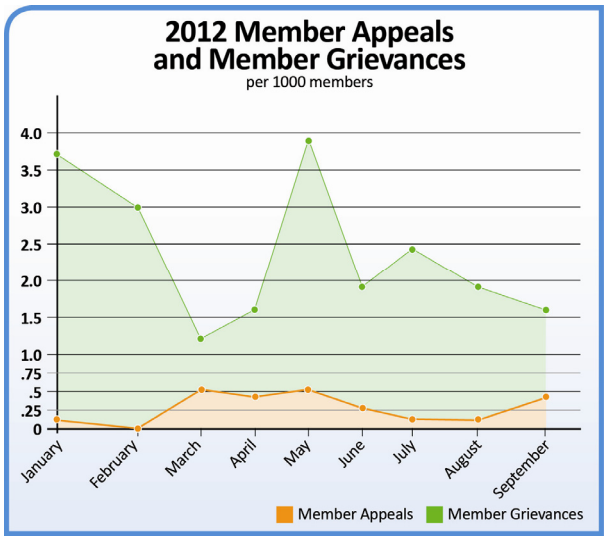
Our claims adjudication system houses and integrates our grievance, appeals, and Fair Hearing documentation to track receipt for response timing, substance of the grievance, resolution, and escalation as well as the grievance and appeals logs. All data entered is stored in the IAP for retrieval, analysis and trending.

Our DHCFP-approved grievance and appeals procedures give direction and structure to the process. In compliance with DHCFP requirements, we resolve 90 percent of written, telephone, or personal contacts from members and providers for appeals within 30 calendar days of the date of receipt and for grievances within 90 days of receipt. To ensure compliance and proper documentation in responding to provider inquiries, a written log is maintained that includes the nature of the complaint, the date filed, dates and nature of actions taken, and final resolution.

The quality employees conduct quarterly audits of grievances and appeals, identifying the top three categories for deeper analysis with a focus on determining barriers and solutions to the identified issues for implementation.

The MAC and the QMC monitor grievance, appeal, and Fair Hearing data on a quarterly basis. Result analysis performed by these committees, which are comprised of departmental leaders and community practitioners, enables them to participate in quality improvement efforts. We report quarterly to DHCFP and annual data is reported through the IQAP annual evaluation.

Figure 5.1.11.5-7. Amerigroup's Rate of Member Grievance and Appeals Remains Low



As an example, our IQAP team conducted a drill-down analysis on the three highest categories to understand the key issues driving these grievances and what action appropriate to the complaint was taken. The three categories were eligibility, reimbursement/balance billing, and dissatisfaction with providers. We are collaborating with DHCFP to address eligibility concerns. The drill-down on balance billing showed that predominantly, grievances were associated with members using out-of-network and out-of-state providers. We continue to address each of these on an individual basis with education and offers for reassignment to network providers. The provider dissatisfaction analysis showed issues were with a limited number of providers. All providers were referred to Provider Relations for follow-through.

In 2011, the highest volume appeal category (57 percent) was providers challenging denials for lack of demonstrated medical necessity to support payment of the claim. Forty one percent of submitted appeals were dismissed or withdrawn. The trend continued in early 2012, and a QIP to decrease provider appeals by 10 percent was initiated.

We referred a total of 36 issues for a State Fair Hearing in 2011 (an average of three per month). We collaborated with several members of Hospital Management to develop a process to review and resolve issues in a real-time setting. This process has prevented any further State Fair Hearing requests from those specific providers. To date, in the first eight months of 2012, we referred 32 issues for State Fair Hearing. This number is deceptive, as one provider submitted 12 issues in August which were subsequently withdrawn, bringing the actual number to 20 or an average of 2.5 per month for a nearly 17 percent reduction. Six of the 20 issues were the result of an out-of-date fee schedule held by a dental vendor that was immediately corrected so that claims could be paid.

Recipient Suggestions (§4.8.14.6)

We have two primary mechanisms for recipient input: participation on the HEAC described in Standard IV: Active QA Committee (§4.8.8.1-5) and through Case Manager and Member service employee daily interaction. The HEAC is designed to foster member representative input into the operations of the health plan through this formal mechanism. In newsletters and the member handbook, we invite our members to provide any suggestion or feedback regarding their experience. Informally, we encourage our employees to solicit, accept, and forward recipient suggestions during their routine contacts with each member.

Steps to Assure Accessibility of Services and Information Requirements (§4.8.14.7-8)

Our member handbook and our new member Welcome Calls are the primary mechanisms to educate members on services available and the methods to access those services, whether the care is routine, urgent, or emergent and whether it is in the service area or out of area. We monitor practitioner availability for primary care practitioners, high-volume specialty care

practitioners, and high-volume behavioral health practitioners. We also conduct quarterly assessment of accessibility through GeoAccess® and report results to the QMC along with an analysis of member access complaints. We take corrective steps for any identified trend or pattern.

We assess performance against access standards quarterly using GeoAccess and report the results through the IQAP. The Annual IQAP Evaluation includes a summary of results showing the number of providers in each category within the 25-mile standard.

- ***99.96 percent of members have at least one PCP per 1500 members within 25 miles***
- ***100 percent of the following providers are within 25 miles of members with desired access:***
  - ***202 BH providers***
  - ***2409 Specialist providers***
  - ***88 Physical Therapy providers***
  - ***39 Occupational Therapy providers***
  - ***36 Speech and Language providers***
  - ***13 Hospitals***

We achieved 100 percent performance for provider access within 10 miles of the member with one exception known to DHCFP. In a rural area of Washoe County, there are no OB/GYN specialists within the 10-mile radius of the 29 members affected. We alerted both the affected members and DHCFP of this situation. We continue to monitor the lack of this one specialist category and will take action if member health is jeopardized or a new OB/GYN specialist moves into the area.

We use software to ensure that written materials are at an 8th-grade level and test readability and understandability with focus groups whenever new material is drafted. We monitor languages and ethnicity on a regular basis. In our most recent analysis, English (81.5 percent) and Spanish (16.5 percent) are the two languages that meet the Nevada threshold.

<u>Confidentiality of Patient Information (§4.8.14.9)</u>

Confidentiality of member information is vital to our employees and our providers. Our policies and procedures, HIPAA compliance, employee education and training, and provider site audits support the philosophy and practice for confidentiality. When a breach occurs, the Privacy Officer conducts a risk assessment to determine the extent of the breach and the

potential for harm, notifies the affected individuals according to our DHCFP-approved notification process, and takes action up to and including notification of law enforcement.

Amerigroup Safeguards

We require our employees to complete annual recertification regarding HIPAA policies, that include training on Protected Health Information (PHI) and Individually Identifiable Health Information (IIHI)and procedures for notification and escalation if an employee discovers a breach in privacy as part of their routine duties.

We clearly define the potential areas where the physical security of PHI and IIHI must be protected as any cubicle, office, conference room or other location such as a home office, either permanent or temporary, where an employee performs any work functions related to our business. We routinely review physical safeguards with employees and have put in place mechanisms to ensure the safety of protected health information. Our policies and procedures cover paper, electronic files and discs, computers, voice mail, and desktops. We protect our buildings and departments with a security key card (proximity token) access. Corporate Security must approve requests for access to buildings, departments and rooms.

Violations of any of the security or privacy criteria in any of the policy and procedure may result in counseling, suspension or immediate termination, depending on the severity of the violations. Employees who witness any violations must report them immediately to their immediate supervisor or to the established Compliance Hotlines.

Provider Facilities

As part of our credentialing of physicians and contracting of other providers, we routinely conduct office site visits to ensure that providers guard against unauthorized disclosure of PHI and IIHI. The standardized form used to conduct the audit includes standards for the protection of member information. Providers who do not meet the standard are not included in the network until the deficiencies are corrected. As an example, an Urgent Care Facility asked to be approved for our network. We performed a site visit and found non-compliance with physical plant and privacy standards. In addition to the physical plant concerns dealing with refrigeration and hand washing, the facility did not address the following confidentiality of member information standards:

- ***A patient bill of rights posted***
- ***HIPPA or PHI information in the new patient packet (only consent to disclose was included)***
- ***Medical License posted in the waiting area***

We chose to not include them in the network. We reviewed the issues identified were reviewed with the office manager during an exit interview and invited the Urgent Care Center to resubmit the request when all non-compliant items were addressed.

Treatment of Minors (§4.8.14.10)

Our written policies and procedures, approved by DHCFP, include applicable language regarding the treatment of minors. Specifically, the treatment of minors is covered in our Member Privacy Rights, Disclosure of PHI, and Member Correspondence policies as each relates to minors.

Minors are defined in our policies to include emancipation situations related to pregnancy, parenthood or by the courts and special protections for mental health, substance abuse, family planning and sexually transmitted diseases. We maintained a current centralized database of applicable state laws for employees to reference regarding consents. We also define parents, guardians, person acting in loco parentis, and personal representatives, as each applies to consents and release of information regarding minors.

Assessment of Recipient Satisfaction (§4.8.14.11)

Morpace, an NCQA–certified external survey vendor, annually administers the CAHPS® member satisfaction survey for us by, using the survey protocol defined in current HEDIS specifications. We currently perform CAHPS surveys on our child, adolescent, and adult members. We will comply with the RFP contract requirements to perform a CAHPS survey on Children with Chronic Conditions, as directed by DHCFP.

In February 2012, Morpace randomly selected 2,145 Amerigroup Nevada members to participate in the 2012 CAHPS® 4.0H Child Medicaid Survey.

This protocol included mailing a questionnaire with a cover letter addressed to the parent or guardian of the child member. For those selected members who did not respond to the first questionnaire, Morpace sent a second questionnaire with a cover letter encouraging participation. If a selected member still did not respond to the questionnaires, they placed at least four telephone calls to complete the survey. In an effort to increase response rates, we elected to leave a voicemail message on the first telephone attempt. We offered members the option to call the toll-free number provided, and they could complete the survey at that time. If the member did not call the toll-free number, Morpace implemented the standard telephone protocol.

Morpace conducted a Key Driver Analysis of the results to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction. They assessed scores both individually and in relation to each other to identify the importance of

individual issues (correlation to overall measures) and current level of performance on each issue (score above/below Medicaid mean). Key drivers help identify areas of high priority for improvement.

We received the most recent member satisfaction report from Morpace in July, 2012 and are in the process of analyzing the findings and implementing actions as part of the "Investing in Quality" Team described in Analysis of Clinical Care and Related Services (§4.8.6.5). We are monitoring results on a monthly and quarterly basis and will adjust our interventions, as necessary, to maintain continued improvement.

We share the results of the CAHPS survey with members through the member newsletter, annually. Figure 5.1.11.5-8 shows a barrier analysis and proposed actions based on the QMC review on August 20, 2012 and our MAC review September 18, 2012.

Figure 5.1.11.5-8. 2012 CAHPS Survey Amerigroup Nevada MAC and QMC Recommendations

2012 CAHPS Survey Amerigroup Nevada MAC and QMC Recommendations

MEASURES	BARRIERS	ACTIONS
GETTING NEEDED CARE		
Ease of obtaining appt w/Specialist	• Lack of Specialists in Network • Lack of referral to available specialists	• Review Panel for adequate number that meets geographical needs of members. • Develop website and materials to increase PCP knowledge to specialists in network • Encourage PCPs to increase referrals pattern • Provider Relations Staff to work with PCP office staff to identify types of specialists that are most difficult to schedule appointments
Ease of obtaining care, tests, or treatment you needed through your health plan	•Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why: ❶ Auth process: 43% ❷ Difficulty finding In-network providers: 16% ❸ Waiting for approval for New RX: 9% •Inaccurate resources for employees responding to member calls	• Review complaints received by Customer Service regarding inability to receive care, tests, or treatments • Continue efforts to make denial reasons understandable to member directly • Educate members on usual procedures and timelines • Review and update resources (ATLAS) used by Customer Service • HP establishes routine meetings with Customer Service to identify and resolve miscommunications or provide new information
GETTING CARE QUICKLY		
Getting care for children as soon as needed	Providers not aware of member expectations	• 2012 external 3rd party access to care survey with feedback to specific Providers • Medical Practice Consultant activities with PCMHs to improve office scheduling and patient services
HOW WELL DOCTORS COMMUNICATE		
Doctors Explain things in a way that was easy to understand	Members' lack of knowledge on how and what questions to ask.	• Conduct member focus group to identify barriers • Provide physicians with member education in materials to give to members in office • Provide member with questions and checklists in member newsletter
Doctor listened carefully	Providers unaware of lack of communication skills	PQIP Provider groups will do separate member satisfaction surveys in 2012-2013
Doctor showed respect for what the member said	To Be Identified	Conduct member focus group to identify barriers
Doctor spent enough time with member	To Be Identified	Conduct member focus group to identify barriers

SECTION 4S.O.W.

Standard XI: Standards for Availability and Accessibility (§4.8.15)

Members value timely access to medical care and telephone inquiries. We monitor primary care and behavioral health practitioner appointment and after-hours accessibility annually against our standards, and initiates actions, as needed, to improve. Our IQAP team measure standards through CAHPS® survey results, rate of member complaints, Access Survey Results, and After-Hours Surveys. We also monitor member service access on a regular basis and initiate actions when needed to improve performance.

In 2012, the CAHPS® survey results for "getting appointment for child as soon as needed" had a statistically higher rate of 83 percent compared to 74 percent in 2011. A multidisciplinary team reviewed the information and surveys and determined the following opportunities for improvement.

- ***Identify key PCP groups without afterhours access and work with them to extend their practices***
- ***Develop provider incentive compensation***
- ***Implement a program targeting increased access and new recruitment for provider availability***

Table 5.1.11.5-2 Member Service Telephone Access Measures Exceeded 2011 and 2012 Performance Goals

Measure	Goal	2011 Performance	2012 Performance
Member Service ASA in seconds	Less than 30 seconds	15.4 seconds ***Exceeding the goal by 49%***	6.33 seconds ***Exceeding the goal by 79% - a one year improvement of 30%***
Member Service Abandon Rate	Less than 5%	1.95% ***Exceeding the goal by 61%***	0.39% ***Exceeding the goal by 92% - a one year improvement of 31%***

Another method for accessing care is the Nurse HelpLine, which offers 24/7 access to members with questions regarding their current health status. The Nurse HelpLine performance met all goals for answer and abandonment rates in 2011. In addition, use of the Nurse HelpLine increased 43 percent from 2,136 calls in 2010 to 3,060 in 2011. We continue to encourage members to use the Nurse HelpLine through member newsletters, provider

updates, provider newsletters, Ameritips distribution at health fairs, open enrollment events, through provider offices, and community-based organization activities, and by enclosures in health plan member communications.

See the Confidential Technical Volume for proprietary information.

Additional information on how we meet specific Network Access and Availability standards is addressed in our response to Section 5.1.11.4.D.

Standard XII: Medical Record Standards (§4.8.16.1-3)

We have documented medical record standards, approved by DHCFP under the current MCO contract, for our network providers; we measure conformance to these standards annually. This analysis of medical records allows us to evaluate documentation patterns, quality of care, clinical performance, and preventive health practice patterns. Our IQAP contains activities to monitor individual and aggregate provider indicators of quality to identify quality of care issues and patterns, including evaluation of severity and frequency. Our IQAP Department monitors and evaluates individual practitioner performance in the areas of quality and administration. We report results to providers at least annually. We use the peer review process up to and including written procedures for taking appropriate remedial action, as needed, to maintain safe practices throughout the network.

In 2011, we reviewed a total of 445 medical records for compliance with documentation requirements using tools specifically designed for different practice settings and including a section to audit documentation of cultural needs such as race/ethnicity or spoken language. Additional documentation of compliance with clinical practice guidelines or HEDIS measurements include ADHD, Adult Preventive, and prenatal/postpartum care.

We piloted the survey tools and review process in the first half of 2011 at five provider sites. In the second half of 2011, we accepted the validity of the tool and expanded the review process at 20 of the largest provider offices. Of the 445 medical records reviewed, 360 medical records were reviewed for compliance with EPSDT requirements.

Eighty-two percent of all medical records met requirements of the Practitioner Clinical Medical Records section. Three of the office sites had consistent opportunities for improvement of documentation in problem lists, preventative services, smoking cessation and continuity, and coordination of care and advance directives; all opportunities were immediately addressed with the providers. Review of EPSDT requirements in the charts showed only 69 percent compliance. The Quality Nurse Reviewer provided feedback and

education to providers specific to individual reviews, with consistent emphasis on lead screening, hearing and eye screenings, and TB screening.

All reviews included an exit meeting where the Quality Nurse Reviewer provided feedback on areas of opportunity, education materials, EPSDT periodicity charts, well-exam templates and other forms, as well as Clinical Practice Guidelines. For providers that did not meet the minimum standard of 80 percent compliance, a follow-up visit(s) was scheduled and completed. We found all providers in compliance upon follow-up review in 2011. In 2012, we expanded reviews to include OB/GYN practitioners, providing additional materials such as Coding Quick Reference Guides to enhance provider/office staff knowledge of quality measures and coding accuracy as well as diverse selection of Ameritips and other educational materials for members.

Standard XIII: Utilization Review (§4.8.17)

UM includes monitoring and reporting of service utilizations: Prior Authorization, Concurrent Review/Discharge Planning, and Ancillary Services. We structure our programs to ensure that our members receive the highest level of quality services as timely as their medical condition indicates, using approved medical and behavioral services approval criteria to ensure the right services at the most appropriate level by the most appropriate healthcare provider. These programs work in a collaborative manner throughout the care continuum. We gather data on each program and its activities, which allows us to monitor our effectiveness and identify opportunities for improving our cross-functional approach.

Our IQAP, CM, and UM processes are fully integrated between physical, behavioral, and psychosocial services. Behavioral health issues cross all populations at different levels of severity. Over 35 percent of our Nevada members with one or more co-morbidities have a concomitant behavioral health diagnosis. In Nevada, where full behavioral health services are managed by our health plan, we implement and incorporate all levels of quality oversight for behavioral providers and processes.

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

- ***We provide real-time authorizations in response to telephone, fax, and online requests from providers. Upon receipt, requests are automatically routed to UM professionals who guide providers through the authorization process.***

- ***We continually evaluate the list of services requiring prior authorization to stay current with industry best practices and utilization guidelines. As a result, we may remove certain services from the prior authorization list.***
- ***We provide evidence-based, clinical practice guidelines, new technologies, and best practices to help providers in delivering optimal care for members.***
- ***We conduct workshops for providers on relevant topics.***
- ***We share information on available continuing medical education credits through the United States Department of Health and Human Services website.***

Written Program Description (§4.8.17.1)

Our current written Utilization Management program description incorporates 2011 NCQA standards. The purpose of the UM program description is to ensure that eligible members receive the most clinically appropriate services in the most efficient manner possible and to enhance consistency in reviewing cases by providing a framework for clinical decision-making. The description covers all of the components within NCQA standards. The UM Program provides relevant UM information to the IQAP for quality improvement activities. This includes identifying quality of care concerns, disproportionate utilization trends, adverse access patterns, and lack of continuity and coordination of care processes.

Utilization Management Scope (§4.8.17.2)

The scope of the Utilization Management Program includes activities related to inpatient and ambulatory care and collaborates with other departments within HCMS in care coordination, discharge planning, and Case Management to meet the physical and behavioral healthcare needs of its members. It adopts an integrated medical management model based on the physical, behavioral, and social needs of eligible members. The UM program, in collaboration with other departments such as Integrated Disease Management Center, Pharmacy Program, and Case Management, facilitates the delivery of the most appropriate medically necessary care to eligible members in the most appropriate setting. The UM Program coordinates with the National Pharmacy Program.

Utilization Management—Nevada-based

We have a singular focus on serving the healthcare needs of those enrolled in public sector healthcare programs. Because of this focus, we concentrate our UM efforts on engaging providers in productive dialogue regarding authorization of behavioral health and physical health services to ensure that members receive the level of care that drives the best health outcomes.

Rather than using UM as a mechanism for authorization or denial of requested service, we use it to creatively address our members' health challenges. Efficiency, accountability, and results drive our UM program design and operations. We strive to identify and implement industry best practices to positively impact our members, providers, and State customers. Our UM program blends clinical integrity with operational efficiency and customer compliance and demonstrates a strong commitment to accountability for Nevada's budget dollars.

We base length of stay for a member's request for hospitalization or surgery on the needs of the member, rather than on arbitrary limits or traditional utilization controls. An assigned UM Nurse manages members who are hospitalized or receiving surgical services. The clinical review drives authorization for covered services as determined by clinical guidelines and individual needs. Subsequently, the UM Nurse, working with the hospital, hospitalists, and specialists, monitors and continually reviews the case to determine discharge readiness and to facilitate discharge planning. Some members might need extended coverage as identified by the concurrent review of individual needs, severity of illness, and services being rendered. The UM Nurse has the authority to extend the hospital stay or other services as needed.

Pre-Authorization and Concurrent Review Requirements (§4.8.17.3)

We use Nevada Medicaid Services Manual, InterQual® Level of Care Criteria and Behavioral Health Guidelines, and Aetna's Clinical Policy Bulletins (CPBs) to review medical necessity and appropriateness of both physical and behavioral health services. These criteria and guidelines are industry standards for medical necessity review and are widely used by health plans, hospitals, and government agencies. They provide a rules-based system for screening proposed medical care based on patient-specific, best medical care processes and consistently match medical services to patient needs based upon clinical appropriateness.

- ***The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, 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 in a holistic manner to ensure that they receive necessary support services within a safe environment optimal for recovery.***
- ***We supplement Nevada Medicaid Services Manual, InterQual Criteria, and Aetna's CPBs with review guidelines. In addition to these standards, we reference national guidelines produced by healthcare organizations such as individual medical and surgical societies, NIH, and the CDC.***
- ***Our Medical Policy Committee reviews, updates when appropriate, and approves criteria and guidelines used by Amerigroup annually. We seek input from the MAC, representing practitioners with knowledge of local delivery systems. The Medical Policy***

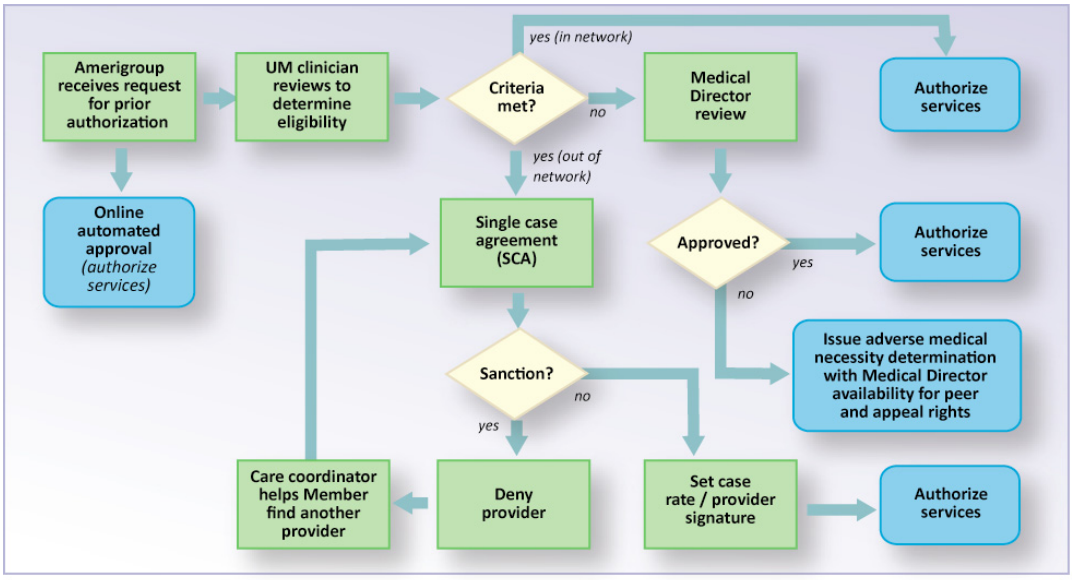
Committee also reviews and approves policies and procedures for application of medical necessity criteria annually.

There are several ways a provider may request authorization for a service or prescription: call or fax to our Provider services line, or online submission. In addition, through our Provider website, we offer a real time, online automated approval process based on specific business rules for both pharmacy and medical authorizations. Our website also allows providers to submit an appeal and view authorization status.

<u>Qualified Clinicians</u>

We have seven UM clinicians who perform the following activities during the review process: 1) review request using the previously described medical necessity criteria; 2) if criteria is not met, the Medical Director reviews the request, 3) if authorization is denied, we send adverse medical determination and denial and appeal process notifications. Figure 5.1.11.5-9 shows our authorization prior authorization review processes.

Figure 5.1.11.5-9. Our Streamlined, Provider-Friendly Authorization Process

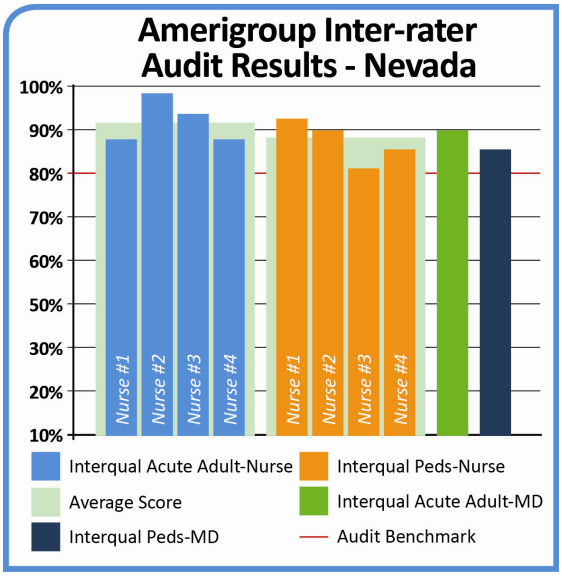


Our UM team has adopted a proactive approach to ensuring services that are required never lapse. For Nevada, we have developed an innovative State-approved process of tracking authorizations scheduled to expire. In this process, we contact the authorized provider and member to determine if the service needs to be continued, prior to the end of the authorized period.

Consistent Application of Review Criteria

Since 2009, our Nevada UM nurses and medical directors have participated in our inter-rater reliability (IRR) assessments that determine our consistency in applying our nationally recognized standard of care criteria sets (Figure 5.1.11.5-10). The UM IRR threshold is 80 percent. In 2012, all UM Adult care nurses received 92 percent, our Pediatric UM nurses achieved 87 percent and our Medical Directors averaged 85 percent for all three IRR reviewed criteria. Our IRR results are reported to the Nevada health plan leadership; Health Care Management Services (HCMS); the Corporate Chief Medical Officer and designated Corporate National Medical Directors; the Corporate Quality Improvement Council; and other identified Nevada stakeholders.

Figure 5.1.11.5-10. Inter-Rater Reliability Exceeds the 80 Percent Threshold



The Clinical Operations' Director at Amerigroup Corporation is responsible for administering the IRR program for all employees who apply criteria to determine medical necessity and who have successfully completed their ninety-day probationary period. During the probationary period, the UM manager of the new employee monitors the employee's work including application of criteria. After successful completion of the probationary period, the employee is subject to the IRR testing cycle.

We maintain a series of internal controls and targeted training requirements for all clinical staff to foster this conformity. In addition to monitoring clinical staff training, the clinical compliance program also guides our inter-rater reliability audit practices and protocols. Upon completion of the assessment, we review the results and take corrective actions as indicated. If the clinicians do not achieve the threshold percent required by the State, we institute individual action plans that include specific remedial tasks such as individual counseling by

the employee's manager, formal retraining on criteria, or retesting through the IRR audit and a timeline for these.

Amerigroup makes UM criteria available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with an Amerigroup Medical Director. This collaborative approach allows us to ensure all necessary information is included for decision making.

The need for precertification is described in the provider manual and on the provider website and lists out the specific services that require plan approval. Precertification is required on selected services to ensure timeliness and appropriateness of care, including:

- ***Planned (elective) inpatient admissions***
- ***Certain outpatient surgeries and procedures such as tonsillectomy and gastroscopy***
- ***Non-emergent, out-of-network, out-of-state services with the exception of covered EPSDT, family planning, and women's preventive health services***
- ***Home health services***
- ***Durable medical equipment***
- ***Rehabilitation services and therapies such as speech, physical, occupational, and cardiac rehabilitation***
- ***Certain medications, such as pain management and injectable drugs***
- ***High-cost radiology***
- ***Outpatient psychosocial rehabilitation services***
- ***Out-of-network and out-of-state services***

We notify providers when we make an adverse decision and make provider appeal and grievance decisions based on available information and within the time frames set for by DHCFP.

SECTION 4 S.O.W.

Standard XIV: Continuity of Care System (§4.8.18)

We maintain policies and procedures that are used by our Medical Management staff to ensure that we implement a comprehensive system to promote continuity of care and case management. We realize that the Medicaid and Nevada Check Up populations require our employees to use specific procedures to promote continuity of care services as deemed medically necessary to avoid adverse impacts upon our new or existing member's health status.

We are concerned about issues related to continuity of care when existing members change PCPs or move from one health plan to another. For example, we provide continuity of care for a new member who is being treated by a non-participating provider. Our policies and procedures outline clear guidelines for ensuring that new members receive medically necessary care from providers that they have seen prior to enrolling with us for a period of time. In the interim, we work to either move the member to a network provider as soon as clinically indicated or bring the provider, if qualified, into our network.

As we identify members who need continuity of care coordination, Case Managers obtain necessary information to determine the member's health needs based on clinical criteria or protocols. We facilitate the transition of referrals and authorizations and register them in the core operations system. For members in the third trimester of pregnancy who are seeing a non-participating provider, the Case Manager approves the continuation of services by this provider unless the member wishes to change to a participating practitioner.

After determining the need for continuity of care coordination and gathering information as part of the initial assessment, the Case Manager consults with the Medical Director to determine if continuing with the current provider is medically necessary. If so, one or more of the following occur:

- ***We approve services by the non-participating provider at the appropriate out-of-network rate or at a negotiated fee schedule.***
- ***We consider the provider for recruitment into our network.***
- ***The member is transferred to a network provider once the condition is stable or if he/she requires long-term treatment available from a participating provider.***
- ***We facilitate coordination of services beyond the PCP and specialists using our established linkages with community organizations.***
- ***We notify the member of his/her right to a second opinion at no cost.***

Our Case Management Program (§4.8.18.1-2)

We deliver a robust Case Management program designed to identify member needs and address them in a person-centered, holistic manner. This approach focuses on the development of realistic, measurable goals and the involvement of all providers, services, and resources required to assist members to achieve these goals. Through careful coordination of Case Management and disease management activities, we provide the right care in the right place at the right time, resulting in positive health outcomes for members.

Case Managers ensure that appropriate referrals are made for services and share pertinent information among providers. Case Managers also ensure that information is provided to members and providers regarding the availability of treatment. The activities of care coordination, disease management, and discharge and transition planning are all part of case management.

Our Case Management program addresses the complex needs of members with serious and complicated medical or behavioral health. Case Management activities include predictive modeling, the development of individual care treatment plans, and supporting primary care provider/specialist treatment of members.

Identification

Our Real Solutions® Health Care Insights suite of predictive models facilitates prospective identification and referral for specialized Case Management of members with elevated risks or ongoing medical or behavioral health conditions. Each month, we perform a detailed analysis of member data to identify those who require Case Management. We manage several tools to further focus our efforts at identifying at-risk individuals. Predictive modeling allows us to monitor members with healthcare needs that may lead to high-intensity intervention. By following them closely, we are frequently able to intervene earlier to facilitate use of appropriate lower-level care. Examples of our predictive modeling follow:

- ***Complex Needs.*** ***Stratifies members into four levels of intensity***
- ***Imminent Hospitalization.*** ***Assesses data related to utilization of hospital services, diagnoses, and demographics to predict inpatient admission within 60 days***
- ***Future Neonatal Intensive Care Unit (NICU) Services.*** ***Incorporates screening for specific factors that have been statistically validated to be predictors for the future need for NICU services, such as history of preterm labor or birth, prior baby with low birth weight, or diagnosis of hypertension or diabetes***

- ***Inappropriate ED Visits.*** ***Identifies members at risk for non-emergent and preventable ED use including visits for conditions that are more appropriately treated outside the ED***

Notification

A key member of the case management team is the PCP. We notify PCPs to enlist their assistance in developing a comprehensive care plan requesting clinical and psychosocial information and sharing utilization information. We routinely advise the PCP when changes are made to the treatment plan and solicit the PCPs continued input.

Assessment

Amerigroup is committed to gathering the most complete and accurate information possible. We conduct all assessments in a way that is culturally sensitive to the needs and preferences of the member, including performing assessments in the member's preferred language. Assessment data forms the foundation of all care planning and future healthcare interventions.

Our six Case Managers use the Amerigroup Universal Assessment Tool, which builds the Universal Care Plan and includes assessment of monitoring of service coordination, for example, high-risk pregnancy, Children with Special Health Care Needs, and pain levels. Data captured through this process is stored in our IAP and supports many of the case management and quality activities.

We are a member-centric organization. We believe that the member is in the center of their healthcare decision and processes. In order for them to make informed decisions, we promote shared decision-making among our staff with our members and between our providers and members. Educational materials in their prevalent language, high percentage of providers with different language abilities, and translation services ensure that the member is provided the information in a way they can best understand and use it. We target the identification of health literacy in our communications with our members. We include two health literacy tools in our comprehensive assessments with members – the REALM (English health literacy screening tool) and SAHLSA (Spanish health literacy screening tool).

Amerigroup Case Managers conduct an in-depth, comprehensive, clinical and psychosocial assessment in which they gather information about:

- ***Psychosocial needs***
- ***Supportive housing needs***
- ***General health status, including possible pregnancy***

- ***Behavioral health status***
- ***ED usage***
- ***Hospital admissions***
- ***Medications***
- ***Health care utilization history***
- ***Functional capacity and the need for supportive services, special needs***
- ***Preventive healthcare history***
- ***Delays in child development***

The assessment uses branching logic to probe into more than 20 potential clinical areas for risk factors.

Prioritizing Care

At the conclusion of the assessment, the Case Manager assigns the member to one of five acuity levels to further define the level of case management needed.

Table 5.1.11.5-3. Acuity/Risk Levels Align Care Management with Member and Family Needs

Acuity Levels	Criteria	Frequency of Contact
Complex/ Catastrophic	The member's medical, psychosocial, safety, and/or functional status is extremely unstable; uncontrolled utilization of acute care; lack of Care Plan progress and/or adherence due to instability; requires intensive trans-disciplinary interventions and monitoring.	Weekly
Severe Risk	The member's medical, psychosocial, safety, and/or functional status is severely unstable; frequent admissions or e-admissions; lack of Care Plan progress; requires very frequent interventions, adjustment, and monitoring of the Care Plan to increase the likelihood of adherence and goals achievement.	Every one to two weeks
High Risk	The member's medical, psychosocial, and/or functional status is unstable, requiring more frequent interventions and monitoring; exhibits a significant risk for admission or re-admission to an acute care setting or safety risk.	Every three to four weeks
Medium Risk	Services are well coordinated; however still requires support and follow-up to ensure compliance.	Every one to two months
Low Risk	Stable, safe environment and following an established Care Plan. Care management focuses on continued stability and increased likelihood of positive outcomes.	Every two to three months

The Case Manager then coordinates communication among the Case Management team, including the member, parent or guardian, providers, and community resources. We provide all practitioners who serve the member with contact information so that they can call our staff for consultation and technical assistance if a member presents with disorders outside of the practitioner's expertise, such as developmental delays or behavioral health conditions. With an early understanding of each member's needs, we can quickly direct the member to any and all available services and programs.

Amerigroup's predictive model, the Chronic Illness Intensity Index (CI3), uses a tiered approach to examine multiple data sources and identify members with the most acute needs and those most at-risk for inpatient care. This tool is used to prioritize members for more immediate outreach by our Case Management team. CI3 incorporates review of physical and behavioral health conditions, utilization, and pharmacy use, providing us with a clear picture of all the specific risks for each individual.

This model has proven to be reliable and accurate in determining the future risk for members at the individual and population levels. After CI3 assigns a score to each member, our predictive model filters their data through clinical criteria that prioritize individuals with clinically manageable conditions. Additionally, we use the Likelihood of Inpatient Admission (LIPA) index to identify members who are most likely to be admitted to the hospital, based on past inpatient utilization. Members enrolled in the highest levels of Case Management receive a monthly CI3 score, which drives re-stratification and program reassignment.

Care Treatment Plan

Our Case Managers prepare personalized care treatment plans based on the results of the assessment within 90 days of membership that maps out coordination of all services from caregivers and providers to help improve the member's quality of life. We include the member in the development of the plan using information gathered during the assessment and from ongoing interaction with the member, their families, or caregivers.

Care treatment plans guide members in reaching their treatment goals while avoiding any barriers along the way. Plans may include a combination of telephone and field-based services delivered by a multidisciplinary team to ensure that all medical, behavioral, functional, and social service needs are addressed. These plans also include member preferences, interventions for each diagnosis, short- and long-term goals, interventions designed to assist members in achieving goals and identification of barriers to meeting goals or complying with the care treatment plan.

An effective care treatment plan also considers all services available to the member from the community, including State and county agencies, volunteer associations, and public assistance

programs. Our Case Managers coordinate all the input from these services with information from the member and PCP to create a comprehensive care plan.

Designation of a PCP

In an effort to support the best coordination of services for our members, we ask them to choose a PCP as their medical home. If they are unable to decide, we select one for them, but they are able later choose another PCP, if necessary. Our Case Managers support these member-provider relationships.

Case Management Program Staffing (§4.8.18.3)

Amerigroup uses a model to predict staffing needed to meet the service requirements of our members. We use this to identify the number of Case Managers to deploy. Please see Section 5.1.10.1 for a more detailed description.

We currently have six Case Management employees reporting to the Vice President of HCMS under the current Contract including:

- ***Two Non-OB Case Managers***
- ***Two OB Case Managers***
- ***One Behavioral Health Case Manager***
- ***One Social Worker***

As a company that lives our mission, our commitment begins with recruiting and hiring Case Managers who share and support our vision, mission, and values. We reinforce this commitment through ongoing educational efforts to improve the knowledge, skills, and capabilities of the employees who serve our members. Our Case Managers are passionate about the service they provide and are committed to the members they serve. A foundation of this passion and commitment is the fact that they live in the same communities as our members and are representative of these areas.

Our most recent employee satisfaction survey showed that our Case Managers are among Amerigroup's most satisfied employees because they understand their mission and believe in their job, and they see the company as customer focused and caring about members. The survey also revealed that staff believes the company does a good job of serving members, thus demonstrating an alignment between staff perception and our capabilities.

Because of our Case Management staff's passion and commitment to serving members, they are focused on engaging these members in Case Management programs. Through techniques

such as motivational interviewing, Amerigroup Case Managers can successfully encourage members to participate in programs that promote positive health outcomes.

<u>Case Management Conditions (§4.8.18.4)</u>

Our Case Management services incorporate strategies of predictive modeling identification and stratification and comprehensive assessments to identify and target high risk members.

Chronic Condition Case Management includes but is not limited to the following conditions:

- ***Congestive Heart Failure (CHF)***
- ***Coronary Arterial Disease (CAD)***
- ***Hypertension (excluding Mild Hypertension)***
- ***Diabetes***
- ***Chronic Obstructive Pulmonary Disease (COPD)***
- ***Asthma***
- ***Severe Mental Illness***
- ***High-Risk or High-Cost Substance Abuse Disorders***
- ***Severe Cognitive and/or Developmental Limitation***
- ***Members in Supportive Housing***
- ***Members with Complex Conditions***
- ***Health Conditions that warrant case management such as cystic fibrosis, cerebral palsy, sickle cell anemia***

<u>Case Management Strategies (§4.8.18.5)</u>

The following sections describe our Case Management strategies currently in place.

- ***Patient-centered case management for members with complex conditions***
- ***Complex and integrated case rounds and clinical oversight***
- ***Training of and coordination between medical and behavioral health practitioners***
- ***Targeted behavioral case management***
- ***Case management for supportive housing***
- ***Case management for members with high-risk pregnancies***

- ***Predictive modeling***
- ***Disease management methodology***
- ***Use of evidence-based clinical practice guidelines (CPGs)***

Patient-Centered Case Management for Members with Complex Conditions

We match the intensity of Care Coordination with each Member's individual risk level to ensure that we focus resources most appropriately to improve outcomes.

We work collaboratively with DHCFP to determine member race and ethnicity and organize interventions specifically designed to reduce or eliminate disparities in health care. Our innovative Case Management program promotes early identification and prioritization of members with the greatest risk levels helping to improve health outcomes associated with the following medical conditions:

- ***Congestive heart failure (CHF)***
- ***Coronary artery disease (CAD)***
- ***Hypertension (excluding Mild Hypertension)***
- ***Diabetes***
- ***Chronic Obstructive Pulmonary Disease (COPD)***
- ***Asthma***
- ***Members with complex conditions***
- ***Health conditions that warrant case management such as cystic fibrosis, cerebral palsy, or sickle cell anemia***

Our model assesses each individual to identity the full range of needs, including physical and behavioral health, social support, and environmental deficits, and engages them in an integrated, member-driven, person-centered care treatment plan. We address concomitant behavioral health diagnoses as we evaluate the entire person's conditions and health needs incorporating treatment plans for the following conditions:

- ***Severe Mental Illness***
- ***High-risk or high-cost substance abuse disorders***
- ***Severe cognitive and/or developmental limitation***
- ***Members in supportive housing***

Case Managers coordinate among all treating providers, including coordination of behavioral health and communities based organizations. In our experience, this model fosters improved communication among providers and other resources, better health outcomes, increased quality of care metrics, greater emphasis on disease prevention and management of chronic conditions, and improved access to specialty services.

The cornerstone of our model leverages technology and data to identify members who would most benefit from Case Management, calibrate the intensity of the Case Management services to each member's needs and establish a personalized care treatment plan that engages the member to improve their health status and adhere to their treatment plan.

Our program considers the whole person while assessing each member's physical, behavioral, and social needs. The Case Manager's role is to engage members within identified risk populations follow them across healthcare settings, collaborate with other healthcare team members to determine goals, provide access to resources, and monitor progress. Case Managers work with members and their parents or guardians to identify specific needs and interface with the member's providers, all toward the goal of coordinating access to quality, necessary and cost-effective care. They also facilitate member-directed care.

REAL STORIES

Karla, a 48 year-old Amerigroup Nevada member, was identified as a member with complex needs through our predictive model. For almost 15 years, Karla suffered from complications related to gall bladder surgery, including bile duct leakage that caused chronic pain and discomfort. She routinely required drainage of excess fluid from her abdomen, experiencing repeated infections that had a profoundly negative impact on her life.

Her Amerigroup Case Manager, Christy, realized more could be done for her. Christy accompanied Karla to her doctor's appointment to gain a clear understanding of her condition and coordinated a referral to a renowned liver and transplant specialist at Loma Linda University Medical Center in June, 2012. In July, Karla underwent surgery to repair the leakage and almost immediately her health improved.

She is now healthy and a happy mom to her two children. When Christy recently talked with Karla's dad, he told her "Thank you for giving us our daughter back."

We promote effective coordination among PCPs, specialists and behavioral health providers. Acting as the "integrator" of the process, this coordination occurs at three levels:

- ***Enhanced Communication.*** ***Our integrated approach requires a high level of communication among treatment providers. This includes sharing relevant treatment information between physical and behavioral health providers. Our provider website includes tools to support these activities.***
- ***Communication Facilitation.*** ***Amerigroup Case Managers facilitate communication, acting as the hub around which these activities occur. After development of the care***

treatment plan, the Case Manager shares this with the treating providers, delivering a copy of the plan to each one.

- ***Regular Case Conferences. The Case Manager schedules and facilitates case conferences on a regular basis to move toward achieving treatment goals. These conferences can be scheduled with short notice so that all parties can share information regarding possible inpatient episodes or visits to the ED. Case conferences also provide a venue for members to share feedback with all involved parties.***

Complex and Integrated Case Rounds and Clinical Oversight

Our clinical leadership, both medical and behavioral, seeks members with co-morbid conditions and actively collaborates as necessary to engage providers, members, and their families.

- ***We conduct complex case rounds in which our physical and behavioral Medical Directors*** lead ***a multidisciplinary team of nurses, behavioral health clinicians, and social workers to strategize on meeting the holistic needs of members with complicated co-morbid needs. For individuals in treatment, clinical rounds offer an opportunity for UM and Case Management employees to anticipate risks that may compromise members' sustained recovery and rehabilitation.***

  For example, in support of a member with uncontrolled diabetes who is being discharged from a behavioral health facility, the behavioral health and medical clinical associates collaborate on an appropriate care treatment plan that brings diabetes under control while concurrently promoting sustained recovery for his or her behavioral health condition.

- ***Additionally, when clinical rounds suggest that the member's care treatment plan may benefit, our Medical Director may call the treating providers to discuss referral or care coordination strategies. This outreach, which is well-received by providers, ensures that cases in which members have complex medical and behavioral health components have appropriate clinical oversight.***

Training of and Coordination between Medical and Behavioral Health Practitioners

Our training plan includes training of PCPs on behavioral health issues and behavioral health providers on integration and cultural competency. We introduce providers to a comprehensive provider website through which all providers can view information on behavioral health screening and care coordination tools.

Our PCP training and our online resources educate PCPs about screening members for behavioral health disorders and provide guidance on when a member should be considered for referral to a behavioral health specialist. We also disseminate information on screening and

responding to members identified as having co-occurring mental health and substance abuse disorders and the importance of addressing both concurrently.

Targeted Behavioral Case Management

We directly manage behavioral health benefits for our members. Our operations fully integrate medical and behavioral health – including clinical oversight by medical and behavioral health Medical Directors, healthcare management, health information technology, claims, predictive modeling, and quality management functions.

We currently manage a recovery- and resiliency-focused member-oriented behavioral health program that leverages a wide array of community-based supports to promote sustained independence for our members. This focus drives our coordination of care across both physical and behavioral health for members who have:

- ***Severe Mental Illness (SMI) or Severe Emotional Disturbance (SED)***
- ***High-risk or high-cost substance abuse disorders***

Our Case Managers are skilled at structuring the array of support that best enable each member to remain in the community but also contribute to sustained recovery and resiliency through:

- ***Review/coordinate/monitor wraparound services for the member***
- ***Deliver hands-on support through field-based case management***
- ***Develop/locate resources for the member in the community***
- ***Leverage psychiatric rehabilitation services and supportive housing, supported employment, and peer support***
- ***Ensure clinical continuity through outpatient follow-up, medication management, and family/support system engagement***
- ***Work with family/support system on education and guidance***
- ***Develop Crisis Plans to prevent, manage and, if necessary, access crisis services***

Amerigroup is strengthening our Case Managers' skills to facilitate transformation in the lives of our members with mental illness through a focus on recovery. We have implemented an intensive two-day training for our Behavioral Health Case Managers. The training focuses on building practicing techniques that enable Case Managers to collaborate with members with SMI to create recovery-oriented care treatment plans that build on each individual's strengths and foster self-determination. This includes identifying and linking members with

peer supports within their community. It also incorporates development of wellness action plans that reinforce recovery strategies, identify potential triggers, and act as a blueprint for crisis avoidance and management. The training also encompasses exercises that boost Case Managers' coaching skills to promote sustained recovery. This training program teaches techniques and provides a theoretical background that links members with the skills and services they need to keep them on their recovery path.

Our Behavioral Health team serving Nevada members participate in this training, enhancing our service to current members with behavioral health diagnoses, but also positioning us well should the State opt to remove the ability for members with SMI or SED to disenroll from managed care.

Case Management for Supportive Housing

We establish relationships with organizations throughout our services area to deliver supportive housing services, leveraging the successes of our affiliate health plan in Tennessee. Our Case Managers establish a plan of intervention tailored to each member's needs that coordinates services from community organizations and housing facilities and ensures that members schedule medical and behavioral health appointments. For example, in Tennessee Amerigroup partners with Mending Hearts, supportive housing for women who have been incarcerated and who have co-occurring behavioral health and substance abuse disorders. Because they also accept children, we are able to secure the appropriate level of care for our members while still maintaining family unity, an important step in recovery. We will actively engage similar providers in Clark and Washoe counties.

Case Management for Members with High-Risk Pregnancies

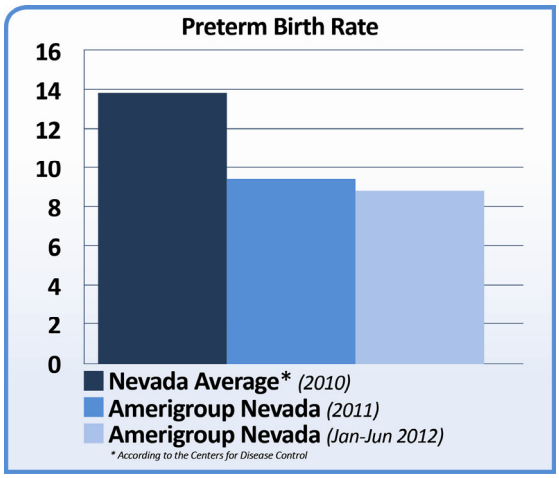
We have established relationships with DHCFP's District Offices in Clark and Washoe Counties, and we will collaborate to promote access to all available services for high-risk pregnant women. Coordination with these Offices is incorporated into care treatment plans for women with high risk pregnancies.

During the first six months of 2012, we achieved a 9 percent preterm birth rate, significantly lower than the statewide average (2010) of 13.9 percent and lower than our 2011 rate of 9.2 percent.

Since 2009, we have implemented our full pregnancy management program in Nevada, Amerigroup's Taking Care of Baby and Me®. This program provides each pregnant member with an array of services that support her and her newborn to provide the best opportunity to have a healthy baby and to be a successful mom. From identification through the birth of her child and the postpartum period, we support the member in each major stage, helping her achieve a healthy outcome. We address each case individually, one mom at a time, using innovative and proven strategies to identify, assess, inform, engage, and support our members. During the first six months of 2012, we achieved a 9 percent preterm

birth rate, significantly lower than the statewide average (2010) of 13.9 percent, according to the CDC and lower than our 2011 rate of 9.2 percent (Figure 5.1.11.5-11).

Figure 5.1.11.5-11. Preterm Births at Amerigroup Significantly Lower than the State Average



Through Taking Care of Baby and Me, we identify our pregnant members as early as possible through our welcome calls, enrollment information and routine Member Service interaction. Through the answers to key questions, screeners use our STORK (Statistical OB Risk) predictive model, refer members for follow-up. Members receive a risk score and are categorized into one of four groups: urgent, high, medium, or low. All members, including the low risk category group, receive informational materials. For those with risk factors and high scores, our specialized OB Case Managers conduct a thorough clinical assessment to further refine risk and develop individualized care treatment plans that correspond to each member's risk level. For adolescent members who are pregnant, the care treatment plan reflects active engagement of the member's parents or guardians when appropriate to facilitate a strong support system.

Pregnant members are also referred to key resources:

- ***Nevada Supplemental Nutrition Program for Women, Infants & Children (WIC) provides nutritious foods to supplement the diets of pregnant, postpartum and breastfeeding women, infants, and children under age 5 who meet WIC eligibility requirements. The Program, working through health professionals, provides participants with:***
  - ***Food Instruments for supplemental foods at no cost***
  - ***Nutrition and breastfeeding education***
  - ***Information on immunizations, prenatal care, and family planning***
  - ***Information about other family support services available in their community***
- ***Nurse Family Partnership of Nevada's Nurse Home Visitors work with low-income young women who are pregnant with their first child to achieve healthier pregnancies and births, stronger child development, and a path toward economic self-sufficiency. The nurse conducts weekly home visits during the mother's pregnancy and continues to follow the family until the child reaches 2 years old. Their focus is on eating healthy during pregnancy, maintaining doctor's appointments, and ensuring the baby is current on immunizations.***
- ***Women's Resource Centers provide mothers with assistance obtaining diapers, car seats, high chairs, formula, and other baby items. Other services include:***
  - ***Pregnancy Testing***
  - ***Peer Counseling regarding pregnancy options***
  - ***Limited Medical Ultrasound to determine fetal activity and viability***
  - ***Post Abortion peer counseling and support groups***
  - ***Referral Services to local resources, such as financial, medical, legal, housing, and general assistance***
- ***Baby's Bounty is a one-time assistance program regardless of how many children are in the family. Pack N' Plays can be requested as part of the safe sleep initiative and other items available include bath tubs, diapers bags, toiletries, clothes, car seats, and baby swings (when available). The service is limited to Case Managers who must pick up and deliver the items to the home or hospital.***

- ***Nevada 211 is a referral source for individuals to dial from their telephone for access to:***
  - ***Basic human needs resource***
  - ***Physical and mental health resources***
  - ***Financial stability***
  - ***Programs for children, youth and families***
  - ***Support for older Americans and persons with disabilities***
  - ***Volunteer opportunities and donations***
  - ***Support for community crisis or disaster recovery***
- ***Text4Baby.org delivers three free text messages per week regarding pregnancy tips and educational information. The program lists their four goals as:***
  - ***Demonstrate the potential of mobile health technology to address a critical national health priority: maternal and child health***
  - ***Demonstrate the potential of mobile health technology to reach underserved populations with critical health information***
  - ***Develop a base of evidence on the efficacy of mobile health interventions***
  - ***Catalyze new models for public-private partnerships in the area of mobile health***
- ***Babies Are Beautiful through Valley Hospital program offers:***
  - ***Referrals to a private OB/GYN physician (some restrictions may apply)***
  - ***Help with filing Medicaid applications for financial assistance, or other help in determining the best payment option for expectant mother and referrals to Nevada Check-Up***
  - ***Discounts for lab work and ultrasounds***
  - ***Free prenatal education classes***
  - ***Free access to a certified lactation educator for breastfeeding issues***
  - ***Referrals to community agencies***
  - ***Hospital preadmission registration***
  - ***Free diaper bag filled with special gifts and educational materials***
- ***Family Ties of Nevada - http://familytiesnv.org/ is a family-run non-profit organization that provides information, education, training, outreach, and peer support at no cost to***

families of children and youth with special health care needs and the professionals who serve them.

- *Southern Nevada Children First - http://www.childrenfirst-nv.org/ assist young, pregnant women and young families attain self sufficiency through:*
  - *Behavioral Health assessments*
  - *Transitional housing program for ages 16-22 years old*
  - *Assist in obtaining birth certificate and social security cards for clients*
  - *Address barriers*
  - *Life Skills Classes (must attend 1x/week)*
  - *Connect with subsidized housing*
  - *Education & Training Program for ages 14-18 years old*
  - *Volunteer opportunities for young, pregnant women who cannot work*
  - *Clinical services: intensive case management*
  - *21 beds in their housing unit*

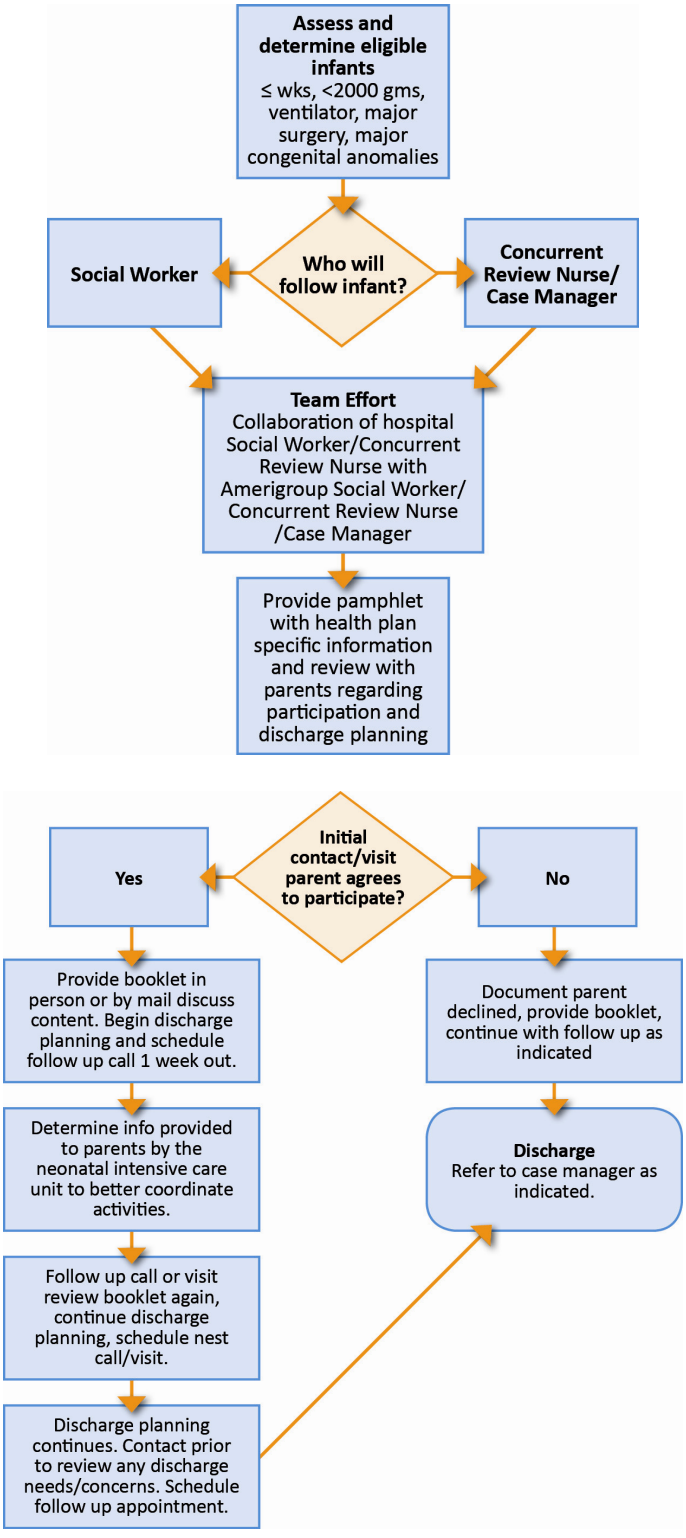
In addition, our Case Managers in Nevada facilitate community-based visits for high-risk members. Field-based clinicians make home visits to monitor our members and assist them as necessary, for example, accompanying them to high-risk OB and Perinatologist appointments.

We also offer specialized support for families whose baby is admitted to the NICU to ease the often stressful process and facilitate a safe transition home. We work closely with the Maternal Fetal Medicine practice to identify babies who are most appropriate for our NICU program including those who are

- *Expected to be in the hospital for more than two weeks and who are:*
  - *Equal to or less than 34 wks gestational age*
  - *Equal to or greater than 2000 grams birth weight*
- *Require ventilator care*
- *Require major surgery*
- *Have major congenital anomalies*

The Case Management process specific for the NICU program is shown in Figure 5.1.11.5-12.

Figure 5.1.11.5-12. Case Management NICU Work Flow Leads to Healthier Babies and Shorter Lengths of Stay



The program experience proves that promoting early family education and involvement in their infant's care has significant benefits to include:

- ***Decreased parental stress, depression, and anxiety***
- ***Increased confidence in caring for the infant***
- ***Developmentally appropriate interaction with their infant***
- ***Improved readiness for their infant's discharge***
- ***Decreased length of stay in the NICU***

In 2012, we actively collaborated with HealthInsight (a non-profit organization that served as convener), Nevada State Health Division and DHCFP, the other Medicaid managed care plan, and the three largest obstetrical practices in Nevada to develop a CMS Innovation Strong Start grant proposal. One component of the proposal included the adoption of Centering Pregnancy, an evidence-based model for delivery system reform adopted in several states by Amerigroup to improve outcomes for maternal and child health. This model uses a group setting to maximize the opportunity to educate women and to help them learn from each other and their shared experience. Once awarded, we will implement this for DHCFP.

Predictive Modeling

We use a systematic, prospective approach when identifying and prioritizing our members with a risk of poor health outcomes, the Chronic Illness Intensity Index (CI3). We use our DHCFP-approved CI3 predictive modeling tool, that is based on the Chronic Illness and Disability Payment System (CDPS), created from population health research work performed at University of California San Diego. Amerigroup continually performs research and analysis of its toolsets and will evaluate replacements when appropriate to improve results.

Our CI3 system is recognized in the healthcare industry and in all 13 states where Amerigroup operates, including Nevada. Our approach employs our proprietary predictive modeling tool that synthesizes member data such as diagnoses, hospitalizations, ED encounters, expenditures, and demographics, to develop individualized risk profiles. This tiered approach (STORK assessment, COR score, and CI3 predictive model) is particularly useful for those members who are challenged with complex, interlocking behavioral and physical health conditions. Such members typically benefit most from case management.

Disease Management Methodology is Employed for Case Management

Amerigroup's DM Program has Full NCQA Accreditation for Patient and Practitioner–Oriented Disease Management with the additional distinction of Performance Measures Reporting.

Our DM program employs a multidisciplinary, continuum-based care team approach to healthcare delivery that proactively identifies populations who have or are at-risk for established medical conditions. We provide secondary and tertiary prevention interventions based on a comprehensive, multidisciplinary, system-wide approach. Our model encompasses evidence-based guidelines and provider practice and member empowerment strategies to improve members' health outcomes. DM supports the practitioner-member relationship, treatment plan, and care treatment plan; emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and member empowerment strategies such as self-management; and continuously evaluates clinical and humanistic outcomes with the goal of improving overall health.

The Disease Management Programs include the following: asthma, bipolar disorder, coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, HIV/AIDS, hypertension, major depressive disorder, obesity, schizophrenia, substance use disorder, and transplants. Eight of out DM programs are accredited with NCQA.

Our CI3 predictive model describes the overall illness burden of a member using a prospective risk score based on the past 12 months of experience. The rank on the CI3 list demonstrates a member's severity of illness and assists in stratification with higher ranked members referred to Case Management and lower ranked members referred to Disease Management.

For members referred to DM, DM Case Managers conduct a thorough assessment to determine each individual's risk/severity level, which drives the intensity of DM interventions. The DM assessment then results in assignment of each DM participant to one of three levels of support, as summarized in Table 5.1.11.5-4.

Table 5.1.11.5-4. Defining the Need for DM Based on Member Assessment

Level	Description
1 – Mild	Member's condition appears to be well-controlled and there are no immediate needs.
2 – Moderate	Member has between one and three needs and is appropriate for DM. An assigned Case Manager contacts these members for initial screening and clinical assessment, and they receive at least bi-weekly telephonic contact for three months or until the goals are met.
3 – High	Member has more than three needs identified and is appropriate for DM. An assigned Case Manager contacts these members for initial screening and clinical assessment, and they receive at least weekly telephonic contact for three months or until the goals are met.

Our DM program also includes other programs to drive health improvements – Healthy Families and smoking cessation. Our healthy behavior and fitness coaching for kids (our Healthy Families program)improves health outcomes, a key goal in Nevada, by reducing childhood obesity which can have both immediate and long-term effects on health and well-being, including cardiovascular disease, diabetes, increased risk for bone and joint problems, sleep apnea, and social and psychological problems, such as stigmatization and poor self-esteem. In Healthy Families, Amerigroup Nevada initiates an outbound call to offer to partner with parents in the identification of potentially overweight pre-teen children. Children ages 7 to 13 who qualify are provided six months of healthy behavior and fitness coaching, including information about community resources. Amerigroup Nevada communicates program progress to the child's PCP to reinforce the role of the medical home.

Smoking cessation improves health outcomes by reducing smoking rates, especially among pregnant women, with a program in which more than 40 percent of participants have successfully quit smoking compared to mid-single digit success rates for the unassisted general population. (Nevada ranks 43rd among the states for smoking rates among adults, according to the Centers for Disease Control.) Amerigroup Nevada will offer a smoking cessation support program for adults 18 and older. This program includes individual cessation counseling (including outbound follow-up calls to participants), coaching to quit, cessation planning and support, and follow-up.

Use of Evidence-based Clinical Practice Guidelines (CPGs)

Amerigroup adopts and disseminates Clinical Practice Guidelines for acute and chronic medical and behavioral health conditions. Amerigroup, through a collaborative review process, involves board-certified practitioners from appropriate specialties in the development and approval of the guidelines. The Amerigroup Medical Policy Committee (MPC) maintains oversight of the review process. We distributed updated guidelines, approved by our local MAC in 2011(with 2012 review in process), to practitioners and posted on our provider website. Please see Standard II: Systematic Process of Quality Assessment and Improvement (§4.8.6) Subsection Use of Clinical Care Standards/Practice Guidelines (§4.8.6.4) for a detailed description of our Clinical Practice Guidelines and Review and Dissemination Processes.

Case Management Innovations:

Amerigroup proposes to share our corporate-wide expertise with DHCFP on the following innovative care coordination processes. We have implemented each of the following in at least one of our affiliate health plans, working collegially with the related state agencies.

See the Confidential Technical Volume for proprietary information.

- ***Juvenile Justice.*** ***We acknowledge that care for individuals associated with the Juvenile Justice system is specifically carved out of this Contract, we offer our experience to DHCFP to implement a care coordination processes for youth exiting juvenile correctional facilities. In other Amerigroup health plans, we provide Case Management and linkage to community-based resources for transitioning youth across multiple domains, and we develop recovery-oriented transition planning. Transition plans reflect the appropriate level of care and recommended service array based upon the youth's behavioral health and functional needs.***

Approximately 65 to 75% of youth in residential juvenile justice facilities and 50% in non-residential settings **struggle with mental health issues.**

Among these populations, Rates of substance use reach nearly 77% in some areas.

Our integrated approach to care coordination will effectively address these issues.

- ***Pharmacy Medication Therapy Management.*** ***As an enhancement to our pharmacy management program, Amerigroup Medication Therapy Management (MTM) is conducted by specially trained clinical pharmacists working directly with the patient and prescribers. The program provides comprehensive medication management services aiming to ensure that each medication prescribed is appropriate for the patient in addition to being effective and safe and that the medication will improve clinical outcomes. Amerigroup's MTM program is a collaborative effort between the pharmacist, the patient, the primary provider, and other members of the Real Solutions Amerigroup Medical Home team. Our MTM program includes several innovative strategies:***
  - ***For members on multiple medications or those prescribed for chronic conditions, clinical pharmacists work with the Amerigroup Medical Home team to ensure that medications are appropriate, effective for their medical condition, safe with respect to co-morbidities and other medications being taken, and able to be taken by the member as prescribed.***
  - ***The program leverages data to improve clinical outcomes, including mining of healthcare claims data such as pharmacy data through our CI3 predictive model. The CI3 uses this information to identify members eligible for outreach services and also prioritizes members for interventions based on their clinical severity.***
  - ***The Pharmacy Lock-In program is both an MTM and a quality-based activity. When a member is identified who uses multiple pharmacies or has prescriptions from multiple providers, we reach out to the member and allow them to select a single pharmacy for receiving prescriptions. The pharmacist evaluates utilization and works with the prescriber and the member to identify and reduce duplicate prescriptions, drug-drug interactions, and overuse.***

Amerigroup's MTM program has shown return on investments (ROI) ranging from 2:1 to 8:1 depending on the level of activity and focus. The ROI reflects an ability to decrease hospital admissions, physician visits, and ED admissions and reduce the use of unnecessary and inappropriate medications.

- *Telemedicine. Especially in rural Nevada, a potential barrier to quality in the rural region is limited access to specialized behavioral health providers. In various parts of the country, Amerigroup is now exploring Real Solutions through collaboration with regional medical centers and large outpatient providers, such as Community Mental Health Centers, to establish telepsychiatry partners that can expand access for members in underserved regions.*

  For example, our Georgia health plan collaborates with the Georgia Partnership for TeleHealth, Inc. Through active engagement, the State has seen a 200 percent increase in telemedicine encounters between 2008 and 2010. Amerigroup is committed to exploring similar programs throughout Nevada.

- *Enhanced Nevada's care coordination with our Nevada Hospitalist program for discharge planning. We designed and implemented an innovative program with a hospitalist network in Nevada to reduce lengths of stay. In the program implemented in March 2011, all adult, non-obstetrical inpatient cases in Clark County are admitted through the hospitalist network of physicians, which provides direct, onsite patient management and discharge planning. Amerigroup concurrent review nurses work closely with the hospitalists and the facility to monitor member care. Savings results are still preliminary.*

  We plan to implement a gain-sharing or shared savings component to the program by the end of 2012. This may eventually expand to a risk sharing model.

Information Technology System for Case Management (§4.8.18.6)

A key component of the Amerigroup MIS is CareCompass, our clinical care management solution. CareCompass provides care managers with a comprehensive solution for developing, documenting, managing, and monitoring care plans for our Medicaid and dual eligible members.

Amerigroup's CareCompass is a comprehensive solution for developing, documenting, and managing member care plans.

CareCompass gathers and organizes member claims, lab results, immunizations, prior authorization, and demographic information to help the care team evaluate the member's current health status and identify the services they should receive and any outreach activities for the member or their providers. CareCompass supports the Case Manager and other participants of the care team in

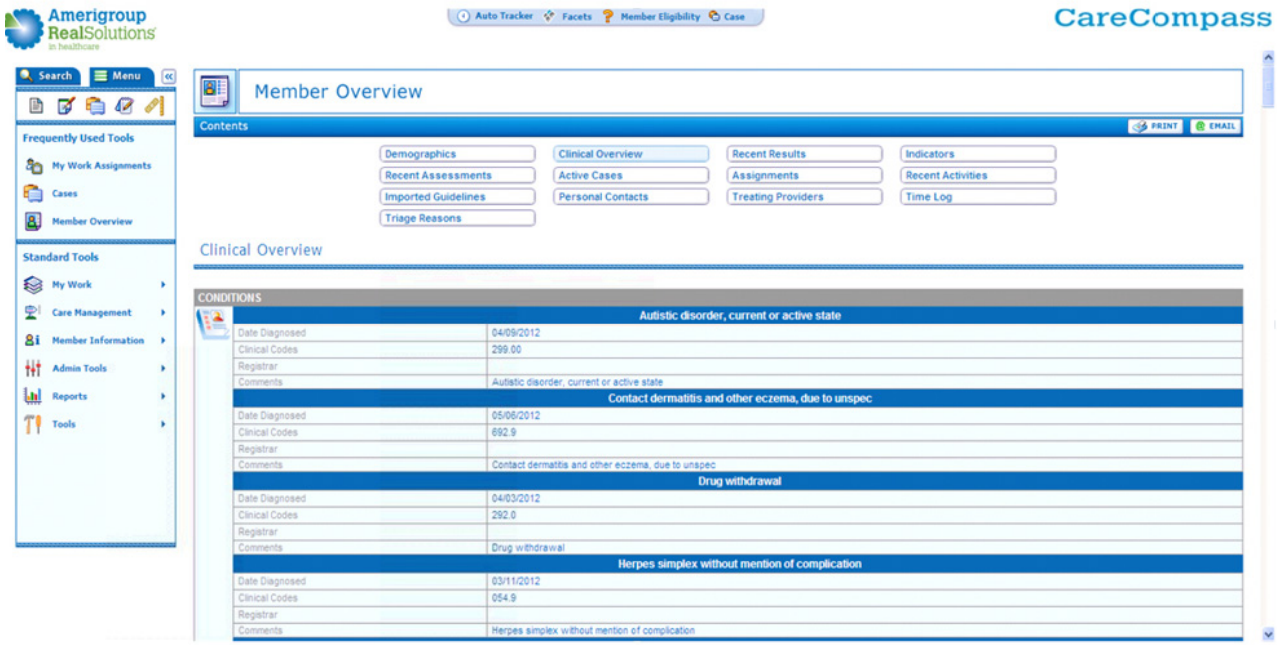
developing an appropriate care treatment plan for the member. CareCompass allows the Case Manager, in conjunction with other members of the care team, to:

- ***Document the care plan, including short- and long-term goals, barriers, milestones, and interventions***
- ***Document progress towards meeting goals***
- ***Set follow-up reminders and interventions***
- ***Modify the care plan as necessary and appropriate to improve member health outcomes***
- ***Record interactions with the member, their designee, or the provider in support of the care plan, including telephone calls, care management activities, clinical interventions and outcomes, education information, care coordination across providers, and referrals***
- ***Deliver care plan and information on interactions and services provided to the member to members of the care team***

CareCompass is built on a series of screens that allow Case Managers to view and document all aspects of a member's health status and care plan. For example, the member Overview screen, shown in Figure 5.1.11.5-14, provides a single consolidated view of a member's information including:

- ***Clinical conditions***
- ***Medications, including dosage and last refill date***
- ***Procedures, such as lab tests, EKGs, screenings, and MRIs***
- ***Recent activity (visits, medications)***

Figure 5.1.11.5-14. CareCompass Consolidates Member Clinical Information into a Single View



Case Managers follow DHCFP-approved policies and procedures that protect the privacy and security of protected health information while sharing the care treatment plan and health information with the member and providers in support of the care treatment plan.

As the availability of a Health Information Exchange (HIE) evolves and more providers adopt Electronic Health Records (EHRs) and connect to HIEs, the methods for provider collaboration and care coordination will also evolve. To support the State's efforts, our CEO and medical director serve on the Board working with DHCFP to bring HIE and EHRs to Nevada.

During this transition, we are committed to delivering a suite of capabilities to our providers that enable effective information sharing regardless of their level of technology adoption. We believe that members should benefit from the care coordination benefits HIE can provide, regardless of whether the provider they choose has embraced EHR and HIE technology. Our plan supports all providers by communicating with them in the manner that works within their practice.

As we move towards an integrated bi-directional data-information sharing world in support of HIE, we are moving our front-end transactional capabilities to more fully embrace EDI as the platform for transactional and clinical information sharing. This positions us to share clinical

quality and care-gap information with providers, caregivers, and members and extends our internal care coordination capabilities to our provider community.

Standard XV: IQAP Documentation (§4.8.19.1-2)

Based upon our IQAP, our quality employees document all activities associated with monitoring and evaluating the quality of care across all services and treatment modalities through the use of electronic and paper files. Our IQAP Work Plan details the specific quality-of-care areas of concern to be monitored and the schedule for the activities involved. Our employees document all meetings, maintain meeting minutes, generate reports for studies conducted, and document the analysis of all data collected for reporting to all appropriate committees and agencies. We produce studies, reports, protocols, standards, worksheets, minutes, and other documentation that is made available to DHCFP and/or CMS as requested for quality assurance activities and corrective actions.

Standard XVI: Coordination of Quality Assurance (QA) Activity with Other Management Activity (§4.8.20)

Coordination with other Management Activities

As part of the IQAP, we provide a written process for coordinating all quality assurance activities with other management functions. We are aware that issues and information gathered during quality assurance studies, PIPs, reviews, surveys, member complaints, and other activities provide valuable data to improve our service levels across the plan. The Nevada IQAP identifies the other functional areas affected by QA activities and provides direction for the coordination of activities.

Our QMC and quality employees share information across our organization. This works to improve the results of our credentialing and re-credentialing efforts, affect network changes, coordinate with benefits redesign, assist Medical Management, provide feedback to providers, educate our members, and improve the offerings of our member services.

Documentation and Use of QA Activity Information

We use many mechanisms to document and disseminate our IQAP system findings and recommendations. We analyze the adequacy of services, quality, utilization, complaints, grievance, appeals, member outcome measurements, provider closure of gaps in care, HEDIS and HEDIS-like measures, continuity of care, provider access and out-to-network usage, on an ongoing basis. These analyses form the basis of our daily improvement processes and are shared between appropriate departments and Quality committees.

Credentialing and Re-credentialing (§4.8.20.1)

When we identify a provider who is out of compliance with our standards, our Provider Relations Representatives visit the provider in person and present a letter requesting a corrective action plan. These employees continue to monitor compliance and re-survey the provider after 90 days to verify that the provider is in compliance. Ultimately, we remove providers from our network if they do not take action to meet the requirements in their contracts and outlined in the provider manual.

Feedback to Utilization and Risk Management (§4.8.20.2)

We conduct an annual evaluation of the IQAP and UM Program in comparison to program objectives and activities, and the MAC and QMC review the results. Results and recommendations become the basis for each subsequent year's activities. Unrealized goals/objectives may be carried over to the plan for that year. As part of the IQAP evaluations, Amerigroup Clinical Quality Management conducts member and provider satisfaction surveys to determine satisfaction with the Utilization Management process. We identify opportunities for improvement and initiate actions to meet program goals and member/provider expectations. We monitor results through ongoing surveys.

Linkage with Management Functions (§4.8.20.3)

Our IQAP ensures the coordination of performance monitoring activities including risk management, UM, credentialing, member services, health promotion, disease and case management, contracted services, and monitoring of member grievances, and appeals. Feedback from CAHPS and provider surveys drive changes in processes for both stakeholders. Requests for new services and local CPGs also drive our benefits.

Trending Measures in Quality and Safety of Care

We thoroughly investigate all potential Quality of Care issues, including those associated with infections, errors, or Never Events. Regardless of which department employees identify the potential issue (Claims, member Call Center, Provider Services, Utilization Management, or Quality Management), all inquiries are documented and routed to our IQAP Department, which is responsible for researching and tracking the issue in the quality database. Adverse incidents and critical events are immediately forwarded to our Risk Manager. Any Hospital Acquired Conditions, Never Events, and serious reportable events that we identify are investigated for cause or contributing factors and reported as applicable by State or federal regulations.

Performance Improvement Projects

The Quality Department monitors all PIP data results at least annually. Employees review data results in comparison to the goals and benchmarks we have established and identify

areas exceeding or not meeting the goals. When data points do not meet goals, relevant workgroups discuss results for identification of barriers for members, providers, and the health plan. We implement new interventions and actions to address the identified barriers and re-measure the following year.

Sharing Quality Improvement Information with our Providers

Amerigroup providers receive information about the IQAP goals and progress toward meeting the goals, PIPs, and initiatives through health plan orientation, newsletters, bulletins, performance reports, Provider Relations Representatives, provider manuals, our provider website, and office site visits. We also publish updates on quality activities in the provider newsletter and on the website.

Sharing IQAP Information with Our Members

We inform members about our IQAP routinely by: 1) reviewing quality initiatives with HEAC; 2) sharing CAHPS and HEDIS scores and the actions we are taking through annual member newsletters; 3) posting information on the member website. For example, dissemination of specific quality processes and results to members are provided through newsletters and on the member website including: HEAC results, HEDIS results for preventive care and chronic diseases and conditions, CAHPS findings, and member satisfaction with services results.

Sharing IQAP Information with DHCFP

When requested or at least annually, we provide DHCFP with the IQAP, IQAP Annual Work Plan, Periodic Reports for Performance Improvement Projects, CAHPS, HEDIS and other prescribed measure reporting, and all other required information through the processes outlined in the Contract. We also share the actions taken in response to the EQRO findings each year with DHCFP.

SECTION 4 S.O.W.

Standard XVII: Data Collection (§4.8.21)

Specific Areas of Study (§4.8.21.1)

We submit uniform data set reports for UM, QA, CAHPS, Provider Satisfaction, cost, and complaint data routinely to DHCFP, in accordance with Contract requirements. In addition, all periodic data measures for quality and performance measures, (HEDIS), will be submitted as required by the Contract.

Timely Submission of Studies (§4.8.21.2)

We submit all reports in a timely fashion to DHCFP, in accordance with the Contract requirements.

Monitoring and Tracking of Grievance/Appeal Information for TANF (§4.8.21.3)

We document member grievances, appeals and Fair Hearing referrals in the member record database. The system documents the date of the receipt automatically and the date of resolution when employees close the item. From this database, we can extract the data used in our required quarterly reporting to the agency. The database also calculates aging from date of receipt, which helps us validate compliance with the state grievance and appeal resolution turn-around time standards as set forth in our current Contract with DHCFP.

Standard XVIII: Dispute Resolution (§4.8.22)

We follow standard policies and procedures to respond to provider questions and to perform dispute resolution. Provider services are handled through our Provider Relations Representatives and by Amerigroup Provider Services employees at the National Contact Center. We train employees to respond quickly and accurately to all inquiries from health plan providers and have a variety of tools available to assist them with their responses. Our employees log provider contacts regarding grievances and appeals into the core operations system for tracking and reporting, and Provider Services Representatives follow-up. We maintain the written record of disputes within the core system which documents all of the following:

- ***The nature of the dispute***
- ***The date filed***
- ***Dates and nature of actions taken***
- ***Final resolution***

Our team of professionals is responsible for ensuring that we meet or exceed the goal of 80 percent of all disputes resolved within 30 calendar days of the initial inquiry. Our current resolution rate is 90 percent within 30 calendar days from receipt.

Our current provider dispute resolution rate is 90 percent within 30 calendar days from receipt which exceeds the 80% goal.

We support a two-tiered approach to provider disputes, and appeals. Our dedicated Provider Grievance System employees, including our Provider Relations Representatives and Amerigroup's NCC-based Provider Services Hotline staff who handle telephone inquiries, initially handle verbal grievances. If the provider is dissatisfied with the resolution of the verbal grievance, the provider can elevate the dispute to a formal appeal. Our provider appeals process complies with all federal and State regulations regarding claims processes and appeals.

Quality Assurance (§5.1.11.5.B)

Amerigroup's response to question RFP Section 5.1.11.5.B includes:

- ***5.1.11.B.*** ***Describes Amerigroup's Continuous Quality Improvement (CQI) process used to monitor and measure quality improvement in compliance with the State's Quality Assessment and Performance Improvement Strategy (QAPIS).***
- ***Scope of Work 4.9.*** ***Reviews our Compliance with each of the DHCFP QAPIS strategies***
- ***Scope of Work 4.7.*** ***Highlights our Nevada performance improvement project examples for DHCFP required Performance Measures.***

Introduction

Since 2009, Amerigroup Nevada has joined DHCFP in a successful collaboration to provide care to Medicaid and Nevada Check Up members that focuses on continuous quality improvement and follows the State QAPIS. As a health plan that completely focuses on Medicaid and Nevada Check Up programs and through our work with our Nevada members, we know that many members are high-risk and high-volume users of healthcare services. Healthcare organizations that focus on commercial members may not understand the complexities and needs of Medicaid populations. Amerigroup Nevada is dedicated to serving the needs of the Medicaid population and brings years of expertise addressing Medicaid populations in more than 13 states. We continue our strong commitment to working closely with DHCFP to provide a community-focused managed care program that promotes health awareness and disease prevention.

B.	In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

Amerigroup's quality employees implement specific CQI processes to monitor and measure quality improvement of care delivered to our Medicaid and Nevada Check Up members. In Section 5.1.11.5.A, we provide details of our internal quality program including our Internal Quality Assurance Program (IQAP) team and quality committees that monitor, measure, evaluate, and recommend quality improvements for implementation. Our Nevada Quality System is data-driven to target the identification of areas for improvement in Member quality of care and treatment.

Monitoring and Measuring Quality of Care for our Members

Input Sources. ***To monitor the quality of our care improvement for our members, our CQI feedback system begins with identification of quality impact areas through collection and tracking of quality input from the following direct communications with our members and providers, the Health Education Advisory Committee (HEAC), Consumer Assessment of Healthcare Providers and Systems (CAHPS), participant input from quality committees, provider satisfaction surveys, community agencies and resources, and organization/employee input. Other key input is received from DHCFP, Health Services Advisory Group (HSAG), Nevada Health Departments (registries and programs), and MCO/DHCFP workgroups. Our quality employees and committees use this input to determine areas of needed improvement and program design adjustments or additions.***

Data Sources. ***Integrated with our input sources, our quality data sources provide the foundation for our data-driven monitoring and tracking of quality areas that demonstrate performance improvement or areas to target with interventions. The following is a representative sample of current and future data sets for Medicaid and Nevada Check Up:***

- *Member Data Sources.* ***Population demographics, race, ethnicity, and language data, outcome data, DM/CM program data; physical, behavioral, Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), Maternal/Child services encounter data, and medical records information.***
- *Provider Data Sources.* ***Claims, Provider Quality Incentive Program (PQIP), future Patient-Centered Medical Homes (PCMHs) indicators, Provider Profiles, and GeoAccess data.***
- *State Data Sources.* ***DHCFP enrollment files and other data, Health Department registries and program information, Health Information Exchange (HIE) and Health Insurance Exchange (HIX) (future) data sets, External Quality Review Organization (EQRO) audit results, and State-required performance measures and performance improvement projects (PIPs).***
- *Plan Data Sources.* ***Behavioral Health indicators, pharmacy, member safety data, HEDIS and NCQA requirements, internal audits, credentialing, utilization, Inter-rater reliability data, customer service line metrics, Nurse HelpLine metrics, medical record audits results, subcontractor indicators, and PIP results.***

These input and data sets are analyzed and evaluated by our quality team. Figure 5.1.11.5-15 describes our quality feedback loop that drives our member quality of care performance improvement.

See the Confidential Technical Volume for proprietary information.

Analysis of Quality Performance and Recommendations

Our quality committees evaluate reports, analyze outcome data, and recommend improvements and enhancements to our quality system. Our committees include quality experts in their fields of practice, our medical directors, pharmacists, practicing Nevada network providers, and population-representative members. Each committee has specific directives that work in unison with those of each sub-committee and advisory board to provide recommendations based on data-driven analyses for the improvement of our programs and services. Through our quality committee structure as shown in Section 5.1.11.5, we carry out tracking, monitoring, evaluating, and providing recommendations for our quality performance enhancement.

Implementation of Recommendations for Improvement

Amerigroup employees implement the quality committees' recommendations across all functional areas for changes in processes and programs, system enhancements, and proactive approaches to improve health and service outcomes of our members. These changes or enhancements, as well as the ongoing sources of quality data and information, continue to be analyzed for ongoing improvements through our CQI feedback process.

We conduct an annual evaluation of the IQAP, utilization management (UM), disease management (DM), and case management (CM) programs in comparison to program objectives and activities and submit the results to the Medical Advisory Committee (MAC), Quality Management Committee (QMC), and the Corporate Quality Improvement Committee. Results and recommendations become the basis for each subsequent year's IQAP work plan activities. Unrealized goals/objectives may also be carried over to the plan for that year. For example, we analyze overall cultural diversity and competency through member and provider feedback and educational materials, employee training, and the activities described in our annual Cultural Competency Plan.

Examples of improvements from member input are outlined in Section 5.1.11.5.A and later in this section. We have incorporated recommendations from DHCFP and HSAG into our operations and performance improvement processes. Provider input from quality committees and provider satisfaction results drive our outreach to providers and enhance supports and

incentives offered to our provider network. HEDIS and NCQA performance audits and accreditation processes support ongoing intervention development and outreach to members.

Ongoing Quality System Performance Improvement

Amerigroup implements a multi-faceted analytic process to identify and evaluate our Nevada quality performance. We use the Plan Do Study Act (PDSA) cycle and embed the use of other quality management tools within that cycle. This process includes a drill-down analysis (Ishikawa diagramming) of an identified performance measure to determine barriers to achieving DHCFP QAPIS goals and interventions to promote care and services related to those goals. This is discussed in greater detail in this section.

SECTION 4 S.O.W.

Nevada Quality Assessment and Performance Improvement Strategy (QAPIS) (§4.9)

Amerigroup Nevada works collaboratively and cooperatively with the DHCFP's External Quality Review Organization (EQRO) Health Services Advisory Group (HSAG) as they monitor the quality of the services.

Compliance with State, Federal, and State Statutory and Regulatory Requirements on Quality

INVesting in Quality

We provide and evaluate all of our MCO activities under the Contract. We have gathered data, analyzed the effectiveness of our programs, and reported the findings to DHCFP and HSAG. We will continue to provide all required reporting and additional information when requested, and we will participate in additional EQRO activities as assigned and required by DHCFP.

NCQA Accreditation Demonstrates Compliance

Amerigroup Nevada is the only health plan in Nevada with Medicaid accreditation. We received the NCQA Medicaid Accreditation with New Health Plan designation in 2011 and are currently the only Medicaid NCQA-accredited health plan in the State. In September 2012, during a re-accreditation for DM, we obtained the status of Accredited with Performance Reporting. NCQA awards the status of Accredited with Performance Reporting to organizations that meet or exceed its standards for DM accreditation and report results for a specified number of DM performance measures.

We follow NCQA quality, UM, and compliance standards for all NCQA components and domains. We integrate our NCQA Accredited Disease Management Program, along with our Care Management and Health Promotion Programs, into our Internal Quality Assurance Program (IQAP) (described in Section 5.1.11.5.A) to facilitate the delivery of the most appropriate, medically necessary care to members in the most cost-effective, least-restrictive

setting. Our programs are flexible and easily adapted to the needs of diverse populations, whether those needs involve attention to co-morbid conditions or cultural or linguistic preferences. In addition, they span a broad clinical spectrum including preventive and primary care, behavioral health treatment as appropriate (mental health and substance abuse disorder), specialty care, chronic conditions, medication management, and dental services.

We have fully integrated our CM and UM processes in our IQAP for physical, behavioral, and psychosocial services. Behavioral health issues cross all populations at different levels of severity. Over 60 percent of members with multiple co-morbidities have a concomitant behavioral health diagnosis. Our DM program employs a multi-disciplinary, continuum-based care team approach to healthcare delivery that proactively identifies populations who have or are at-risk for established physical and behavioral health conditions. We provide secondary and tertiary prevention interventions based on a comprehensive, multidisciplinary, system-wide approach that encompasses evidence-based guidelines, provider practice, and member empowerment strategies to improve members' health outcomes for specific and multiple co-morbid conditions.

SECTION 4 S.O.W.

Quality Measures (§4.7.2)

As a healthcare partner of the state of Nevada, we focus on our compliance with all requirements set forth in the QAPIS and our Contract as we demonstrate by our compliancy report from the 2011 HEDIS audit (Nevada 2010-2011 EQR Technical Report):

We have effective policies and procedures in place for collecting, processing, and reporting our HEDIS data, and we were found in full compliance with the HEDIS 2011 technical specifications.

Our claims and encounter data systems employed by Amerigroup Nevada use sophisticated scanning processes and advanced software to ensure accurate data processing.

To ensure accurate programming and reporting of the rates, we use certified HEDIS software for reporting HEDIS rates.

The 2012 HSAG Technical Report reaffirmed that all three submitted PIPS maintained the overall "Met" validation status with a percentage score of critical elements at 100 percent "Met".

We improved in all 22 comparable Medicaid rates over the previous period and had a remarkable 15 out of 18 reportable rates above the 50th percentile, including nine rates above the 90th percentiles per the HSAG 2011 Technical Report.

All three of our PIPs received an overall "Met" validation status, which represented an area of strength for Amerigroup and provided confidence in the technical aspects of the studies. This was the baseline reporting year for our

PIPs, so no comparison to the previous year's results was available. (HSAG – Nevada 2010-2011 EQR Technical Report.) The 2012 report reaffirmed that all three submitted PIPS maintained the overall "Met" validation status with a percentage score of critical elements at 100 percent "Met."

QAPIS STRATEGIES

Provide a framework for DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Check Up system. The Quality Strategy promotes the identification of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and quality of services.

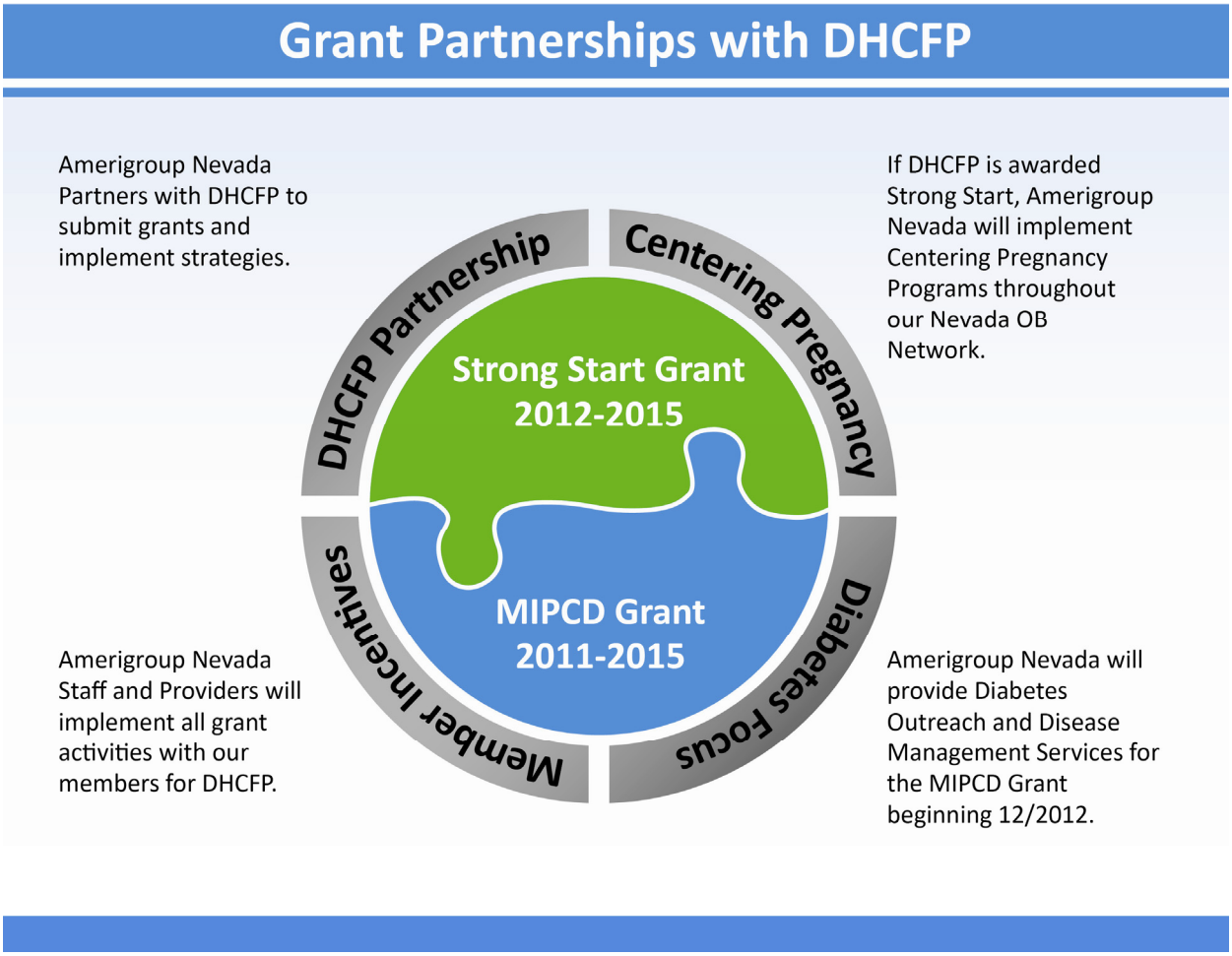
Going Beyond the Minimum—Continuous Quality Improvement (CQI)

Amerigroup Nevada goes beyond required quality processes through our enhanced strategies and those developed by DHCFP. Our "Investing in Quality" Team comprises all Amerigroup health plan employees in all operational areas and supports intensive analysis of our performance toward goals for DHCFP-chosen measures and all HEDIS measures. The following examples describe several of these CQI processes as we continuously Go Beyond the Minimum!

DHCFP Collaboration Strategy. ***Every month, we participate in DHCFP collaborative meetings as part of DHCFP's strategy to promote a collaborative quality improvement environment. This has been a very successful mechanism to share in the development and monitoring of performance improvement processes that both plans implement. We have embedded this CQI philosophy of collaboration within Amerigroup Nevada's Culture of Quality, and we consider this collaborative process a key mechanism to support integration of the delivery system for Medicaid and Nevada Check Up to raise the quality of care for our members.***

As part of DHCFP's strategy, we have collaborated with the State on two grant submissions for additional funding for intervention services including the Medicaid Incentive Program for Chronic Diseases (MIPCD) and the Strong Start Grant proposal, which targets high-risk pregnant women (Figure 5.1.11.5-16). We will begin implementation of the MIPCD Diabetes Self-Management Skills activity in December 2012 and the Strong Start's Centering Pregnancy group program following the award to DHCFP.

Figure 5.1.11.5-16. Amerigroup Nevada Partners with DHCFP on Grants



SECTION 4 S.O.W.

Supporting State Responsibilities (§4.9.1)

State Responsibilities (§4.9.1.1-5)

As a partner with the State, we support all efforts and strategies for evaluating and assessing the quality of our managed care services. Amerigroup Nevada supports and implements all updates to the DHCFP strategies to improve the quality of services for our members and providers. We ensure compliance with all standards that DHCFP has established and cooperate fully with HSAG periodic reviews to document this. We are proud to be a part of the state of Nevada DHCFP healthcare strategy.

CQI Monitoring through Data Analysis and Reporting to DHCFP

As part of DHCFP's quality improvement framework, we align our philosophy of CQI with all requirements of the State. When requested or at least annually, we provide DHCFP with our IQAP Program Description; IQAP Annual Work Plan; Annual IQAP Evaluation; Periodic Reports for Performance Improvement Projects; CAHPS, HEDIS, and other prescribed measure reporting; EQRO reports; and all other required information through the processes outlined in the Contract. The following are a sample of reports we use to internally monitor the quality of our services:

- ***Annual HEDIS measurements audited by a third party and compared to findings from previous years and with national and State value-based performance goals***
- ***Third-party CAHPS assessments with results communicated to the MAC; QMC; and to our provider network through PCP office visits and our annual Quality Report***
- ***Annual provider satisfaction surveys***
- ***Operational reports on the aging, resolution, and trending of grievances, appeals, and complaints by provider and category***
- ***Ad hoc clinical care, service, and UM reports***
- ***Profiles of high-volume PCPs on HEDIS results and providing peer comparisons for well-child visits, diabetes mellitus, and cervical cancer screenings***
- ***Quarterly reports that identify members who have not received clinical service(s) based on nationally recognized guidelines***
- ***Semi-annual EPSDT/well-child exams, communicating missed opportunities***
- ***Other reports as indicated by DHCFP***

QAPIS STRATEGIES

Identify opportunities for improvement in the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.

SECTION 4 S.O.W.

QAPIS Strategies (§4.9.2)

Assessing the Quality and Appropriateness of Care and Services (§4.9.2.1)

To ensure that the care and services delivered through our plan align with State and nationally recognized clinical criteria, we use the Nevada-specific Medicaid Services Manual (MSM) and nationally recognized sources of evidence-based criteria for our utilization review; we implement clinical practice guidelines within our case management and predictive modeling systems and with our providers. This promotes appropriate utilization of services and supports better health outcomes for our members.

Identifying Quality of Care and Services

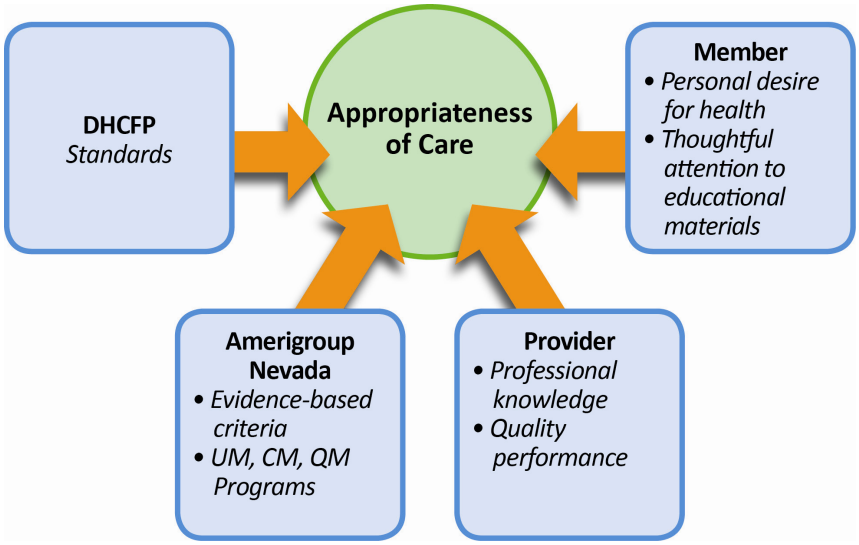
We assess the quality of services through HEDIS, CAHPS, provider surveys, quality committee reviews, EQRO evaluation, and multiple other sources detailed in Section 5.1.11.5.A. We use these methods to identify opportunities to improve the delivery of care and services to member, including those with special needs. Besides direct interventions through UM and CM, we use health fairs, printed materials (Ameritips), and mail and automated telephone reminders to encourage member self-care and health promotion.

In addition, Amerigroup Nevada thoroughly investigates all potential quality-of-care issues including those associated with infections, errors, or never events. Regardless of which operational area identifies the potential issue, all inquiries are documented and routed to our IQAP, which is responsible for researching and tracking the issue in the quality database. We immediately forward adverse incidents and critical events to our Risk Manager. We identify hospital-acquired conditions, never events, and serious reportable events; investigate them for cause or contributing factors; and report them as applicable by Nevada or federal regulations.

Appropriateness of Care

We believe that the appropriateness of care is a four-pronged process that includes the State, health plan, providers, and members. Each population drives appropriate care through the use of standards, evidence-based criteria, professional knowledge, and personal desire to be well. All four play integral parts in our member-centric delivery system (Figure 5.1.11.5-17).

Figure 5.1.11.5-17. Everyone Participates in Driving Appropriateness of Care



Appropriateness of Care Driven by DHCFP. We use the DHCFP QAPIS, the Nevada MSM, required performance objectives, and measures to support requirements for the delivery of appropriate services for recipients of the State's funded medical programs.

Appropriateness of Care Driven by Amerigroup Nevada IQAP/UM. To ensure appropriateness of care, we use the Nevada Medicaid Assistance Manual, InterQual criteria, and the Aetna Clinical Policy Bulletins to determine authorizations for physical and behavioral services for our members.

We evaluate our UM employees annually to ensure consistency of application of these guidelines through a rigorous inter-rater reliability (IRR) process. Amerigroup Nevada has participated in IRR assessments since 2009. We require IRR testing for all employees who have successfully completed the 90-day probationary period and who apply criteria to determine medical necessity (our Medical Director as well as our UM clinical employees). During the probationary period, the UM manager of the new employee is responsible to monitor the employee's work, including application of criteria. After successful completion of the probationary period, the employee enters the IRR testing cycle.

Our outreach to our members to assess their needs provides us with specific information regarding their service needs. Members with special healthcare needs and those with high-risk conditions (both physical and behavioral) benefit from our added coordination and case management.

Appropriateness of Care Driven by the Provider. To ensure that our providers use processes that result in the delivery of appropriate care, we support providers through various mechanisms.

- ***Medical Practice Consultant outreach. We are working with three PCP practices that are implementing strategies toward becoming NCQA-Accredited PCMHs and seven PCPs PQIP practices that have attained Amerigroup Quality Certification. These practices include FQHCs and large PCP groups. Both medical home strategies promote incentives for provider practices that perform well, based on key performance goals that affect positive health outcomes of our members.***
- ***Amerigroup Nevada PCMH and PQIP reports. In support of our Amerigroup PCMH development in Nevada, we will deliver, through our provider website and Medical Practice Consultants, an array of reports that equip PCMHs with information to better manage their assigned members' care. We deliver data on daily census; weekly summary of ED visits and missed care opportunities (members who are overdue for well-care visits or periodic appointments); and lists of high-risk members assigned to the Medical Home.***

Amerigroup providers receive information about the IQAP goals and progress toward meeting the goals, PIPs, and initiatives through health plan orientation, newsletters, bulletins, performance reports, provider relations representatives, provider manuals, our provider website, and office site visits. We also publish updates on quality activities in the provider newsletter and on the provider website.

Appropriateness of Care Driven by the Member. Amerigroup Nevada is a member-centric organization and delivery system. We believe that members are at the center of their healthcare decisions. In order for them to make informed decisions, we promote shared decision making among our employees with our members and among our providers and members.

Educational materials in our members' prevalent languages, a high percentage of providers with different language abilities, and translation services ensure that our members receive information in a way they can best understand and use it.

We target the identification of health literacy in our communications with our members. We will include two health literacy tools in our comprehensive assessments with members—the REALM (English health literacy screening tool) and SAHLSA (Spanish health literacy screening tool). In addition, we use the Patient Activation Measurement assessment with all case-managed members to identify their willingness to make key behavioral changes supportive of their positive health outcomes.

We inform our members about our IQAP activities through: 1) Healthcare responsibilities delineated in the Member Handbook; 2) Representation on our HEAC; 3) Member newsletters; and 4) Information posted on our member website. For example, we disseminate

specific quality processes and results to members through newsletters and on the member website, including HEAC information, HEDIS results for preventive care and chronic diseases and conditions, CAHPS findings for member satisfaction with services, and provider satisfaction results. All of these quality-focused efforts support improvements in member satisfaction.

QAPIS STRATEGIES

Improve recipient satisfaction with care and services.

SECTION 4 S.O.W.

Cultural Competency (§4.9.2.2)

Amerigroup Nevada has a current, DHCFP-approved Cultural Competency Plan. We view this as a living document that guides our interventions and sensitivities with all ethnic, racial, language-, age-, or gender-specific and disabled populations. We submit a revised Cultural Competency Plan annually, and we have met 100 percent compliance for all criteria listed.

QAPIS GOAL

Reduce and/or eliminate healthcare disparities for Medicaid and Nevada Check Up recipients.

Collection of Race, Ethnicity and Language Data

Amerigroup Nevada supports the development of new methods to collect, report and identify race, ethnicity, and primary languages spoken by our members. We currently obtain this data from DHCFP through the monthly enrollment files, and we collect additional information through a variety of member contact points. In Section 5.1.11.C, we describe our efforts to expand the collection of any revisions to this data and updating them to the DHCFP, in accordance with ACA Sec. 4302 Understanding Health Disparities: Data Collection and Analysis.

Race/Ethnicity Analysis for PIPs

For each PIP, we analyze the ethnicity distribution of services that our members access and identify gaps in care through stratified reports. The following examples show how we have used this analysis to change our interventions and outreach to support the cultural differences and address any known or unknown healthcare disparities. In particular, we are focusing our analysis on members in special needs groups to identify community connections and resources that resonate with their cultural needs.

QAPIS STRATEGIES

Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure that Nevada Medicaid and Check Up recipients have access to high-quality and culturally appropriate care.

Targeted Outreach to High Volume Diverse Communities

Through our very significant cultural community-based outreach efforts, our work with community-based organizations on events (12 in the last month in targeted, culturally high-volume Medicaid member communities) and with the Latin Chamber of Commerce and the Mexican Consulate, we go beyond the requirements and delve into the cultural needs of our members. In the past year, we have reached more than 75,000 members and community individuals who do not have healthcare through our participation or funding of large outreach events.

Hispanic Outreach Strategy. ***According to our ethnicity analysis performed for our diabetes PIP, ethnicity revealed no significant disparities for our diabetic member population. However, overall diabetes screening for all members is lower than the NCQA 50 percent HEDIS percentile, so we sought specific outreach interventions for each ethnic group. For the Latin/Hispanic population, our work with the Mexican Consulate and the Latin Chamber of Commerce revealed significant cultural findings. In this population, both diabetes and asthma are viewed as stigmas and resulted in reduced timely and preventive services related to both conditions. With that in mind, we are collaborating with the Consulate and the Chamber in developing an outreach educational program specific to this population and implemented by our Promotoras employees. This program will be implemented by December, 2012.***

Black/African American Outreach Strategy. ***We analyzed our HEDIS measure rate for potential race/ethnicity disparities in Childhood Immunization Status for Combo 2 and Combo 3. The data showed a race/ethnicity disparity as defined by a lower rate of both Combos for Black/African American children. Targeted outreach to the high-volume Medicaid member communities is part of the identification of location for every outreach event. Our work on the Board of Directors of the Southern Nevada Immunization HealthCare Coalition (SNIHC) supports this process. We are being honored again this year as a community partner in childhood immunization and will be awarded the Silver Syringe Award for 2012.***

Our recent Amerigroup Nevada-sponsored Back to School event provided backpacks with school supplies to our child and adolescent members and others in this underserved community. This face-to-face contact provided us with another opportunity to educate parents and adolescents about the need for their preventive services. We will be opening a school-based clinic in 2013 at the C.P. Squires School in Las Vegas to further our efforts in promoting EPSDT services to our members and other children and adolescents in need. Our plans include subsequently expanding school-based clinics in five other locations.

In the sections below, we describe our detailed and in-depth analysis of our PIPs and other standard measures we report to DHCFP and HSAG. However, in this cultural competency section, the information regarding the ethnic distribution of ER usage patterns for

Ambulatory Care Sensitive Conditions is Relevant. ***We found that the White population over-utilized the ER for ACSCs more than other ethnic sub-groups, followed by Black/African American and Hispanic. We describe our interventions in detail below in Monitoring of Established Standards and EQRO Evaluations (§4.9.2.3-4).***

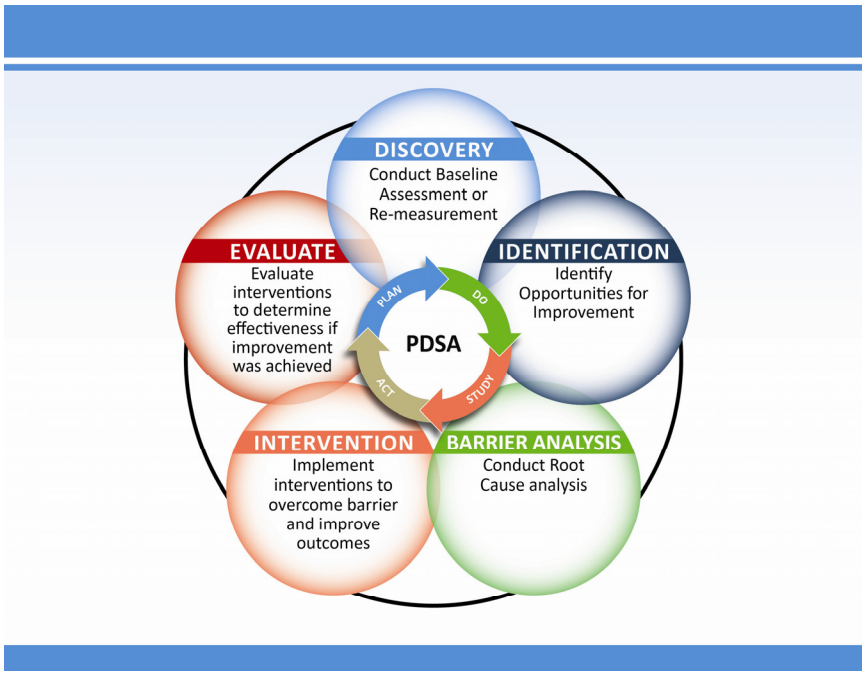
SECTION 4 S.O.W.

Monitoring of Established Standards and EQRO Evaluations (§4.9.2.3-4)

We work cooperatively and collaboratively with DHCFP and HSAG to continuously improve the quality of care and services for Medicaid and Nevada Check Up members. As we have described, we provide access to all reports, medical records, data collection systems, and other sources of information to support the evaluation of our services.

We work closely with DHCFP and HSAG on our PIPs and incorporate their recommendations, including their PIP flow analysis, into our processes as described in Section 5.1.11.5.A Performance Improvement Projects (PIPs) (§4.8.1.1-5). We melded our Deming-based PDSA model with the HSAG PIP Flow model to enhance our analysis of our performance. We use Ishikawa Fishbone diagramming to identify barriers and interventions to improve performance and establish suitable goals (Figure 5.1.11.5-18).

Figure 5.1.11.5-18. DHCFP/HSAG Amerigroup Nevada Hybrid PIP Analysis Flow Model



Our quality employees monitor all PIP data results on an interim and annual basis. We review data results in comparison to the goals and benchmarks established by DHCFP and identify areas exceeding or not meeting the goals. When data points do not meet goals, we analyze results with our hybrid PIP flow process at the relevant DHCFP and internal workgroup meetings for identification of barriers for members, providers, and us. When it is necessary to quickly intervene, we apply the Rapid Cycle Learning process to identify necessary modifications to the PIP. We implement new interventions and actions to address the identified barriers and perform interim re-measurements. The following analysis of our PIPs is a combination of our work with DHCFP, HSAG recommendations, our "Investing in Quality" Team, and our implementation interventions that support our ongoing improvement.

SECTION 4 S.O.W.

Performance Measures Developed with DHCFP (§4.9.2.5)

Navigation: In the following response to section 4.9.2.5 of the RFP, we also include reference to Section 4.7 of the Scope of Work.

Amerigroup Nevada, working with DHCFP and using the HSAG hybrid methodology for setting performance goals, continues to strive to improve performance with the following improvement projects. For this response, we have enhanced the PIP descriptions that are familiar to DHCFP and HSAG to include the additional analysis and new interventions recommended in HSAG's June, 2012 evaluation.

SECTION 4 S.O.W.

Childhood Immunization Status – Combo 2 (§4.7.2.3)

QAPIS GOAL

Improve the health and wellness of Nevada children by increasing the use of preventive services, thereby modifying healthcare use patterns for the population. Immunizations–increase by 10%; Blood Lead Testing–increase by 10%; Decrease Avoidable ED Visits–by 10%

Childhood immunization status is a challenging issue for Medicaid and Nevada Check Up populations. Throughout 2009, we concentrated our efforts on provider and member education and outreach, which included telephone outreach, mailings, newsletters, and community events. We routinely encourage our providers to submit data to the Immunization Registry and regularly download data from the registry to enter into our data stores. This added data source provides us with more accurate information on the actual immunization rates within the population and provides a more valid basis for performance improvement activities.

When results did not dramatically improve following our interventions, we implemented an "Investing in Quality" Team where we applied the Amerigroup (CQI) approach to our concerns regarding low childhood immunization rates (Figure 5.1.11.5-19). We performed a barrier analysis to determine root cause and used the Ishikawa (fishbone) method for analysis. In addition, we reviewed an immunization barrier analysis on race, ethnicity sub-group, and

health disparities that showed that our Black members do have a significant difference in rates than Whites with regard to immunization rates.

See the Confidential Technical Volume for proprietary information.

We enhanced our interventions to include more events for our Medicaid and Nevada Check Up members in areas of highly concentrated population. We either directly participate in the event or fund events coordinated by other community organizations. We marked interventions (*) that were implemented during our mid-course correction, based on our interim analysis of performance, in the following discussions.

*Member-focused Interventions. Baby Shower Event in malls, *reminder letters to parents of 1-2 year olds, annual EPSDT birthday cards, quarterly automated preventive services calls, member events, Immunization AmeriTips with member communications, *phone calls to members in selected ZIP codes and *fliers mailed to members in selected ZIP codes.*

Provider-focused Interventions. Monthly EPSDT physician reminder of overdue services, annual provider data-sharing reports, annual or as needed AmeriTips to provider offices, monthly PQIP/PCMH incentive program (education and reporting) for 5 large groups, quality visits to 10 largest groups (request records and provide educational materials for PCP and members), and missed opportunity reports.

Community Collaborations/Outreach. SNIHC events in the North and South; Amerigroup Nevada-sponsored Back–to- School events (backpacks with school supplies); assisting other organizations with health fairs and events such as back to school, summer night programs, and immunizations; sponsoring the annual National Immunization Week; and sponsoring the after-school soccer program.

SECTION 4 S.O.W.

Lead Screening in Children (§4.7.2.7)

Amerigroup Nevada will continue to monitor and report the number of children who had a lead screening by their second birthday by either capillary or venous lead blood tests.

Organizational Intervention. Our lead screening rate increased from a low of 14.71 percent in 2009, during our first year of operation, to 33.33 percent in 2011, an increase over two years of 126 percent. We attribute this increase to a simplification of the process for obtaining

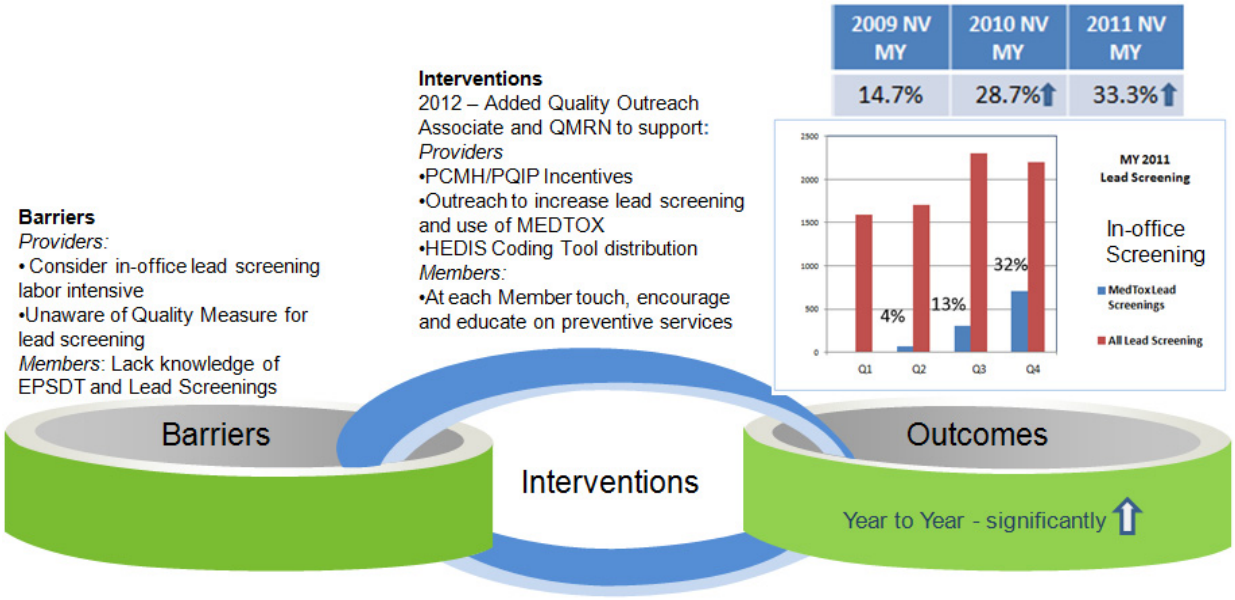
TESTIMONIAL

"The study indicator outcomes for the Lead Screening in Children PIP, which improved significantly from the baseline to the second re-measurement, reflected the success of the quality improvement interventions previously implemented by the MCO."

HSAG 2010-2011
External Quality Review
Technical Report for Managed Care
Organizations (MCOs)
Referring to Amerigroup Nevada

the test in the provider's office. In 2010, we collaborated with the Southern Nevada Health District to obtain reports of Amerigroup members who had immunizations through the health district. In 2011, DHCFP approved our proposal to use the capillary method of testing, which is now being implemented in the other Medicaid MCOs. The process improvement reduced a barrier by eliminating the need for busy mothers of toddlers to make a second trip to the lab following the well-care physician visit. We recommended that DHCFP approve reimbursement to PCPs for obtaining and mailing the MedTox capillary sample (filter paper technology for lead screening) as part of the office visit. Once this practice change was implemented, the number of children receiving lead screening significantly increased (Figure 5.1.11.5-20).

Figure 5.1.11.5-20. In-office Lead Screening Supports Significant Increase in Screening Rates



Ongoing Efforts. Although this PIP was retired by DHCFP, this is a key measure for DHCFP and HEDIS that we continue to measure. We actively promote lead screening to parents and PCPs (pediatricians and family practice physicians) for children 12 to 24 months and any children under the age of 5 years. Representatives from MedTox continue to support training for providers. MedTox participated in our Town Hall meeting for our provider offices. We include the measure in our PQIP measures for provider incentives as well as in our Eliza (automated telephone) preventive outreach calls to our members' parents or caregivers. We also send EPSDT member monthly overdue services reminders.

Decreasing Avoidable Emergency Department Visits PIP

In coordination with the DHCFP/HSAG Reducing Avoidable Emergency Department (ED) Visits Work Group initiated in 2010, we developed the PIP for decreasing avoidable ED visits. Our approved set of PIP interventions includes:

- *New member welcome call addresses 24-hour Nurse HelpLine, "What is an Emergency" instruction, and a reminder to call the PCP first for non-emergent care*
- *AmeriTips (24-hour Nurse HelpLine): Place in PCPs and OB offices, enclose in letters to members, and distribute at health fairs*
- *Partner with Customer Service and 24-hour Nurse HelpLine to steer callers to appropriate settings*

Organizational Intervention for ED Utilization. Amerigroup developed a predictive model to identify at-risk ED members. We contact identified members for telephonic screening and refer them to Disease Management or Case Management as appropriate to their clinical condition. Based on decisions within the DHCFP Workgroup, we are also implementing the following CQI processes (Figure 5.1.11.5-21):

- *Modify our 24-hour Nurse HelpLine message to include information on colds and flu and palliative care suggestions*
- *Promote UMC urgent care with providers to help direct their patients to an available source of ambulatory care in their community*
- *Update all urgent care center 24/7 or after-hours services in the Member Services Reference regularly*
- *Perform provider office audits to validate that extended hours are accurate and consistently available of members*
- *Perform "Secret Shopper" reviews to verify answering services' response time for provider callback*

See the Confidential Technical Volume for proprietary information.

- *Outreach to ED users with three or more avoidable ED visits through Case Management to identify barriers and facilitate follow up with the PCP or medical home.*
- *Notify providers regarding members with three or more avoidable ED visits.*

INVesting in Quality

To ensure that members have access to covered services, Amerigroup Nevada is implementing with this Contract a successful ED diversion intervention (Amerigroup On Call) adopted from several Amerigroup affiliates. This program promotes alternatives to receiving care in the ED. In addition to our Nurse HelpLine,

Amerigroup on Call offers members access to PCPs with extended hours, urgent care centers, limited services clinics, and physician telephone consults. During telephone consults, board-certified, licensed doctors provide diagnosis, recommend treatment, and write short-term, non-DEA-controlled prescriptions when appropriate—all of which broaden member access to ED alternatives, especially after hours.

The following analysis incorporates our work with DHCFP and our internal processes.

SECTION 4 S.O.W.

Pregnancy (§4.7.2.1)

Amerigroup Nevada is very supportive of DHCFP efforts to implement presumptive eligibility in Nevada. We know that in other states where Amerigroup serves pregnant members, this process appears to increase earlier entry into pre-natal services that support an increase in the accuracy of gestational age dating that may help reduce pregnancy complications.

Through internal performance improvement activities, we have steadily improved the HEDIS rates for the following pregnancy-related measures between 2009 and 2011:

- ***Post-partum care from 42.08 percent to 58.75 percent, an increase of 39.61 percent***
- ***Frequency of ongoing prenatal care (81-100 percent visits) from 22.85 percent to 65.95 percent, an increase of 188.62 percent***
- ***Timeliness of prenatal care from 56.33 percent to 82.25 percent, an increase of 46.01 percent***

QAPIS GOAL

Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness. Increase the rate of post-partum visits by 10 percent.

Through our holistic focus on maternity care, we applied a CQI team approach. Using the Ishikawa (fishbone) process, we identified a number of areas for attention. One outcome is the intended improvement in the HEDIS measures (Figure 5.1.11.5-22). To increase adherence with pre-natal visits, we offer the Text4Baby application as an educational tool. We have implemented Taking Care of Baby and Me® for all pre-natal members. For those members whom we identify as high risk, OB Case Managers provided outreach calls to members and work with provider offices to coordinate care. We include those members with previous pre-term deliveries, pregnancy-induced hypertension, gestational diabetes, placenta previa, multiple gestations, and other high-risk conditions in OB Case Management Services. Amerigroup Nevada provides medically appropriate in-home monitoring of members requiring bed rest or limited activity. We encourage childbirth classes provided free to Medicaid members through the hospitals or provider practices to supply additional support and education for our pregnant members.

See the Confidential Technical Volume for proprietary information.

We perform a follow-up call to all delivered members to make sure that they have scheduled their post-partum appointments and assist them if they have not. We advise them to schedule an appointment for their infant to start immunizations, and we encourage our new mothers to contact us with any concerns.

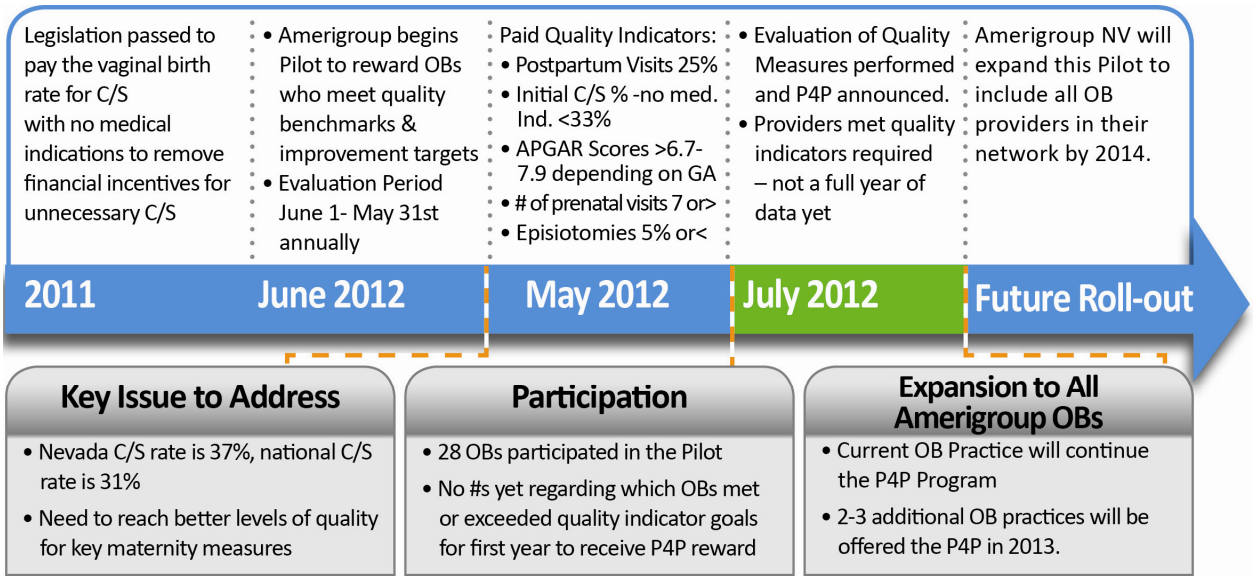
Strong Start and Centering Pregnancy Program. On August 9, 2012, DHCFP submitted the Strong Start Grant proposal to target high-risk pregnant women. DHCFP included Amerigroup Nevada in the grant submission to implement the Centering Pregnancy Group Program post award.

Amerigroup Nevada Internal Performance Improvement Project

In addition to the State-mandated PIPs, Amerigroup designed and implemented a number of studies targeting improved healthcare outcomes for the Medicaid and Nevada Check Up population that we currently serve. Amerigroup Nevada continuously monitors the care that our members receive. When we identify opportunities for improving the quality of the care or services, we initiate a formal analysis to determine the most effective interventions. Identification may come from an internal source such as employee observations or data analysis, or from external sources such as DHCFP, CMS, or HSAG. We track the results of these interventions monthly or quarterly and report through our quality structure described in Section 5.1.11.5.A Standard IV: Active QA Committee (§4.8.8.1-5).

Amerigroup Nevada OB P4P Pilot. Based on a Statewide concern over the ever-increasing Cesarean Section (C-Section) rate, the Nevada legislature enacted a law to reduce uncomplicated C-section payments to the level of a normal vaginal birth in an effort to reduce any financial incentive to perform unnecessary primary C-sections. Amerigroup Nevada took this legislative direction even further by implementing a pilot Pay for Performance (P4P) for obstetric care to reach several pre-natal, delivery, and post-partum indicators that support American College of Obstetrics and Gynecology Guidelines for obstetric care (Figure 5.1.11.5-23). Launched in 2011 and implemented in January 2012, the program included 28 participating obstetricians (OBs). In the past 12 months, Amerigroup providers have managed 4,454 Medicaid deliveries.

Figure 5.1.11.5-23. OB Pay for Performance Pilot Timeline and Participation



Amerigroup Nevada OB P4P Description. This program rewards eligible OBs who meet quality benchmarks and improvement targets. We selected the pilot program quality indicators based on an analysis of meaningful quality improvement opportunities for our members. OBs must meet all of the following requirements to be eligible for the program:

- ***Execute an OB P4P Letter of Agreement with Amerigroup Nevada before enrolling in the program.***
- ***Participate in the program for the entire quality review measurement period to adequately measure quality***
- ***Maintain good standing throughout the program year with an open-panel status with Amerigroup Nevada***

For the 2012 program year, the quality indicators are as follows:

- ***Post-partum Visits and Family Planning Services. The Amerigroup Nevada average post-partum visit rate is 58.8 percent. To qualify for this measure, the OB must have a post-partum visit average above 50th percentile (65 percent for the measurement period).***
- ***Initial C-section Percentages (without medical indication). The Amerigroup Nevada C-section average was 37 percent in 2010 (higher than the national average of 31 percent). In order for the OB to qualify for this measure, they must have a primary C-section percentage below 33 percent for the measurement period. This applies only to***

primary C-sections for pregnant members without established high-risk indicators. We identify such C-sections based on the diagnosis code submitted on the claim.

- *APGAR Scores. There are three categories of newborns for APGAR comparison (a simple and repeatable method to quickly assess the health of newborn children immediately after birth). To qualify for this measure, the OB must be above the Amerigroup Nevada APGAR average for the applicable newborns delivered to members in the measurement period.*
  - *Group 1 – 38 weeks and older (Amerigroup Nevada average is 7.9)*
  - *Group 2 – 34 to 37 weeks (Amerigroup Nevada average is 7.7)*
  - *Group 3 – less than 34 weeks (Amerigroup Nevada average is 6.7)*
- *Frequency of Pre-natal Visits. The target threshold is seven or more pre-natal visits for each member, pro-rated based on length of eligibility with Amerigroup for the measurement period.*
- *Percentage of Episiotomies. The Amerigroup Nevada episiotomy average is 9.5 percent. To qualify for this incentive, the OB must have a rate at or below 5 percent for the measurement period.*

INVesting in Quality

We measure the metrics for each Quality Indicator each quarter. When the OB meets all targets or thresholds, the OB's reimbursement increases by five percent prospectively. We discontinue the increased reimbursement for any OB who fails to maintain the program thresholds and adjust payment prospectively until the OB meets the quality indicator thresholds in subsequent quarters. The program indicators will remain stable for follow-up years. We will add three additional OBs this year and we anticipate continued expansion of the program.

Other DCHFP PIPs and Specific Required Measures That We Analyzed For Action:

SECTION 4 S.O.W.

Comprehensive Diabetes Care (§4.7.2.8)

Amerigroup has participated in the DHCFP-required Diabetes Management Performance PIP since 2009. This study focuses on Nevada Medicaid-eligible members from 18 to 75 years of age with diabetes (type 1 and type 2) who have received specific control levels (Hemoglobin A1c testing, LDL-C screening, and medical attention for nephropathy). Because Amerigroup Nevada began service on February 1, 2009, the eligible denominator for our Medicaid population in 2009 (HEDIS 2010) was minimal: 137 members between the ages of 18-75 years of age in 2009. Because we were a new MCO in Nevada during 2009, plan-specific data was not available from the previous years.

- ***The baseline 2010 HEDIS Medicaid hybrid rates were: HbA1c of 70.07 percent, LDL-C screening 64.23 percent, and nephropathy screening 60.58 percent. Fee-for-service comparisons were not available.***
- ***For re-measurement year 1, HEDIS 2011 Measurement Year (MY) 2010 Medicaid hybrid rate for HbA1c testing, LDL-C screening, and nephropathy were higher than our 2010 baseline year but did not meet DHCFP established guidelines for the NCQA 2011 Quality Compass 50th percentile.***

Table 5.1.11-5. HEDIS Diabetes Screening Measurement Rates for three years

Measure	2009	2010	2011
Diabetes Care: HbA1C Testing	70.07%	73.58%	71.57%
Diabetes: LDL screening	64.23%	67.45%	64.38%
Diabetes Care: Retinal Eye Exams	31.39%	48.58%	42.81%
Diabetes Medical Attention for Nephropathy	60.58%	66.51%	68.95%

Our Amerigroup "Investing in Quality" Team implemented interventions addressing a broad spectrum of care and services for diabetes, including health plan education, outreach to members and providers, and educational services and materials (Figure 5.1.11.5-24). In 2011, we standardized the interventions that provided specific outreach to members and providers. These interventions are as follows: Member interventions including automated telephone calls, outreach, mailings, health fairs, and distribution of AmeriTips; and provider interventions including Amerigroup newsletters, fax blasts, clinical guidelines, provider profiling with identified diabetes screening care opportunities, and medical record reviews. We use monthly and quarterly interim reports to monitor improvements made by our interventions. Based on continued improvement results, we will continue these interventions. In addition, Medicaid and Nevada Check Up beneficiaries who are at risk for or diagnosed with diabetes will receive rewards for participating in diabetes self-management programs conducted by Nevada's Medicaid MCOs, the University Medical Center, or the YMCA.

See the Confidential Technical Volume for proprietary information.

Partnership with DHCFP. ***Recognizing that rates remained below NCQA 50th percentile, we partnered with DHCFP to find more innovative solutions. In support of additional funding focused on quality improvement processes in Nevada, we supported DHCFP on a grant submission for intervention services for the Medicaid and Nevada Check Up populations. Nevada was awarded the MIPCD Grant and will begin implementation in December, 2012 by targeting members with diabetes to support their development self-management skills. For this grant, Amerigroup Nevada providers and members will work together on diabetes management skills with the assistance of our Disease Management Care Managers. The Nevada MIPCD will assign points, redeemable for rewards, for participation in programs to control weight, lower cholesterol and blood pressure, and avoid the onset of diabetes.***

Use of Appropriate Medications for People with Asthma (ASM) (§4.7.2.6)

While we were unable to report 2009 asthma medication rates due to the length of eligibility criteria, we did capture rates in 2010. For HEDIS 2011, our rate was 91.95 percent, which decreased to 85.52 percent in 2012.

As described in Cultural Competency (§4.9.2.2), Amerigroup Nevada is working closely with the Mexican Consulate and the Latin Chamber of Commerce to develop a comprehensive Hispanic Outreach and Education program that will reach our Hispanic member communities through our Promotoras employees. We plan to roll out this program by the end of the year. For our Hispanic members with asthma, we will focus on reducing the cultural barriers—seen as stigmas—of the diagnosis. Because of this barrier, many Hispanic members do not seek timely, appropriate care for this condition.

We have established an internal HEDIS work group— one of our "Investing in Quality" focus groups. Our interventions for our Medicaid and Nevada Check Up asthma populations include:

- ***Member-focused Interventions.*** ***Collaborate with health promotion for health fairs and events, continue CM and DM programs, support Asthma Camp (described below), identify members who do not refill asthma medications for phone call reminders and education***
- ***Provider-focused Interventions.*** ***Distribute clinical practice guidelines on asthma, continue PQIP/Medical home, share data with providers***
- ***Community Outreach.*** ***An Amerigroup Nevada value-added benefit that supports the high rates of compliance is the access to local Asthma Camps sponsored by the American Lung Association for children with asthma. In a fun setting, children learn to manage their disease and use medication appropriately. Asthma Camps are a current offering for Medicaid members in Nevada, and we will continue to offer***

coverage of them under the new Contract. Our program with the Mexican Consulate and the Latin Chamber of Commerce will be launched by the end of 2012.

SECTION 4 S.O.W.

Comprehensive EPSDT Healthy Kids (§4.7.2.2)

Amerigroup Nevada well-child HEDIS measures continue to improve as the result of the dissemination of EPSDT reminders and improvements in data collection after a change in our medical record extraction vendor. We implemented the following interventions to increase the EPSDT services our members receive.

Member-focused Interventions. ***Reminder letters to parents of 1-2 year olds, EPSDT annual birthday cards and annual automated telephone outreach calls (Eliza Calls), quarterly member events and Immunization AmeriTips with member communications, ongoing telephone outreach, and flyers to members in selected postal ZIP codes.***

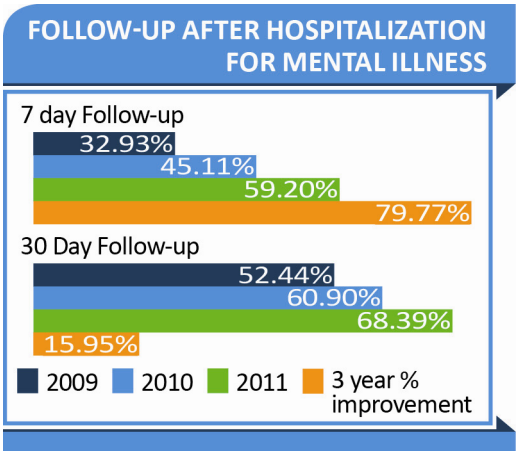
Provider-focused Interventions. ***Monthly EPSDT physician reminders of overdue services, annual provider data sharing reports, annual distribution of AmeriTips to provider offices, ongoing PQIP/PCMH incentive program for five large groups, monthly education and reporting of progress, and quality office audits to 10 largest groups to review records, provide educational materials for PCP and members, and review missed opportunity reports.***

Community Collaborations/Outreach. ***Collaborating with Southern Nevada Immunization and Health Coalition on events, support for other organizations holding health fairs and events (for example, back to school, summer night program) and sponsorship of the annual National Immunization week.***

SECTION 4 S.O.W.

Mental Health (§4.7.2.4)

Amerigroup Nevada understands the importance of ensuring that Medicaid and Nevada Check Up populations receive medically necessary mental health and mental health rehabilitative services. Our experience in the past four years in Nevada and in the other 12 states where Amerigroup serves the Medicaid population shows us the importance of providing mental health care concurrent with physical healthcare to achieve optimum outcomes for each individual.



We provide behavioral health outreach through our behavioral health case managers who make calls to members to ensure that they have follow-up appointments scheduled for seven and 30 days post-hospitalization. In addition, we have a behavioral health outreach specialist

who works with our members (and their families) regarding ADHD medication compliance and any ongoing behavioral issues.

We will continue to report on all mental health HEDIS and other performance measures.

Table 5.1.11-6. Level of Care for Nevada Check Up Mental Health Services

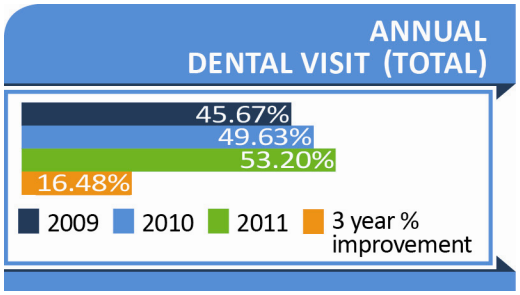
Quality Measure	MY 2009	MY 2010	MY 2011
Mental Health Utilization-Percentage of Members Receiving:			
Inpatient	0.13%	0.26%	0.31%
Intensive Outpatient /Partial Hospital	0.17%	0.26%	0.38%
Outpatient/ED	2.54%	2.80%	3.98%

Amerigroup is strengthening our case managers' skills to facilitate transformation in the lives of our members with mental illness through a focus on recovery. We implemented an intensive two-day training for our Behavioral Health Case Managers that teaches techniques for communication and collaboration with members with SMI. Using return demonstration and role-playing, Case Managers learn to create recovery-oriented care treatment plans that build on each individual's strengths and foster self-determination. The curriculum includes methods to identify and link members with peer supports within their communities. It also incorporates development of wellness action plans that reinforce recovery strategies, identify potential triggers for relapse, and act as a blueprint for crisis avoidance and management. The training also encompasses exercises that boost Case Managers' coaching skills to promote sustained recovery. This training program teaches techniques and provides a theoretical background that links members with the skills and services they need to keep them on their recovery path.

SECTION 4 S.O.W.

Dental Services (§4.7.2.5)

Monitoring and assessment of the dental visit rate improvement for the Nevada Check Up population from 2009 to 2011, showed a 23.26 percent improvement from 58.7 percent to 72.39 percent in two years.



Our 2012 Medicaid dental visit rate continues to improve to 53.2 percent, which exceeds the 50th percentile while our Nevada Check Up rate for 2012 exceeds the NCQA 90th percentile. Over three years, our Medicaid results have improved by 16.48 percent.

Information System That Supports DHCFP Quality Strategies (§4.9.2.6)

We provide a detailed description of our health information system in Section 5.1.11.4.A- (§4.8.4).

We have been working closely with HSAG to enhance the Performance Tracking Tool that the MCOs use. This system had increased in its capabilities to offer more tracking and analysis features that support our PIP development, monitoring and evaluation process. The Chi-square and p value calculator show statistically significant performance changes. We look forward to continuing this collaborative effort.

SECTION 4 S.O.W.

Intermediate Sanctions to Improve Quality (§4.9.2.7)

Amerigroup Nevada acknowledges the role that sanctions from DHCFP may play in driving quality performance, and we are prepared to respond immediately to any sanctions that DHCFP may direct. Under our current Contract, we have received no sanctions.

SECTION 4 S.O.W.

Standards (§4.9.2.8)

We have reviewed the Standards set forth in the RFP and in our current Contract for access to care, structure and operations, and quality measurement and improvement. We are currently meeting all of the standards under our existing Contract and will continue to strive for continued full compliance. Our processes are more fully described in the response to the related sections in Section 4.7, 4.8, 4.9 Scope of Work, and Section 5.1.11 Plan of Operations.

Quality Assurance (§5.1.11.5)

C.	In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

Amerigroup Nevada understands that collecting and using race, ethnicity, and language data helps in identifying healthcare disparities and driving culturally sensitive interventions and solutions supporting enhanced quality of care for all members.

Amerigroup Nevada is compliant with NCQA HEDIS Measure of Diversity of Medicaid Membership requirements.

Amerigroup Nevada is compliant with the recent NCQA HEDIS Measure of Diversity of Medicaid Membership changes and is able to report information in the required manner. Amerigroup closely monitors NCQA direction and recommendations and is currently pursuing NCQA's Multicultural Health Care distinction for delivery of culturally and linguistically appropriate services and reduction of healthcare disparities.

Our systems support DHCFP's use of the Department of Agriculture's race distinctions, and we continue to support and extend DHCFP's ability to collect race, ethnicity, and language data from our Medicaid and Nevada Check Up members. We have processes in place to capture race, ethnicity, and language information during member interactions and use updated information in reporting and improving quality of care and member experience.

We recognize, however, that the Affordable Care Act (ACA) Sec. 4302 Understanding Health Disparities: Data Collection and Analysis introduced new requirements regarding the specific values of race, ethnicity, and language that should be collected on members. Amerigroup is working closely with state partners in other markets to expand data collection efforts to meet ACA requirements.

Amerigroup proposes that DHCFP collaborate with Amerigroup and the other selected MCOs to confirm consistent understanding of the data collection methods that the DHCFP wants MCOs to use for race, ethnicity, and language, in addition to the best method for reporting information to the State. Implementation of ACA demographic collection standards would also benefit from a collaborative approach.

The following sections discuss:

- ***Current State.*** ***How race, ethnicity, and language are being collected and used in Nevada today***
- ***NCQA HEDIS Diversity of Medicaid Membership.*** ***The two HEDIS measures and NCQA's direction for health plans***
- ***ACA Collection Standards.*** ***ACA requirements to collect race, ethnicity, sex, primary language, and disability status***
- ***Amerigroup Expands Capability.*** ***Amerigroup's current efforts to support our state partners and meet ACA requirements***
- ***Amerigroup's Proposed Approach in Nevada.*** ***Amerigroup proposes a collaborative approach with DHCFP and selected MCOs***
- ***Using Expanded Data to Benefit Medicaid and Nevada Check Up Members.*** ***How expanded demographic data can be used to better serve Nevadans***

Current State: Collecting Race, Ethnicity, and Language

Amerigroup Nevada currently collects and reports race, ethnicity, and language data from the following: State enrollment files, our Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, chart audits, and case management assessments. We currently have operational systems and processes in Nevada to:

- ***Capture enrollee race, ethnicity, and language from the monthly interface from DHCFP and store with the member record***
  - ***Amerigroup currently receives race/ethnicity and language on all members listed on the monthly enrollment file***
  - ***Race/ethnicity is provided as a single field***
  - ***Our more than 85,000 members represent***
    - ***Seven different race/ethnicity values, plus values of "other race or ethnicity" and "unknown"***
    - ***Eight different languages, plus a value of "unknown"***
- ***Modify race, ethnicity, and language data if more accurate data is identified based on interactions with the member such as new member welcome calls, inbound member calls to Member Services, health assessments, or Case Manager outreach***
- ***Review and reconcile the quarterly race and ethnicity report from the State against our member data***
- ***Use race, ethnicity, and language data in:***
  - ***Creation of HEDIS reports***
  - ***Outreach to members***
  - ***Assignment of Case Managers***
  - ***Information provided to PCPs on their member panel listing***
  - ***Quality Program Review and Analysis reports and Cultural Competence report***

Amerigroup Nevada uses all available race, ethnicity, and language data to produce HEDIS reports, including the Diversity of Medicaid Membership, in the required format for DHCFP.

Amerigroup Nevada trains providers in cultural competency and provides access to training materials on our provider website. Training materials include information about the United States Health and Human Services Cultural Competency training. Further demonstrating our commitment, we will add cultural competency and diversity training to our PQIP, PCMH, and Health Home performance incentive measures in 2013.

<u>NCQA HEDIS Diversity of Medicaid Membership</u>

The NCQA HEDIS Diversity of Medicaid Membership measure includes two HEDIS measures:

- ***Race/Ethnicity Diversity of Membership (RDM) Measure.*** *"An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity"*
- ***Language Diversity of Membership (LDM) Measures.*** *"An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for healthcare and preferred language for written materials"*

In 2010, an NCQA workgroup reevaluated the RDM and LDM measures to clarify them and ensure their alignment with ACA recommendations. The updated measures were also included in the NCQA program that evaluates healthcare organizations' delivery of culturally and linguistically appropriate services (CLAS). Through this program, health plans and other organizations can earn a Multicultural Health Care distinction for their efforts to provide CLAS and reduce healthcare disparities. Amerigroup is currently pursuing Multicultural Health Care distinction through NCQA.

Amerigroup is currently pursuing Multicultural Health Care distinction through NCQA.

NCQA has provided direction for health plans on collecting race and ethnicity. NCQA encourages collecting and reporting race and Hispanic ethnicity as defined by the Office of Management and Budget (OMB) and has provided crosswalks that show how to map varying classification schemes to HEDIS. NCQA indicates that crosswalks, as shown in Table 5.1.11.5-7, are only a guide.

Table 5.1.11.5-7. RDM - Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

Race/Ethnicity Combined Category	HEDIS/OMB Race	HEDIS/OMB Ethnicity
White	White	Not Hispanic/Latino
Black	Black	Not Hispanic/Latino
American Indian/Alaska Native	American Indian/Alaska Native	Not Hispanic/Latino
Asian	Asian	Not Hispanic/Latino
Native Hawaiian and Other Pacific Islander	Native Hawaiian and Other Pacific Islander	Not Hispanic/Latino
Hispanic/Latino/White	White	Hispanic/Latino
Hispanic/Latino /Black	Black	Hispanic/Latino
Other	Some Other Race	Unknown
Multiple races marked	Two or more races	Unknown
Unknown	Unknown	Unknown

Language Collection

NCQA has provided data collection guidance to health plans on the best methods to collect information on a member's preferred spoken language for discussing their healthcare and a member's preferred language for written materials in the form of questions that can be asked.

NCQA considers collecting data directly from members to be a best practice because this method reflects members' self-identification.

ACA Collection Standards

"ACA Sec. 4302 Understanding Health Disparities: Data Collection and Analysis" specifically requires the Secretary of Health and Human Services to ensure that any federally conducted or supported healthcare or public health program actively surveys, collects, and reports:

- ***Data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants***
- ***Data at the smallest geographic level, if data can be aggregated***
- ***Sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients, or participants using statistical oversamples of these populations***
- ***Any other demographic data as deemed appropriate by the Secretary regarding health disparities***

ACA provides detailed data standards for collecting the five demographic categories of member information:

- ***Race.*** ***Allows selection of one or more categories; provides more granular definitions for Asian and Other Pacific Islander***
- ***Ethnicity.*** ***Allows selection of one or more categories; provides more granular definitions for Hispanic, Latino/a, or Spanish origin***
- ***Gender.*** ***Male or female***
- ***Primary Language.*** ***Separate data standards for primary language and spoken language***
- ***Disability Status.*** ***A set of six yes/no questions assessing any present physical, mental, or emotional impairments***

Amerigroup Expands Capability

Amerigroup has a corporate project underway expanding our ability to collect data in accordance with new and proposed ACA provisions. Expanding Amerigroup's capabilities supports our state partners in their data collection efforts and delivering data to our health plans enabling more precise HEDIS and other quality reporting and developing targeted cultural competency plans.

Amerigroup is expanding our systems to support the ACA provisions for race, ethnicity, gender, language, and disability.

We are expanding our data repository and systems to support the storage of member demographic data, integration with existing reporting capabilities, and delivery of data to our state partners. The project team is also identifying and evaluating different options for collecting expanded demographic data from our members. The analysis of data collection methods includes components of scalability, effectiveness, and cost.

<u>Amerigroup is Piloting Data Collection Methods</u>

Our Amerigroup Tennessee affiliate health plan is planning to use outbound member calls to collect expanded demographic data. The outbound calls uses the same Eliza technology used for new member welcome calls and annual telephonic surveys.

The technology uses a scripted speech-recognition program to ask specific questions and capture member answers. Script sequence is carefully developed to limit the number of questions for most members. For example, options for race selection can be presented in an order that corresponds to the current distribution profile, with more prevalent races being asked first.

The project team will share the results of the pilot with Amerigroup Nevada as input to developing a data collection method best suiting the needs of DHCFP and the Nevada population.

<u>Amerigroup's Proposed Approach in Nevada</u>

Amerigroup proposes collaboration between DHCFP and the selected MCOs to determine an approach for data collection to be used across all Medicaid and Nevada Check Up recipients. Developing and implementing a centralized approach provides a number of key benefits to DHCFP:

- ***Promoting consistency in what data is being collected***
- ***Promoting compliance with Federal requirements—NCQA and ACA***
- ***Creating a common data collection strategy applying to all members, regardless of their Medicaid MCO or whether they are fee-for-service***

- ***Developing requirements for using MCO–collected data and reporting updated demographic data to DHCFP and DWSS***
- ***Developing a baseline of methods for using expanded member demographic data to benefit Medicaid and Nevada Check Up recipients***

Adding member demographic questions to one of the quarterly EPSDT calls could provide a vehicle for data collection based on the results of the pilot. We would also evaluate what the impact of executing a longer script may have on call success.

Amerigroup advocates a collaborative approach engaging the State and all operating MCOs in developing a statewide solution. We have seen significant value in creating and fostering a culture of cooperation across the MCOs.

Using Expanded Data to Benefit Medicaid and Nevada Check Up Members

Amerigroup sees a number of opportunities to use expanded data in Nevada, including the ability to:

- ***Create new community outreach programs or modify existing ones***
- ***Add or modify health education materials***
- ***Add additional questions to CAHPS and add HEDIS-like diversity measures***
- ***Use interpreter services proactively for member outreach calls***
- ***Target Case Manager assignments to better support the member***

Additional opportunities are discussed in Section 5.1.11.5.B of our response.

Fiscal Requirements (§5.1.11.6)

A.	How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?

Ensuring Timely Payment of Claims

Amerigroup has more than 16 years of experience processing Medicaid claims and has been processing Nevada claims since 2009. Amerigroup continues to process claims in accordance with State and federal statutes and regulations.

We are committed to adjudicating claims in a timely, accurate, and provider-friendly manner. Our single claims processing system is fully integrated with enrollment and provider systems, consistently meets federal requirements, and meets all current DHCFP requirements.

We have processed more than 1.6 million claims under our Nevada Medicaid and Nevada Check Up Contract since beginning our operations. September 2012 quality results showed financial accuracy of 99.94 percent and payment accuracy of 99.21 percent.

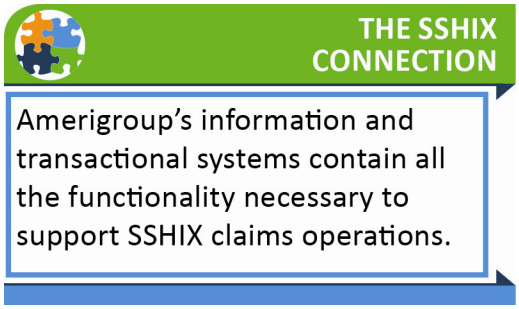
Our claims process is engineered to adjudicate and pay claims in a timely manner through:

- ***Experienced Claims Analysts.*** ***Our claims processing team is staffed with employees experienced with Medicaid managed care claims and knowledgeable in the needs of the Nevada marketplace. These employees collaborate with others to solve any problems that arise so that providers can be paid quickly.***
- ***Multiple Submission Methods.*** ***We accept paper and electronic claims to give our providers maximum flexibility. Electronic claims are accepted through three different methods. Claim formats are industry-standard and HIPAA-compliant.***
- ***Efficient and Reliable Processing.*** ***We quickly capture and adjudicate claims with minimum manual intervention by combining our core claims transaction platform with***

electronic document imaging, a workflow management system, and electronic claims solutions. This leads to faster, more accurate claims turnaround and provider payment.

- *Automated Clearinghouses Speed Payment. We offer providers reimbursement using Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). This speeds delivery of payment and makes it easy for providers to review claims and remittance details.*
- *Designated Mental Health/Substance Abuse Services Team. Our Claims Department maintains a designated team that processes claims for mental health and substance abuse services and handles all related claims inquiries. This team is experienced with the unique aspects of behavioral health, including provider types and coding, in addition to issues that require coordination between behavioral and physical health.*

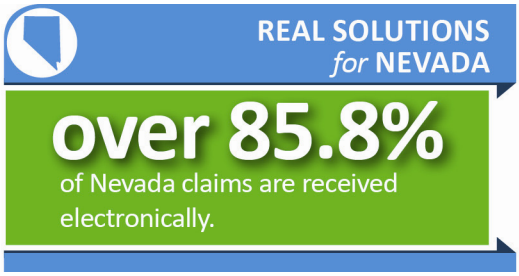
The claims adjudication process is highly automated to deliver fast and consistent claims processing and payment. Claims adjudication processes are executed every night, seven days a week, so claims are processed soon after receipt. We use automated routines to apply a series of standard and State-specific edits, and we edit claim data using industry-recognized products such as code review and code-bundling software.



Amerigroup's comprehensive policies and procedures govern our claims process. Policies and procedures cover a wide variety of claims topics for both corporate-wide and State-specific guidelines, including claims submission (paper and electronic), timely filing standards, prompt payment requirements, and claim interest payments. Compliance with policies and procedures is validated through a number of methods, including management oversight, management audits, and internal audits.

Claims Submission Delivers Flexibility to Providers

Amerigroup accepts claims on paper and electronically to give our providers maximum flexibility. Claims formats are industry-standard and HIPAA-compliant. For electronic claims submission, we accept claims through:



- *Three nationally recognized EDI clearinghouses*

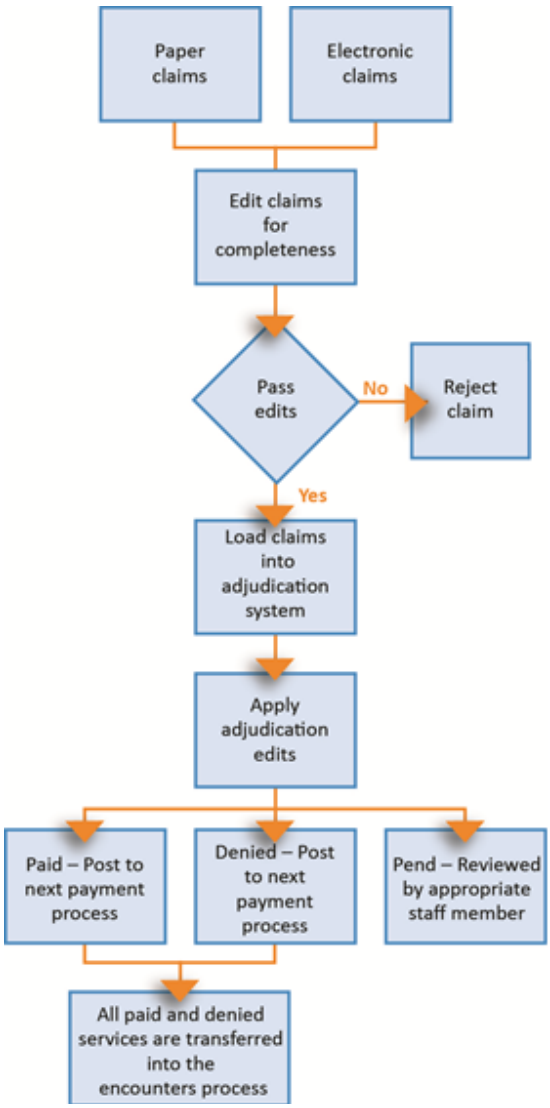
- ***Submission of an X12N 837 claims file from our provider website***
- ***Direct entry of a claim from our provider website***

In September 2012, 85.8 percent of Nevada claims were received electronically.

Paper claims are received by our Document Management team, who batch, scan, and export the files to our data entry vendor each production day. The vendor converts claims to an electronic format and returns X12N 837 claims data files for processing. This cycle occurs, on average, within 48 hours of receipt, helping us process clean claims as quickly as possible.

All claims, regardless of entry source, pass through the same edits and adjudication processes ensuring consistency. We assign each claim an internal control number to track its progress from initial entry into our system to final adjudication and online storage.

Figure 5.1.11.6-1. Claims Processing is Highly Automated



Claims Processing Overview

As shown in Figure 5.1.11.6-1, claims that are paid or denied are captured in the encounter submission to DHCFP.Our Claims Department is responsible for all claims processing functions from receipt to final adjudication and uses the following procedures:

- ***We apply initial HIPAA compliance and State-specific edits prior to adjudication. Claims that fail edits are rejected.***
- ***Our system applies adjudication edits based on eligibility, provider status, medical necessity, type and quantity of benefits, pricing, authorization, and fraud and abuse detection.***
- ***Claims that pass adjudication edits are processed during the next payment cycle. Claims that fail edits are denied.***
- ***Claims that pend for additional review related to medical necessity, prior authorization, or other reasons are monitored closely ensuring timely resolution.***

Claims Adjudication Process is Highly Automated

The system applies a series of edits to all submitted claims, regardless of source of entry. Before a claim is accepted into our claims processing system, we apply a variety of automated pre-processing edits designed to validate the quality of the data submitted. These edits verify that the data is relevant, complete, and contextually appropriate, and includes HIPAA Level 6 compliance edits in addition to specific edits based on claim type. Initial edits check for data accuracy and completeness, including verifying that the member ID matches a valid Amerigroup Nevada member record and State-specific editing such as requirements for birth weight on newborn claims.

Claims that fail these initial edits are rejected. If the claim was submitted electronically, the provider is notified via the claim entry source, which is either the clearinghouse or the provider website. Rejected paper claims are returned to the provider via postal mail with a description of the issue.

During claim adjudication, we use automated routines to apply State-specific HIPAA Level 7 edits. We also apply hundreds of standard system edits supporting tasks such as verifying member eligibility, checking provider status, checking dates of service against timely filing requirements, validating authorization requirements, ensuring that services are covered and not excluded under the DHCFP managed care contract or the Nevada Medicaid State Plan, and checking for duplicate claims. Industry-recognized products such as code review and code bundling software are also used to edit claim data, in addition to internally developed data verification applications.

Adjudication edits check for duplicates by evaluating claims against claims history. Duplicate claims are denied, or if duplicate status cannot be determined, they are pended. In October 2011, we implemented a new systems process using the Pega Business Process Manager platform as a rules engine to perform additional analysis on claims pended as suspected duplicates. Our Claims Repair system has reduced manual review efforts and increased the overall auto-adjudication rate by 1.5 percent.

Auto-adjudications are up 1.5 percent with our new rules-based duplicate claims edit logic.

Claims that successfully pass adjudication edits are processed during the next twice-weekly payment cycle. If a claim does not pass the edits, it is denied. For example, the claim would be denied if the member is not eligible at the time of service. All adjudicated claims receive a specific explanation code informing the provider of the level of payment or corrective action required to complete the claim.

Claims that require further information from the provider or a third party are denied. We notify the provider of the issue and after receipt of the requested information, the claim is processed as an adjustment.

Claims pended for additional review related to medical necessity, prior authorization, or other reasons are monitored by the management team daily through our work flow management system, ensuring timely resolution. Management reports list the number of pended claims by aging category, allowing us to quickly react to any fluctuations in claims submission and volumes. By working pended claims in order of receipt, we pay providers efficiently and achieve processing goals. Complex claims requiring review are funneled to specialized employees with experience in handling specific provider types and situations.

In compliance with section 2702 of the Patient Protection and Affordable Care Act, we utilize concurrent reviews as well as reporting against the POA indicator to identify provider-preventable conditions. Claims are evaluated for conditions identified by a secondary diagnosis acquired during the initial course of treatment. Depending on the situation, we deny payment for claims indicating a provider-preventable condition.

Timely Claims Payment – Twice a Week Pay Cycles

We execute 2 payment cycles each week to pay our providers as quickly as possible.

In order to pay our providers as quickly as possible, we execute a claims payment cycle twice a week where we generate physical checks, initiate EFT, and generate an Explanation of Payment (EOP). The EOP identifies the level of payment or corrective action required to complete the claim for denied claims. In addition, we issue an Explanation of Benefits (EOB) to members in those circumstances where member EOBs are appropriate.

As required by DHCFP in Amendment 9, Amerigroup's claims payment system prevents payments for items or services to any financial institution or entity located outside of the United States.

Our claims process also does not pay claims submitted by providers who are excluded or suspended from the Medicare, Medicaid, or CHIP (Nevada Check Up) programs due to fraud, waste, or abuse. If we have a provider that has been sanctioned or suspended from these programs or is on payment hold under the authority of DHCFP or its authorized agent(s), our Credentialing Department reviews and takes the appropriate actions to terminate the provider from our network. We suspend the provider's record, which ensures that any current and future claims submitted by the provider are flagged for review by the Corporate Investigations Department or denied with cause.

Paying providers quickly and efficiently is an Amerigroup priority and a key component of provider satisfaction. Today, we pay many providers through EFT. This service is free and offered through our claims settlement solution vendor, which, in addition to EFT, also offers providers the option of ERA services. Providers can view the ERA online and print it at their office, download a HIPAA-compliant X12 835 data file for processing in their practice management system, or receive paper remittances via mail. The EFT program offers the following to providers:

- ***Electronic deposits directly to designated provider accounts***
- ***Remittance Advice (RA) statements that can be downloaded electronically***
- ***RA archive with fully integrated reporting functionality***
- ***X12 835 file compatibility with most electronic billing software***

Our overall adoption rate of EFT among our Nevada providers is 22 percent. In August and September 2012, 39 percent of claims and 65 percent of claim dollars were paid using EFT.

To encourage further adoption of EFT within our provider network, we post alert messages and updates on the provider website announcement area as reminders to sign up. We have also launched a multi-pronged provider engagement strategy that includes:

- ***Discussing EFT in all of our provider training including forums, town halls, and orientations***
- ***Targeting high-volume providers for direct outreach concerning EFT***
- ***Including an EFT brochure with claims payments to network providers not currently participating in EFT***

We are confident that these tactics will continue to advance the adoption rate by our Nevada network providers.

B.	Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?
1.	Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended. If you are not currently a Nevada Medicaid HMO, redacted sample reports will be accepted.

Claims Payment Performance

Amerigroup focuses on claims payment performance and relies on established standards and reporting, ensuring that performance consistently meets the expectations of health plan management and our state partners.

Amerigroup processed more than 803,000 claims under our Nevada MCO Contract in the 12 months ending September 30, 2012. Amerigroup executes nightly claims adjudication cycles. Twice a week we run claims payment cycles during which we process all claims adjudicated since the last payment cycle. The frequency of our claims adjudication and claims payment cycles results in fast claims turnaround time. On average, we pay our Nevada Medicaid claims in 4.7 days. For non-clean claims, we notify the provider within 4.6 days, on average, using the input submission method of the claim.

We consistently exceed DHCFP clean claims payment timeliness requirements, as shown in Table 5.1.11.6-1.

Table 5.1.11.6-1. Amerigroup Exceeds DHCFP Clean Claims Payment Timeliness Standards

DHCFP Clean Claims Payment Standard	Amerigroup Performance 10/1/2011 – 9/30/2012
90% within 30 calendar days	99.66 %
99% within 90 calendar days	99.94 %

During the 12-month period ending September 30, 2012, more than 19 percent of Nevada claims pended. Pended claims are routed to Amerigroup employees for research and resolution. Our denial rate averages 14.9 percent. Denial reasons are communicated to

providers on the EOP and available on our secure provider website through the Claim Status tool.

Paid and denied claims can be resubmitted by the provider. The resubmitted claim is processed as an adjustment and linked to the original claim by adding a suffix to the internal control number. In the 12-month period ending September 30, 2012, our claims resubmission rate was 1.6 percent.

Recent Set of Unedited Month-End Management Reports

Amerigroup continually monitors claims processing performance and compliance. Daily, weekly, monthly, and ad hoc reports allow management to gauge processing performance, identify problem areas, and monitor quality.

A set of unedited month-end management reports from our claims processing system are provided in Attachments 5.1.11.6-1 – 5.1.11.6-9. Reports are from our current Medicaid and Nevada Check Up Contract for the month of September 2012. Table 5.1.11.6-2 provides information on how the reports are used to manage the Nevada claims process.

Table 5.1.11.6-2. Amerigroup Uses Management Reports to Monitor the Nevada Claims Process

Report Name	Key Report Information and Use
Claims Dashboard	Reports key claims metrics on a month-to-month basis. Health plan leadership uses the report to monitor claims performance and address any areas of concern.
Claims Activity and Inventory Report	Comprehensive report of claims metrics including claims turnaround time percentages, auto adjudication rates, claim denial rates, and inventory metrics. Individual report pages include: ▪ Overall Turnaround Time in Calendar Days ▪ Denied Turnaround Time in Calendar Days ▪ Ending Inventory Aging in Calendar Days ▪ Auto-Adjudication Rate ▪ Claim Count by Input Method Health plan and claims operations leadership use the reports to monitor performance and trends.
Claims Audit Report	Reports claims audit results for payment and financial accuracy. Health plan and corporate leadership analyze data to monitor trends and identify opportunities for claims process improvement.
Work Item Aging by Queue	Reports claims volume and age by work queue. Health plan and claims operation leadership review the report daily to quickly resolve pended claims and identify any outliers.
Internal Resolution Unit Work Item Aging	Reports volume, type, and aging of service forms submitted by providers for analysis of processed claims. The report includes hyperlinks for easy access to service form information. Health plan leadership reviews this report daily to monitor timely resolution of all items.

Many of these reports are also reviewed on a daily basis by health plan and claims operations leadership. Claims reports are also analyzed for issues such as possible provider submission problems, system problems, or other areas of improvement. If, for example, we see a high number of claims pending for a specific reason, we will analyze the claims to determine the need to implement an appropriate intervention, including provider education, reviewing authorization rules, or modifying a system edit. A high volume of claims pending or denying for a specific provider will prompt a review and outreach to the provider.

Careful review of the Work Item Aging by Queue report has also resulted in process improvements that produced faster claims adjudication and provider payment. During review of a report earlier this year, health plan operations identified a claim that was approaching 30 days. After checking with claims management, it was determined that this claim was pended due to lack of single case agreement (SCA) documentation to price the claim. Investigation

determined that the out-of-network provider had not returned the signed SCA. Amerigroup Nevada worked with corporate provider and claims employees on a process improvement effort to identify and quickly resolve this type of problem. The result was quicker resolution of pended claims, faster provider payment, and greater provider satisfaction.

C.	Describe your plan to identify and report suspected provider and recipient fraud.

Identifying and Reporting Suspected Provider and Recipient Fraud

Amerigroup Nevada is committed to the prompt identification and prevention of fraud, waste, and abuse. Amerigroup Nevada maintains a comprehensive Fraud, Waste, and Abuse Plan that complies with DHCFP requirements and drives our efforts to prevent, identify, investigate, and report suspected provider and recipient fraud and abuse. We review and update our Fraud, Waste, and Abuse Plan annually to address changes in the industry and changing fraud schemes and patterns. The plan addresses all aspects of our program, including:

Amerigroup Nevada maintains a comprehensive Fraud, Waste, and Abuse Plan that complies with DHCFP requirements.

- ***Definitions.*** ***Explains the differences between fraud, waste, and abuse.***
- ***Staffing and Responsibilities.*** ***Provides identification of corporate and health plan departments and employees and their associated responsibilities.***
- ***Employee Education.*** ***Details policies and procedures for employee training, including the Amerigroup Code of Business Conduct and Ethics; how employees can help identify and prevent fraud, waste, and abuse; the federal False Claims Act; and laws governing the rights of employees to be protected as whistleblowers.***
- ***Identification Methods and Indicators.*** ***Identifies the various methods used to identify suspected provider or recipient fraud, waste, or abuse, including referrals and system-based detection methods and controls.***
- ***Investigation Process.*** ***Describes the stages of the investigative process, including the key questions during each stage.***
- ***Reporting.*** ***Documents procedures for reporting instances of suspected provider or recipient fraud and/or abuse to the Surveillance and Utilization Review Section (SURS) at the DHCFP and other DHCFP reporting requirements.***

Our efforts to identify and report suspected provider and recipient fraud and abuse in Nevada are supported by Amerigroup's Corporate Investigations Department (CID), an experienced internal team dedicated to the identification, prevention, investigation, and prosecution of fraud, waste, and abuse.

Our comprehensive plan for the prevention of fraud, waste, and abuse includes a variety of activities:

- ***Creating a rigorous provider and supplier screening and monitoring process to prevent network participation or payment to providers or facilities who are excluded from the Medicaid and Medicare programs***
- ***Preventing inaccurate claims submission and payment through rigorous system configuration, claims edits, and prepayment reviews***
- ***Detecting patterns of suspected fraud, waste, and abuse through the use of various analytical tools***
- ***Suspending payments to providers and payers in cases of suspected fraud***
- ***Expanding overpayment recovery efforts through internal efforts and the utilization of audit recovery vendor partners***
- ***Recognizing and preventing member fraud and abuse***
- ***Internal auditing and risk management to prevent and detect unlawful activities by employees, providers, and contractors***
- ***Utilization management review to monitor the under and over utilization of services and the effectiveness of our prior authorization procedures***

Amerigroup Nevada tracks all activity related to our fraud, waste, and abuse program as one of the methods to measure program success. From our start of operations in February 2009 through October 31, 2012, we have documented impressive results as shown in Table 5.1.11.6-3.

Table 5.1.11.6-3. Amerigroup Nevada's Plan Demonstrates Results

Metric	Description	Results
Identified Cases	Dollar value of Nevada provider and recipient fraud and abuse cases opened by the CID	$2,690,488.78
Money Recovered	Actual money recovered	$231,809.46
Prevented	Dollar value associated with direct actions initiated to prevent continued fraud or abuse by specific providers	$953,989.53

Through the end of October 2012, we have opened 80 fraud and abuse cases; 77 percent of the cases involved providers and 23 percent involved members. Based on our investigation, we have referred 37 cases of suspected provider or recipient fraud or abuse to the SURS unit. We

maintain an open dialog with the SURS and meet quarterly to review active cases and discuss those that may result in a referral.

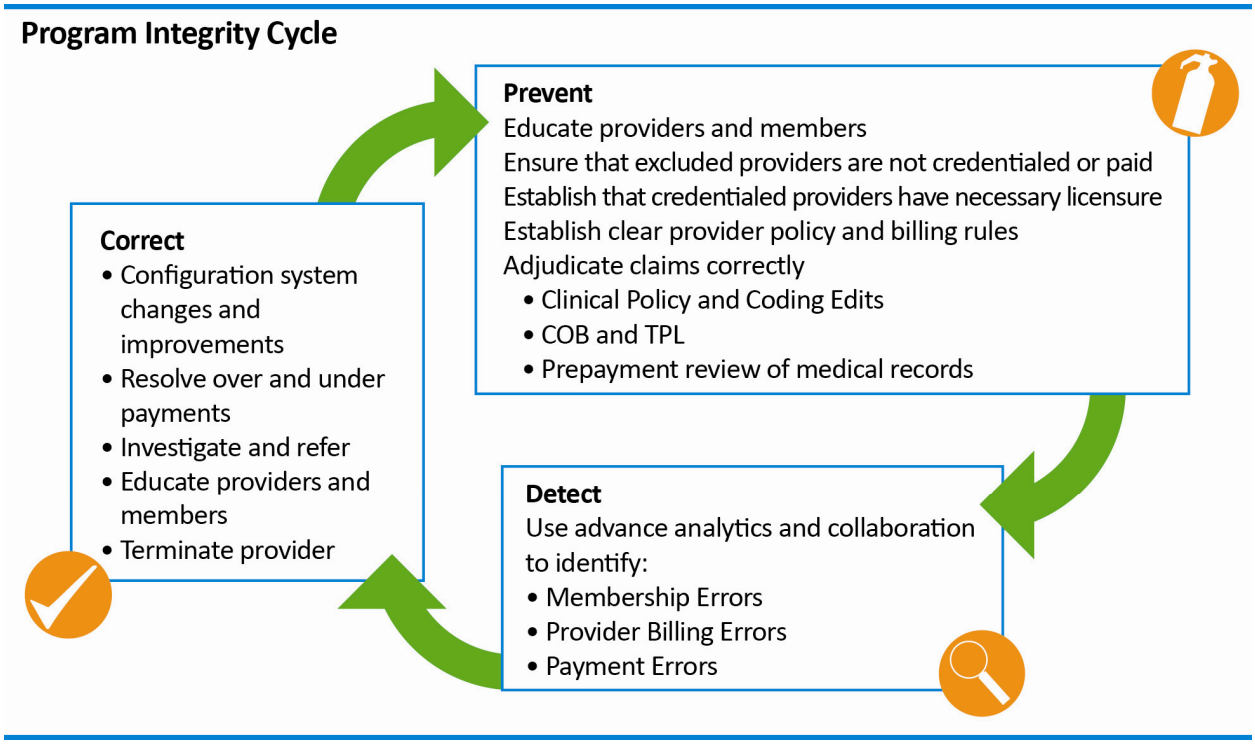
Our experience in Nevada shows that provider fraud and abuse most often involves billing for services not rendered, misrepresenting a non-covered service as a covered service, or upcoding a service. Recipient cases are most often due to identify theft or seeking narcotics for pain management through "doctor shopping." This understanding of the fraud and abuse patterns among our providers and members is used as input to our culture of continuous improvement, impacting training materials, provider manuals, member handbooks, and outreach activities, as appropriate.

Amerigroup Nevada recognizes that all of our employees share the responsibility to report possible incidents of fraud, waste, or abuse. We include sections in our provider manual and member handbook that discuss fraud, waste, and abuse and detail ways to report concerns. The home page of our corporate website includes a link where anyone can report fraud, waste, or abuse. Our employee handbook details our policies and procedures regarding fraud, waste, and abuse prevention and detection specific to false claims recovery and our methods of detecting and preventing fraud, waste and abuse. As shown in Figure 5.1.11.6-2, posters, e-mail, and other employee-communication vehicles are also used to remind and emphasize requirements related to fraud, waste, and abuse.

Figure 5.1.11.6-2. Posters Reinforce Education on Fraud, Waste, and Abuse Responsibilities

Amerigroup Nevada uses a three-pronged approach to combat fraud, waste, and abuse as shown in Figure 5.1.11.6-3. This comprehensive approach uses multiple methods to prevent, detect, and correct fraud, waste, and abuse in all its forms and through every means available.

Figure 5.1.10.6-3. Amerigroup Strives to Prevent, Detect, and Correct Fraud, Waste, and Abuse



The following sections discuss specific components of our approach to identifying and detecting, correcting and preventing, and reporting fraud and abuse in Nevada.

Identification/Detection

Amerigroup Nevada identifies provider and recipient fraud and abuse through referrals and software applications designed to detect such incidents.

We receive referrals from various sources, both internal and external. Referrals are received by mail or telephone, in person, e-mail, Internet, intranet, or from our compliance hotline; referrals originate from members, providers, employees, law enforcement agencies, and professional organizations. Members and providers can report suspicions of fraud and abuse through Amerigroup's toll-free number, the Corporate Compliance Hotline, or the fraud and abuse reporting links on our website. Newsletters periodically remind members and providers of the mechanisms to report suspicions of fraud and abuse. The Amerigroup CID also independently identifies cases through the media, partnerships, data analysis, anti-fraud software and databases, and other intelligence-gathering techniques.

Amerigroup also identifies fraud, waste, and abuse through the use of:

- ***Claims submission and billing logic***

- ***Algorithmic and statistical detection methods***
- ***Innovative data mining initiatives***
- ***Utilization review and auditing***

Regardless of how an incident of provider or recipient fraud or abuse is identified, our goal remains the same—correct the behavior through specific actions that include investigation and referral, education, resolution of over- and under-payments, and systems configuration changes and improvements.

Claims Submission and Billing Logic

We use a number of mechanisms to identify improper claim submission and billing; we then use the data generated to tailor behavior modification techniques for the provider submitting the claim:

- ***Business Rules.*** ***A variety of rules check for known patterns of behavior, such as upcoding, unbundling, incorrect charges, daily billing limits, and data issues.***
- ***Anomaly Detection.*** ***System tools look for patterns of behavior, including unusual billing, especially when compared to peers of the same provider type or specialty; unusually high volume of procedures performed on one recipient or at one location; higher billed charges with respect to the norm; or unusual patterns of member geographical utilization of a provider.***
- ***Predictive Modeling.*** ***Sophisticated analytical tools identify complex patterns based on known fraud cases, including upcoding behaviors that are similar to previously***

REAL STORIES

In March, 2012, our fraud and abuse detection systems flagged an out-of-network nurse practitioner provider who was writing prescriptions for our members in a network provider's office. Amerigroup Nevada contacted the provider and indicated we could not accept prescriptions from the flagged practitioner. Shortly thereafter, a member notified us alleging that other patients were seeing the prescriber simply to get prescription narcotics. The member complaint, coupled with the fraud and abuse flag, prompted a site visit where our Provider Services Lead and the Quality Management Coordinator were able to confirm the member allegation.

As a result, our Corporate Investigation Department (CID) requested medical records of four Amerigroup Nevada members identified for filling prescriptions for excess pain medications from the provider. During the member medical record review, we discovered poor record keeping, including incomplete member information, diagnosis, and medical history; we also found records that indicated the same underlying condition or injury for each member. These findings were supported by evidence gathered during the corresponding claims audit, where we also discovered that the provider was billing for higher-level visits.

On June 4, 2012, the provider was terminated from our network. Amerigroup Nevada also filed complaints with the Nevada State Board of Pharmacy and the Nevada State Board of Medical Examiners which resulted in two counts and multiple charges of misconduct filed against the provider.

identified cases of provider fraud, problems matching predicted diagnoses to those on the claim, or differences in the growth rate of a provider's practice with respect to peers.

- ***Social Link Analysis.*** ***Still in development, these analytical tools will examine patterns of behavior that could indicate collusion or conspiracy between providers or members, including patterns of association with known fraudulent individuals, or suspicious patterns of referrals.***

REAL STORIES

Amerigroup Nevada received a whistleblower letter from the office manager of one of our network providers in late 2011. The letter alleged that the provider was asking the manager to submit claims for services performed to insert intrauterine devices (IUDs) by using the same IUD serial number on multiple member claims. The office manager believed the provider was purchasing and inserting non-FDA approved IUDs, but was submitting an invoice that indicated that the IUD was FDA approved.

Our Corporate Investigation Department (CID) investigated the allegation and attempted to resolve the discrepancy or clear up any confusion and recover overpayments. During the investigation the provider refused to comply with our request to provide the IUD purchase invoices. Amerigroup Nevada terminated the provider in 2012. We recovered all overpayments and are currently working with the provider to notify members of the non-FDA approved IUD.

Amerigroup will never compromise the health of our members. Swift action will be taken to remove providers and make notifications and recover overpayments when those same values are not reflected in our provider network.

Algorithmic and Statistical Detection Methods

Algorithmic and statistical detection methods coupled with predictive models score claims and providers for likelihood of fraud, waste, or abuse and the level of financial risk. Statistical analyses within these tools also identify overutilization, underutilization, and inappropriate utilization. We use the results to prioritize and allocate the right resources to the right claims at the right time to create greater efficiencies in healthcare management. The algorithms generally fall into three different categories: overpayment, metric, and model.

- ***Overpayment algorithms are based on coding, reimbursement, and contracting standards and target claims with a high indication of improper payments.***
- ***Metric algorithms derive metric values for comparison of utilization among providers. Metric algorithms do not calculate overpayment amounts but can identify suspicious activity.***
- ***Model algorithms examine several indicators and data elements and produce a composite ranking based on the combination of those elements. Rather than a direct***

overpayment amount, a model algorithm identifies potential fraud, waste, and abuse activities that may then be subject to further review.

With the information provided using these algorithms, we are able to prioritize investigations based on the level of risk and the potential for program savings.

Innovative Data Mining Initiatives

Data mining initiatives identify providers whose billing practices are outside the norm for their specialty, a process that has been valuable to both Utilization Management and CID. We identify outlier providers by using a combination of predictive modeling techniques and well-documented algorithms based on relative distribution of services. We then refer the cases to appropriate functional areas for intervention, which can range from fraud investigation to education of providers to pre- or post-payment claims review.

Utilization Review and Auditing

In addition, our medical management employees use utilization review and auditing to identify instances of fraud, waste, and abuse. Employees regularly review both medical and pharmacy prior authorization and utilization reports to identify unusual patterns of utilization that may indicate provider or recipient fraud or abuse. Analysis is also performed to identify potential under-utilization of services, especially in the case of sub-capitated providers.

We incorporate pharmacy data analysis and auditing due to the high cost of pharmacy fraud and abuse. Our CID leads an initiative to create an anti-fraud workgroup with our Pharmacy Benefit Manager (PBM) and includes representatives from CID, our PBM's Internal Audit Department, and senior employees from Amerigroup's Pharmacy Department. The goal of this workgroup is to develop and implement protocols specifically aimed at reducing the risk of fraud and abuse and their correlated negative effect on our ability to administer effective medical, dental, vision, and pharmacy benefits while maintaining costs.

Each year, Amerigroup's Medical Policy Committee (MPC) reviews and approves all prior authorization procedures, medical necessity criteria, and guidelines and then updates them when appropriate. The MPC may review the criteria more frequently if a new version of the criteria, such as updates to the DHCFP Medicaid Services Manual, is published before the annual review date. The MPC identifies regulatory and contractual barriers to implementation; concerns regarding the medical accuracy, validity, or scope of the criteria; and Statewide or supplemental guidelines that may be used for medical necessity determination when the nationally adopted criteria do not address pertinent issues.

Correction/Prevention

Once we have detected possible fraud, waste, or abuse activity, we initiate action to correct the problem. Some actions are punitive; others focus on continuous improvement and address the systemic or behavioral issues that created the issue. These include:

- ***Investigations and referrals***
- ***System configuration changes and improvements***
- ***Member education and monitoring***
- ***Provider education and monitoring***
- ***Payment suspension***
- ***Payment recovery***
- ***Provider termination***

We discuss these activities in the following paragraphs.

Investigations and Referrals

All potential cases of fraud or abuse are reported to our CID, entered into a tracking system, and prioritized. The investigative team performs an initial assessment of the available evidence, including claims, reports, medical records, and other information as available, to establish whether there is a need for additional investigation. If the CID investigator finds that fraud or abuse is likely, the investigator refers the case to the SURS at the DHCFP for a final disposition. We prioritize and complete investigations in a timely manner.

System Configuration Changes and Improvements

Our process is not final until we complete the root cause analysis to understand why an issue occurred. We manage and track the resolution of our leads so we can categorize and track the impact to our process. When we find opportunities to mitigate the problems from occurring in the future, we have a team that reviews and approves policy changes or edits to our claims processing system.

Member Education and Monitoring

Amerigroup Nevada uses a variety of tactics to enhance member awareness of fraud, waste, and abuse. Our member ID card clearly indicates that the "Use of this card by any person other than the member is fraud." As another example, the member handbook clearly instructs members to show their card to their providers and further instructs them regarding how to report suspected cases of fraud and abuse.

To correct abusive behavior, we tailor a case management approach that provides coordinated services and member-specific education to address the unique physical, behavioral, social, functional, and environmental needs of each member. Following identification, our case manager will work with the PCP and any other treating professionals involved in the member's care, including behavioral health and disability providers, to develop an individualized care treatment plan that will help the member address abusive behaviors.

We address pharmacy-specific member education under a pharmacy program that ensures that case managers have access to a full array of member information to effectively coordinate services.

Continued non-compliant behavior may warrant the member being placed into a lock-in program to ensure the appropriate provision of services based upon member needs. Our goal in managing members through the lock-in process is always to improve patient behavior and avoid unnecessary disenrollment that can disrupt continuity of care for those who need it most.

Provider Education and Monitoring

Amerigroup identifies aberrant behavior patterns and works to change billing practices through an education process focused on how to document, code, and bill services while assuring compliance with industry and regulatory standards.

The billing process for Medicaid and other public programs can be complex. This complexity can make it difficult to determine intent. In an effort to realign billing processes and to encourage more accurate provider billing, we maintain an education program for providers whose billing patterns are outside the norm. This program includes, but is not limited to:

- *Education. Providers with aberrant billing behaviors are sent educational letters that describe the specific billing behavior and that provide proper coding instructions. We will send multiple mailings to the providers during this educational period.*
- *Monitoring. Once we inform the provider of the correct billing behaviors, we monitor that provider's billing patterns to verify that a behavioral change has occurred.*
- *Post-payment Medical Record Review. If the provider behavior has not changed, our coding specialists —Nurses, Physicians and Certified Coders —conduct a post-payment review of the provider's medical records to verify that the documentation meets standards and supports the claim billed. Depending on the outcome of these reviews, the provider might receive additional education or be placed on pre-payment review for a period of time until documentation supports the codes billed. These*

reviews can identify potential fraud, waste, and abuse leads. Such leads are immediately referred to the CID for investigation.

Payment Suspension

When the alleged fraud is pervasive, we may suspend the provider's payments while the investigation occurs. Suspensions are an important tool in cases where credible allegations of fraud exist and would only be implemented at the direction of DHCFP.

Payment Recovery

While our claims adjudication process goals focus on timely and accurate claims payment, some claims are inevitably paid inaccurately for a variety of reasons. Therefore, we incorporate aggressive and comprehensive efforts of claims payment recovery in instances of membership error, provider billing error, and payment error. All of these contribute to inaccurate claims payment and necessitate recovery processes.

Some instances of claims payment errors are due to fraud or abuse and are identified by internal or external sources, or through routine data analysis and reported to our CID for investigation. If the lead is determined not to be fraud or abuse and would be more appropriately defined as waste, the claim is referred to our overpayment identification and recovery teams for review and payment recovery. This process also includes identification of the root cause of the error and may result in correction of system configuration or provider education.

We recognize that fraud, waste, and abuse is about more than financial recoveries. Amerigroup Nevada is very concerned about the safety and well-being of our membership. Detection is just a part of our compliance effort to ensure effective healthcare programs for our members. As examples, reports of patient abuse or services performed that were not medically appropriate are handled as a high priority, with quick review and reporting to the appropriate agency.

When investigations result in proven fraud where correction of claims payment is warranted, Amerigroup uses several processes to recover overpayments and realign behaviors. Overpayments can occur as a result of unintentional mistakes by the provider. We use data mining to identify these types of overpayments. Overpayments are requested from providers following State regulations for notification. We also recoup overpayments from future payments after we have issued the required notification to the provider. A dedicated call team works directly with providers on overpayments to ensure that the provider understands the request and to answer any questions. This process has significantly enhanced the success of our recovery program and reduced the amount of time from identification to recovery by more than half.

We are aware of the federal requirement to address underpayments with the same vigor as overpayments. If the underpayment is in excess of an overpayment, it is forwarded to the Internal Resolution Unit for review and payment.

We also have processes in place to recover any monies identified that were paid to excluded entities.

Terminating a Provider

If providers are found to have participated and/or contributed to fraud or abuse through the contractual agreement executed by the provider and Amerigroup Nevada, they may be terminated from participation. An edit is placed in the claims system terminating the identified individual or entity to prevent future payment to the terminated provider.

Reporting

Amerigroup Nevada currently complies with all DHCFP reporting requirements related to fraud, waste, and abuse under our existing Medicaid and Nevada Check Up Contract.

Amerigroup Nevada reports suspected cases of fraud and abuse, including those committed by Amerigroup employees, contractors, or subcontractors, to the SURS at the DHCFP. We are currently in compliance with the new requirement to report no later than 10 business days after completion of the investigation and to provide the information specified in Section 4.13.8.5. We have an open dialog with the SURS and meet quarterly to review active investigations.

We currently submit the required DHCFP fraud and abuse report monthly; it reports the number of cases and suspected cases of provider and member fraud and abuse. The reported information includes the number of providers sanctioned and the number of ongoing investigations carried over from the previous time period. We will implement any modifications to these existing reports as may be required by DHCFP under the new Contract.

We have procedures in place to provide immediate notification to DHCFP of suspected recipient or provider fraud and abuse and upon our awareness of disciplinary actions or sanctions against a network provider.

D.	Describe and submit your policies and procedures for determining and collecting patient liability.

Determining and Collecting Patient Liability

Amerigroup has extensive experience and established processes to identify, validate, and collect any requisite legal liability of third parties, in accordance with State and federal requirements. Our cost avoidance and post-pay recovery efforts resulted in $4,172,283 in savings in 2011 and are projected to reach more than $5.2 million for 2012. Amerigroup's comprehensive approach includes:

- ***Maximizing cost avoidance through identification of other health insurance (OHI) and coordination of benefits (COB)***
- ***Collecting third-party liability (TPL) and subrogation through a retrospective recovery program***

Per the State's response to Question #62 in Amendment 1 to the RFP, we describe our efforts in subrogation.

We maintain sound fiscal management by staffing a Cost Containment Department (CCD) responsible for a wide variety of programs, including identification of OHI, cost avoidance through COB, overpayment/collections, and subrogation. We leverage experienced financial personnel; technology and automated applications; and consistent, replicable processes.

Amerigroup Nevada will continue to follow our policies and procedures that comply with all federal and State laws and regulations for TPL and subrogation, including the requirements contained in Section 4.10.7 of the RFP.

We acknowledge and will continue to comply with the requirements contained in Section 4.10.3 of the RFP that states that members will not be held liable for any of the following:

- ***Vendor's debts in the event of the Vendor's insolvency***
- ***Services provided to the member in the event of the organization's failing to receive payment from the State for such services***

- ***Services provided to a member in the event a healthcare provider with a contractual, referral, or other arrangement with the Vendor fails to receive payment from the state or the organization for such services***
- ***Payments to a provider who furnishes covered services under a contractual, referral, or other arrangement with the Vendor in excess of the amount that would be owed by the recipient if the Vendor had directly provided the services***

Amerigroup Seeks to Maximize Cost Avoidance

Amerigroup recognizes the importance of a strong TPL cost-avoidance program in managing the cost of the Medicaid program.

We employ a number of cost-avoidance strategies, including capturing OHI data from all available sources, validation of OHI leads, storing OHI information on a member's electronic record, and extensive edits in our claims processing system.

Amerigroup strives to maximize the identification of OHI and TPL and increase cost avoidance by:

- ***Capturing any available data regarding OHI, including information received from DHCFP on the monthly 834 enrollment file***
- ***Dedicating staff to the daily review and update of potential OHI and TPL leads received from members and providers***
- ***Validating potential OHI leads with the primary carrier and storing information in the member's electronic record***
- ***Incorporating a series of edits into our claims processing system to evaluate alternate insurance information during adjudication***
- ***Suspending claims where OHI data is attached to the member record and triggering these claims for follow-up***
- ***Performing root-cause analysis and educating providers to reduce billing errors***

We actively pursue third-party resources that we identify and those communicated to us by DHCFP in accordance with State and federal laws and regulations and the Nevada Medicaid Services Manual.

Identifying Other Insurance Information

Amerigroup stores in each member's electronic record any available data regarding alternate insurance carriers, such as a commercial health care insurer, Medicare, or an employer-

administered Employee Retirement Income Security Act of 1974 (ERISA) plan. In Nevada, sources include DHCFP; Amerigroup's post-pay recovery vendor; providers indicating this information on claims; and Amerigroup Provider Relations Representatives, Member Services Representatives, and Case Managers.

All potential OHI leads are submitted to a dedicated Amerigroup unit for validation. This unit conducts a daily review of all OHI and TPL leads received throughout the company from members, providers, and others. The information is validated with the primary carrier; if appropriate, it is added to the member's record in our claims system. The member record includes OHI (the policy issuer and number, effective and termination dates, and last date verified). It also identifies the policy holder, which is important if the member is a child and the insurance coverage is through an absent parent. Member OHI information is available to providers through self-service tools on our secure provider website. OHI information is automatically incorporated into the claim adjudication process.

Member demographic data is regularly shared with our post-payment recovery vendor, who uses it to search an extensive data repository of OHI information for any new, modified, or terminated coverage for members. The findings are reported at least monthly to the CCD for validation and addition to the member's record.

Integrating Cost-Avoidance Efforts into Claims Adjudication

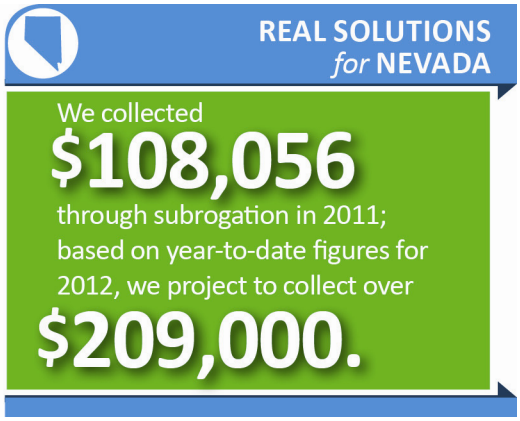
Amerigroup's claims processing system is fully integrated with our TPL process. When alternate insurance is noted with the claim or we have alternate coverage information on file, our claims system automatically evaluates the claim for subrogation.

During adjudication, claim service dates are compared to OHI coverage dates. If dates match, the claim is pended for analyst review. If the claim is eligible for cost avoidance, the analyst coordinates the claim using established guidelines. For example, if an OHI source is identified and the required explanation of benefits (EOB) is not attached, Amerigroup will deny the claim and notify the provider that it must be submitted to the appropriate third party for a determination of the OHI amount. If the required information is attached, the claim is suspended for additional analyst review prior to final adjudication.

Collecting TPL and Subrogation

We will continue to pursue TPL and conduct subrogation in accordance with State and federal laws and regulations, as well as Sections 103.6 and 3603.20 of the Nevada Medicaid Services Manual. In 2011, we collected $108,056 in subrogation and, based on year-to-date figures for 2012, we project to collect over $209,000. Subrogation is typically an 18- to 24-month litigation process; therefore, subrogation recoveries are not realized for a significant period of time after operations begin. As an existing MCO serving Medicaid and Nevada

Check Up recipients, our continued participation will help us to continue to realize savings instead of the State losing this recovery process to a new MCO.



We analyze paid claim data to retrospectively identify opportunities for TPL recoveries. We provide our recovery vendor with a monthly data file of all processed claims to identify the appropriate primary carrier. Our vendor compares claims information against their data repository that contains health information from more than 150 health insurance organizations.

When overpayments are identified, we follow documented procedures to recover the overpayments. When new OHI information is identified, it is incorporated into the member record to facilitate proper coordination of future claims. All reimbursements are directed to Amerigroup Nevada, and recoveries are noted in the claims record for reporting to DHCFP through reports and the encounter process.

Written Policies and Procedures Guide our Processes

Included as Attachment 5.1.11.6-10 is our policy and procedure on subrogation. This policy and procedure ensures that claims that may offer subrogation opportunities are investigated and processed timely. It includes Nevada-specific requirements for our current Contract with DHCFP.

Grievances, Appeals, and Fair Hearings (§5.1.11.7)

A.	Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

Amerigroup Nevada ensures members' rights to due process throughout our grievance and appeals process and we afford members access to the State Fair Hearing process. We present our methods in our response to Section 5.1.11.7.A. We describe our experience with tracking, trending, and reporting our performance in Section 5.1.11.7.B. We address the measures we use to ensure fairness handling provider appeals and grievances in our response to Section 4.11.7.

We have a mature DHCFP-approved grievance and appeal process which includes referral to the State Fair Hearing process when our internal appeal process is exhausted and a wholly favorable resolution is not yet reached for the member. Our processes were approved by NCQA as part of their accreditation review which we passed with an overall score of 98.28 percent. Health Services Advisory Group (HSAG), the Nevada External Quality Review Organization, also approved our grievance, appeal, and access to State Fair Hearings process. Our HSAG overall approval score was 96 percent.

Our method for ensuring due process is tiered, begins with our first contact with the member, and continues through final resolution. The key concepts providing the foundation for our processes are listed below and discussed in Section A of our response to Section 5.1.11.7.

- ***Member Notification of Rights (§4.11.1) through:***
  - ***Member handbook and website***
  - ***Provider manual and website***
  - ***Member Services/Provider Services/Member Advocate contacts with individuals***
- ***Timelines for Communicating Adverse Decisions and Notice of Action (§4.11.2-3)***
- ***Handling Grievance, Appeals and Access to the State Fair Hearing Process(§4.11.4-5)***
- ***Continuation of Benefits (§4.11.6)***

We discuss the remainder of our tiered approach Section B of our response to Section 5.1.11.7:

- ***Tracking, trending, and reporting our activities internally***
- ***Reporting quarterly to the State for oversight***

In our response, we demonstrate the effectiveness of our tiered approach and the respect we hold for each member or provider with consistent and fair treatment of individuals at every encounter.

Member Notification of Rights (§4.11.1)

Informing members of their rights is the foundation of a successful grievance and appeal process. Upon enrollment, we advise members of their grievance and appeal rights through the new member packet which includes a member handbook. Information also explains the right to request a State Fair Hearing if members are not satisfied with the results following completion of the Amerigroup appeal process. We let members know that the member handbook is also available for immediate reference on the member website.

In the handbook, we define the difference between:

- *An inquiry which is generally handled immediately through Member Services*
- *An appeal which includes:*
  - *Denial or limited authorization of a requested service*
  - *Reduction, suspension, or termination of a previously authorized service*
  - *Denial, in whole or in part, of payment for a service*
  - *Failure to provide services in a timely manner*
  - *Our failure to act within the required timeframes for resolution and notification of grievances and appeals*
- *A grievance which is an expression of member dissatisfaction about any matter other than an appeal such as access to care, quality of services, interaction with one of our employees, or failure to respect a member's rights*

Our Member Services Representatives and each of our employees who interact with the member are trained to correctly identify a member's concern as an inquiry, which does not enter the grievance and appeal process; an appeal, as defined, or a grievance. We advise members that they can also have a personal representative who may be their provider, an attorney, family member, or friend speak for them.

Timelines for Communicating Adverse Decisions and Notice of Action (§4.11.2 and §4.11.3)

When our Utilization Management (UM) department makes an adverse decision regarding services, we provide a notice of that action within 14 days of receipt of the request, unless an

extension is requested by the member or provider or approved by DHCFP. We recognize that members have a right to understand why a decision is made and have a right to question or challenge our decisions. Our employees support those rights and provide assistance for members to understand why we made the decision and their options for contesting the decision. Each decision notice includes information for the member:

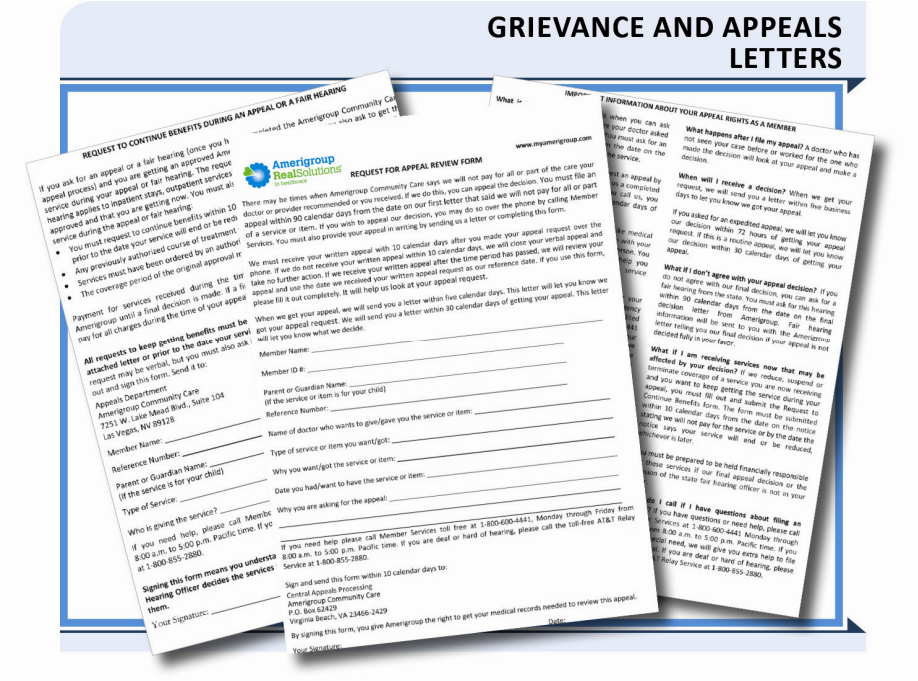
- ***About the adverse decision:***
  - ***Our action – one taken or one we intend to take***
  - ***Our reason(s) for the action and criteria used to make the decision***
- ***Information regarding the member's appeal rights and the process for submitting an appeal or grievance and the timelines involved:***
  - ***The member's (or a provider on his or her behalf) right to file an appeal***
  - ***The member's right to request a State Fair Hearing after our appeal process is exhausted***
  - ***The steps to take when exercising the right to appeal***
  - ***The circumstances under which expedited resolution is available and how to request it***
  - ***The member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services***
  - ***The member's right to self-representation or use of legal counsel, a relative, a friend, or other spokesman***
  - ***The specific regulations that support, or the change in federal or State law that requires, the action***

When we send an adverse decision notice, we routinely enclose the request form for the appeal and the form to continue medical benefits during an appeal or a Fair Hearing.

Member rights are included in the "Important Information about Your Appeal Rights as a Member" notice which answers the following questions:

- ***What is an appeal?***
- ***How do I file an appeal?***
- ***Can someone help me file an appeal?***
- ***What happens after I file my appeal?***

Figure 5.1.11.7-1. Examples of Grievance and Appeal Letters



- ***When will I receive a decision?***
- ***What if I don't agree with your appeal decision?***
- ***What if I am receiving services now that may be affected by your decision?***
- ***Who do I call if I have questions about filing an appeal?***

We commit to meeting the following timeframes associated with authorization decisions shown in Table 5.1.11.7-1. We monitor the application of authorization criteria and the timeliness of decision making as part of our UM program discussed in Quality Assurance Section 5.1.11.5.A.

Table 5.1.11.7-1. Authorization Decision Timeframes to Ensure Member Rights Are Met

Authorization Decision	Time Frame
Standard Authorization Decision	Within 14 calendar days
Extensions (requested by member or provider or approved by DHCFP)	Up to 14 calendar days
Expedited Decision (if delay would seriously jeopardize life, health, or potential to attain, maintain, or regain maximum function)	3 calendar days
Extensions of Expedited Decision (requested by member or provider or approved by DHCFP)	Up to 14 calendar days

We recognize that members need time to receive our decision, review it, and choose to file a grievance or appeal, or to make other arrangements based on our decisions for continued authorization of services. When we make a decision to terminate, suspend, or reduce a previously authorized service, we do not act on the decision until 10 days after we send the notice to the member to allow the member to file an appeal. We shorten that timeframe to five days when we verify member fraud associated with the service. We also notify members on or before the time we make an adverse determination for the following situations:

- ***When we are notified of a member's death – notice is sent to the estate with explanation of appeal rights for the surviving family.***
- ***When we receive a signed written member request to terminate service or when the member supplies information that requires us to terminate or reduce services. In this case, our UM employees or Member Advocate make sure the member understands the implications.***
- ***Upon the member's admission to an institution where he or she is ineligible for further services.***
- ***When the member's address is unknown and mail directed to him or her has no forwarding address.***
- ***When the member is accepted for Medicaid services by another jurisdiction.***
- ***When their physician prescribes the change in level of medical care.***
- ***If a member receives an adverse determination for preadmission screening to a nursing facility.***
- ***When the safety or health of individuals in a facility would be endangered; the member's health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the member's urgent medical needs; or the member has not resided in a nursing facility for 30 days (applies only to adverse action for nursing facility transfers).***
- ***When we issue a denial of payment for services.***
- ***When a service authorization determination is not decided by the end of the timeframe for decision (standard or expedited) since our failure to act is considered an untimely service and constitutes a denial.***

Handling Grievance, Appeals and Access to the State Fair Hearing Process (§ 4.11.4-5)

Grievance and Appeal Acceptance and Processing Including the Right to Present Information in Person or by Telephone

Our employees assist members by accepting oral appeals and grievances; documenting the required elements in our core system, thereby establishing the earliest date of receipt and facilitating tracking and trending; and helping members to complete a subsequent written request for standard appeals. We do not require a written request for expedited appeals.

We also accept grievances and appeals routed to us from DHCFP. To ensure that we respond in a timely fashion, our system automatically ages the appeal or grievance from the date of receipt by Amerigroup.

Appeals Process Ensures Due Process Rights for Members

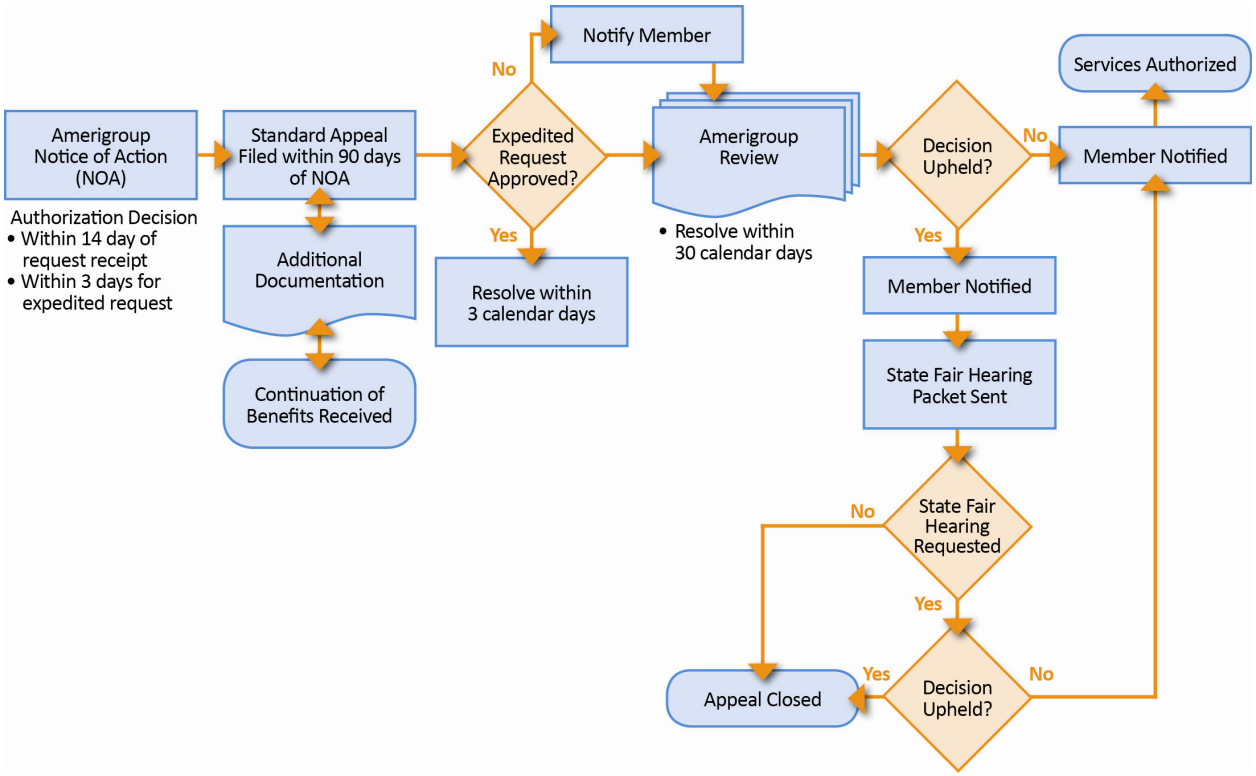
Our notice of adverse decision includes all member information for filing an appeal as described above, including the limited timeframe for presenting additional information. We require that a provider submit evidence of written permission from the member before we accept an appeal from a provider on behalf of the member.

We proactively include the form for continuation of services until the appeal process concludes. We continue a member's benefits as soon as we receive the completed request and continue those benefit pending resolution of our appeals process. A separate request for continued benefits is requested associated with the State Fair Hearing process. We continue member benefits when the applicable conditions described in Section 4.11.6 Continuation of Benefits are met. Thus, we are not depriving members of needed medical care while the administrative processes proceed. We advise members at the time of the request to continue benefits that they are financially responsible for the cost of the continued services, if the final decision of the State Fair Hearing Officer upholds the Amerigroup decision.

Amerigroup makes expedited appeal decisions within three calendar days from receipt of the appeal which exceeds the requirement for three working days. We do not penalize providers who support expedited reviews. When a request for an expedited appeal is denied, the appeal is transferred to the standard process. Our Member Advocate notifies the member of that decision verbally and follows it with written notification within two calendar days.

We acknowledge receipt of the standard appeal in writing within five days, review the information for completeness, and assemble the supporting documentation for the reviewer.

Figure 5.1.11.7-2. Overview of Appeals Process



We may contact the treating provider to obtain additional clinical information, in anticipation of a reviewer request. Regardless of the provider response to our request for additional clinical information, we ensure the appeal documentation is sent to the appeal reviewer within a few days from receipt. The appeal reviewer packet includes all the pertinent documentation necessary for review including clinical documentation used for the initial determination and any additional information received from the member or provider to support the appeal request.

Members who exercise their right to present their case to the appeal reviewer are given the option to appear in person; however, most prefer to communicate with the reviewer by telephone, which we facilitate. When necessary we provide interpreters, TTY/TTD, conference call facilities, or other assistance to members to ensure their rights. We also make case files available to members who request to examine their files, medical records, or any documentation used to make decisions to deny or reduce previously approved medical services before and during the appeal process.

All of our appeal reviewers meet Board certification in the same or similar specialty as required by DHCFP and NCQA to ensure that the appeal decision is made by a clinician with

knowledge and expertise in the specific clinical area. We monitor the progress of reviews to ensure that we complete review and communication of the decision within 30 days.

We send written notification of the appeal determination which includes:

- *Overturn the adverse decision and the necessary information to the member for obtaining the service, authorization, payment for services rendered, or information on next steps*
- *Uphold the adverse decision and the process to request a State Fair Hearing and the form for continuation of services pending State Fair Hearing decision*

We participate in the preliminary calls between the member and DHCFP and when the issue is not resolved, we participate in the scheduled hearing before the Administrative Law Judge.

Once a decision is made, we accept and implement the decision as expeditiously as possible.

Grievance Process Ensures Due Process Rights for Members

Grievances may arrive by telephone, in writing or routed from DHCFP. For verbal grievances, we request that the member follow with a written statement. We offer information on the process to file a grievance in writing in English and Spanish. We send members a form to confirm their intention and provide any additional information that will ensure we correctly understand their concern and their expectations for resolution.

We acknowledge receipt of the grievance in writing within five days and initiate research and action. Our bilingual Member Advocate contacts the member to clarify any questions about the concern expressed and to clearly document the member's expectations for resolution. If the grievance is with access to care, we help the member find an appropriate provider, or help the member understand any potential benefit limitations; and we provide members with options to reach their goals.

When the grievance concerns a provider, we send a Provider Relations Representative to the location to address the concern such as office cleanliness, staff attitude, or balance billing. The Provider Relations Representative addresses the situation with the provider and establishes a plan for correction.

If the member is not satisfied with the proposed grievance resolution, we escalate the concerns to Amerigroup Nevada leadership as a second level review of the grievance. We acknowledge that grievances are not eligible for referral to the State Fair Hearing process. We resolve second level grievances within the 30-calendar-day time limit.

We resolve grievances within 90 calendar days. Our performance on resolving grievances and appeals is discussed further in our response to Section 5.1.11.7.B.

Notice of Action Taken on a Grievance or Appeal

As soon as we make a determination on an appeal or grievance, our Member Advocate makes a good faith effort to verbally notify the member of the decision ensuring that all member rights to privacy and HIPAA regulations are preserved in the process. In the packet we mail to the member, we include information about:

- *The results of the resolution process for both grievances and appeals*
- *The date the resolution was completed*

For appeals where the decision is in favor of the member, we also send any additional actions we are taking, such as entering additional authorizations or referral to optional sources of care. For appeals that are not wholly resolved in favor of the member, the notice also includes:

- *The member's right to request a State Fair Hearing from DHCFP*
- *Information on next steps and how to file the request with DHCFP*
- *The form to request continuation of benefits while the hearing is pending*
- *A request (on the Continuation of Benefits request form) for members to attest that they understand that they may be held liable for the cost of those benefits if the State Fair Hearing Officer upholds our actions*

Our bilingual Member Advocate continues to communicate with members to ensure their understanding of the process and is available to answer questions as the process continues.

Continuation of Benefits (§4.11.6)

We proactively provide the request form for continued benefits to members as part of the adverse decision for authorization and again with information concerning our appeal decisions. On our forms for continued benefits during the appeal and State Fair Hearing process, we include instructions explaining that all of the following conditions must be met for submitting the requests:

- *The appeal must be submitted on or before the later of the following:*
  - *Within 10 days of our Notice of Action letter*
  - *The intended effective date of our action*

- ***The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment***
- ***The services were ordered by an authorized provider***
- ***The original periods covered by the original authorization have not expired***
- ***The member requests that benefits are continued during the process***

As part of our communication with the member who requests continued benefits, we explain that we continue benefits until one of the following situations occurs:

- ***The member withdraws the appeal***
- ***Ten days pass after we mail the notice of action that provides the resolution of the appeal unless the member, within the 10 days, requests a State Fair Hearing with continuation of benefits***
- ***A State Fair Hearing Officer issues a hearing decision adverse to the member***
- ***The time period for service of a previously authorized service has been met***

Our communication also advises that we may recover costs of the continued service rendered while the appeal or State Fair Hearing was pending when the final resolution is adverse to the member.

When the State Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, we modify the authorization promptly so that the member can obtain the service. If the member received the appealed service while the decisions were pending, we promptly generate an approval for payment, as directed.

B.	Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

Amerigroup Nevada tracks and trends member grievances, appeals, State Fair Hearings, and provider appeals by total numbers and by categories within each type of issue. As part of our monitoring and quarterly analysis, the quality management team selects the top three categories for a deeper review. We summarize and report these findings to the Medical Advisory Committee (MAC) and the Quality Management Committee (QMC). The structure and responsibilities for these oversight committees are described in Section 5.1.11.5.A Quality Assurance Committee Structure.

The information gathered from the analysis of grievances, appeals (member and provider), and the outcomes from the State Fair Hearing process feeds into our quality improvement activities focused on operational improvements and actions to improve our HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)satisfaction scores. We report details of grievance and appeal activity to DHCFP on a quarterly basis using the form required by the State.

Amerigroup Nevada's core documentation system includes a component for managing both member and provider grievance and appeals. The system includes screens and functionality for:

- *Entering grievance and appeals including all required data elements*
- *Aging those requests from the earliest date of receipt*
- *Supplying comprehensive reports for monthly analysis, tracking, and trending*
- *Producing reports for routine reporting to the MAC and the QMC*

Performance Outcomes

Our performance goal for all grievance and appeals, against which our performance is measured, is the time from receipt of an appeal to communication of that decision to the member or provider. It is measured against DHCFP- mandated timeframes discussed in Section 5.1.11.7.A and includes standard and expedited appeals.

To date in 2012, we have consistently exceeded the 95 percent achievement of the goal with nearly half of the reported months exceeding 99 percent.

In 2012, we have consistently exceeded the appeals and grievance 95% turn around time goal. Nearly half of the reported months exceeded 99%.

Member Appeals

Within the total appeals category we further break out member appeals. During 2012 to date, our frequency of member appeals has been low with a rate of 0.3 per 1000 members. Following review of the appeal documentation by our external appeal reviewers, our adverse decisions were overturned only three times with an uphold rate of 83 percent.

Provider Appeals

Our analysis of the top three categories for all appeals frequently focuses on provider issues. We receive an average 5.3 provider appeals per 1000 members and for 2012, we have averaged a decision uphold rate of 61 percent, an overturn rate of 33 percent and a partial overturn rate of six percent. We find that the overturn rate is influenced by the member or provider offering additional clinical information not provided for the initial decision.

The analysis of the top three categories continues to reflect provider issues with medical necessity decisions related to inpatient lengths of stay, payment for prescription drugs, and an assortment of radiology, durable medical equipment, and outpatient payment issues. The two main operational issues that drove most of the volume were identified and resolved. Details of this information and our plan of action were discussed with DHCFP. We continue to monitor the processes to confirm effectiveness of the corrective action.

Member Grievances

The average number of grievances received in 2012 was 2.32 per 1000 members with an average turnaround time of 60 days which is well within the 90 day timeframe. We performed an analysis of the top three categories of grievances with issues related to eligibility as the highest problem (42 percent of top three category grievances) which occurred in the first quarter of the year. The other two highest categories from the analysis of the top three categories of grievance were dissatisfaction with the provider (20 percent) and balance billing (20 percent).

The eligibility issue was a single-time occurrence which we resolved by adding staff. The problem has not recurred. We further analyzed the two provider issues to identify a pattern with providers or provider types. Provider Relations Representatives met with the providers for whom the highest number of grievances were filed and contacted the remaining providers by telephone to address the concerns.

State Fair Hearings

We averaged 0.52 appeals per 1000 members referred to the State Fair Hearing process since January of 2012. This overall average number is skewed by one provider who submitted multiple claims payment appeals at a single time. As part of the preliminary hearing process, the provider agreed to withdraw the requests and the payment issue was resolved with an updated fee schedule. In 2012, 95 percent of the State Fair Hearing issues were disposed of at the preliminary call level:

- *12 percent overturned*
- *40 percent withdrawn*
- *43 percent upheld*

The remaining five percent of hearing issues for 2012 were withdrawn at the formal Hearing Officer level.

We continue to look for opportunities through the review and analysis of our performance to improve our services to Medicaid and Nevada Check Up members and to the providers who deliver care and services to our members.

Operational Requirements (§5.1.11.8)

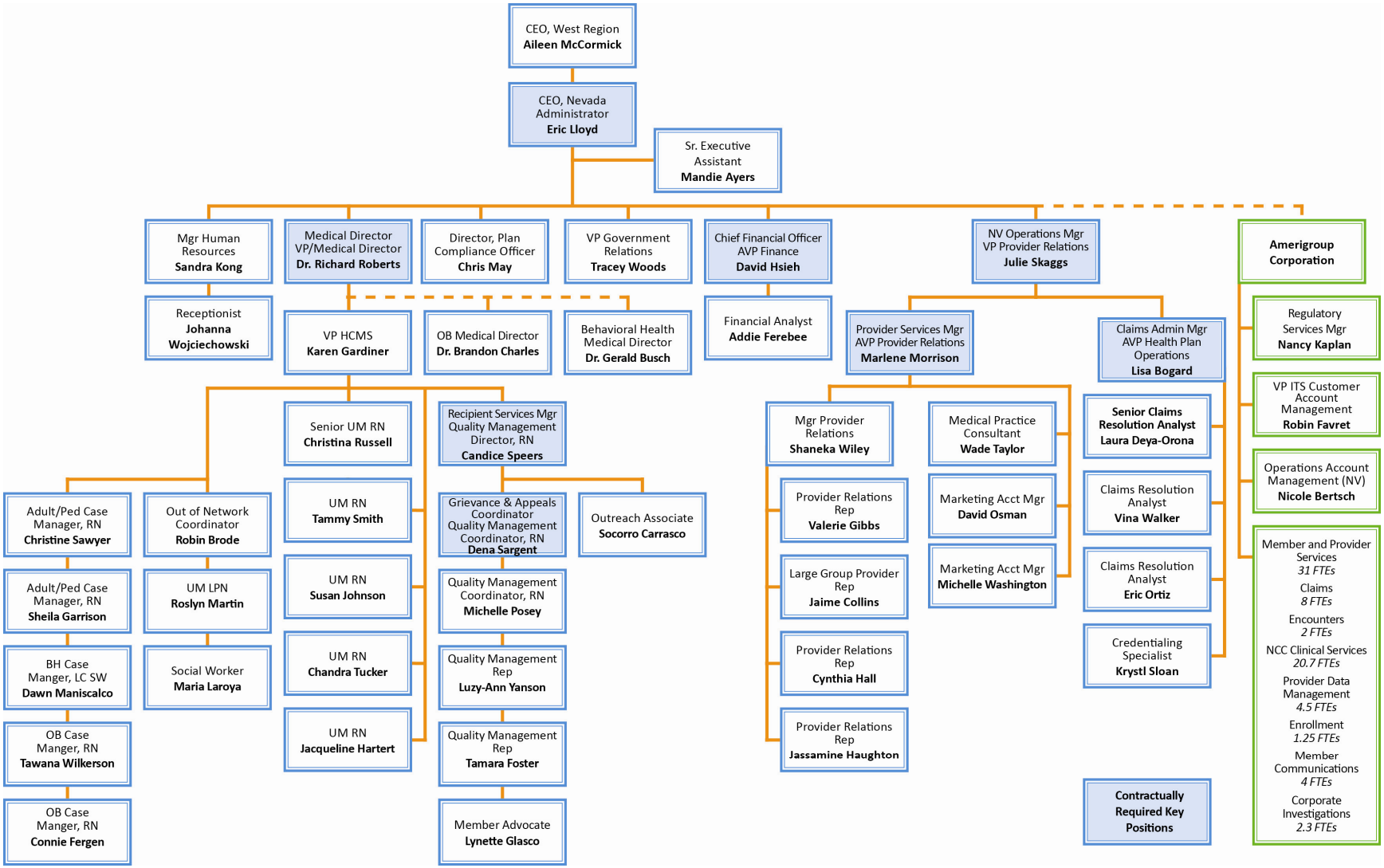
Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.

Amerigroup Nevada's organizational chart, Figure 5.1.11.8-1, is included on the following page. As illustrated in the chart, Amerigroup Nevada is fully accountable to DHCFP for delivery of Medicaid Managed Care services. As with our current contract, decision-making authority and program performance resides with our Nevada health plan leadership, who remain attuned to the local needs of our members, providers, community stakeholders, and DHCFP. Locally, we have demonstrated a strong commitment to face-to-face interactions with stakeholders, extensive community engagement, and active participation on various local boards and committees. Collectively, this local team of key employees has more than 144 years of managed care experience and 25 years of experience operating the Nevada health plan.

Local Accountability for the Medicaid Managed Care Program

We will build on the proven local health plan staffing model that we have operated in Nevada since 2009 that focuses the organization on achieving DHCFP goals. Delivering a managed care program requires local provider collaboration; engagement with members and families in the community; and intimate knowledge of local communities to link members with the array of covered and non-covered services that align with their physical, behavioral, social, and environmental needs. Our model consists of a Nevada-based team that supports the overall program, the community, and the State. This team will continue to work closely with DHCFP, as we do today, and ensure that we implement and manage all program components effectively. We promote timely member access to culturally relevant services and supports that reflect member choices and preferences and, in collaboration with network- and community-based providers, drive improved health outcomes.

Figure 5.1.11.8-1. A Robust Amerigroup Nevada Organization Promotes Achievement of DHCFP Goals and Objectives



Amerigroup Nevada will directly deliver the following key functional areas:

- *Health plan leadership and administration*
- *Utilization and case management*
- *Provider relations*
- *Quality performance and management*
- *Grievance and appeals*
- *Government relations*
- *Community relations*
- *Compliance and program integrity*

We anticipate that our Nevada health plan will employ 42 full-time equivalents (FTEs) based on membership and staffing projections for Clark and Washoe counties. With an established presence and staff recruitment efforts already in place, Amerigroup Nevada remains prepared to quickly respond to any future changes in the program, including expansion into new counties or inclusion of new populations, such as Medical Assistance for Aged, Blind and Disabled (MAABD); juvenile justice; and child welfare recipients as well as launch of the Silver State Health Insurance Exchange (SSHIX). We will continue to monitor staffing levels and increase them as necessary as our membership grows and our Nevada product offerings evolve, leveraging reliable staffing models to support this process.

Amerigroup Nevada recognizes that we are fully accountable for the performance of each of our subcontractors. As detailed in our response to Section 5.2, Subcontractor Information, we maintain a comprehensive program to select qualified and reliable subcontractors and monitor the performance of all subcontractors to optimize the resources of both Amerigroup and our subcontractors and to establish and maintain compliance with all program requirements and expectations.

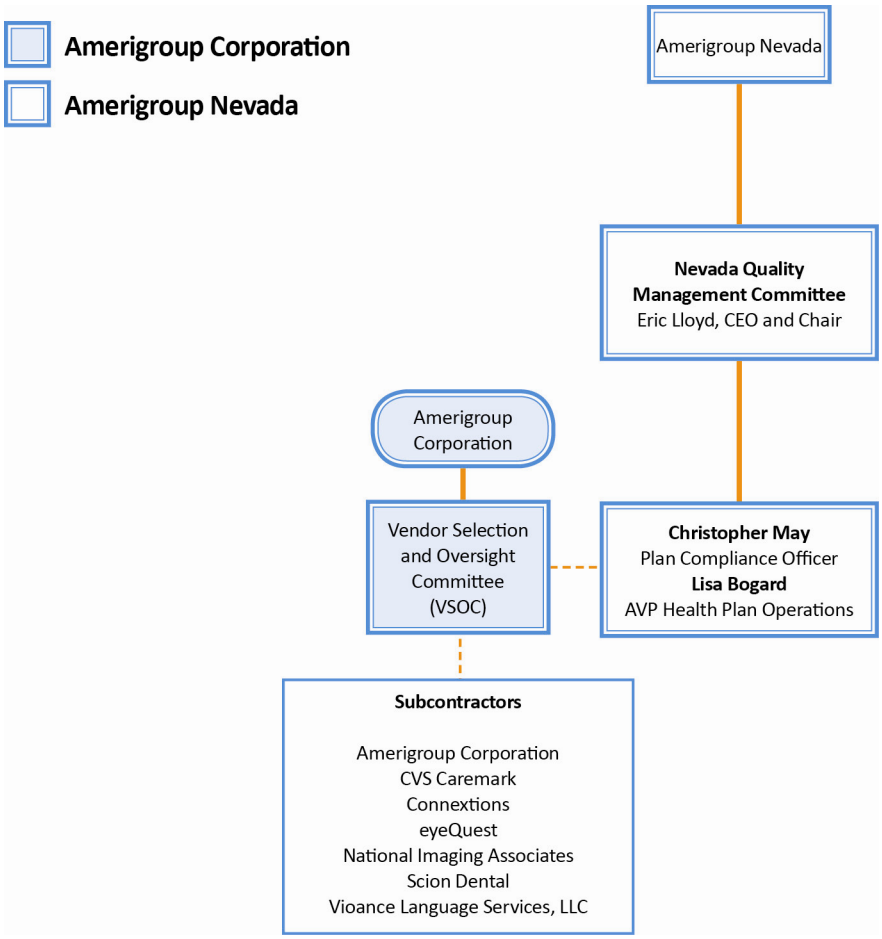
For example, when we were dissatisfied with our dental subcontractor's performance in Nevada, we proactively approached DHCFP to communicate about the specific issues and put forth our plan to remedy the situation by replacing the subcontractor. Amerigroup Nevada recognizes that at all times we are responsible for overall program performance, and we have a history of being responsible in managing them closely

Our Vendor Selection and Oversight Committee (VSOC) currently leads vendor management activities for all Amerigroup health plans. The VSOC is an interdisciplinary team of employees from corporate departments and each local health plan who manages

subcontractors and monitor delegated activities. The Amerigroup Nevada Plan Compliance Officer and AVP Health Plan Operations both participate in the VSOC to ensure that subcontractors understand Nevada requirements and take appropriate actions as necessary to assure compliance.

Further, members of the Nevada leadership team join the quarterly joint operations meetings to review and further strengthen local oversight of subcontractors. Our organizational strategy for subcontractor oversight is summarized in Figure 5.1.11.8-2.

Figure 5.1.11.8-2. Effective Oversight Maximizes Subcontractor Performance



Amerigroup Corporation Support

Amerigroup Corporation provides specialized, centrally delivered services that complement local employees in strategically determined functional areas to create both better value and results for our members. The group is composed of Amerigroup experts designated to the Nevada health plan.

Some of the key functions that will be provided by Amerigroup Corporation include:

- ***Member and Provider Call Center***
- ***Implementation (for new programs)***
- ***National care management, disease management, and quality programs***
- ***Claims administration***
- ***Information technology systems and services***
- ***Healthcare economics***
- ***Member and provider communications***
- ***Actuarial services***
- ***Legal advisory and oversight***
- ***Corporate compliance advisory and oversight***
- ***Regulatory advisory and oversight***
- ***National and state government affairs advisory***

For example, we augment our Nevada team with Amerigroup Quality Management experts who lead national efforts related to development and implementation of quality metrics and identification of effective interventions in affiliate health plans for inclusion in performance improvement initiatives. Another example is our Disease Management team, which supports the health plan with targeted Disease Management programs tailored to the needs of members and caregivers. Within their specific functions and across the effort, Amerigroup resources will share best practices learned from our experience in Nevada as well as affiliate health plans over 16 years in 12 other states.

Additionally, Amerigroup's Western Regional Service Center, located in Houston, Texas, primarily supports the Nevada health plan with back-up available through three other service centers. Focused exclusively on Amerigroup health plans in the western part of the country, this service center handles all member and provider calls and claims, and its staff has been

thoroughly trained on Nevada-specific programs and processes. This focused approach fosters optimal customer service.

To promote peak performance, Amerigroup Corporation has designated an Operations Account Manager, Nicole Bertsch, who works directly with our Nevada team to monitor the performance of corporate functions. Close collaboration between the Account Manager and the health plan has optimized coordination and communication on subcontracted functions. In addition, an AVP ITS Customer Account Management Services, Robin Favret, works with the health plan to support information technology improvements and innovations.

The combined strengths of this model will ensure that DHCFP continues to benefit not only from a fully accountable local team that understands member and provider needs and local market conditions, but also from years of cumulative institutional and customer knowledge and experience by our national teams. All designated employees know and follow the DHCFP program requirements, and their functions will be fully accountable to the local Nevada-based leadership team. As we do today, the teams will collaborate closely to ensure that we provide seamlessly integrated, effective, and transparent services and meet or exceed the Agency's expectations.

This model will continue to deliver to DHCFP the best of what Amerigroup Nevada has to offer: local accountability, control, and robust market-focused staffing, matched with an array of supplementary corporate and functional support services. The combination of local expertise and national best practices will enable DHCFP to cultivate the Nevada Medicaid Managed Care program performance to which it aspires.

Implementation (§5.1.11.9)

One of Amerigroup's core competencies is its ability to successfully implement new business while seamlessly transitioning new members and providers into its operations. Amerigroup has never missed a contract implementation deadline in its experience of conducting 92 program implementations. Amerigroup has a proven track record for successfully and effectively implementing programs within short timelines, particularly recruiting, hiring, and training qualified employees.

In September 2008, DHCFP approached Amerigroup Nevada to serve recipients enrolled in the Medicaid and Nevada Check Up managed care program when one of the State's Medicaid managed care organizations left the program. Expediting our structured implementation protocols, our team rapidly built a provider network and established local operations. Our network development in Nevada began in early October, soon after we received notice of the contract award from DHCFP, and was completed within 120 days. By February 2009, Amerigroup Nevada had recruited and credentialed nine hospitals, 497 PCPs at 713 locations, and 838 specialists at 1,595 locations.

A.	If you currently do not have an established network, what time frame and approach will you use to build a network?

Established Provider Network in Clark and Washoe Counties

Amerigroup Nevada already has a comprehensive network of providers in place in Clark and Washoe counties to serve Medicaid and Check Up recipients. Our network currently meets requirements for access and availability; therefore, we will not have to build a network to meet the requirements of the RFP. We are, however, actively recruiting additional provider types for the newly covered services including orthodontia, hospice, methadone treatment, and nursing facilities.

Once contracted, we maintain a very high level of provider retention; in the last year, only one percent of our providers chose to terminate their participation in our network.

See Section 5.1.11.4, Network, for more information on our provider network.

<u>Expanding our Provider Network to Meet Future DHCFP Requirements</u>

Our existing relationships with Nevada's providers position us at the forefront of the provider contracting process should we need to expand our network. In recruiting additional providers, we focus on providers who traditionally serve our members. We seek these key providers, such as Essential Community Providers, because they maintain the appropriate geographic

presence, the established trust of our members, a keen awareness of the diverse needs of the population, and access to key local resources available within their communities.

We strive to develop positive and lasting relationships with providers who are committed to member education and empowerment as well as to our initiatives on quality and cost. Strengthening relationships with these high-performing providers includes helping them grow their practices when they better serve our members. We offer providers a reason to participate in our provider network. Key elements of our network development approach for providers include:

- *Offering financial incentives, such as our Provider Quality Incentive Program (PQIP), that promote quality and cost-effective care*
- *Transforming select PCP practices into Amerigroup Real Solutions® Medical Homes*
- *Delivering practice supports and health information that enhance access, guide evidence-based decision-making, improve quality, and decrease patient care fragmentation*
- *Reducing administrative burdens for providers*

We are prepared to expand our network to meet any future changes in covered services, geographic service area, covered population, or legislative requirements.

Amerigroup Nevada is prepared to cover additional Vendor-covered services as required. Home and community-based waiver services and non-emergency transportation services, for example, are already managed successfully by several of our affiliated health plans, including New Mexico. We will draw upon the experience and best practices at affiliated plans to develop protocols and standards for these services should we cover them. And, should the State require Seriously Emotionally Disturbed (SED)/Severely Mentally Ill (SMI) members to remain in a managed care plan, we will leverage existing relationships to provide members a seamless transition from fee-for-service. We have solid, collaborative relationships with key providers including Harmony Healthcare, Nevada behavioral health clinics, and community-based organizations that ensure quality outcomes for these members through a holistic approach, including behavioral health medical homes.

Covered Population

We are prepared to cover additional populations such as Medicaid Aged, Blind, and Disabled recipients or children and adolescents under the juvenile justice or foster care program. Amerigroup currently serves members enrolled in the Aged, Blind, and Disabled/Supplemental Security Income category in 10 states and almost 92,000 dual eligibles in eight states through our affiliated plans, and we would draw upon their understanding of

the populations' specialized service and care coordination requirements to serve this population in Nevada.

Legislative Requirements

As Nevada continues toward full implementation of Health Care Reform and the Patient Protection and Affordable Care Act (ACA) of 2010, Amerigroup will expand our provider network to meet future needs, such as the addition of childless adults should the State choose to cover this population. We closely track legislative initiatives at the local, Nevada level as well as through our corporate Amerigroup Office of Health Reform Integration. The Office of Health Reform Integration focuses solely upon the integration of health reform and its impact upon our state customers and Amerigroup health plans.

Regardless of the impetus for expansion of our provider network, we are prepared to further meet the changes ahead in Nevada and will offer provider networks that are accessible with providers who are highly qualified, motivated, and fully able to meet the needs of Nevadans.

B.	Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.

Gantt Chart Detailing Implementation Process and Proposed Timeline

A Gantt Chart detailing the implementation process and proposed timeline for implementation is included as Attachment 5.1.11.9.

Amerigroup's implementation for the new Nevada Contract will be led by a Project Manager based in Amerigroup's Implementation Management Office (IMO). Most of our Project Managers are certified through Project Management International (PMI) as Project Management Professionals. The IMO ensures that Amerigroup Nevada and its corporate support proceed effectively through each phase of the implementation and meeting deliverables as requested by DHCFP. We employ PMI's methodology to quickly and thoroughly identify, track, and resolve any gaps in project management. By having a structured approach to managing implementations, Amerigroup has a replicable process that the entire Company understands and follows. This approach has resulted in 92 successful implementations of business growth initiatives. It enabled us to quickly mobilize and build Amerigroup Nevada's Medicaid and Nevada Check Up operations on time to successfully transition members effective February 1, 2009.

For the new Contract, we will focus upon and execute changes needed with our existing contract with the State. We will update configuration of our system to manage the new benefits, update policies and procedures, and update member and provider materials. Because we have a strong team in place that has knowledge and proficiency in day-to-day processes,

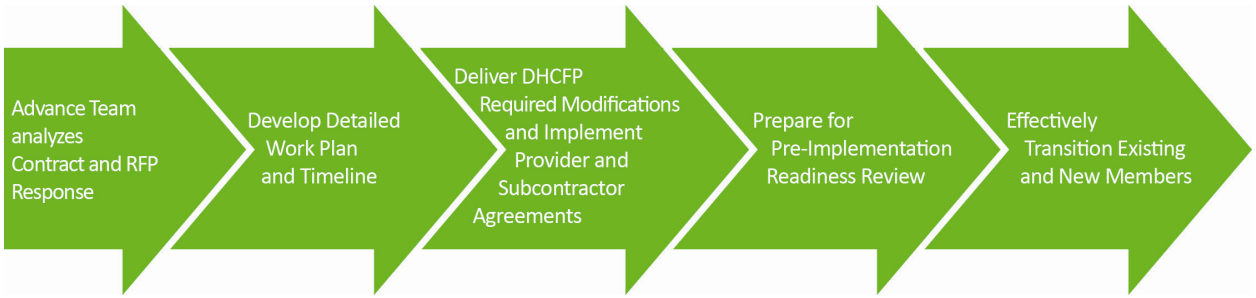
the State's expectations, the member population, and provider community, we will be able to educate and enculturate additional Amerigroup employees more quickly than a managed care organization new to the Medicaid and Nevada Check Up program.

One of Amerigroup's strengths is our approach to cross-functional teams. Amerigroup Nevada employees partner with their corporate support areas to develop and implement solutions to meet Contract requirements. This results in a team that considers all relevant information, analyzes upstream and downstream impacts, and quickly reaches the best solutions. Each functional area has a subject matter expert or project lead to represent their area on the project team. They have responsibility for ensuring that their team fully understands and works to meet the requirements of the Contract. All functional area teams are brought together to resolve gaps between current and future state, policies, and objectives. As an example, when the Amerigroup team discusses the functional needs of the Amerigroup Nevada member, representatives from Amerigroup Nevada and our corporate teams in Communications, Member Services, Organizational Development, Technology Services, and eBusiness are part of that meeting.

Implementation Steps

Our structured process ensures a successful and timely implementation. Major steps are depicted in Figure 5.1.11.9-1 below.

Figure 5.1.11.9-1. Amerigroup's Implementation Process



We start implementation before Contract award. An advance team consisting of Amerigroup Nevada employees and corporate support leads starts planning for tasks and defining timelines based on our submission to the RFP and the State's proposed Contract. This enables functional leads to have as much time as possible to begin planning how to accomplish that work ahead of Contract award.

After Contract award, the full cross-functional team of subject matter experts and project leads reviews the Contract and our proposal to identify changes to existing business processes, policies and procedures, and systems. They will develop a full list of requirements and

deliverables that need to be met to achieve full compliance with the Contract. From there, the team builds its detailed work plan and timeline development for execution.

As implementation progresses, Amerigroup Nevada will submit any modifications as required by the Contract. By 30 days before the effective date of the new Contract, we will ensure that additional provider and subcontractor requirements and any necessary amendments to existing agreements are fully implemented.

As the team works on Contract deliverables such as updating policies and procedures, configuring the system, and updating materials, the dedicated Project Manager will ensure that we are prepared for all phases of the DHFCP readiness review. This includes such aspects as desk submission and onsite visit.

In addition to any requested State readiness visits, we conduct our own detailed readiness review as a further measure to ensure that we are fully prepared for implementation. Our team will gauge readiness, discuss risks or issues, and determine next steps prior to all key business milestones. As always throughout the project, these meetings will involve Amerigroup Nevada and corporate support leads, rather than separate discussions with each department.

Amerigroup is keenly focused on ensuring that all employees who will support the Nevada member and provider community are fully prepared by the appropriate implementation date. In many cases, this is before the member effective date, as in the case of those who conduct provider orientations. Amerigroup Nevada partners with the corporate Organizational Development and Communications teams to plan and execute employee training and materials development.

As part of effective transition, we will continue processing enrollment through the procedures we use today, including creating and mailing member ID cards and new member packets and conducting clinical assessments.

Our team will also develop a plan for support of the business after the member effective date. This "post go-live support" typically lasts 30-90 days, consisting of onsite support and daily calls to discuss issues and target rapid response. As part of the project planning and execution, Amerigroup Nevada and its corporate support will develop and execute a well-defined transition plan to ensure that those who worked on implementation effectively shift the work into the day-to-day operations of the business.

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Reporting (§5.1.11.10)

The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge of the DHCFP financial reporting requirements.

Amerigroup Nevada has reviewed all reporting requirements listed throughout the RFP and in Attachment I, Forms and Reporting Guide. We confirm our ability and commitment to meeting DHCFP reporting requirements. We are compliant with DHCFP reporting requirements today in support of our existing Contract to provide managed care services to Medicaid and Nevada Check Up members and we will provide new reports as required under this Contract.

Amerigroup is compliant with all DHCFP reporting requirements for our Medicaid and Nevada Check Up Contract.

As a Medicaid MCO in Nevada, we are currently submitting 107 contractually required reports and filings to DHFCP in the prescribed format, schedule, and method, including 69 regularly scheduled reports and 38 reports/filings generated on an as-needed basis. We are currently submitting another 14 regulatory reports to the Nevada Division of Insurance. Amerigroup Nevada is always willing to modify existing reports, provide new reports or data extracts, or create ad hoc reports to meet DHCFP requirements.

Amerigroup Nevada Reporting Capabilities

Amerigroup Nevada fully understands the reporting requirements of DHCFP and the operational commitment necessary to meet them. Compliance is an essential part of our corporate culture and we work continuously to meet DHCFP expectations and requirements.

Our Regulatory Services Department and the Regulatory Services (RS) Manager are central to our strategy for report submission. They develop and maintain a database that documents the submission of contractually required reports. In addition, the Nevada RS Manager works with DHCFP to disseminate program and contractual requirements and regulations throughout the organization, manage required regulatory reporting and submissions, and coordinate communication between DHCFP and Amerigroup Nevada.

The RS Manager will remain the centralized and dedicated point of contact for DHCFP, regardless of issue or concern.

We will continue to collaborate with DHCFP during the report request and development phases to confirm that we have a clear understanding of the reporting needs and can generate accurate reports that meet DHCFP parameters and definitions. We are also willing to share

samples of reports we produce for other state markets with DHCFP as potential options for new reports.

Amerigroup Nevada is able to meet DHCFP reporting needs because of these factors:

- ***Our information systems and supporting data warehouses collect, capture, and maintain a comprehensive set of raw data necessary for report generation and analysis.***
- ***We promote the accuracy of the data we maintain through consistent edits on incoming data and carefully monitored processing.***

THE SSHIX CONNECTION

Amerigroup's robust information and technical infrastructure will enable us to meet expanded SSHIX reporting needs.

- ***A suite of technology tools is available to format, aggregate, and report data to streamline and facilitate report development.***
- ***Our report development team maintains a thorough understanding of the data, managed healthcare, technology tools, and the needs of our state partners.***
- ***Business owners are responsible for report completeness and review all reports before submission.***
- ***Our extensive experience delivering reports to DHCFP gives us a foundation of tested reports across all program areas and populations.***

Most importantly, we maintain a thorough understanding of State programs, populations, and monitoring requirements, enabling us to appreciate how DHCFP will use the report information to assess performance of the Medicaid and Nevada Check Up Programs.

Monitoring Report Accuracy and Compliance

Our reporting timeline generates reports in advance of the DHCFP submission deadline to allow adequate time for a thorough review. Business owners and Amerigroup Nevada leadership review reports for completeness and accuracy. Business owners submit approved reports to the RS Manager who reviews the reports with the Nevada Compliance Officer (CO) and then submits the reports to DHCFP. This close collaboration allows the RS Manager and CO to proactively identify any concerns or issues and, if warranted, initiate an internal project for additional review and analysis. Collaboratively, the RS Manager, Amerigroup Nevada leadership, and business owners work together to submit complete, accurate reports on or before scheduled due dates.

Information Systems and Technical Requirements (§5.1.11.11)

Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.

Amerigroup Nevada has reviewed all interface requirements listed throughout the RFP and in the Vendor's library. We acknowledge our ability and commitment to provide compatible interfaces with existing information systems of DHCFP or its agents. As a Medicaid MCO in Nevada, we are currently compliant with DHFCP interface requirements and will continue compliance under the new Contract. Based on the currently operational interfaces and the technical infrastructure of our systems, we are confident in our ability to provide compatible interfaces to proposed and future information systems as required by DHCFP and outlined in Section 4.15.2 of the RFP.

Amerigroup Nevada is currently compliant with DHCFP interface requirements.

We closely monitor federal and State requirements that impact interface requirements and will continue to collaborate with DHCFP and its fiscal agent to define testing and implementation schedules for transitioning to new interface formats.

As a current partner in Nevada, Amerigroup has proactively reached out to provide assistance with DHCFP's encounter data warehouse project.

We support the direction that DHCFP is taking with its data warehouse approach to encounters. We understand the challenges that the State is currently facing and are providing whatever assistance we can to help the DHCFP meet its goals for encounter file submission.

Amerigroup Interface Capabilities

Secure ongoing data interfaces are a strength and core competency of Amerigroup's Technology Services (TS) Department. We have more than 16 years of experience in exchanging data with our ancillary vendors and states and their agents, including enrollment brokers, fiscal agents, and intermediaries; external quality review organizations; recovery audit contractors; and others. We are 5010 compliant and currently support interfaces in the HIPAA standard X12 and National Council for Prescription Drug Programs (NCPDP) formats as well as HL7 and many state-specific formats.

Adherence to HIPAA and Use of Industry Standard Codes

Amerigroup systems transmit, receive, and process data in current HIPAA-compliant formats. We will continue to comply with changes to any applicable federal and HIPAA standards and regulations and will adhere to other standards developed jointly with DHCFP. We edit against standard code sets including Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), Current Procedural Terminology (CPT), revenue, Current Dental Terminology (CDT)/American Dental Association (ADA), and National Drug Code (NDC) codes. In addition, we maintain and use HCPCS Level II and Category II CPT Codes. Code edits are applied in our core operations system for claims we process and in the systems of our delegated vendors. We apply code edits to encounter data before we submit it to DHCFP.

Timing, Format, and Delivery of Interfaces

We will continue to coordinate the format, timing, and delivery mechanism for interfaces with DHCFP and its fiscal agent. Upon receipt, we validate incoming interface files for completeness and credibility and then load them into the production environment.

THE SSHIX CONNECTION

Amerigroup's existing infrastructure, connectivity, and operating experience with the State creates a solid platform for extension to the SSHIX space and new BOS vendor.

The TS Department has experience establishing appropriate protocols for connectivity and developing solutions that foster interoperability and conformance to generally accepted open-systems architectural standards. Most of our interfaces are performed using Hypertext Transfer Protocol Secure (HTTPS) or Secure File Transfer Protocol (SFTP) over secure connections, including virtual private network (VPN). We will continue collaborating with DHCFP to determine the best method for each interface.

Amerigroup applies comprehensive system and process checks to monitor data integration and confirm that data is successfully imported and exported. TS employees monitor data interfaces, address any transmission or data errors, and confirm successful processing.

Interface Testing

Rigorous testing of interfaces between the State and Amerigroup is a critical component of our implementation plan. We perform extensive internal and joint testing on all incoming and outgoing interfaces with the State. For incoming interfaces, we verify that the external file loads properly, evaluate loaded data for accuracy and completeness, and review exception reports for errors or data issues and resolve any file/data issues with the sender. For external interfaces, we review and evaluate the outgoing file to verify that all data elements are included and that the file complies with format requirements.

HIPAA Compliance (§5.1.11.12)

A.	Describe your status, resources, and approach to HIPAA compliance.

Amerigroup is fully compliant with the privacy and security requirements of HIPAA. Amerigroup is also fully compliant with the requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

Amerigroup will continue to provide DHCFP and our Nevada Medicaid members and providers with the knowledge, expertise, systems, policies, and procedures that consistently meet federal and State compliance requirements regarding member privacy and security.

Status, Resources, and Approach to HIPAA Compliance

HIPAA compliance covers three areas:

- ***Electronic Transactions and Code Sets.*** ***We are compliant with 5010 and NCPDP D.0 transactions, and we have a corporate project underway for ICD-10 compliance.***
- ***Privacy.*** ***We have invested in protecting member confidentiality and disclosure of mental health records, medical records, and other member protected health information (PHI) in accordance with federal and State requirements.***
- ***Security.*** ***We are committed to physical security within our facilities and data and network security within our management information system.***

Amerigroup is fully compliant with HIPAA and HITECH.

The following sections discuss our compliance status, resources, and approach to each area.

Electronic Transactions and Code Sets

Technology plays a vital role in HIPAA compliance and the protection of member privacy. We are currently accepting and transmitting HIPAA-standard transactions listed in Section 4.15.4 of the RFP, including 834, 837 I, P, and D, 835, 820, 824, 277U, 271U, 270/271, and 997 formats. We also have the capability to exchange the 276/277 and 278 transactions. We are compliant with the 5010 standard for these transactions and also support the NCPDP D.0 standard.

Amerigroup has been National Provider Identifier (NPI) and Atypical Provider Identifier (API) compliant since 2007.

Our Technology Services (TS) Department carefully monitors HIPAA, HITECH, and other federal and State requirements to identify the impact that changes in electronic transactions

Our approach to HIPAA and HITECH compliance includes continuous emphasis, education, and review.

and code sets have on our systems and operations. To address changes required for compliance, we create a project, define the scope, assign resources, and monitor progress towards compliance. Compliance with ICD-10 is currently underway.

Amerigroup's approach to ICD-10 is to adopt and implement the code set standard, and we are on track to be compliant by October 1, 2014. Amerigroup has continued our work on ICD-10 despite the delay in compliance deadline. Our approach is to assess the functional/operational impact of ICD-10, working with all business areas across the organization to identify ICD-9 usage and potential for ICD-10 impact. We have completed a thorough gap analysis of and identified all impacted processes. By the end of 2012, we will have completed the following:

- ***Analysis of the systems and operational processes requiring remediation***
- ***Internal and external communications plans for 2013 and 2014***
- ***Identified internal and external training needs and begun development of detailed training plan***
- ***Developed training materials for our claims coding employees, including knowledge base for continued skills development***
- ***Identified contracts for facility and non-facility providers impacted by ICD-10 implementation***

We are positioned to begin remediation activities in early 2013 and plan to be ready for external testing in the first quarter of 2014. We are also working closely with our vendors to track their ICD-10 status and monitor their progress towards compliance.

Amerigroup also has a corporate project focused on compliance with new federal operating rules as part of the Patient Portability and Affordable Care Act (ACA) mandate for Administrative Simplification. Section 1104 requires that all HIPAA covered entities be compliant with applicable HIPAA standards and associated operating rules. Amerigroup is on track to meet the January 2013 compliance date for Council for Affordable Quality Healthcare (CAQH®) Committee on Operating Rules for Information Exchange (CORE®) Eligibility & Claim Status Operating Rules and planning for the timely implementation of the EFT/ERA Standard and Operating Rules by January 2014. Amerigroup continues to monitor related legislation and developments for ongoing compliance with all measures of Administrative Simplification.

Privacy

We have reviewed the Nevada Revised Statutes related to the protection of personally identifying information and confirm that our systems meet privacy requirements.

As a health insurance company with substantial public program experience, Amerigroup maintains the infrastructure, processes, and culture that comply with federal and State requirements to protect member confidentiality.

Amerigroup's Member Privacy Unit (MPU) manages the corporate HIPAA Privacy Program. The MPU consists of the Chief Privacy Officer, a manager, and four analysts who:

- ***Maintain HIPAA privacy policies and procedures***
- ***Develop HIPAA privacy training***
- ***Review and fulfill member privacy rights requests***
- ***Investigate and resolve privacy incidents***
- ***Provide breach notifications***

Amerigroup Nevada also employs a Compliance Officer (CO), Chris May, who manages the regulatory compliance of the State contract and supports the health plan's compliance with State and federal regulations.

The CO conducts HIPAA audits at least quarterly and provides education and training to employees as indicated. The CO also delivers continuing education, providing examples of HIPAA violations around the country and discussing actions that employees can take to prevent such a breach.

Amerigroup maintains a library of detailed policies and procedures that specify the protocols for protecting member privacy as shown in Table 5.1.11.12-1. Our policies and procedures protect member privacy and safeguard member information in accordance with HIPAA, HITECH, and other State and federal requirements.

Table 5.1.11.12-1. Comprehensive Policies and Procedures Protect Member Privacy

Corporate Policies	
▪ Affiliated Covered Entity, Management of Relationship ▪ Code of Business Conduct and Ethics ▪ Confidentiality ▪ Corrective Actions ▪ Compliance Program-Mitigating Non-Compliance Data Center and Telecommunications Space Access ▪ Desktop PCs/Workstation Screen Savers ▪ Disclosure of Enrollee PHI ▪ Electronic Data Destruction ▪ HIPAA Overview ▪ HIPAA Corporate Testing Guidelines HIPAA-Code Sets	▪ Enrollee Privacy Rights ▪ HIPAA Transactions ▪ Information Security Incident Management ▪ Information Technology Data Backup ▪ Information Technology Resource Security and Awareness Training ▪ Identification Badges and Card Access System ▪ Information Technology Security Policy ▪ Notification to Enrollee of Breach of Unsecured PHI or Personal Information ▪ Reporting of Suspected Child, Elder, and Partner Abuse and Neglect
Departmental Policies	
▪ Account Management ▪ Employee Behavior, Conduct, and Performance ▪ Corrective Action ▪ Data Center Access ▪ Data Transfer Methods ▪ Deceased Individuals ▪ De-identification of PHI/IIHI ▪ Designated Record Set ▪ Disclosing PHI for Research ▪ Electronic Data Destruction ▪ Equipment Disposition or Donation ▪ HIPAA Corporate Guidelines for Enrollee Address File Generation ▪ HIPAA Desktop PC/Workstation Screen Savers ▪ HIPAA E-mail Communications ▪ HIPAA Faxing PHI ▪ HIPAA Guidelines for Use of the Fax Server ▪ HIPAA Marketing Requirements ▪ HIPAA Privacy Quarterly Audits ▪ HIPAA Privacy and Security Training ▪ Information Technology Data Backup	▪ Information Management Security Incident Management Procedures ▪ Information Technology Resource Security and Awareness Training ▪ Enrollee Correspondence ▪ Non-Provider Contracting ▪ Physical Safeguards for PHI and Individually Identifiable Health Information (IIHI) ▪ Psychotherapy Notes ▪ Printers, Facsimile Machines, Speakerphones, and Shred Bins (HIPAA) ▪ Privacy Incident Reporting ▪ Privileged Access Accounts ▪ Restriction to Enrollee PHI from State and Federal Agencies ▪ Supporting Privacy Compliance Reviews ▪ Telephone and Face-to-Face Communications Involving PHI ▪ Telecommuting ▪ Vendor Contact for Enrollee Rights Requests ▪ Verification Requirements to Disclose PHI by Phone Calls, Faxes, Correspondence, and E-mail ▪ Voice Mail Messages Involving PHI

We maintain a project plan to track each section of HITECH, its implementation dates, and the Amerigroup policies and procedures that may be affected. When the remaining HITECH regulations are published, we will identify changes to business practices and update the appropriate policies and procedures, as necessary, to remain in compliance.

Amerigroup's approach to compliance includes:

- ***Education.*** ***We train and educate all employees on HIPAA requirements; HIPAA requirements are also covered in our provider training and documentation.***
- ***Technology.*** ***We use technology to support data transmission and communication safeguards.***

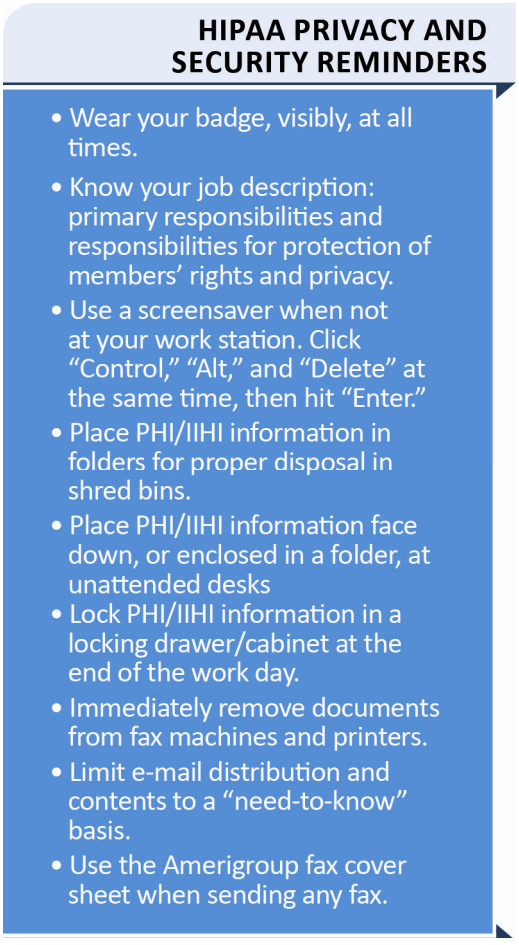
Education

All Amerigroup employees must attend HIPAA training within 60 days of their date of hire. Through a computer-based training tool, employees must achieve at least a 90 percent score to successfully complete their training. Participation and scoring is electronically tracked and reported to our Compliance Department. We also require annual refresher training. Management can require more frequent training for individual employees as necessary. Amerigroup maintains 100 percent compliance with HIPAA training.

Amerigroup employees are subject to random HIPAA audits conducted each quarter. The audit includes a checklist of items that verify compliance with Amerigroup's privacy and security program. Employees who are not in compliance are given additional training and guidance as necessary.

We also remind our employees about privacy program compliance through communications such as posters and flyers throughout the office, as shown in Figure 5.1.11.12-1.

Figure 5.1.11.12-1. HIPAA Tips are Routinely Provided to Amerigroup Employees



Additionally, Amerigroup offers training to providers on member privacy, and our provider orientation covers HIPAA. Provider responsibilities are specified in the provider manual and on the provider website.

Technology

Technology plays a vital role in HIPAA compliance and the protection of member privacy. Amerigroup uses encryption protocols to securely transfer files containing PHI. We monitor all file transfers to ensure that files containing PHI are protected. This includes automatic encryption of all e-mail that contains PHI for which the destination address is outside of the Amerigroup network. We encrypt portable devices such as laptop computers. The software also controls what can be saved to removable devices on our personal computers. Authorized employees can save PHI to a portable device for business purposes, but the system will automatically encrypt the data.

We also restrict access to PHI through the use of security profiles, system user names, and passwords that limit access to member data, claims history, care management data, and PHI. Only those employees who need access to fulfill their job requirements are authorized.

Security

Amerigroup is committed to physical security within our facilities and, in addition, data and network security within our management information system.

Information Technology Security manages the HIPAA Security program. Resources include the Security Officer, an Associate Vice President (AVP) of Security, an AVP of Compliance, and 10 information technology professionals who:

- ***Provide proactive security analysis***
- ***Develop and manage a security architecture and strategy***
- ***Respond to security events and incidents***
- ***Prepare and deliver security training and communication***
- ***Develop and manage security controls***
- ***Conduct reviews and vulnerability assessments***

Our approach to security includes strict security policies and procedures to protect all data maintained within our systems and applications. The first line of security is to limit access to our facilities. Next, the TS Department limits access to systems, applications, and data warehouses

Employees have access only to private health information they need to do their jobs.

to individuals who have a legitimate business need for the data. The access management function also restricts users by varying hierarchical levels of entry based upon system function and the information available. Remote access to systems is granted only to individuals who must work from a distance and cannot be physically located in an Amerigroup facility.

The following sections provide additional detail about Amerigroup security practices.

Physical Security

Amerigroup restricts access to all facilities and controls access by using proximity-based electronic security badges. All employees and visitors must complete a security access request form and obtain approval signatures before gaining unsupervised access. After-hours access to facilities requires the use of specially coded security badges for building and department access.

All Amerigroup data centers have formal policies for visitor control. We limit data center access to employees responsible for network engineering, system administration, and network security. All servers and data storage devices are located within secure areas of the data centers that can be accessed only by individuals with special clearance.

User IDs, Passwords, and Unauthorized Access

Amerigroup requires use of a unique user identifier and complex password to gain access to workstations or systems. The TS Department employs the Microsoft Windows Active Directory infrastructure to limit access to a system or application and role-based security within applications. The role-based security limits update capabilities and access to application functionality. We grant access to data and information based upon job responsibilities and the sensitivity of the data stored.

All workstations and systems are guarded by security policies that prevent access if an individual tries to log in and has three unsuccessful attempts. The Security Department receives system-generated reports and alerts on unsuccessful attempts to access systems and websites. Additionally, passwords must be complex, users must change passwords every 60 days, and re-use of recent passwords is prevented.

Protecting Privacy over the Internet

Amerigroup provides secure e-mail for sending and receiving information. The e-mail system automatically encrypts outbound messages if key numbers or keywords are detected. We use an extensive list of keywords related to drugs, treatments, and diseases to determine whether encryption should be applied. Additionally, the sender can request encryption by using the word "encrypt" in the message. On the receiving side, a message is delivered with an

encrypted PDF attached that contains the original e-mail. Users can send a secure and encrypted reply by clicking on the reply link in the PDF.

Data Network Security

Amerigroup uses state-of-the-art monitoring tools to audit system access, utilization, account usage, and resource usage to verify compliance with established policies. We use a number of technologies and security management systems to provide twenty-four hours a day, seven days a week real-time security event monitoring and reporting capabilities. We maintain a formal security incident handling process that includes security incident response reporting. The Security Officer enforces policies and monitors all security issues.

The TS Department controls network access through usernames and passwords and Entrust IdentityGuard Two-Factor authentication will soon control remote access. We control individual user level access to systems through the use of Active Directory group membership, in addition to application, file, directory, and drive-level security. We manage and protect our network using industry-standard tools, including NetIQ Enterprise Administration Suite, CiscoWorks Management Software, WebSense®, Symantec™ MessageLabs®, Sourcefire® Intrusion Prevention, Symantec Data Loss Prevention, Entrust® eMail encryption, Citrix®, and a combination of Cisco Firewalls.

External vulnerability scans of the network are performed by WhiteHat and IBM. Varonis® Data Advantage is used to provide file level access monitoring and reporting. A combination of McAfee®, Symantec, and Microsoft® virus detection and software is installed on all personal computers and corporate servers. A Trustwave® Enterprise Information Security Management system collects, correlates, and centralizes log information from systems on the network to monitor compliance with established policies. We apply the COBIT® information technology governance framework for information technology controls.

The TS Department uses third-party tools to prevent external systems attacks. These tools combat known and unknown threats to our network and websites. Our toolsets assist the TS Department with safeguarding our network, websites, and information in our systems. The TS Department policies and procedures related to system security, access, and use are readily accessible to employees. As part of HIPAA Privacy and Security compliance, we conduct extensive education, and ongoing training materials serve as continuous reminders.

Data Center Environmental Controls

Amerigroup's central data center incorporates environmental controls such as uninterruptible power supply (UPS), moisture detection, heat ionization detection, temperature alerts, and backup generators. These controls are used in our supporting data centers as appropriate.

Security and safety controls such as smoke detectors, electrical alarms, and an advanced fire retardant system help prevent the spread of fire to the data centers.

B.	Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.

Experience Processing HIPAA-Compliant Claims

Amerigroup has been processing HIPAA-compliant provider claims in Nevada since 2009. We are committed to adjudicating claims in a timely, accurate, and provider-friendly manner. Amerigroup maintains a single claims processing system that is fully integrated with enrollment and provider systems, consistently meets federal requirements, and currently meets DHCFP requirements. Amerigroup processed more than 803,000 HIPAA-compliant claims under our Nevada Medicaid and Nevada Check Up Contract in the 12 months ending September 30, 2012. Across all markets, Amerigroup processed more than 27.7 million claims during the same 12-month period.

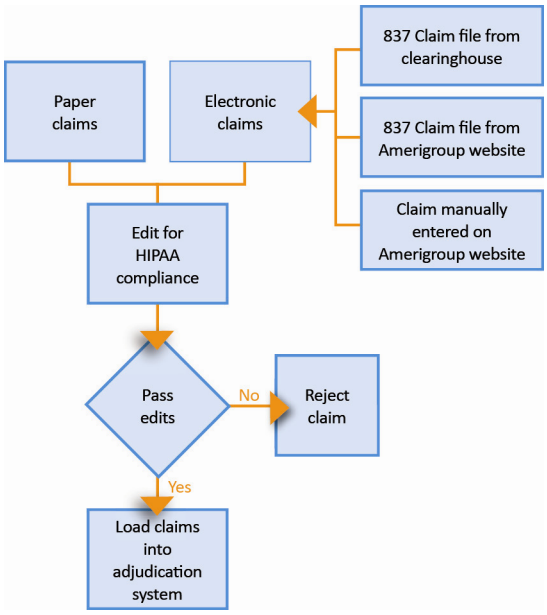
Amerigroup's experience in processing HIPAA-compliant claims is addressed through:

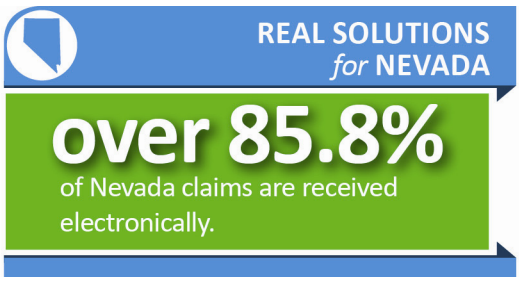
- ***Claim input***
- ***Claim editing and adjudication***

Claim Input – HIPAA-Compliant Paper and Electronic Claims

Amerigroup accepts claims on paper and electronically to delivery maximum flexibility to our providers. All claims formats are industry-standard–compliant and HIPAA-compliant and include CMS 1500 and CMS 1450 (UB 04) formats. As shown in Figure 5.1.11.12-2, all claims, regardless of source, are submitted to the same HIPAA compliance edits and adjudication process.

Figure 5.1.11.12-2. Amerigroup Accepts HIPAA Compliant Claims via Multiple Methods





Paper claims are received by our Document Management team, who batch, scan, and export the files to our data entry vendor throughout each production day. The vendor converts claims to an electronic format and returns HIPAA-compliant X12 837 claims data files to Amerigroup for processing.

For electronic claims submission, we accept claims through:

- ***Three nationally recognized electronic data interchange (EDI) clearinghouses***
- ***Submission of an X12 837 claims file from our provider website***
- ***Direct entry of a claim from our provider website***

In the past 12 months, more than 85.8 percent of all Nevada claims were received electronically.

Amerigroup offers our providers a number of different resources for technical support for submitting HIPAA-compliant claims, including training classes, provider manual, provider website, and toll-free hotline numbers.

Amerigroup maintains two EDI companion guides, one for professional and one for institutional claims that include detailed information on electronic claims submission. These document the EDI process and its benefits to providers. They provide an overview of the EDI process and include topics such as:

- ***Responsibilities of Amerigroup and the clearinghouses***
- ***Provider responsibilities for using the clearinghouse and the provider website***
- ***How to get started with EDI***
- ***Clearinghouse fees and charges***
- ***EDI claim requirements***

REAL STORIES

One of our prominent obstetrical providers was having trouble submitting claims to Amerigroup through their EDI clearinghouse and was in jeopardy of having claims denied for timely filing. After being alerted to the problem, their designated Provider Relations Representative went to the provider's office to help. We sat down with the provider's staff and educated them on the process to submit HIPAA-compliant claims using our provider website. Our representative stayed at the provider's office until the staff felt comfortable with the process and the backlog of claims were successfully entered.

Working hand-in-hand with our providers with claims submission is part of our commitment to provider satisfaction and HIPAA compliance.

- *Claim rejection scenarios*
- *EDI report options and features*

Amerigroup encourages providers to call our toll-free numbers if they require additional support. We maintain a dedicated EDI Hotline to answer specific questions related to electronic claims. The EDI Hotline employees can help providers with set-up questions, help resolve any submission issues, and help resolve claim rejections. Customer Service Representatives and Provider Relations Representatives are also available through a toll-free number to assist providers with any questions or concerns.

If we find that any of our providers may benefit from technical assistance, we will proactively reach out to them. Our EDI Hotline employees will reach out to providers with high-volume paper claims submission to discuss EDI methods, how electronic claims can work in their office, and the benefits they can achieve. If a provider is submitting a high number of rejected claims or generating a high number of pends, we can contact the provider to help identify and correct any problems to expedite claims processing and payment.

Claim Editing and Adjudication

All claims, regardless of entry source, pass through the same edits and adjudication processes to ensure consistency and HIPAA compliance. We assign each claim a unique internal control number used to track its progress from initial entry into our system to final adjudication and online storage. The system applies a series of edits to all submitted claims, regardless of source of entry. Before a claim is accepted into our claims processing system, we apply a variety of automated pre-processing edits designed to validate the quality of the data submitted. These edits verify that the data is relevant, complete, and contextually appropriate and include:

- *Compliance edits that validate data through HIPAA Level 6 in accordance with the Workgroup for Electronic Data Interchange's Strategic National Implementation Process (WEDI SNIP) standards*
- *Professional (X12 837P) and institutional (X12 837I) claim edits such as:*
  - *CPT or HCPCS code validations*
  - *ICD-9 code validations, including validity for the date of service*
- *Institutional (X12 837I) claim validations such as:*
  - *Presence and correctness of dates, including admission date*
  - *Balancing total charged amount against the sum of service line charges*
  - *Code set validations*

Claims that fail these initial edits are rejected. If the claim was submitted electronically, the provider is notified by the claim entry source, which is either the clearinghouse or the provider website. Paper claims that are rejected are returned to the provider via postal mail with a description of the issue.

Experience Submitting HIPAA-Compliant Encounters

Amerigroup submits HIPAA-compliant version 5010 X12N 837 encounter files in 11 of our 13 state markets, as well as HIPAA-compliant NCPDP D.0 encounter files in eight markets. In the 12-month period ending August 30, 2012, Amerigroup affiliate health plans transmitted almost 47.5 million HIPAA-compliant encounters to our state partners.

In 12 months, Amerigroup submitted almost 47.5 million HIPAA-compliant encounters.

We understand and support the direction that DHCFP is taking with their data warehouse approach to encounters. We understand the challenges that the State is currently facing and are providing whatever assistance we can to help the DHCFP meet its goals for encounter file submission.When DHCFP is ready to receive a HIPAA-compliant encounter file from Amerigroup, we will be ready.

Amerigroup understands that DHCFP's fiscal agent will apply edits to encounters and that a companion guide will include edit descriptions. Amerigroup has experience working with DHCFP's fiscal agent, Hewlett Packard, including submitting encounter files through their HIPAA compliance editor. In our Georgia health plan, for example, during the 18-month period ending March 31, 2011, more than 99 percent of our encounters passed both the fiscal agent's HIPAA compliance checks and Medicaid Management Information System (MMIS) edits and were accepted. We have developed a good relationship with technical employees, working closely with them to understand state-specific edits and technical rules, as well as submission timing and protocols. We will leverage this knowledge and experience to generate accurate X12 837 encounter files for DHCFP.

Amerigroup will submit HIPAA-compliant encounter files on a monthly basis or more frequently as requested by DHCFP. We submit weekly encounter files in most of our current markets.

We will support the submission of complete, accurate, and HIPAA-compliant encounter files to DHCFP through a tightly managed encounter submission process.

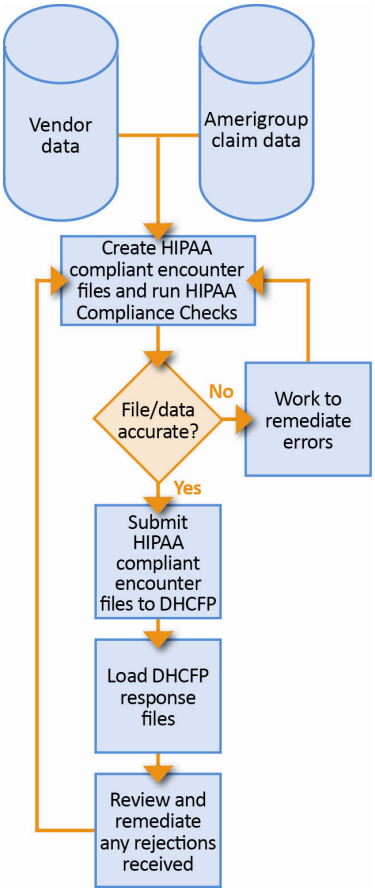
Encounter Submission Process

Amerigroup delivers complete, accurate, and timely encounter data through dedicated staffing, a robust Encounter Management System (EMS), and a tightly managed submission

schedule. Using our EMS, we extract, track, correct, report, log, and archive encounter data. The Encounters Management team closely monitors all encounter processing and meets at least weekly to discuss any issues and ensure that we are meeting standards for encounter completeness, accuracy, and timeliness in each of our markets.

We use automated routines to extract encounter data for transmission to DHCFP. We process data through a comprehensive series of edit routines to verify HIPAA compliance and to confirm that all fields contain accurate and complete information before submission.

Figure 5.1.11.12-3. Our Encounter Process is HIPAA-Compliant



As shown in Figure 5.1.11.12-3, we combine claims and claims adjustment data processed since the last submission of encounter records with encounter data from our delegated vendors and load the data into our EMS. Initial validations confirm that all retrieved claims records load into the EMS for subsequent processing.

Encounter File Completeness—All Claims from All Providers

Amerigroup will continue to submit encounter files to DHCFP that contain all encounter data regardless of source of claim (electronic or paper format) or type of provider. Our EMS is currently configured to differentiate between Medicaid and Nevada Check Up recipients on the monthly encounter file that we submit to DHCFP.

The submission of encounter data is a contractual requirement in all Amerigroup Nevada provider contracts. We contract with most of our providers on a fee-for-service basis, which inherently drives claims submission and results in encounter data. We require providers with capitated reimbursement to submit encounter data as zero pay claims. Claims from capitated providers process through our claims processing system, receive all the same edits and validations, and become part of the overall claims data set extracted for encounter submission.

For all providers, we account for submission compliance through records audits and data-trending analysis, including comparing claim volume from similar providers to identify potential issues. We collaborate with Provider Relations to address any provider compliance

issues and develop corrective action plans for providers who fail to consistently submit complete encounter data.

Amerigroup collects encounter data from our delegated vendors, including our pharmacy and dental vendors, and includes it in our encounter data submission. Contractual language requires that delegated vendors submit encounter data and specifies penalties for non-compliance. Account managers monitor vendor compliance. We edit encounter data from vendors and combine it with other claims data in our encounter submission.

Encounter Data Accuracy

Accurate encounter data begins with accurate claims data. We evaluate the accuracy of encounter data by applying the same set of edits to all incoming claim records, regardless of whether they originate on paper or electronic submission.

Amerigroup configures our EMS to edit and process all encounter records against Nevada-specific program requirements to confirm completeness and validity. Business rules evaluate each claim or service line to validate that the encounter records meet State-specific processing requirements and ensure the presence and validity of all required data elements, including member and provider data, date of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and date of claim payment.

We pend claims or service lines that fail an edit or business rule without impacting remaining records. The Encounters Management team reviews pended records and coordinates corrective action with the appropriate operational unit such as Claims or Provider Data Management. The team logs encounter pend dates and monitors encounter aging. Corrected encounters are automatically included in the next submission. Management reports help monitor pended encounters and ensure timely remediation and submission.

We format encounter records that pass all edits in the HIPAA-compliant X12 837 format. Encounter files pass through HIPAA compliance software to ensure compliant data through Level 6 and structurally sound files.

We also validate member and product eligibility for the date of the encounter. Retroactive enrollment changes could cause an encounter to pend at this point. As with business rule remediation, we pend any encounters that fail compliance checks and submit them after remediation and resolution.

After all issues that can be resolved are addressed, we create a final encounters file. To confirm compliance, we re-run the file through HIPAA compliance software and the member/product eligibility check before submission.

Encounter File Submission

We understand the importance of transmitting encounter data accurately, securely, efficiently, and in accordance with the State's schedule; we have a 100 percent compliance rate for encounters under our current Nevada contract.

We currently transmit encounter data in state-specific formats, as we are doing in Nevada today, as well as the HIPAA-compliant ANSI X12N 837 format. We can transmit encounter files through Hypertext Transfer Protocol Secure (HTTPS) or Secure File Transfer Protocol (SFTP) and always include the required attestations and reports.

We log the details of each encounter submission, capturing information on each claim submitted, including claim number, line, submit type (original, adjustment, void), file, path, and creation date.

Tracking and Monitoring Encounter Record Submission and Acceptance

The Encounters Management team uses a series of internal reconciliation and certification reports to manage and monitor the encounter submission and allow the encounter analyst to validate claims counts and dollars. We review and analyze any variations and make any necessary corrections to ensure encounter file accuracy. When necessary, we make program changes to enhance encounter processing and reporting.

The Encounters Management team reviews and remediates all rejections to ensure timely correction and re-submission. The team works with all necessary departments and delegated vendors to identify and correct all data and process issues. If we identify a pattern of deficiencies for specific providers or vendors, we will work with the necessary business function to identify and resolve deficiencies.

We understand that DHCFP's fiscal agent will apply HIPAA compliance edits and other edits to encounters. Based on the extensive editing that our systems perform and our experience with our other state partners, we expect to easily exceed the requirement that 95 percent of encounter records pass compliance edits executed by DHCFP within the first six months and 97 percent thereafter.

We evaluate and correct encounter records that fail DHCFP edits. We also analyze returned encounters to determine a root cause and make changes to operational and system processes, as indicated, to increase the number of accepted encounter records.

5.1.12 Financial Information and Documentation

In accordance with Section 10.5, Part III – Confidential Financial, Amerigroup Nevada's financial information and documentation are included in the binder marked Part III – Confidential Financial, located behind Tab II – Financial Information and Documentation. In addition, financial information and documents for our proposed subcontractors can be referenced within the Binder marked Part III – Confidential Financial.

5.2 SUBCONTRACTOR INFORMATION

Amerigroup Nevada will use subcontractors for the provision of specialized covered services and administrative services within the Nevada Medicaid Managed Care Contract. We subcontract with entities that have a similar healthcare philosophy and with which we have long-standing relationships. Such established relationships provide us, our members, and the State of Nevada tremendous continuity and familiarity moving forward, rather than proposing changes and implementing new subcontracts.

AMERIGROUP Corporation (Amerigroup), with more than 16 years of experience solely serving Medicaid and Medicare members, will be the primary administrative services subcontractor for Amerigroup Nevada. While Amerigroup Corporation is headquartered in Virginia, it maintains a large office in Las Vegas for the Amerigroup Nevada health plan. This unique corporate and local plan presence facilitates sharing of responsibilities, readily avails the project of corporate resources at the local level, and enhances support for Amerigroup local resources that focus on caring for members.

5.2.1 Use of Subcontractors

Does this proposal include the use of subcontractors? Check the appropriate response in the table below. If yes, vendor must address 5.2.1.1 through 5.2.1.7.

Yes	√	No	

Subcontractors and Specific Requirements (§5.2.1.1)

Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

Amerigroup Nevada will contract with the subcontractors identified in Table 5.2.1.1-1 for the identified services and associated Contract requirements.

Table 5.2.1.1-1. Amerigroup Nevada Subcontractors and Contract Requirements Matrix

Amerigroup Nevada Subcontractors	Subcontracted Services
Amerigroup Corporation	Claims services
	Credentialing
	Legal and regulatory services

Amerigroup Nevada Subcontractors	Subcontracted Services
	Medical management support services for care management, disease management, quality management, utilization management
CVS Caremark	Pharmacy services
Connextions	Nurse *HelpLine*
	Disease management
eyeQuest	Vision services
National Imaging Associates (NIA)	Radiology services
Scion Dental	Dental services
Voiance Language Services, LLC	Over-the-telephone interpreter services

Oversight of and Experience Working with Subcontractors (§5.2.1.2)

If any tasks are to be completed by subcontractor(s), vendors must:

A. Describe the relevant contractual arrangements;

B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

C. Describe your previous experience with subcontractor(s).

Relevant Contractual Agreements

Amerigroup executes formal contract agreements with each subcontractor, upon approval by DHCFP. The subcontract defines the subcontractor's roles and responsibilities, performance standards, quality assurance requirements, reimbursement, financial responsibilities, hold-harmless and insurance provisions, privacy and security requirements, and data exchange and reporting requirements. As the prime contractor, we flow down all RFP requirements and DHCFP contractual requirements to each subcontractor as appropriate. We incorporate the RFP, attachments, and Amerigroup Nevada DHCFP MCO Contract into the subcontract by reference. Our subcontracts follow standard language and content, as developed and approved by our Amerigroup Corporate Legal Department, tailored to the specific requirements of the State and subcontracted functions.

Amerigroup's subcontract documents are available for review by DHCFP upon request. Amerigroup Nevada will execute comprehensive, DHCFP-approved subcontracts with each proposed subcontractor before commencement of Contract operations.

Subcontractor Supervision, Communication, and Contract Compliance

Amerigroup, through our Vendor Selection and Oversight Committee (VSOC), retains oversight of delegated services performed on our behalf and ensures compliance with State, federal, NCQA, and any other applicable regulatory and accreditation standards. VSOC, which is currently used by all 13 Amerigroup health plans, includes representatives from the following corporate departments: HealthCare Delivery Systems, Finance, Quality Management, Senior and Special Services Organization, Office of Business Ethics, Health Care Management Services, and Legal. We include additional departments as needed. Our Amerigroup Nevada Compliance Officer participates in the VSOC, ensuring subcontractors not only understand program requirements, but also take all appropriate and necessary actions to assure full compliance.

Amerigroup accepts full responsibility for subcontractor performance and has established and effective processes to supervise subcontractor activities, promote effective and open communications, and verify and enforce contract compliance.

Subcontractor Supervision

Amerigroup Nevada senior management, department managers responsible for the functional areas for which subcontractors perform contracted activities, and the VSOC supervise subcontractor work. Each subcontract document defines the subcontractor's functions and specifies how Amerigroup will oversee its operations, including the names or titles of Amerigroup supervisory personnel. Amerigroup provides each subcontractor with the documented policies and procedures applicable to its responsibilities.

Subcontractor Communications

Amerigroup uses formal and informal channels to promote and maintain effective communications with our subcontractors. A primary component of subcontractor communications is establishing a partnership with each subcontractor and including representatives from each organization in overall project management activities. In this way, subcontractors become participating members of the management team and remain informed about, and invested in, successful project execution. Amerigroup uses the following communications methods:

- ***Senior management meetings***
- ***Regularly scheduled management and employee meetings, as necessitated by specific functions (which may be conducted in person, by video/teleconference, web conference, or conference call)***
- ***Subcontractor performance review meetings***
- ***Formal written notifications, used to convey contract, performance, and deliverables information***
- ***Informal written communications (such as e-mail, fax, or text)***
- ***Informal face-to-face and telephone or electronic communications among Amerigroup and subcontractor employees, as needed***

Contract Compliance

- ***Amerigroup monitors and verifies subcontractor contract compliance using established Corporate and local resources and processes. At the Corporate level, Amerigroup confirms subcontractor compliance with federal and State program integrity requirements***
- ***Reviewing management reports***
- ***Conducting readiness reviews and annual on-site audits of delegated services***
- ***Monitoring subcontractor financial stability***
- ***Facilitating quarterly joint operations meetings between Amerigroup and each subcontractor to review performance, follow up on any corrective actions, and address any other issues identified by DHCFP or Amerigroup***

We monitor subcontractors delivering healthcare services locally, through our Nevada Medical Advisory Committee, headed by the Amerigroup Nevada Medical Director, and at the corporate level through the VSOC.

Amerigroup Nevada's Oversight Steering Committee routinely monitors the performance of Amerigroup as the primary administrative services subcontractor. The Nevada Oversight Steering Committee reviews the following quarterly summaries of Amerigroup activity:

- ***Service-level standards and reports***
- ***Fraud and abuse activity***
- ***Clinical quality initiatives, HEDIS® scores***

- ***Outreach initiatives conducted and planned for the following quarter***

As an example of how we oversee our subcontractors, Amerigroup has explicit policies and procedures that govern how all subcontractors receive and process claims data. These policies and procedures address the verification as well as the format and storage of reported data to ensure that our subcontractors meet our strict standards. Amerigroup establishes these standards within our subcontractor agreements and review and communicate them with subcontractors regularly.

Amerigroup Nevada's Experience Working with Proposed Subcontractors

Amerigroup has well-established partnerships, both in Nevada and in other markets, with each of our proposed subcontractors and will build upon these experiences to continue serving our Nevada members with distinction.

Table 5.2.1.2-1. Amerigroup Nevada's Experience with Proposed Subcontractors

Amerigroup Subcontractors	Experience with Subcontractor
Amerigroup Corporation	**Summary of Experience:** Amerigroup Corporation has 16 years of experience solely serving Medicaid and Medicare members and providing administrative support services to its affiliate health plans. **Nevada Experience:** Amerigroup Corporation has served as a subcontractor for administrative services to the Nevada health plan since 2009 in the areas of claims and encounter processing, medical services, legal and regulatory, and provider credentialing. **Experience in Other Markets:** Amerigroup Corporation currently provides administrative services support for its affiliate health plans in 12 other markets.
CVS Caremark	**Summary of Experience:** CVS Caremark is a leading pharmacy benefits manager (PBM) that provides specialty/biotech services, disease management, and other related health services. **Nevada Experience:** CVS Caremark has provided pharmacy benefit management services under subcontract to Amerigroup Nevada since 2009. **Experience in Other Markets:** CVS Caremark has provided PBM services to Amerigroup members since 1998 and currently does so in 12 state markets.
Connextions	**Summary of Experience:** Connextions provides acquisition, service, retention, and technology services to its clients. The Connextions client base consists of most of the major healthcare providers, as well as some commercial clients. Connextions provides clients technology and Business Process Outsourcing (BPO) services in a direct-to-consumer market. **Nevada Experience:** Connextions provides Nurse *HelpLine* services. **Experience in Other Markets:** Connextions has provided Nurse *HelpLine* services to

Amerigroup Subcontractors	Experience with Subcontractor
	Amerigroup members under a subcontract for multiple markets.
eyeQuest	**Summary of Experience:** eyeQuest administers vision benefits as a dependable partner for health plans in Medicaid markets on behalf of 12 clients in 13 states. **Nevada Experience:** eyeQuest has administered vision benefits, under subcontract to Amerigroup Nevada, for nearly four years, beginning in 2009, and serves 86,000 Nevadans. eyeQuest's Nevada vision network includes 133 general practices. This equates to one practice per 643 members, exceeding the industry standard. eyeQuest's network is compliant with Amerigroup's access standards—all urban members have access to a provider within 15 miles of their home, and all rural members have access to a provider within 30 miles. eyeQuest's Nevada experience, both urban and rural, serves Nevada well and demonstrates understanding of its members' needs. As testament to eyeQuest's exceptional services for all of 2011 and 2012 to date, there have been no member or provider grievances or appeals. **Experience in Other Markets:** eyeQuest also provides subcontracted vision services to Amerigroup in Louisiana.
National Imaging Associates (NIA)	**Summary of Experience:** As a recognized leader in radiology benefits management (RBM), NIA has provided innovative clinical solutions since 1995, partnering with more than 51 national/regional customers and serving more than 17 million lives in 26 states. **Nevada Experience:** NIA has provided RBM services, under subcontract to Amerigroup Nevada since 2009. Dr. Thomas Dehn, MD, NIA's Medical Director, attends each quarterly review meeting held with DHCFP and Amerigroup Nevada. Dr. Dehn has demonstrated proactive collaboration with DHCFP's Medical Director, Dr. Richard Roberts, MD in analyzing potential outlier providers in denial rates versus their peers. Dr. Dehn also ensures that NIA continually meets DHCFP's needs in the provision of imaging services under the current Contract. **Experience in Other Markets:** NIA provides radiological and imaging services to Amerigroup members under a subcontract in other markets.
Scion Dental	**Summary of Experience:** Scion Dental, a national leader in dental services, will cover approximately 4.9 million Medicaid members by January 1, 2013. Scion is the first dental company to receive full URAC accreditation for Health UM, and the only dental company to be awarded full URAC accreditation for Claims Processing. **Nevada Experience:** Scion Dental has provided dental services, under subcontract to Amerigroup Nevada, for nearly four years, beginning in 2009. Amerigroup's and Scion's joint goal in Nevada has been to build health literacy among members to empower them to understand and adopt those behaviors that drive improved oral health outcomes. To amplify this message and integrate messaging, Amerigroup and Scion will integrate dental outreach with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) under the new Contract. **Experience in Other Markets:** Scion Dental has provided dental services to Amerigroup members under a subcontract that currently provides dental services to

Amerigroup Subcontractors	Experience with Subcontractor
	more than 400,000 Medicaid and CHIP recipients in four states – a Georgia, Florida, Ohio, and the Amerigroup Nevada health plan.
Voiance Language Services, LLC	**Summary of Experience:** Voiance provides over-the-telephone interpretation (OPI) services can and translations for 170 languages, using language-appropriate, health care-aware translators. It provides TDD/TTY services for those who are deaf or hearing impaired. With ISO 9001:2008 certified processes, onshore contact centers, and advanced telecommunications infrastructure, Voiance delivers high quality language services to Amerigroup members. **Nevada Experience:** Voiance provides translation services, under subcontract to Amerigroup Nevada. **Experience in Other Markets:** Voiance provides translation services to Amerigroup members in other markets.

Methodology, Processes, and Tools (§5.2.1.3)

Vendors must describe the methodology, processes and tools utilized for:

A. Selecting and qualifying appropriate subcontractors for the project/contract;

B. Ensuring subcontractor compliance with the overall performance objectives for the project;

C. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

D. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State's request, the State will be notified of such payments.

Selecting and Qualifying Subcontractors

Amerigroup partners with carefully selected and closely monitored key subcontractors to deliver quality services for DHCFP. We choose subcontractors that we are confident will provide the highest quality care, services, and support to our members and deliver the desired results for DHCFP based on our past contractual arrangements with them in Nevada and other contracts. All subcontractors proposed here are currently in place as partners with Amerigroup in our Nevada health plan.

In the future, if we need to implement a new subcontract, or replace an existing subcontractor, we use the processes described here to identify and select those potential subcontractors.

Amerigroup Account Managers lead the process of subcontractor selection and oversight of the contract post-selection. This process must include:

- ***Notification of proposed agreement to the VSOC***
- ***Completion of the VSOC Checklist and delegated Activity grids***
- ***Request of VSOC review and approval***
- ***Presentation of the proposed agreement to the VSOC***
- ***Verification of the completion of all necessary pre-delegation audits and Corrective Action Plans (CAP) before Contract execution, if applicable***
- ***Adherence to all contracting requirements set forth by the Provider Contract Service team***
- ***Coordination with the VSOC to ensure the completion, review, and presentation of oversight and reporting to VSOC in a timely manner***

Upon selection of the desired subcontractor candidate, Amerigroup will formally submit all required subcontractor information and documentation, including the subcontracting agreement, to DHCFP and request written approval prior to entering into the subcontract.

The Account Manager is responsible for educating subcontractors and their employees regarding Amerigroup products and processes. The Account Manager acts as a liaison among the subcontractor, health plan, and VSO,C and establishes direct relationships between the health plan subject matter expert (SME) and subcontractor, but is expected to assist in resolution of any ongoing concerns. In addition, Account Managers:

- ***Ensure the availability of necessary financial solvency documentation to Finance and the VSOC.***
- ***Proactively maintain open communications with the subcontractor on health plan issues including, but not limited to, claims, eligibility, utilization management, reimbursement, and quality programs.***
- ***Schedule, organize, and chair, at a minimum, quarterly joint operations meetings for each subcontractor.***
- ***Ensure the upload of all reports monitoring delegated functions into designated health plan folders for SME review at least quarterly. This responsibility includes the upkeep of the comprehensive state specific reporting grid, regulatory requirements, templates, naming conventions and due dates. While each subcontractor provides these reports to***

the Account Manager, it is the responsibility of the Account Manager to ensure their timely, accurate delivery to Regulatory and for review by the health plan.

- *Submit all subcontractor member or provider communications that meet CMAP criteria through Amerigroup's internal CMAP process and ensure the receipt of all necessary state/federal approvals. Account Manager will notify the delegate of received approvals.*

Amerigroup Account Managers are SMEs regarding the regulations and requirements in all applicable state contracts pertaining to the services our assigned delegates provide. Account Managers must be aware of all updates and changes made to these regulations and requirements. We ensure that Account Managers review the accuracy of subcontractor information in our member handbook and member communications, provider directory, provider manuals, and our website.

Ensuring Subcontractor Compliance with Performance Objectives

As noted above, our Account Managers serve as liaisons to our delegated subcontractors and conduct periodic reviews through the VSOC to ensure compliance with our performance goals and objectives. These quarterly reviews provide a comprehensive review of each of our subcontractors and their performance outcomes.

Ensuring Subcontractor Deliverables Meet Quality Objectives

We assure subcontractors meet our quality objectives by tying quality objectives directly to the Nevada Contract requirements in our subcontractor contract agreements. We specify performance standards, measurement metrics, processes, and schedules, and remedies and penalties for failure to comply with standards.

Providing Proof of Payment to Subcontractors upon State Request

If requested by DHCFP, Amerigroup Nevada will provide records detailing payments to our subcontractors. Amerigroup Nevada will provide the State check copies, check registers, or records of wire transfers, as appropriate, to prove payment to subcontractors. We will provide this information within the timeframe specified by the State.

Subcontractor Responses (§5.2.1.4)

Tables starting on page 5.2-13 include all information required in RFP Sections 5.1.1 through 5.1.12 for each of our seven proposed subcontractors.

References for Subcontractors (§5.2.1.5)

Provide the same information for any proposed subcontractors as requested in Section 5.1, Vendor Information.

Amerigroup's subcontractors have submitted required business reference in compliance with RFP requirements no later than November 14, 2012 directly to Geoff Landry with the State of Nevada Purchasing Division.

Meeting Insurance Requirements (§5.2.1.6)

Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

Each Amerigroup Nevada subcontractor in the table within Section 5.2.1 asserts its compliance with the insurance requirements of this Contract.

Notifying Agency of Intended Use of Subcontractors (§5.2.1.7)

5.2.1.7 Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in Section 5.2, Subcontractor Information. The vendor must receive agency approval prior to subcontractor commencing work.

If Amerigroup Nevada identifies new subcontractors to accomplish contract requirements after submittal of this proposal, we will notify DHCFP immediately and submit a request for agency approval of use of the subcontractor before the subcontractor begins work.

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

5.1.1

Company name:	Amerigroup Corporation
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	Delaware
Date of incorporation:	December 9, 1994
# of years in business:	17 years. Amerigroup Corporation became Incorporated in December 1994. Amerigroup's first health plan went live in February 1996.
List of top officers:	▪ James G. Carlson ▪ John E. Littel ▪ Mary T. McCluskey ▪ Nicholas J. Pace ▪ Leon A. Root ▪ James W. Truess ▪ Linda K. Whitley-Taylor ▪ Richard C. Zoretic ▪ Scott W. Anglin ▪ Margaret M. Roomsburg ▪ Jeffrey L. Stredler ▪ Jack L. Young ▪ Karen L. Shields
Location of company headquarters:	4425 Corporation Lane Virginia Beach, VA 23462
Location(s) of the company offices: Location(s) of the office that will provide the services described in this RFP:	**West Region Service Center** 5959 Corporate Dr., Ste. 3500 Houston, TX 77098 **Tampa Claims** 4200 W. Cypress St., Ste. 900 Tampa, FL 33607 **National Support Centers** 1300 and 1330 Amerigroup Way Virginia Beach, VA 23464 **Virginia Beach Home Offices** 4425 and 4433 Corporation Lane Virginia Beach, VA 23462
Number of employees locally with the expertise to support the requirements identified in this RFP:	0
Number of employees nationally with the expertise to support the requirements in this RFP:	76.75
Location(s) from which employees will be assigned for this project:	7251 W. Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128

5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.
Amerigroup Corporation is registered with the Nevada Secretary of State's Office as a foreign corporation in the State of Nevada under the fictitious name of AGP Corporation. Its business identification number is NV20061492147.
5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us. Is "Legal Entity Name" the same name as vendor is doing business as? If "No", provide explanation.
Nevada license: NV20061492147 Amerigroup Corporation, the legal entity name, is not the same as the DBA name of corporation.
5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.
AMERIGROUP Nevada, Inc. holds a Certificate of Authority to operate as an HMO in the mandatory managed care counties issued by the Department of Insurance. The license was issued on March 30, 2006, and has been maintained continuously since its date of issue. Additionally, based on our proposed corporate structure, AMERIGROUP Corporation also holds two licenses issued by the Nevada Division of Insurance in accordance with Nevada statutes and regulations governing utilization review and claims payment activities: ▪ Utilization Review Agent license issued February 8, 2006, and maintained continuously since its date of issue ▪ Third Party Administrator license issued June 2, 2009, and maintained continuously since its date of issue
5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency? If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified. A. Name of State Agency? B. State Agency Contact name? Date when services were performed? C. Type of Duties Performed? D. Total Dollar Value of the contract?
Yes. Amerigroup Corporation is currently providing the same services under Amerigroup Nevada's current contract with DHCFP. Amerigroup Nevada holds the contract with DHCFP. A. Nevada Department of Health and Human Services, Division of Health Care Financing and Policy B. John Whaley, Chief of Business Lines; February 1, 2009 - present

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

C. RFP/Contract #1509: Provide risk-based capitated HMO services in support of the Title XIX (Medicaid) and Title XXI State Child Health Insurance Program (SCHIP) medical assistance programs

D. $761,765,047.54

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

No

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

No, none of the above applies.

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverage as specified in Attachment E, Insurance Schedule for RFP 1988.

Yes. Amerigroup Nevada acknowledges the requirement to provide the Certificates of Insurance upon contract award.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Amerigroup Corporation (the parent company) and its affiliates (collectively Amerigroup) have more

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

than 16 years of experience providing managed care services to Medicaid, CHIP, the uninsured, and Medicare populations, including managing large-state Medicaid contracts and serves approximately 2.7 million members through health plans in 13 states with the 14th going live in the first quarter of 2013.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

Amerigroup Corporation, Amerigroup Nevada's parent company, is an organization that focuses on meeting the healthcare needs of low-income and medically vulnerable Americans in the Medicaid and Medicare programs. Amerigroup Corporation owns 100 percent of the issued and outstanding shares of common stock of Amerigroup Nevada. As of production of this proposal, Amerigroup is aware that four entities own beneficially five percent or more of the outstanding shares of Amerigroup Corporation common stock. These entities are FMR, LLC; Artisan Partners Limited Partnership; Capital World Investors; Vanguard Group, and Institutional Investment Advisors.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

Amerigroup Corporation is headquartered in Virginia Beach, Virginia and has an affiliate in Nevada that is a resident of Nevada and was incorporated as a Nevada-domiciled company on August 11, 2005. Amerigroup does not apply preference.

D. The location of disaster recovery back-up site.

The DR Collocation Site,

AT&T Internet Data Center C/O Site 18396

11830 Webb Chapel Rd.

Dallas, TX 75234.

There is a direct connection between the production data center in Virginia Beach, VA, and the Dallas, TX, hot site, which allows immediate backup Internet access for the entire enterprise if needed.

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Eric Lloyd

Chief Executive Officer, Amerigroup Nevada, Inc.

7251 W. Lake Mead Blvd., Ste. 104

Las Vegas NV 89128

(702) 228-1308

F. The size of organization in assets, revenue and people.

Assets: $2.9 billion in assets

Revenue: $6.4 billion in revenue

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

People: 6,600 employees

G. The organizational chart of your senior management by function including key personnel.

See the Amerigroup Corporate organizational chart in Amerigroup Corporation Attachments Tab.

H. The areas of specialization.

Amerigroup specializes in Medicaid managed care and serves more than 2.7 million members through a variety of public programs, including Medicaid, Temporary Assistance for Needy Families (TANF—with more than 1.4 million mothers and babies), CHIP, uninsured adults, and people with disabilities/ Supplemental Security Income (SPD/SSI), as well as Medicare.

I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.

2010 Revenue	**2011 Revenue**
TANF: $3,410,558,785	**TANF:** $3,568,451,571
CHIP: $358,176,435	**CHIP:** $365,785,402
ABD/SSI: $1,030,720,599	**ABD/SSI:** $1,241,884,613
Long-Term Care: $752,823,394	**Long-Term Care:** $853,961,413
Medicare Revenue: $231,178,499	**Medicare Revenue:** $271,341,712

J. The corporate philosophy and mission statement.

Corporate philosophy: We will be a different kind of health insurance company—a company that does well by doing good. Mission: To provide Real Solutions® for members who need a little help by making the healthcare system work better while keeping it more affordable for taxpayers.

K. A description of any plans for future growth and development of your organization.

Amerigroup Corporation is ready to continue partnering with states as they add new populations, services, and geographies. We anticipate future growth and development to support an influx of members through expansions and opportunities offered by the Accountable Care Act (ACA). Areas we will focus on include:

- Medicaid Expansion: Leverage our depth of experience around providing cost-effective integrated benefits, services, care management, and transition plans
- Health insurance exchange: Expand the framework we have developed so far to meet future individual needs and state challenges and integrating member transition processes
- Health homes: Support ACA guidelines to provide health homes to Medicaid members with chronic illnesses to achieve more accessible, cost-effective, high-quality primary care, and further support primary care practices in their effort to improve patient outcomes
- Health information exchange: Deepen the links and training among the health information exchange, electronic health records, and the methods for provider collaboration
- Other populations: Anticipate the changing needs for future populations such as the ABD and children/adolescents in the juvenile justice system or foster care programs. We now serve more

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
than 317,000 ABD/dual-eligible individuals and will continue to expand current benefits/services/transition plans to include these populations.
L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?
Amerigroup Corporation has expanded products, including long-term care and the uninsured; services, ranging from physician/hospital and 24-hour institutional care to personal care services offered in the community; and geographic locations. Our methodology is to leverage our experience, fully engage our local leadership/administrative infrastructure, and build on strong relationships with state officials and established provider networks. A natural extension of effort is the major opportunity to serve the dual eligible population—managed care is part of the organic solution for this high-cost population. Our implementation approach is an expertly managed process. From a highly trained, professional group of subject matter experts who are pulled from key functional areas to our Implementation Project Team, we adhere to a formal project management lifecycle.
5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.
Amerigroup Corporation has provided similar services as a subcontractor serving to other Amerigroup health plans serving the public sector since 1996.
5.1.10.1 Experience A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:
1. Managing a network of Medicaid Providers;
Not Applicable. Amerigroup health plans directly develop and manage networks of Medicaid providers. Amerigroup Corporation provides strategic support to our affiliate health plans when appropriate, such as providing resources necessary to facilitate rapid network development in new markets, establishing and testing of innovative provider payment methodologies, and creating best practices related to Real Solutions® Medical Homes and ACA-compliant health homes.
2. Managed care programs for Medicaid recipients;
Since 1996, Amerigroup Corporation has provided administration and technology support to 13 health plans that manage Medicaid programs today and one additional plan that will be operational on January 1, 2013. Amerigroup Corporation does not manage these programs directly, but provides support in conformance with local health plan policies and procedures.
3. Administering Medicaid utilization and case management programs;
Amerigroup Corporation has 16 years of experience providing administration and technology support to 13 health plans that administer Medicaid utilization and case management programs. An additional plan will become operational on January 1, 2013. Amerigroup Corporation does not manage utilization

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

and management programs directly.

Under the direction of each local health plan and in accordance with local policies and procedures, Amerigroup Corporation provides cost-effective services related to utilization management (UM), (physical and behavioral health) through our National Customer Care (NCC) Center which coordinates UM activities with each health plan, disease management (DM) through designated state-specific care management teams at our Integrated Disease Management Center, and pharmacy management through an in-house clinical leadership team. In addition, our corporate Health Care Management Services team, led by an experienced team of national Medical Directors for both physical and behavioral health, provides strategic support with respect to:

- Implementing healthcare management programs in new markets
- Identifying national trends and best practices which are shared with all affiliate health plans (such as our Taking Care of Baby and Me® program)
- Monitoring provider reimbursement trends
- Monitoring clinical operations (such as promoting consistent use of UM guidelines and criteria)
- Developing health promotion materials

4. Medicaid claims processing and adjudication

Amerigroup Corporation has 16 of years of experience processing Medicaid claims, including almost four years in Nevada. In the 12-month period ending September 30, 2012, we processed more than 803,000 Nevada claims. Our average claims turnaround time was 4.7 calendar days. In Nevada, an average of 99.6 percent of claims was paid within 30 calendar days, with September, 2012 financial and payment rates of 99.94 percent and 99.21 percent, respectively. We have effective technology and experienced employees in place to ensure prompt and accurate claims payment. Our employees and systems are also capable of administering any type of provider payment arrangement (for example, prospective payment, case rate, and per diem).

5. Project management; and

Amerigroup Corporation brings discipline and rigor to project management across the organization. We rely on leaders and employees with the training and skills required to achieve our goals and objectives efficiently.

- Implementation. Amerigroup Corporation has never missed a contract implementation and has completed 92 program implementation and expansion projects since 1996. Across the organization, we maintain teams of project management professionals who use proven methodologies, such as the Project Management Institute and Agile.
- Business Process Improvement. Amerigroup integrates Six Sigma and Lean Six Sigma methodologies into all parts of the organization because we value the disciplined approach and focus on measurable improvements inherent in the process.
- Quality Management Performance Improvement Process. Amerigroup Corporation adopts nationally-recognized processes to support quality gains, including methodologies that align with NCQA standards.

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

6. Qualifications of key personnel.

Not applicable. All Key Personnel identified for the Contract are Amerigroup Nevada employees.

B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.

Amerigroup Corporation provides administrative and technological support to health plans in Georgia, Maryland, and Tennessee who currently operate under performance incentive programs that reward the health plan for achieving targeted health outcomes. These incentive programs are for full-risk managed care programs for Medicaid and CHIP populations similar to Nevada. When a performance incentive is tied to a targeted health outcome, measures are consistent with HEDIS® or other measures that are evidence-based and carefully tested.

C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

Amerigroup Corporation supports its 13 health plans to identify, test, and measure the impact of potential program innovations and best practices. Each individual health plan then adopts and adapts those that may be applicable based on their specific market needs. This includes:

- Mobile identification cards
- Innovative training and certification programs for Case Managers
- Technology enhancements to improve customer services delivered to members and providers
- Online appointment scheduling of preventive and primary care services
- Maternal and child health programs such as Taking Care of Baby and Me and You and Your Baby in the NICU (neonatal intensive care unit)
- Innovative outreach tools such as interactive voice response (IVR) and texting for members with high-risk pregnancies and text reminders for parents about preventive health and screening services
- Personal health cards that store member health records
- Amerigroup on Call, an innovative approach to reducing unnecessary emergency department (ED) visits
- Predictive models to identify and prioritize outreach for those members with the greatest risk levels

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

Amerigroup Corporation and our health plans have more than 16 years of experience working with state governments across the country. In addition to our deep and lasting relations in the states where we have operational health plans, Amerigroup is a thought leader in a variety of policy forums and works to continue to develop innovative solutions to state governments' most vexing health care issues. Our subsidiary health plans serve 2.7 million members in 13 states (with our 14th health plan becoming operational on January 1, 2013).

This experience also has led to the development of best practices on working with state agencies that

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

assist our members outside the MCO, such as agencies responsible for Medicaid and CHIP enrollment and eligibility, food stamps, supplemental assistance for pregnant women, and energy assistance.

E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

Nancy Kaplan, Manager of Regulatory Services, is a valuable member of the Nevada health plan. Ms. Kaplan is involved with several functional areas resulting from the Contract, including state contracts, reporting resources, regulatory tasks, collateral material, and performance standards. Under the Contract, Ms. Kaplan:

- Researches and provides guidance to the Nevada health plan and corporate departments regarding compliance with the requirements of the Nevada managed care contract, as well as state and federal statutes and regulations
- Serves as representative for the Nevada health plan and the corporate departments with state regulatory agencies
- Assesses proposed and final legislation with potential impacts on business activity and operations

Robin Favret, Associate VP of Information Technology Services Customer Account Management, has more than 28 years of healthcare experience and 14 years with Medicaid and CHIP programs. With her extensive experience, Ms. Favret's expertise supports Amerigroup Nevada's Data Coding functional area. Under the Contract, Robin:

- Leverages industry, corporate, and health plan knowledge to partner with the state in developing solutions to operational or system issues
- Ensures the communication of key service and performance measures to the health plan and its customers

Stephen Ford, Associate VP, Senior Counsel, supports the health plan by providing legal expertise. In this role, Mr. Ford:

- Serves as counsel for the Nevada plan
- Handles intake and resolution of legal issues related to regulatory compliance, provider network development and maintenance, provider disputes, agency disputes, product development and plan extension, and risk management
- Participates with merger and acquisition activity and new market development
- Participates with negotiations and process improvement
- Manages paralegal and administrative employees

Stephen Williams, VP of West Regional Services Center Operations, has been with Amerigroup for almost six years. Under the Contract, Mr. Williams leads operations for the Regional Service Center, which is responsible for customer services and claims processing

Richard Marucut, Director of Service Operations, is a leader in the West Regional Service Center. As director, he helps manage the claims team responsible for supporting Amerigroup Nevada. Under the

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

Contract, Mr. Marucut:

- Monitors claims quality reporting and ensure fulfillment of all State requirements
- Analyzes reports to identify areas of concern, trends, and issues across entities that impede customer service
- Collaborates with internal partners to develop process improvement initiatives to reduce defects, improve overall operating efficiencies, and maximize dollar recovery through cost containment
- Ensures appropriate scheduling of employees to manage claims volume
- Works with the Nevada health plan to resolve operational issues including enrollment, benefit configuration, call metrics, authorizations, high dollar claims, pending claims, appeals, adjustments, customer service, and policy issues

Denise Ward, Claims Manager, directly manages claims for the Nevada market. With more than 21 years of experience in healthcare, Ms. Ward has the expertise necessary to manage an efficient claims team. Under the Contract, Ms. Ward:

- Manages the Nevada claims inventory
- Provides updated claims training as required
- Ensures that all market performance guarantees are met
- Partners with cross-functional areas to ensure timely resolution of all claim errors
- Processes high dollar, complex, and adjustment claims

Shaun Wayne, Information Technology Service Field Service Technician III, supports Amerigroup Nevada's information systems. Mr. Wayne has almost 10 years of experience with Amerigroup and more than 15 years of experience working with Information Technology Services (ITS). Under the Contract, Mr. Wayne:

- Provides technical support and direction for Amerigroup Nevada staff members
- Contributes advanced, top-level technical knowledge and experience in the areas of software and hardware testing, change control, configuration management, test plan development, and systems documentation
- Provides information to internal and external customers and vendors
- Provides and implements innovative ideas and solutions for complex problems
- Ensures system security is maintained and strengthened through implementation of current technologies

F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:

1. Information Systems
2. Utilization/Case Management
3. Claims Payment
4.Quality Improvement and Reporting (i.e. HEDIS, CMS)

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
5. Health education 6. Data / coding 7. Contract negotiations, Network recruiters 8. Encounter data 9. Other staff as needed
1. Information Systems: Shaun Wayne, ITS Field Service Tech III 2. Not applicable 3. Claims Payment: Stephen Williams, VP West Regional Service Center; Richard Marucut – Director Service Operations; Denise Ward, Manager Claims 4. Not applicable 5. Not applicable 6. Data Coding: Robin Favret, AVP, ITS Customer Account Management 7. Contract Negotiations/Network Recruiters: Stephen Ford, AVP, Senior Counsel 8. Encounter Data: Robin Favret, AVP ITS Customer Account Management 9. Other: Nancy Kaplan, Manager Regulatory Services
G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.
Copies of relevant Amerigroup Corporation licenses are included in the Amerigroup Corporation Attachments Tab of this binder.
H. List any bilingual staff, the area to which they are assigned and the languages spoken.
Amerigroup's NCC is well equipped to handle large volumes of calls from members who do not speak English as a first language. The NCC currently has 135 employees that are fluent in both English and Spanish. In 2012, NCC associates have directly handled more than 326,000 calls for our Spanish-speaking members.
I. List any associations or organizations to which the organization belongs.
Among the associations and organizations to which Amerigroup Corporation belongs includes the American Health Insurance Plans, Medicaid Health Plans of America, and the SNP Alliance.
5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included. **5.1.11.1** Medical Services A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

Amerigroup Corporation
Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
Amerigroup Nevada remains fully responsible for delivery of services under the Contract.
B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.
Amerigroup Corporation operates in accordance with the Policies and Procedures of Amerigroup Nevada when providing these services.
C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.
Not applicable. Amerigroup Nevada, through our Medical Advisory Committee (MAC), monitors and evaluates UM guidelines and procedures. Amerigroup Corporation's Medical Policy Committee supports the MAC by providing annual review of all guidelines.
D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.
Not applicable. Amerigroup Nevada is fully responsible for identifying, arranging, and monitoring all out-of-network services that our members need.
E. Describe the roll and responsibilities of your case managers.
Amerigroup Nevada is fully responsible for delivery of case management services for our members. In accordance with Amerigroup Nevada policies and procedures, Amerigroup Corporation Disease Management (DM) Case Managers coordinate care and services for members enrolled in a DM program. They work with members, PCPs and other treating providers, families, and other stakeholders to identify, implement, and monitor a member-directed care treatment plan that addresses each individual's physical, behavioral, social support, and functional needs. These plans follow evidenced-based clinical practices guidelines, and DM Case Managers actively engage members to adopt self-care strategies. DM Case managers educate and coach members to take greater responsibility for their personal health status and empower them to adopt improved self-care skills—boosting access to primary and preventive care, enhancing health outcomes, and reducing preventable ED visits or inpatient admissions.
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Not applicable. Amerigroup Nevada is fully responsible for coordination and communication with DHCFP District Office care coordination staff on behalf of high-risk pregnant women.
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Not applicable. Amerigroup Nevada is fully responsible for assessing and developing comprehensive care treatment plans for Children with Special Health Care Needs.
H. Describe the network you have in place to provide mental health and rehabilitative services to

Amerigroup Corporation
Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Not applicable. Amerigroup Nevada is fully responsible for developing and maintaining a comprehensive network to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
I. Provide your policies and procedures for emergency and post stabilization services.
Not applicable. Amerigroup Nevada is fully responsible for developing and managing policies and procedures for emergency and post-stabilization services
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable. Amerigroup Nevada is fully responsible for developing and managing policies and procedures for transitioning a recipient from or to fee-for-service (FFS) or another Vendor's plan.
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable. Amerigroup Nevada is fully responsible for developing and managing the member handbook and identification cards issued to enrolled members.
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Amerigroup Corporation operates in accordance with the Policies and Procedures of Amerigroup Nevada when providing these services.
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
Not applicable. Amerigroup Nevada is fully responsible for developing and maintaining a network that ensures the ability to provide managed care services to enrolled members in Clark and Washoe Counties.
B. Provide a sample of all base network provider contracts.
Not applicable, as Amerigroup Corporation is not subcontracted for these services.
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
Not applicable, as Amerigroup Corporation is not subcontracted for these services.
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?

Amerigroup Corporation
Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
Not applicable, as Amerigroup Corporation is not subcontracted for these services.
E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.
Not applicable. Amerigroup Nevada is fully responsible for monitoring its contracted network provider's activities to ensure they comply with requirements.
F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.
Not applicable. Amerigroup Nevada is fully responsible for determining and managing physician incentive plans.
G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.
Not applicable. Amerigroup Nevada is fully responsible for maintaining subcontracts for any of the benefits services.
H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?
Not applicable. Amerigroup Nevada is fully responsible for the proper use of National Provider Identifiers (NPI).
5.1.11.5 Quality Assurance A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.
Amerigroup Nevada develops the Quality Assurance Plan (QAP) in accordance with the State of Nevada and DHCFP requirements. Amerigroup Corporation provides certain elements that support the QAP , including: ▪ Development and review of clinical practice guidelines and the delivery of disease management services ▪ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) transfer of claims files and reminder cards to member/providers ▪ HEDIS data management and audits ▪ Support databases
B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

Amerigroup Nevada is accountable for the development of the Quality Assessment and Performance Improvement Strategy and Work Plan. Amerigroup Corporation provides quality management oversight and expertise to ensure that the health plan is following the plan and assessing the quality of care delivered to enrolled members effectively.

C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

Amerigroup Corporation delivers the technological infrastructure and administrative support for the collection and reporting of race, ethnicity and language. Amerigroup Corporation supports current DHCFP data collection and reporting requirements for the HEDIS Measure of Diversity of Medicaid Membership. We support Amerigroup Nevada's efforts to capture race, ethnicity, and language information during member interactions and use updated information in reporting.

Amerigroup Corporation has a project underway expanding our ability to collect data in accordance with new and proposed provisions of the Patient Protection and Affordable Care Act.

5.1.11.6 Fiscal Requirements

A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?

Amerigroup Corporation has more than 16 years of experience processing Medicaid claims and has been processing Nevada claims since 2009. Amerigroup Corporation is committed to processing claims in accordance with state and federal statutes and regulations. Amerigroup Corporation accepts paper and electronic claims. We accept electronic claims through three different methods. Claim formats are industry-standard and HIPAA-compliant. We capture and adjudicate claims with minimal manual intervention to deliver faster, more accurate claims turnaround and provider payment. The claims adjudication process is highly automated to deliver fast and consistent claims processing and payment. Amerigroup Corporation executes claims adjudication processes every night, seven days a week, so claims are processed soon after receipt. Automated routines apply a series of standard and state-specific edits, and we edit claim data using industry-recognized products such as code review and code-bundling software. Comprehensive policies and procedures govern our claims process. Policies and procedures cover a wide variety of claims topics for both corporate-wide and state-specific guidelines, including claims submission (paper and electronic), timely filing standards, prompt payment requirements, and claim interest payments. We validate compliance with policies and procedures through a number of methods, including management oversight, management audits, and internal audits.

B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?

Amerigroup Corporation processed more than 803,000 claims for Amerigroup Nevada in the 12 months

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

ending September 30, 2012. Amerigroup Corporation executes nightly claims adjudication cycles and twice a week we run claims payment cycles. On average, we pay Nevada claims in 4.7 days. For non-clean claims, providers receive notification within 4.6 days, on average, using the input submission method of the claim. Additional claims payment performance statistics for Nevada claims for the 12-month period ending September 30, 2012 include:

- 99.66% of claims paid within 30 calendar days, compared to DHCFP standard of 90%
- 99.94% of claims paid within 90 calendar days, compared to DHCFP standard of 99%
- Claims pend rate of 19.3%
- Claims denial rate of 14.9%
- Claims resubmission rate of 1.6%

1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.

Amerigroup Corporation continually monitors claims processing performance and compliance. Daily, weekly, monthly, and ad hoc reports allow management to gauge processing performance, identify problem areas, and monitor quality.

The Amerigroup Corporation Attachments Tab provides a set of unedited month-end management reports from our claims processing system. Reports are from Amerigroup Nevada Medicaid and Nevada Check Up Contract for the month of September, 2012.

C. Describe your plan to identify and report suspected provider and recipient fraud.

Amerigroup Corporation maintains a comprehensive and rigorous plan to protect against fraud, waste, and abuse across the corporation and our 13 health plans. The Corporate Investigation Department (CID) implements the Amerigroup Nevada Fraud, Waste, and Abuse Plan that complies with DHCFP requirements and drives efforts to prevent, identify, investigate, and report suspected provider and member fraud and abuse. The Amerigroup Nevada plan addresses all program components, including:

- Staffing and responsibilities: Corporate and health plan departments and employees and their associated responsibilities
- Employee education: Policies and procedures for employee training; how employees can help identify and prevent fraud, waste, and abuse; the federal False Claims Act; and laws governing the rights of employees to be protected as whistleblowers
- Identification methods and indicators: Methods to identify suspected provider or member fraud, waste, or abuse, including referrals and system-based detection methods and controls
- Investigation process: The stages of the investigative process, including the key questions during each stage
- Reporting: Procedures for reporting instances of suspected provider or member fraud or abuse in accordance with DHCFP reporting requirements

D. Describe and submit your policies and procedures for determining and collecting patient liability.

Amerigroup Corporation operates in accordance with the policies and procedures of Amerigroup

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

Nevada when providing these services.

5.1.11.7 Grievances, Appeals and Fair Hearings

A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

Amerigroup Corporation provides administration to support the management of grievances and appeals in accordance with the Nevada Requirements.

B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

Not applicable. Amerigroup Nevada is fully responsible for establishing performance standards for the frequency of enrolled member grievances and appeals and provider disputes.

5.1.11.8 Operational Requirements

Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.

An organizational chart is included in the Amerigroup Corporation Attachments Tab. Amerigroup Corporation provides specialized, centrally delivered services that complement local employees in strategically determined functional areas to create both better value and results for our members. The group consists of Amerigroup experts designated to the Nevada health plan. Some of the key functions that will be provided by Amerigroup Corporation include:

- Member and Provider Call Center
- Implementation (for new programs)
- National care management, disease management, and quality programs
- Claims administration
- Information technology systems and services
- Healthcare economics
- Member and provider communications
- Actuarial services
- Legal advisory and oversight
- Corporate compliance advisory and oversight
- Regulatory advisory and oversight
- National and state government affairs advisory

5.1.11.9 Implementation

A. If you currently do not have an established network, what time frame and approach will you use to

Amerigroup Corporation
Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
build a network?
Not applicable. Amerigroup Nevada currently has an established network and is fully responsible for maintaining it.
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Please see Attachment 5.1.11.9-1 for Amerigroup Nevada's Gantt Chart detailing the implementation process. Amerigroup Corporation is not providing a separate Gantt Chart.
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
Amerigroup Corporation has reviewed all reporting requirements listed throughout the RFP and in Attachment I, Forms and Reporting Guide. We confirm our ability and commitment to meeting reporting requirements. Amerigroup Corporation is experienced in meeting the reporting needs of 13 health plans. Amerigroup Corporation is currently generating reports that meet all DHCFP reporting requirements under Amerigroup Nevada's Medicaid and Nevada Check Up Contract. Amerigroup Nevada reviews reports for completeness and accuracy prior to on-time delivery to DHCFP.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
Amerigroup Corporation has reviewed all interface requirements listed throughout the RFP and in the Vendor's library. We confirm our ability and commitment to provide compatible interfaces with existing information systems of DHCFP or its agents. Amerigroup Corporation is currently meeting all DHCFP interface requirements. Based on our currently operational interfaces and the technical infrastructure of our systems, we are confident in our ability to provide compatible interfaces to proposed and future information systems. Our Management Information System (MIS) follows the managed Medicaid model and currently supports more than 2.7 million members in 13 states, including more than 85,000 Nevada members. We support our MIS with a dedicated internal Technology Services Department of more than 450 technology employees. Secure ongoing data interfaces are a strength and core competency of Amerigroup Corporation. We have more than 16 years of experience in exchanging data with our ancillary vendors and states and their agents, including enrollment brokers, fiscal agents, and intermediaries; external quality review organizations; recovery audit contractors; and others. We are 5010 compliant and currently support interfaces in the HIPAA standard X12 and National Council for Prescription Drug Programs (NCPDP) formats as well as HL7 and many state-specific formats.
5.1.11.12 HIPAA Compliance

Amerigroup Corporation

Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)

A. Describe your status, resources, and approach to HIPAA compliance.

Amerigroup Corporation is fully compliant with the privacy and security requirements of HIPAA. Amerigroup Corporation is also fully compliant with the requirements of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. Amerigroup Corporation's approach to HIPAA compliance covers three areas:

- Electronic Transactions and Code Sets. We are compliant with 5010 and NCPDP D.0 transactions. We also have corporate projects underway for ICD-10 compliance and compliance with the new federal operating rules.
- Privacy. We have invested in protecting member confidentiality and disclosure of mental health records, medical records, and other member Protected Health Information (PHI) in accordance with federal and State requirements. We train and educate all employees on HIPAA requirements; HIPAA requirements are also covered in our provider training and documentation.
- Security. We are committed to physical security within our facilities and data and network security within our management information system.

Amerigroup Corporation dedicates full-time resources to support our HIPAA compliance. Our Member Privacy Unit manages the corporate HIPAA Privacy Program under the direction of our Chief Privacy Officer. In addition, we maintain an Information Technology Security Department to manage our HIPAA Security program.

B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.

Amerigroup Corporation has been processing HIPAA-compliant provider claims in Nevada since 2009. Across our 13 health plans we process more than 2.3 million HIPAA-compliant claims each month. We accept claims on paper and electronically. Paper claims formats are industry standard and converted into a HIPAA-compliant X12 837 file by our data entry vendor. We accept electronic claims through:

- Three nationally recognized electronic data interchange (EDI) clearinghouses
- Submission of an X12 837 claims file from our provider website
- Direct entry of a claim from our provider website

All claims, regardless of entry source, pass through the same edits and adjudication processes to ensure consistency and HIPAA compliance. Amerigroup Corporation submits HIPAA-compliant version 5010 X12N 837 encounter files in 11 of our 13 state markets, as well as HIPAA-compliant NCPDP D.0 encounter files in eight markets. Annually, Amerigroup Corporation health plans submit more than 47 million HIPAA-compliant encounters to state partners. Amerigroup Corporation has experience with the direction that DHCFP is taking with its data warehouse approach to encounters and are providing whatever assistance we can to help the DHCFP meet its goals for encounter file submission.

5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial.

5.1.12.1 Dun and Bradstreet Number

AMERIGROUP Corporation's Dun and Bradstreet number is 87-851-7747.

Amerigroup Corporation
Administrative services covered under administrative services agreement (claims, credentialing, regulatory services, legal)
5.1.12.2 Federal Tax Identification Number
AMERIGROUP Corporation's Federal Tax Identification Number is 54-1739323.
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement
We have included this information in the Amerigroup Corporation Attachments Tab.

5.3 REFERENCES

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Amerigroup Corporation, directly to the Purchasing Division.

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Amerigroup Nevada, Inc. and Amerigroup Corporation directly to the Purchasing Division.

Table 5.3-1. Texas Health and Human Services Commission

Reference #:	1		
Company Name:	Amerigroup Corporation		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	HHSC Managed Care Contract		
Primary Contact Information			
Name:	Lisa Neal Manager, Health Plan Management Texas Health and Human Services Commission		
Street Address:	11209 Metric Boulevard, Building H		
City, State, Zip	Austin, TX 78758		
Phone, including area code:	(512) 491-1313		
Facsimile, including area code:	--		
Email address:	Lisa.Neal@hhsc.state.tx.us		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Providing comprehensive Medicaid managed care services for families, children, seniors, and individuals with disabilities for more than 600,000 members in 230 counties.		
Original Project/Contract Start Date:	9/1/2011		
Original Project/Contract End Date:	8/31/2015		
Original Project/Contract Value:	$1,550,685,776		
Final Project/Contract Date:	N/A – contract currently effective		
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective		

Table 5.3-2. Tennessee Department of Finance and Administration, Bureau of TennCare

Reference #:	2		
Company Name:	Amerigroup Corporation		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	TennCare		
Primary Contact Information			
Name:	Darin J. Gordon Executive Director Tennessee Department of Finance and Administration Bureau of TennCare		
Street Address:	310 Great Circle Road		
City, State, Zip	Nashville, TN 37243		
Phone, including area code:	(615) 507-6443		
Facsimile, including area code:	(615) 741-0882		
Email address:	darin.j.gordon@tn.gov		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Participating at-risk managed care organization in the State's Medicaid managed care program. Responsible for care coordination activities and the provision of Medicaid covered services, including long term care and support services, through a contracted network of providers in the Middle Grand Region of the state. Total membership is currently 205,000 members in 39 counties in the middle Tennessee region.		
Original Project/Contract Start Date:	4/1/07		
Original Project/Contract End Date:	12/31/14		
Original Project/Contract Value:	$896,910,240		
Final Project/Contract Date:	N/A – contract currently effective		
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective		

Table 5.3-3. Georgia Department of Community Health

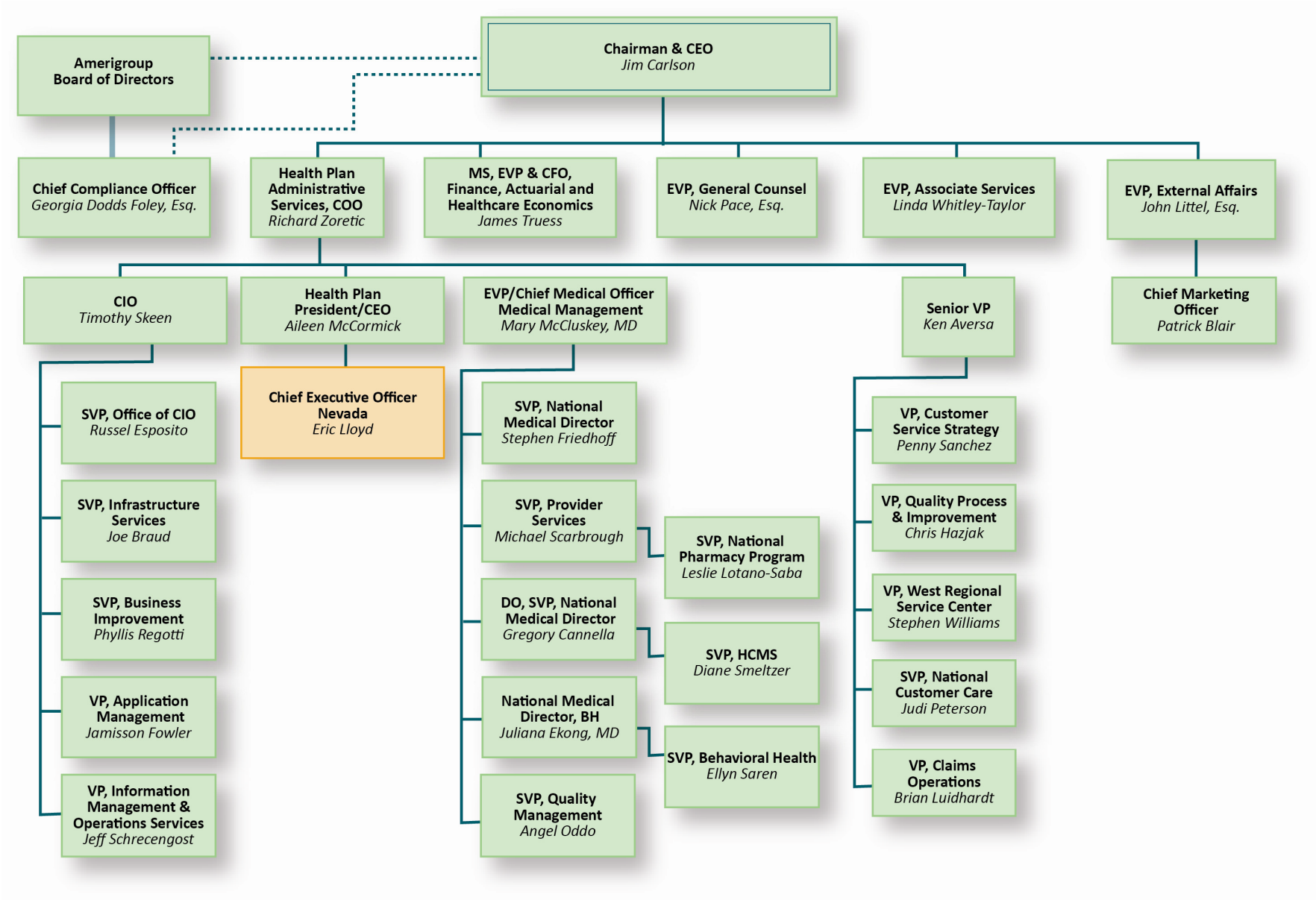
Reference #:	3		
Company Name:	Amerigroup Corporation		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Georgia Families and PeachCare for Kids		
Primary Contact Information			
Name:	Jerry Dubberly Chief, Medicaid Division Georgia Department of Community Health		
Street Address:	2 Peachtree Street, NW 40th Floor		
City, State, Zip	Atlanta, Georgia 30303		
Phone, including area code:	(404) 651.8681		
Facsimile, including area code:	(866) 283-0128		
Email address:	jdubberly@dch.ga.gov		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Participating at-risk managed care organization in the State's Medicaid and CHIP (PeachCare for Kids) managed care program (Georgia Families). Responsible for care coordination activities and the provision of Medicaid and CHIP covered services through a contracted network of providers in multiple service areas across the state. Includes care coordination activities and family planning services for the Planning for Healthy Babies (P4HB) 1115 Demonstration program. We currently serve 290,000 Georgians in across all counties.		
Original Project/Contract Start Date:	6/1/06		
Original Project/Contract End Date:	6/30/13		
Original Project/Contract Value:	$729,289,205		
Final Project/Contract Date:	N/A – contract currently effective		
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective		

Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective

Table 5.3-4. Florida Healthy Kids Corporation

Reference #:	4		
Company Name:	Amerigroup Corporation		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Florida Healthy Kids		
Primary Contact Information			
Name:	Rich Robletto Florida Healthy Kids Corporation		
Street Address:	661 East Jefferson Street, 2nd Floor		
City, State, Zip	Tallahassee, FL 32301		
Phone, including area code:	(850) 701-6111		
Facsimile, including area code:	(866) 867-0054		
Email address:	robletor@healthykids.org		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment if applicable:	Participating at-risk managed care organization in the Florida Healthy Kids (CHIP) program. Responsible for care coordination activities and the provision of CHIP covered services through a contracted network of providers in multiple service areas across the state.		
Original Project/Contract Start Date:	1/1/03		
Original Project/Contract End Date:	9/30/13		
Original Project/Contract Value:	$92,665,468		
Final Project/Contract Date:	N/A – contract currently effective		
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective		

Amerigroup Corporation Organizational Chart



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AMERIGROUP CORPORATION PROPOSED STAFF RESUMES

Nancy Kaplan

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Amerigroup Corporation		
☐ **Contractor**		**X Subcontractor**	
Name:	Nancy A. Kaplan	☐ **Key Personnel**	
Classification:	Regulatory Market Manager	**# of Years in Classification:**	2
Brief Summary: of Experience:	Regulatory market manager at Amerigroup Corporation providing research and guidance to Amerigroup Nevada, Inc. on contractual requirements, the Nevada Medicaid Services Manual, and state and federal statutes and regulations.		
# of Years with Firm:	2		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information:			
MMYYYY to Present:	02.2010 – Present		
Vendor Name:	Amerigroup Corporation		
Client Name:	4425 Corporation Lane		
Client Contact Name:	Virginia Beach, VA 23462		
Client Address, Phone Number, Email:	P. 757.473.2737 ext. 33460 Nancy.Kaplan@amerigroup.com		
Role in Contract/Project:	*Manager, Regulatory Services*		
Details and Duration of Contract/Project:	• Research and provide guidance to the Nevada health plan and corporate departments regarding compliance with the requirements of the Nevada managed care contract, the Nevada Medicaid Services Manuals, as well as state and federal statutes and regulations. • Serve as the representative for the Nevada health plan and the corporate departments with state regulatory agencies • Negotiate with Nevada state agency regarding amendments to the Amerigroup managed care contract and draft proposed contractual language upon request. • Revise Nevada non-provider subcontractor addendum to be used to supplement corporate vendor contracts. • Assess proposed and final legislation with potential impacts on business activity and operations, discuss such legislation with the government relations team, and alert the health plan and corporate departments about legislative impacts. • Meet with health plan leadership on a regular basis to discuss areas of concern and to problem solve. • Review all marketing materials, member and provider correspondence		

	materials, and outreach materials for compliance with the Nevada managed care contract and applicable statutes and regulations. • Review new federal and state statutes and regulations. • Review and revise health plan and corporate policies and procedures and draft health plan policies as necessary, including a policy on never events/provider preventable conditions. • Review and revise marketing materials to ensure contractual, statutory and regulatory compliance • Respond to material requests and questions for audits; facilitate interactions with auditors. • Lead interdisciplinary team to raise Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health scores.
Required Information:	
MMYYYY to MMYYYY:	07.2009 – 10.2009
Vendor Name:	Troutman Sanders LLP through Lawyer's Staffing, Inc.
Client Name:	6800 Paragon Place #115
Client Contact Name:	Richmond, VA 23230
Client Address, Phone Number, Email:	P: 804-282-1289
Role in Contract/Project:	*Contract Attorney*
Details and Duration of Contract/Project:	• Worked with team of healthcare attorneys to prepare materials for a CDC Essential Services Grant for the allocation of scarce medical resources during a large scale pandemic or other disaster. • Drafted ethics chapter of an implementation guide to be used in conjunction with a pandemic planning guide. • Prepared materials for a statewide hospital ethics meeting and for a statewide home health care and hospice conference call for pandemic preparedness and planning, and prepared manuals and workbench materials for a medical tabletop exercise to test the effectiveness of pandemic planning. • Researched and prepared a presentation on the 2009 changes to the Stark law including the modified definition of DHS entity, the change in the per-click and percentage based compensation rules, and the impact of the Fraud Enforcement and Recovery Act on the False Claims Act; researched the anti-markup rule, billing reassignment rules, and Stark exceptions to advise a client on a business arrangement; and researched HIPAA and state health records privacy acts to advise a client on an employee records issue. • Advised a client regarding pandemic planning issues under the Americans with Disabilities Act. • Reviewed business related agreements.
Required Information:	
MMYYYY to MMYYYY:	08.2006 – 01.2009
Vendor Name:	Hancock, Daniel, Johnson & Nagle, P.C.
Client Name:	4701 Cox Road, Suite 400
Client Contact Name:	Glen Allen, VA 23060
Client Address, Phone Number, Email:	P: 804.967.9604

Role in Contract/Project: Details and Duration of Contract/Project:	*Associate Attorney* • Assisted clients on issues relating to Medicare and Medicaid enrollment and reimbursement, HIPAA, Stark, the Federal Anti-Kickback statute, DEA and Board of Pharmacy issues, non-profit taxation and Virginia Department of Taxation issues, and patient consent issues. • Provided guidance on medical research ethics issues and served as a member of a hospital bioethics committee. • Assisted clients in review and preparation of compliance plans and materials. • Drafted, reviewed, and negotiated business agreements, including employment agreements, financial assistance agreements, business associate agreements, and agreements for other goods and services. • Established corporations and limited liability companies and worked on corporate governance projects.
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	University of Richmond School of Law Richmond Virginia Juris Doctor Virginia State Bar University of Virginia Charlottesville Virginia Master of Arts, Bioethics University of Virginia Charlottesville Virginia Bachelor of Arts
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Sharon Brumley Senior Vice President, Regulatory Services AMERIGROUP Corporation 4425 Corporation Lane Virginia Beach, VA 23462 P: 757.962.6452 F: 757.222.2377 Sharon.Brumley@amerigroup.com Bobbie Jo Jonas Associate Vice President, Regulatory Services, West Region AMERIGROUP Corporation 4425 Corporation Lane Virginia Beach, VA 23462 P: 757.473.2737 ext. 32590 F: 757.222.2377 Roberta.Jonas@amerigroup.com

	Christine Canedy Associate Vice President, Document Compliance AMERIGROUP Corporation 4425 Corporation Lane Virginia Beach, VA 23462 P: 757.473.2737 ext 33527 F: 757.222.2377 Christine.Canedy@amerigroup.com

Robin Favret

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Amerigroup Corporation		
☐ **Contractor**		**X Subcontractor**	
Name:	Robin Favret	☐ **Key Personnel**	
Classification:	AVP, Account Management	**# of Years in Classification:**	14
Brief Summary: of Experience:	28 years of health care experience with 14 years in an acute care hospital and 14 years experience with Medicaid and CHIP programs. Previous Medicaid and CHIP experience in Texas, Maryland, New Jersey, Florida, South Carolina, Arizona, New Mexico, Washington, Colorado, Massachusetts, Nevada, and Michigan.		
# of Years with Firm:	12		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	08.2011 – Present Amerigroup Corporation 1300 Amerigroup Way Virginia Beach, VA 23464 P: 757-473-2737 ext. 32757 Robin.Favret@amerigroup.com Associate Vice President, Account Management • Functions as the lead technical contact to the state and associated state trading partners, participating in technical and operational meetings, audits, readiness reviews, and implementations. • Monitors operational and system trends and performance across the Regional Health Plans to determine best practices, potential solutions to a Health Plan's operational or system issue, and to ensure compliance with mandated performance guarantees. • Responsibility for compliance with all state requested system changes, ad hoc ITS requests, and ITS contractual deliverables for Health Plans within the Region.		
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:***	02.2009 – 08.2011 Amerigroup Corporation 1300 Amerigroup Way Virginia Beach, VA 23464 P: 757-473-2737 ext. 32757 Robin.Favret@amerigroup.com Director, Account Management • Functioned as primary contact for state technical business partners and		

Role in Contract/Project: Details and Duration of Contract/Project:	coordinates cross-functional participation in requirement changes and issue resolution for assigned markets. • Had responsibility for compliance with all state requested system changes, ad hoc ITS requests, and ITS contractual deliverables. Provides feedback and alternate solutions on state proposed changes. Serves as ITS Lead for state audits and assessments and coordinates on site reviews. • Had responsibility for understanding the requirements of the state programs in terms of business rules, nuisances between programs, system requirements, and interdependencies.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project: Details and Duration of Contract/Project:***	 08.2000 – 02.2009 Amerigroup Corporation 1300 Amerigroup Way Virginia Beach, VA 23464 P: 757-473-2737 ext. 32757 Robin.Favret@amerigroup.com Business Analyst Principal II • Served as technical liaison with multiple State agencies with responsibility for all system requirements, changes and ITS compliance per state contracts. Had responsibility for State ITS audits, assessments, and corrective action remediation activities; provided responses to all ITS questions; and coordinated on-site reviews. • Provided analytical and technical expertise to Health Plan to support internal initiatives, day-to-day operations, and strategic goals. • Had responsibility for gathering requirements, performing analysis, supporting the development and testing processes and understanding the applications, data and associated technologies for the organization.
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Old Dominion University Norfolk VA Bachelor of Science in Business Administration (Major – Information Systems)
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Amanda Devine Program Analyst VI Texas Health and Human Services Commission P: 512-491-1190 F: 512-491-1984 Amanda.Devine@hhsc.state.tx.us

	Alan Scantlen Deputy Director of Operations Coordination Texas Health and Human Services Commission. P: 512-491-1304 F: 512-491-1984 Alan.Scantlen@hhsc.state.tx.us Aileen McCormick Regional CEO Amerigroup Corporation P: 713-218-5101 Aileen.McCormick@amerigroup.com

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Nicole Bertsch

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Amerigroup Corporation		
☐ **Contractor**		☒ **Subcontractor**	
Name:	Nicole Bertsch	☐ **Key Personnel**	
Classification:	Operational Account Manager	**# of Years in Classification:**	2
Brief Summary: of Experience:	Thirteen years of health care experience. Over 10 years experience in provider business analysis and practice management, and 3 years experience in managed care business analysis and operational account management.		
# of Years with Firm:	2		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	11.2010 – Present **Amerigroup Corporation** 1300 Amerigroup Way Virginia Beach, VA 23464 P: 757-473-2737 ext. 33362 Nicole.Bertsch@amerigroup.com *Business Analyst Principal I, Account Management and Implementation* ▪ Functions as the lead technical contact to the state and associated state trading partners, participating in technical and operational meetings, audits, readiness reviews, and implementations. ▪ Assists with contract deliverables requirements and testing ▪ Attends state calls and facilitate in cross-functional communication and projects ▪ Provides health plan and corporate with technical support – analysis, development and testing of reports ▪ State eligibility portal system administrator for TX, NM, WA, NV, KS ▪ Transmit, download and format state files ▪ Create and run ad hoc reports as needed for health plan and for validation purposes ▪ Developed SQL query library ▪ Facilitate weekly Account Management meetings

	▪ Manage and facilitate projects to support the health plan and corporate on cross functional issues ▪ Established weekly meeting with Enterprise Reporting to coordinate all ER/AM activities for West Region. ▪ Actively involved in modifying, developing and testing ER reports that affect West Region include new reports and rewrites of existing reports ▪ Actively involved with Implementation of new markets, expansion of existing markets, and implementations related to new products offered
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	2003 – 2010 **Virginia Oncology Associates** 5900 Lake Wright Drive Norfolk, VA 23502 P: 757-466-8683 *Practice Quality and Efficiency Manager/Practice Manager/Business Services Analyst Supervisor* ▪ Functioned as Process Improvement Manager using Lean Six Sigma methodology for improvements ▪ Launched and managed 9 process improvement projects in 2010 ▪ Engaged in revenue cycle improvement project implementation ▪ Designed and implemented core organizational key performance metrics ▪ Accountable for reporting key performance metrics to corporate monthly ▪ Managed daily operations and staff for 4 clinic sites ▪ Project manager of Port Warwick construction and site opening ▪ Project manager of Hampton office remodel ▪ Coordinated logistics for Williamsburg, Hampton and Port Warwick relocation project ▪ Enacted new team concept to streamline workflow of 22 staff members ▪ Super user for new Practice Management System implementation

	▪ Designed and implemented process flowcharts for new office positions ▪ Established Reporting/Data Analysis department ▪ Supervised 8 employees across 3 departments in Central Business Office ▪ Designed and generated critical monthly accounting and financial reports using Plus Medic, Cognos Impromptu Query and Monarch reporting software ▪ Developed and maintained claims scrubber reporting system ▪ Supported research department by providing data for oncology clinical trials ▪ Served as primary training resource for business systems ▪ Generated all production and ad hoc reports to facilitate management decisions
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	2001 – 2003 **ValueOptions** 240 Corporate Boulevard Norfolk, VA 23502 P: 757-459-5100 *Business Systems Analyst* ▪ Developed provider data reports using MS Access, Seagate Crystal Reports and Cognos Impromptu reporting software ▪ Translated functional requirements into detailed technical requirements ▪ Delivered timely and accurate production and ad hoc reports ▪ Effectively communicated progress and status of requests to the end-user ▪ Assisted in project implementations to include new development initiatives, client implementations, and program enhancements

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Virginia Wesleyan College Virginia Beach VA Bachelor of Science in Business Administration - Management

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Kerry Sutton Vice President, Account Management Amerigroup P: 757-473-2737 ext. 36486 F: 757-233-6309 Kerry.Sutton@amerigroup.com Robin Favret Associate Vice President, ITS Customer Account Management Amerigroup P: 757-473-2737 ext. 32757 F: 757-233-6309 Robin.Favret@amerigroup.com Liv Moir Director, Account Management Amerigroup P: 757-473-2737 ext. 38834 F: 757-233-6309 Liv.Moir@amerigroup.com

AGP CORPORATION
4425 CORPORATION LANE
VIRGINIA BEACH VA 23462

Scott Kipper, Commissioner of Insurance

AGP CORPORATION

License Number 219992

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

		Effective Date:	Expiration Date:
License Type:	Non-Res. Third Party Admin.	10-01-2009	06-01-2015
Qualifications:	TPA1 -Life/Health Insurance		

Licensees must notify the Division of any change of address within 30 days of the change. You are subject to revocation for noncompliance. Individuals – If you are affiliated to a business entity it will not print on the license. Individuals must be properly affiliated to the business entity's license prior to transacting insurance on the entity's behalf. The individual and the business entity are responsible for maintaining the affiliation.

A producer of insurance acting as an agent of the insurer must be appointed by the insurer prior to transacting insurance.

This license must be conspicuously displayed in your place of business that is open to the public.

AGP CORPORATION

License Number 219992
National Producer ID

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

LICENSE TYPE	EFFECTIVE DATE
Non-Res. Third Party Admin.	10-01-2009
QUALIFICATIONS	**EXPIRATION DATE**
TPA1 -Life/Health Insurance	06-01-2015

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AGP CORPORATION
4425 CORPORATION LANE
VIRGINIA BEACH VA 23462

Scott Kipper, Commissioner of Insurance

AGP CORPORATION

License Number 20092

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

		Effective Date:	Expiration Date:
License Type:	Utilization Review	02-08-2006	03-01-2013

Qualifications:

Licensees must notify the Division of any change of address within 30 days of the change. You are subject to revocation for noncompliance.
Individuals – If you are affiliated to a business entity it will not print on the license. Individuals must be properly affiliated to the business entity's license prior to transacting insurance on the entity's behalf. The individual and the business entity are responsible for maintaining the affiliation.

A producer of insurance acting as an agent of the insurer must be appointed by the insurer prior to transacting insurance.

This license must be conspicuously displayed in your place of business that is open to the public.

AGP CORPORATION

License Number 20092
National Producer ID

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

LICENSE TYPE	EFFECTIVE DATE
Utilization Review	02-08-2006
QUALIFICATIONS	**EXPIRATION DATE**
	03-01-2013

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Connextions

Administration of Nurse *HelpLine* and disease management services

5.1.1	
Company name:	Connextions
Ownership (sole proprietor, partnership, etc.):	Corporation
State of incorporation:	Florida
Date of incorporation:	1999
# of years in business:	13
List of top officers:	▪ Jack LeForte, CEO ▪ Dave Palmer, COO ▪ Steve Auerbach, President
Location of company headquarters:	3600 eCommerce Place Orlando, FL 32808
Location(s) of the company offices:	Orlando, FL
Location(s) of the office that will provide the services described in this RFP:	Orlando, FL
Number of employees locally with the expertise to support the requirements identified in this RFP:	40
Number of employees nationally with the expertise to support the requirements in this RFP:	40
Location(s) from which employees will be assigned for this project:	Orlando, FL

5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

Connextions is willing to review the requirements for registering in the State of Nevada.

5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Is "Legal Entity Name" the same name as vendor is doing business as?

If "No", provide explanation.

Connextions is willing to review the requirements for licensing in the State of Nevada. Yes, the legal entity name is the same as the name under which Connextions is doing business.

Connextions

Administration of Nurse *HelpLine* and disease management services

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

Connextions is willing to review the requirements for licensing in the State of Nevada.

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

A. Name of State Agency?

B. State Agency Contact name? Date when services were performed?

C. Type of Duties Performed?

D. Total Dollar Value of the contract?

No

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

No

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

No

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Connextions

Administration of Nurse *HelpLine* and disease management services

Connextions possesses the proper insurance requirements.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Connextions has been providing triage services for more than 10 years. Connextions recruits nurses with a specific skill set to include previous triage, urgent care, or emergency care treatment.

Connextions provides acquisition, service, retention, and technology services to its clients. The Connextions client base consists of most of the major healthcare providers, as well as some commercial clients. Connextions provides clients technology and Business Process Outsourcing (BPO) services in a direct-to-consumer market.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

Connextions corporation started in 1999, attracted outside investors in 2004, and was acquired by Optum Health in 2011.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

Florida is resident state, with no preference afforded.

D. The location of disaster recovery back-up site.

Tampa, FL

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Ebony Langston

3600 eCommerce Pl.

Orlando, FL 32808

(407) 926-2411, ext. 10307

F. The size of organization in assets, revenue and people.

5,000 employees. Connextions does not share financial details with clients.

G. The organizational chart of your senior management by function including key personnel.

See Attachment 5.1.11.8 for Connextions' organizational chart.

- Jack Leforte, CEO

Connextions
Administration of Nurse *HelpLine* and disease management services
▪ Steve Auerbach, President ▪ Dave Palmer, COO ▪ Jamie McGinn, CFO
H. The areas of specialization.
Acquisition, service, retention, technology in direct-to-consumer/member interactions.
I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.
Nurse *HelpLine* and disease management programming
J. The corporate philosophy and mission statement.
"Our vision is to be seen as world class in the eyes of our clients by providing superior service through integrated outsourcing solutions."
K. A description of any plans for future growth and development of your organization.
Connextions plans to continue to support and provide solutions to plans to meet the increasing focus on quality of services.
L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?
Not applicable, acquired by Optum Health in 2011
5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.
Connextions has been providing nurse triage services since 2004.
5.1.10.1 Experience A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:
Connextions has been providing nurse triage services since 2004. Nurses average 10 years of experience in the nursing field, including emergency and urgent care treatment.
1. Managing a network of Medicaid Providers;
Not applicable
2. Managed care programs for Medicaid recipients;
Connextions has provided sales, service, and triage services for several clients that provide products for Medicaid recipients.
3. Administering Medicaid utilization and case management programs;
Not applicable

Connextions
Administration of Nurse *HelpLine* and disease management services
4. Medicaid claims processing and adjudication
Not applicable
5. Project management; and
Not applicable
6. Qualifications of key personnel.
Through the recruitment process, applicants must take assessments that judge their fitness for the position. Connextions completes background and licensing checks on applicants before extending any final offer.
B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.
Not applicable
C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.
Connextions call quality program reviews at least five calls per nurse per month. Nurses must pass call evaluations with a score of 95% or higher. Connextions assigns a performance improvement plan to nurses who consistently do not meet standards. Connextions maintains all processes and documents on the Wiki, as well as online training material and job aids for easy access by on-call nurses.
D. Describe the experience your organization has had working with state government and/or experience in specifically related services.
Connextions has been providing nurse triage services since 2004. Nurses average 10 years of experience in the nursing field , including emergency and urgent care treatment.
E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.
▪ Ebony Langston, Director of Operations. Responsible for management of the team to meet contractual performance targets. ▪ Patrice Wooten, Nurse Manager. Responsible for the day-to-day operations, coaching, and quality of the nursing team.
F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area: 1. Information Systems 2. Utilization/Case Management 3. Claims Payment 4. Quality Improvement and Reporting (i.e. HEDIS, CMS)

Connextions

Administration of Nurse *HelpLine* and disease management services

5. Health education
6. Data / coding
7. Contract negotiations, Network recruiters
8. Encounter data
9. Other staff as needed

1. Bronson Tubb, Vice President of Information Technology
2. Not applicable
3. Not applicable
4. Ebony Langston/Patrice Wooten
5. Ebony Langston/Patrice Wooten
6. Not applicable
7. Not applicable
8. Ebony Langston/Patrice Wooten
9. Not applicable

G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.

Not applicable

H. List any bilingual staff, the area to which they are assigned and the languages spoken.

- Jenica Casanova, RN, Spanish
- Elsie Cruz, RN, Spanish

I. List any associations or organizations to which the organization belongs.

None

5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

5.1.11.1 Medical Services

A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

Connextions will work with Amerigroup Nevada to identify any additional required services to support Amerigroup members. If Amerigroup Nevada needs additional services, Connextions will identify business requirements and create an implementation plan.

B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.

Connextions does not review service authorization requests.

C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.

Connextions
Administration of Nurse *HelpLine* and disease management services
Connextions' call quality program reviews at least five calls per nurse per month. Nurses must pass call evaluations with a score of 95% or higher. Connextions assigns performance improvement plans to nurses who consistently do not meet standards.
D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.
Not applicable
E. Describe the roll and responsibilities of your case managers.
Connextions does not have case managers.
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Connextions sends all triage records to Amerigroup daily. This information includes the applied guidelines to triage the call, any additional presented risk factors, and the care advice the member received. Amerigroup can use this information to coordinate additional care.
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Connextions sends all triage records to Amerigroup daily. This information includes the applied guidelines to triage the call, any additional presented risk factors, and the care advice the member received. Amerigroup can use this information to coordinate additional care.
H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Connextions sends all triage records to Amerigroup daily. This information includes the applied guidelines to triage the call, any additional presented risk factors, and the care advice the member received. Amerigroup can use this information to coordinate additional care.
I. Provide your policies and procedures for emergency and post stabilization services.
After triage, if the nurse determined that the situation warrants emergency care, the nurse will advise the member to call 911 or go to the emergency department. If, for some reason, the member is unable to comply, the nurse will call 911 on the member's behalf.
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS,

Connextions
Administration of Nurse *HelpLine* and disease management services
including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
Not applicable
B. Provide a sample of all base network provider contracts.
Not applicable
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
Not applicable
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?
Not applicable
E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.
Not applicable
F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.
Not applicable
G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.
Not applicable
H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?
Not applicable
5.1.11.5 Quality Assurance A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality

Connextions
Administration of Nurse *HelpLine* and disease management services
standards in Section 4.8 of this RFP.
Connextions call quality program reviews at least five calls per nurse per month. Nurses must pass call evaluations with a score of 95% or higher. Connextions assigns a performance improvement plan to nurses who consistently do not meet standards. Connextions maintains all processes and documents on the Wiki, as well as online training material and job aids for easy access by on-call nurses.
B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?
Not applicable
C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?
Not applicable
5.1.11.6 Fiscal Requirements A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?
Not applicable
B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?
Not applicable
1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.
Not applicable
C. Describe your plan to identify and report suspected provider and recipient fraud.
Connextions trains employees in fraud and abuse awareness. If Connextions or its employees suspect any type of fraud, Connextions will notify Amerigroup Nevada for further investigation.
D. Describe and submit your policies and procedures for determining and collecting patient liability.
Not applicable
5.1.11.7 Grievances, Appeals and Fair Hearings A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.
Not applicable
B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance

Connextions
Administration of Nurse *HelpLine* and disease management services
outcomes?
Not applicable
5.1.11.8 Operational Requirements Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.
See Connextions Attachment 5.1.11.8 for Connextions' organizational chart behind the Connextions Attachments Tab.
5.1.11.9 Implementation A. If you currently do not have an established network, what time frame and approach will you use to build a network?
Not applicable
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Not applicable
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
Connextions will comply with reporting requirements and timelines related to this Contract.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
Not applicable
5.1.11.12 HIPAA Compliance A. Describe your status, resources, and approach to HIPAA compliance.
Upon hire, all agents take training regarding HIPAA compliance and must pass the final test with a 100% score, acknowledging they understand the expected actions to comply with HIPAA mandates. Connextions subjects any employees who violate any HIPAA compliance policies to progressive discipline, up to and including termination.
B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.
Not applicable

Connextions
Administration of Nurse *HelpLine* and disease management services
5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial. 5.1.12.1 Dun and Bradstreet Number
Connextions does not share financial information with its clients. Please see the Connextions Attachment Tab for a letter describing Connextions' policy on this issue. Please see the letter included in the Connextions Attachments Tab.
5.1.12.2 Federal Tax Identification Number
Connextions does not share financial information with its clients. Please see the Connextions Attachment Tab for a letter describing Connextions' policy on this issue. Please see the letter included in the Connextions Attachments Tab.
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement
Connextions does not share financial information with its clients. Please see the Connextions Attachment Tab for a letter describing Connextions' policy on this issue. Please see the letter included in the Connextions Attachments Tab.

5.3 BUSINESS REFERENCES

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Connextions directly to the Purchasing Division.

Table 5.3-1. Connextions Reference 1

Reference #:	1		
Company Name:	Connextions		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Mindy Benefiel Customer Relations and Call Center Director Teladoc		
Street Address:	4100 Spring Valley Ste 515		
City, State, Zip	Dallas, TX 75244		
Phone, including area code:	(214) 302-5212		
Facsimile, including area code:	(972) 661-2312		
Email address:	mbenefiel@teladoc.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Connextions provides call center representatives to support members calling to register for Teladoc services or complete health questionnaires to initiate a tele-consult with one of Teladoc's physicians.		
Original Project/Contract Start Date:	12/01/2008		
Original Project/Contract End Date:	Annually renewable		
Original Project/Contract Value:	Contract value is proprietary information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

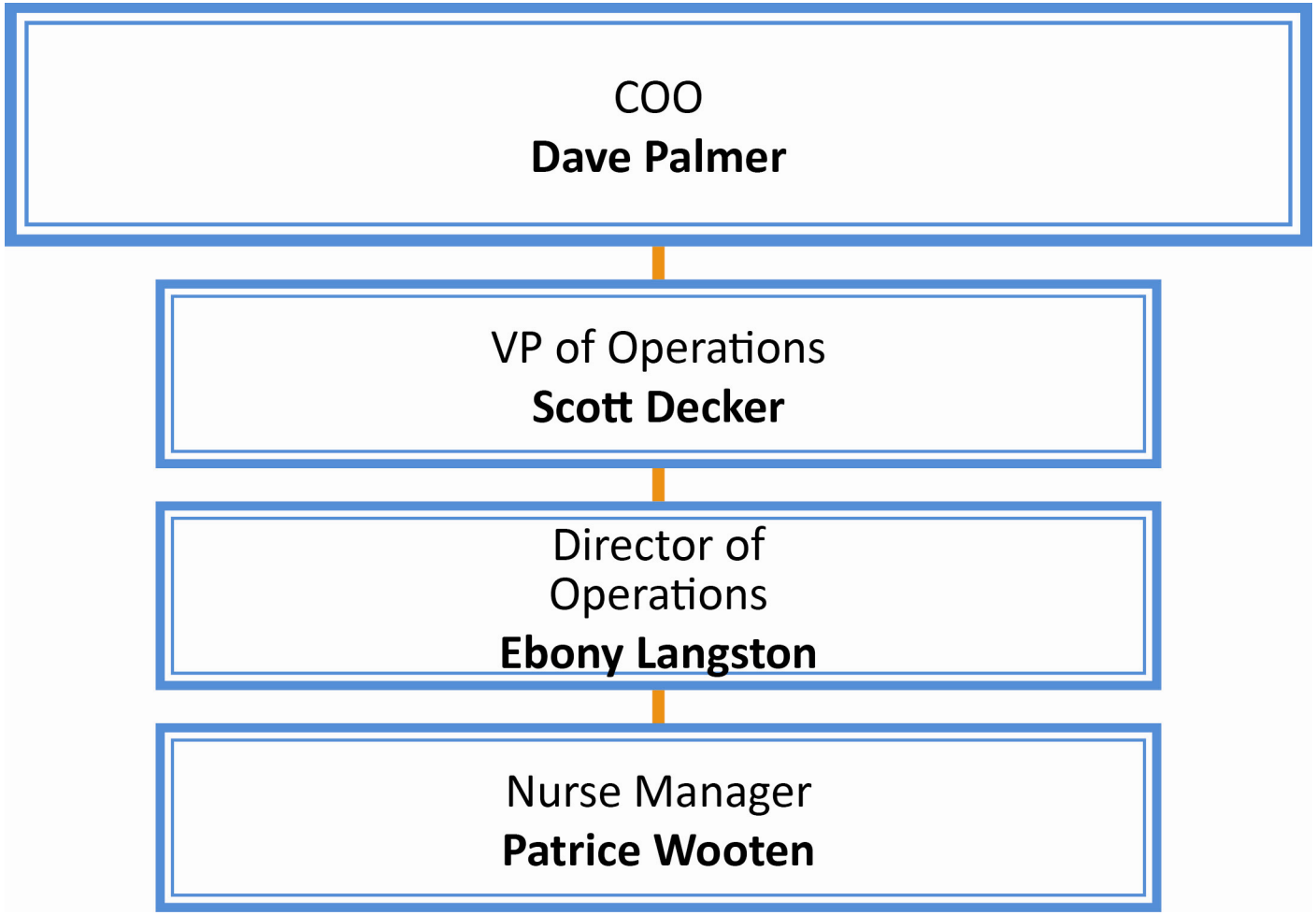
Table 5.3-2. Connextions Reference 2

Reference #:	2		
Company Name:	Connextions		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Kate Kunkel Manager, Quality and Training Kaiser Permanente Medicare		
Street Address:	7707 N West Lane		
City, State, Zip	Stockton, CA 95210		
Phone, including area code:	(707) 481-2451		
Facsimile, including area code:	N/A		
Email address:	Kate.Kunkel@kp.org		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Provide call center representatives to support prospective members calling to find out more information on Medicare plans and telephonically enroll prospective members as requested. Also provide CRM to manage prospects and campaign to track responses and performance.		
Original Project/Contract Start Date:	07/07/2007		
Original Project/Contract End Date:	09/01/2017		
Original Project/Contract Value:	Contract value is proprietary information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

Table 5.3-3. Connextions Reference 3

Reference #:	3		
Company Name:	Connextions		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Keyona Dyson Operations Management Connecticut General Life Insurance Company Cigna Healthcare		
Street Address:	1601 Chestnut St		
City, State, Zip	Philadelphia, PA 19192		
Phone, including area code:	(860) 226-5344		
Facsimile, including area code:	(877) 253-6014		
Email address:	Keyona.Dyson@Cigna.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Provide licenses agents to sell Medical, Dental and Supplemental policies to individuals and families		
Original Project/Contract Start Date:	12/02/2009		
Original Project/Contract End Date:	12/31/2014		
Original Project/Contract Value:	X		
Final Project/Contract Date:	X		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing, since CIGNA is still under contract		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

Connextions Organizational Chart



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CONNEXTIONS PROPOSED STAFF RESUMES

Ebony Langston

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Connextions		
☐ **Contractor**		**X Subcontractor**	
Name:	Ebony Langston	☐ **Key Personnel**	
Classification:	Director of Sales and Operations	**# of Years in Classification:**	1
Brief Summary of Experience:			
# of Years with Firm:	8		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	09.2011 – Present **Connextions** 3600 eCommerce Place Orlando, FL32808 P: 407-926-2411 Ebony.Langston@connextions.com *Director of Sales and Operations* • In charge of strategic planning and goal setting to continue to drive performance in telesales center • Responsible for up to 275 direct and indirect reports • Implement strategies that increase sales effectiveness in insurance agents • Serve as subject matter expert in insurance, healthcare form, and Medicare • Find opportunities for organic growth by identifying more services to be offered to clients • Assist in negotiating pricing and contract terms for new services offered		

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	04.2009 – 09.2011 **Connextions** 3600 eCommerce Place Orlando, FL32808 *Operations Manager* • Was in charge of developing, staffing, management, and financial performance for telesales center • Was responsible for daily functional operations of assigned accounts to include technical and systems operations, proper staffing, supervisor assignments, managing client requests, addressing complaints and solving problems all while meeting cost, productivity, and quality goals • Developed and implemented several policies and processes used on account, as well as developed training materials for use in training new employees and continuing education for existing employees
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	10.2008 – 04.2009 **Connextions** 3600 eCommerce Place Orlando, FL32808 *Project Manager* • Was responsible for tracking and implementing new development for existing clients • Created Business Requirements Documents to outline development and obtain sign-off and agreement by all parties • Was responsible for tracking and implementing software solutions for new clients to include technical development, hiring, and training while keeping project on time and on budget as defined by contractual obligations
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Duke University Durham North Carolina Bachelors of Science, Psychology Webster University Orlando Florida Masters in Business Administration

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Scott Decker VP of Operations, Connextions P: 407-926-2411 x10312 F: N/A Scott.decker@connextions.com Kate Kunkel Manager Training and Quality, Kaiser Permanente P: 707-481-2451 F: N/A Kate.kunkel@kp.org Stephanie Harris-Holley Digital Specialist Townsquare Interactive P: 832-640-4977 F: N/A stephaniemarieh@gmail.com

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Patrice Wooten

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Connextions		
☐ **Contractor**		**X Subcontractor**	
Name:	Patrice Wooten	☐ **Key Personnel**	
Classification:	Director of Strategic Accounts, Healthplans	**# of Years in Classification:**	1
Brief Summary of Experience:			
# of Years with Firm:	1		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	09.2011 – Present **Connextions** 3600 eCommerce Place Orlando, FL32808 P: 407-926-2411 Patrice.Wooten@connextions.com *Clinical Nurse Manager* • Manages a team of 23 registered nurses for 24 hours nurse helpline call center • Implements and monitors compliance with policies and procedures • Manages monthly and quarterly reports • Monitors key performance indicators and service level agreements
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	10.2009 – 09.2011 **Amerigroup Florida, Inc.** 4200 West Cypress Street Suite 900 Tampa, FL 33607 P: 813-830-6900 pwooten@amerigroupcorp.com *National Call Center Medical Management Supervisor* • Directed supervision of team of pre-authorization nurses in call center • Managed staffing assignments and departmental reports

	• Monitored team members' cases to ensure appropriate application of clinical information to criteria guidelines • Involved with tracking and trending nurse errors project and in early stages if Utilization Management development programs for pre-certification nurses
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	06.2008 – 07.2009 **Golden Living Center** 25 Armory Street West Newton, MA 02465 P: 619-969-2300 glc00116@goldenliving.com *Weekend Nursing Supervisor* • Supervised operations of a 120 bed long term care skilled facility and a total of 31 employees • Delegated tasks to licensed nurses and certified nursing assistants • Increased employee morale and decreased weekend call out rates by serving as a reliable resource person for staff • Reviewed nursing documentation and made recommendations, addressed concerns and provided feedback to nurses and department leadership
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Monroe Community College Rochester New York Associates Degree Liberal Arts, Science Concentration University of Rochester Rochester New York Bachelor of Science, Nursing Framingham State College Framingham Massachusetts Masters of Arts, Business Administration Degree Massachusetts Licensed Registered Nurse 1996-2010

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Nancy Mulcahy, RN Campion Health Center 319 Concord Road Weston, MA 02493 P: 781-788-4700 F: 781-788-4751 acopponi@campioncenter.org Morris Smile, Nursing Assistant Campion Health Center 319 Concord Road Weston, MA 02493 P: 617-901-4533 F: 781-788-4751 acopponi@campioncenter.org Scott Decker, Vice President of Operations Connextions P: 407-926-2411 x10312 F: N/A Scott.decker@connextions.com

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CVS Caremark	
Pharmacy benefit administration	
5.1.1	
Company name:	CVS Caremark
Ownership (sole proprietor, partnership, etc.):	CaremarkPCS Health, LLC (CVS Caremark) is a wholly-owned direct subsidiary of CaremarkPCS, LLC, a subsidiary of Caremark Rx, LLC, whose ultimate parent company is CVS Caremark Corporation.
State of incorporation:	Delaware
Date of incorporation:	CaremarkPCS Health, LLC (formerly known as AdvancePCS Health, L.P.) was formed as a limited partnership in the State of Delaware on May 31, 2000. It converted from a limited partnership to a limited liability company on January 1, 2009.
# of years in business:	43 years. CVS Caremark has been providing PBM services since 1969.
List of top officers:	▪ Eva Boratto, President and Treasurer ▪ Allison L. Brown, Senior VP ▪ Sara M. Hankins, Secretary ▪ Jonathan C. Roberts, VP Note: Because it is a limited liability company, CaremarkPCS, LLC does not have directors. The LLC is managed by its sole member, Caremark Rx, LLC
Location of company headquarters:	One CVS Dr. Woonsocket, RI 02895
Location(s) of the company offices: Location(s) of the office that will provide the services described in this RFP:	Please refer to CVS Caremark's Locations. 9501 E. Shea Blvd. Scottsdale, AZ 85260.
Number of employees locally with the expertise to support the requirements identified in this RFP:	CVS Caremark does not currently track this information.
Number of employees nationally with the expertise to support the requirements in this RFP:	CVS Caremark's pharmacy benefit management affiliates had more than 15,400 employees in 2011.
Location(s) from which employees will be assigned for this project:	9501 E. Shea Blvd. Scottsdale, AZ 85260
5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.	

CVS Caremark

Pharmacy benefit administration

CaremarkPCS Health, LLC was registered on April 22, 2009 (# E0212502009-9).

5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Is "Legal Entity Name" the same name as vendor is doing business as?

If "No", provide explanation.

Nevada Business License #: NV20091142864

Legal Entity Name: CaremarkPCS Health, LLC

Yes, the legal entity name is the same as the name under which CVS Caremark is doing business.

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

- CVS Caremark is in material compliance with all rules and regulations that may have an impact on its operations. CVS Caremark has all applicable federal and state licenses required for the provision of PBM services, and is licensed and conduct business in all 50 states, Puerto Rico, and the Virgin Islands. Each pharmacy holds a resident state license from the pharmacy board of the state in which the pharmacy is located. In addition, where required, each pharmacy is licensed as a non-resident pharmacy in states in which such pharmacy delivers product.

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

A. Name of State Agency?

B. State Agency Contact name? Date when services were performed?

C. Type of Duties Performed?

D. Total Dollar Value of the contract?

No.

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

CVS Caremark is a publicly traded company.

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

CVS Caremark

Pharmacy benefit administration

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

Legal actions involving CVS Caremark include the following:

1. In December, 2007, the Company received a document subpoena from the Office of Inspector General (OIG), requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. In October, 2009, and October, 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under this OIG subpoena and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two of Caremark's adjudication platforms. The Company has been producing documents on a rolling basis in response to requests for information contained in the OIG subpoena and in these civil investigative demands. The Company cannot predict with certainty the timing or outcome of any review of such information.

2. In August, 2009, the Company was notified by the Federal Trade Commission (FTC) that it was conducting a non-public investigation under the Federal Tort Claims Act (FTCA) into certain of the Company's business practices. In March, 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 28 states, the District of Columbia, and the County of Los Angeles, are known to be participating in this multi-state investigation. On January 3, 2012, the FTC accepted for public comment, subject to final approval, a consent order.

3. In March, 2009, the Company received a subpoena from the OIG requesting information concerning the Medicare Part D prescription drug plans of RxAmerica, the PBM subsidiary of Longs Drug Stores Corporation which was acquired by the Company in October, 2008. The Company continues to respond to the request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

4. Since March, 2009, the Company has been named in a series of putative collective and class action lawsuits filed in federal courts around the country, purportedly on behalf of current and former assistant store managers working in the Company's stores at various locations outside California. The lawsuits allege that the Company failed to pay overtime to assistant store managers as required under the Fair Labor Standards Act (FLSA) and under certain state statutes. The lawsuits also seek other relief, including liquidated damages, punitive damages, attorneys' fees, costs and injunctive relief arising out of the state and federal claims for overtime pay.

5. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as

CVS Caremark

Pharmacy benefit administration

defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December, 2009, in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January, 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire.

6. Caremark was named in a putative class action lawsuit filed in October, 2003, in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November, 2003, by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. The attorneys and law firms named as defendants in McArthur's intervention pleadings have been dismissed from the case, and discovery on class certification and adequacy issues are underway.

7. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August, 2003, Bellevue Drug Co., Robert Schreiber, Inc. (d/b/a Burns Pharmacy) and Rehn-Huerbinger Drug Co. (d/b/a Parkway Drugs #4), together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October, 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. (d/b/a Big C Discount Drugs, Inc.), filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

8. In August, 2009, the Company was notified by the FTC that it was conducting a non-public investigation under the FTCA into certain of the Company's business practices. In March, 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 28 states, the District of Columbia, and the County of Los Angeles, are known to be participating in this multi-state investigation. On January 3, 2012, the FTC accepted for public comment, subject to final approval, a consent order. The proposed consent order would prohibit

CVS Caremark

Pharmacy benefit administration

the Company from misrepresenting the price or cost of Medicare Part D prescription drugs, or other prices of costs associated with Medicare Part D prescription drug plans. The proposed order would also require the Company to pay $5 million in consumer redress, to be distributed to impacted RxAmerica Medicare Part D beneficiaries. The proposed order contains no allegations of antitrust law violations or anti-competitive behavior related to the Company's business practices or its products or service offerings. In addition, the Company has received a formal letter from the FTC closing all other aspects of the investigation. With respect to the multi-state investigation, the Company continues to cooperate in this investigation. The Company is not able to predict with certainty the timing or outcome of the multi-state investigation. However, it remains confident that it is conducting business practices and service offerings (which are designed to reduce health care costs and expand consumer choice) in compliance with the antitrust laws.

9. In March, 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to its pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company continues to respond to this request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any reviews by the government of such information.

10. In January, 2012, the Company received a subpoena from OIG requesting information about its Health Savings Pass program, a prescription drug discount program for uninsured or under-insured individuals, in connection with an investigation of possible false or otherwise improper claims for payment involving Health and Human Services programs. In February, 2012, the Company also received a civil investigative demand from the Office of the Attorney General of the State of Texas requesting a copy of information produced under this OIG subpoena and other information related to prescription drug claims submitted by its pharmacies to Texas Medicaid for reimbursement.

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

CVS Caremark confirms that it possesses the correct insurance coverages identified in Attachment E.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

CVS Caremark is a pharmacy innovation company that has grown to become a national leader in providing programs currently serving more than 2,000 clients. It offers mail, retail, and specialty distribution channels, administering programs for a diverse client base, including corporations, managed care organizations, insurance companies, state governments, unions, third-party

CVS Caremark

Pharmacy benefit administration

administrators, and other organizations that pay for healthcare products and services.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

CVS Caremark is a leading prescription benefit manager that provides specialty/biotech services, disease management and other health services related to prescription benefit management services.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

CaremarkPCS Health, LLC (CVS Caremark) is a wholly-owned direct subsidiary of CaremarkPCS, LLC, a subsidiary of Caremark Rx, LLC, whose ultimate parent company is CVS Caremark Corporation.

CVS Caremark is a pharmacy innovation company that has grown to become a national leader in providing programs currently serving more than 2,000 clients and their members across all 50 states, Puerto Rico, and the Virgin Islands. Through mail, retail, and specialty distribution channels, it administers programs for a diverse client base, including corporations, managed care organizations, insurance companies, government entities, unions, third-party administrators, and other organizations that pay for healthcare products and services.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

CVS Caremark Corporation

One CVS Dr.

Woonsocket, RI 02895.

CaremarkPCS, LLC

9501 E. Shea Blvd.

Scottsdale, AZ 85260.

D. The location of disaster recovery back-up site.

One CVS Drive

Woonsocket, RI 02895

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Jennifer Hendrix, Strategic Account Director

9501 E. Shea Blvd.

Scottsdale, AZ 85260

(623) 444-4274

CVS Caremark

Pharmacy benefit administration

F. The size of organization in assets, revenue and people.

Employees: As of December 31, 2011, CVS Caremark employed approximately 202,000 associates, which included more than 25,000 pharmacists, nurse practitioners, and physician assistants.

Assets: $64.5 million as of 2011

Revenue: $107 million in 2011

G. The organizational chart of your senior management by function including key personnel.

See CVS Attachment 5.1.11.8 for CVS Caremark's organizational chart.

H. The areas of specialization.

CVS Caremark is a leading prescription benefit manager that provides specialty/biotech services, disease management, and other health services related to prescription benefit management services.

I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.

Pharmacy benefit management: $96 million in 2010 and $107 million in 2011

J. The corporate philosophy and mission statement.

CVS Caremark is a pharmacy innovation company.

PURPOSE: Helping people on their path to better health

STRATEGY: Reinventing pharmacy

VALUES:

- Innovation
- Collaboration
- Caring
- Integrity
- Accountability

K. A description of any plans for future growth and development of your organization.

CVS Caremark will continue to monitor industry trends for risks and opportunities for its clients. More importantly, it will also continue to shape the future of pharmacy care through innovation and continuous resetting of industry performance benchmarks. Caremark sees the following key trends influencing pharmacy care in the next five years:

1. Healthcare reform
2. Significant growth in specialty therapies
3. Increasing availability of generic medications
4. The changing role of pharmacy care

L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management

CVS Caremark
Pharmacy benefit administration
techniques, what resources and organization, etc.?
CVS Caremark has not expanded into any new markets within the last 24 months.
5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.
43 years. CVS Caremark has been providing PBM services since 1969.
5.1.10.1 Experience A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:
CVS Caremark is a pharmacy innovation company and currently operates with Amerigroup in partnership for pharmacy services in 12 state Medicaid programs, beginning in 1998.
1. Managing a network of Medicaid Providers;
Not applicable
2. Managed care programs for Medicaid recipients;
Not applicable
3. Administering Medicaid utilization and case management programs;
Not applicable
4. Medicaid claims processing and adjudication
Not applicable
5. Project management; and
Not applicable
6. Qualifications of key personnel.
Not applicable
B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.
Not applicable
C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.
Customer feedback and our knowledge of industry trends have resulted in the following best practices within our managed Medicaid segment. **Account Management** ▪ Dedicated clinical, account, and analytics resources with managed Medicaid expertise to provide ongoing analysis and suggestions ▪ Management of per member per month (PMPM) performance to meet client goals during

CVS Caremark

Pharmacy benefit administration

challenging budgetary times

- Policy and legislative tracking activities and a firm grasp of Medicaid regulations at the state level

Clinical Support

- Clinical pharmacist with managed Medicaid experienced assigned to each account
- Comprehensive clinical solutions and online reporting to help meet HEDIS standards
- Evidence-based interventions to help improve member health
- Targeted health management programs for the Medicaid population, including an emphasis on disease states/conditions such as HIV and behavioral health
- Managed Medicaid Drug List that saves time and money

Systems, Programs, and Tools

- Automated prior authorization tool to add efficiency to the PA process
- Desktop access to plan design and eligibility to support client customer service representatives and allow eligibility on the fly
- Robust, online reporting tool to help clients quickly and effectively manage their benefit

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

CVS Caremark has supported plans and members within the healthcare sector for 15 years and has Medicaid program experience in these states:

Market	Effective Date
Florida	January 1, 2003
Georgia	July 1, 2008
Louisiana	November 1, 2012
Maryland	August 1, 2000
Nevada	February 1, 2009
New Jersey	March 1, 1998
New Mexico	August 1, 2008
New York	May 15, 2007
Ohio	October 1, 2001
Texas	March 1, 2012
Virginia	September 1, 2005
Washington	July 1, 2012

E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

Strategic Account Director

The Strategic Account Director assumes total accountability for a client's level of satisfaction with

CVS Caremark

Pharmacy benefit administration

services. This individual is responsible for leading the assigned Account Services team in developing, implementing, and maintaining the client's strategic business plan. The Strategic Account Director coordinates any necessary support from each of the functional areas within CVS Caremark (for example, operations, clinical services, customer service, and health improvement) to ensure overall account satisfaction with program administration, strategic planning, data analysis, plan design, and drug coverage.

Benefit Relationship Manager

The Benefit Relationship Manager (BRM) provides consultation, expertise, and ownership of strategic clients' prescription benefits by:

- Obtaining and clarifying client requests for plan design changes by working with the client, account team, and operations
- Determining requirements from client meetings with them via e-mail, conference, or face-to-face interactions

Clinical Advisor

The Clinical Advisor will thoroughly address support and representation of all client clinical-based programs and will meet with the client at least quarterly to discuss utilization patterns and trends CVS Caremark identifies through analysis of claims data. The Clinical Advisor will assist in analyzing trends gleaned from ad hoc reports and review the overall effectiveness of the program.

Account Manager

The Account Manager will be responsible for overseeing benefit design and plan performance, as well as helping to maintain overall satisfaction with the services CVS Caremark provides. He or she will manage a variety of problem-solving activities on the client's behalf. The Account Manager also will work closely with designated personnel and the Strategic Account Director to recommend benefit programs and to monitor the quality of daily benefit program operations.

Manager of Account Management

The Manager of Account Management maintains client satisfaction and retention efforts. In addition, the Manager of Account Management will develop and maintain a team dedicated to supporting clients by analyzing complex problems, identifying root causes, and assisting with driving practical and creative solutions. One of this position's key initiatives is to foster teamwork and a supportive departmental culture with an emphasis on ensuring exceptional client service.

Director of Account Management

The Director of Account Management is responsible for the delivery of account management and benefits service to the assigned respective client base within the business unit while engaging, understanding, and communicating the unique service needs of the business unit with Sales, internal partners, and other key operational areas to provide effective support.

F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:

1. Information Systems

2. Utilization/Case Management

CVS Caremark
Pharmacy benefit administration
3. Claims Payment 4.Quality Improvement and Reporting (for example, HEDIS, CMS) 5. Health education 6. Data/coding 7. Contract negotiations, network recruiters 8. Encounter data 9. Other employees as needed
Not applicable
G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.
Refer to the CVS Attachments Tab.
H. List any bilingual staff, the area to which they are assigned and the languages spoken.
Not applicable
I. List any associations or organizations to which the organization belongs.
CVS Caremark has no association memberships to list.
5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included. **5.1.11.1** Medical Services A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.
Not applicable
B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.
Not applicable
C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.
Not applicable
D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.
Not applicable
E. Describe the roll and responsibilities of your case managers.

CVS Caremark

Pharmacy benefit administration
Not applicable
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Not applicable
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Not applicable
H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Not applicable
I. Provide your policies and procedures for emergency and post stabilization services.
Not applicable
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
CVS Caremark's retail network strategy takes both the client and the member into consideration. CVS Caremark builds its networks with a focus on providing broad access, choice, and convenience to maintain and enhance member satisfaction, along with competitive pricing, and to help reduce total costs for its clients. CVS Caremark offers its clients a variety of network options to meet the varying objectives of its diverse client base. These options include a national network, with broad national coverage and excellent access, and narrow networks, which offer an effective balance between savings for clients and access for members.
B. Provide a sample of all base network provider contracts.
Not applicable

CVS Caremark

Pharmacy benefit administration

C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?

Not applicable

D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?

Not applicable

E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.

Not applicable

F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.

Not applicable

G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.

Not applicable

H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?

Not applicable

5.1.11.5 Quality Assurance

A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.

CVS Caremark's pharmacy quality assurance initiatives include the following:

- Desktop and on-site pharmacy claim audits
- Review and trending of complaints and appeals
- Accuracy and timeliness of eligibility file loads
- Accuracy and timeliness of claims payments
- Trending and analysis of pharmacy payment issues
- Trending and analysis of claim rejection rates
- Customer service center performance monitoring, including:
  - Average speed to answer

CVS Caremark

Pharmacy benefit administration

- Abandon rate
- Peak call times and staffing ratios

B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

Not applicable

C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

Not applicable

5.1.11.6 Fiscal Requirements

A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?

Given current technologies used by many PBMs and MCOs, pharmacies access information about covered benefits and submit claims in real time. Pharmacies can adjudicate transactions that entail processing a request for coverage to verify eligibility, drug coverage, benefit limitations, and prior authorization requirements. Priced according to provider contract agreements, on average, the pharmacy receives an authorization for payment in less than three seconds. Clinical and technical staff support the technology is supported to ensure that the system includes all benefit design and utilization management system edits. This automated process facilitates fast processing with minimal human intervention.

B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?

Not applicable

1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.

Not applicable

C. Describe your plan to identify and report suspected provider and recipient fraud.

Not applicable

D. Describe and submit your policies and procedures for determining and collecting patient liability.

Not applicable

5.1.11.7 Grievances, Appeals and Fair Hearings

A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

Not applicable

CVS Caremark

Pharmacy benefit administration
B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?
Not applicable
5.1.11.8 Operational Requirements Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.
See Attachment 5.1.11.8 for the CVS Caremark organizational chart.
5.1.11.9 Implementation A. If you currently do not have an established network, what time frame and approach will you use to build a network?
CVS Caremark has an established network.
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Not applicable
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
CVS Caremark will comply with all reporting requirements and timeframes.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
CVS Caremark meets these requirements.
5.1.11.12 HIPAA Compliance A. Describe your status, resources, and approach to HIPAA compliance.
CVS Caremark's pharmacy compliance team works closely with the corporate regulatory market leaders to ensure efficient response to all regulatory alerts. The team supplies State-required reports to corporate regulatory employees for monthly state submissions. CVS Caremark reviews irregularities in reporting for necessary action plans and resolutions.
B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.

CVS Caremark
Pharmacy benefit administration
Each pharmacy applicant requesting membership in the network must have specific credentials and must meet specific contractual standards, including: ▪ Active membership in the National Council for Prescription Drug Programs (NCPDP) ▪ Compliance with Health Insurance Portability and Accountability Act (HIPAA) regulations ▪ Appropriate state licensure ▪ An active Drug Enforcement Agency (DEA) number
5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial. **5.1.12.1** Dun and Bradstreet Number
CVS Caremark Corporation's Dunn & Bradstreet number is 00-133-8912. This DUNS number shows CVS Caremark at One CVS Dr., Woonsocket, RI 02895-6146.
5.1.12.2 Federal Tax Identification Number
75-2882129
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement
$6.1 billion (2010) $6.3 billion (2011)
B. Balance Statement
Total Net Equity: $37.7 billion (2012), $38.1 billion (2011)

5.3 BUSINESS REFERENCES

CVS-CareMark Reference Information

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding CVS-Caremark directly to the Purchasing Division.

Table 5.3-1. Caremark Reference 1

Reference #:	1		
Company Name:	CVS-Caremark		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Patryce A. Toye Medical Director MedStar Family Choice		
Street Address:	8094 Sandpiper Circle Suite O		
City, State, Zip	Baltimore, MD 21236		
Phone, including area code:	(410) 933-2204		
Facsimile, including area code:	N/A		
Email address:	Patryce.Toye@medstar.net		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	CVS Caremark provides PBM Services to MedStar Family Choice, a Medicaid plan in Maryland.		
Original Project/Contract Start Date:	2010		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is proprietary information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	N/A		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A		

Table 5.3-2. Caremark Reference 2

Reference #:	2		
Company Name:	CVS-Caremark		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Dr. Ken Joslyn Medical Director Metropolitan Health Plan		
Street Address:	400 South Fourth St Suite 201		
City, State, Zip	Minneapolis, MN 55415		
Phone, including area code:	(612) 596-0727		
Facsimile, including area code:	N/A		
Email address:	Ken.Joslyn@co.hennepin.mn.us		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	CVS Caremark provides PBM Services to Metropolitan Health Plan, a Medicaid and Medicare Part D plan in Minnesota.		
Original Project/Contract Start Date:	2007		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is proprietary information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	N/A		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A		

Table 5.3-3. Caremark Reference 3

Reference #:	3		
Company Name:	CVS-Caremark		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	Hugh Fatodu Director of Pharmacy Johns Hopkins Healthcare		
Street Address:	6704 Curtis Court		
City, State, Zip	Glen Burnie, MD 21060		
Phone, including area code:	(410) 424-4671		
Facsimile, including area code:	N/A		
Email address:	fatoduH@jhhc.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	CVS Caremark provides PBM Services to Johns Hopkins Healthcare.		
Original Project/Contract Start Date:	1989		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is proprietary information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	N/A		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A		

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ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

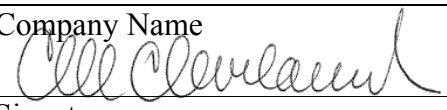
I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

YES X I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

CaremarkPCS Health LLC
Company Name


Signature

Colleen Cleveland
Print Name

November 9, 2012
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

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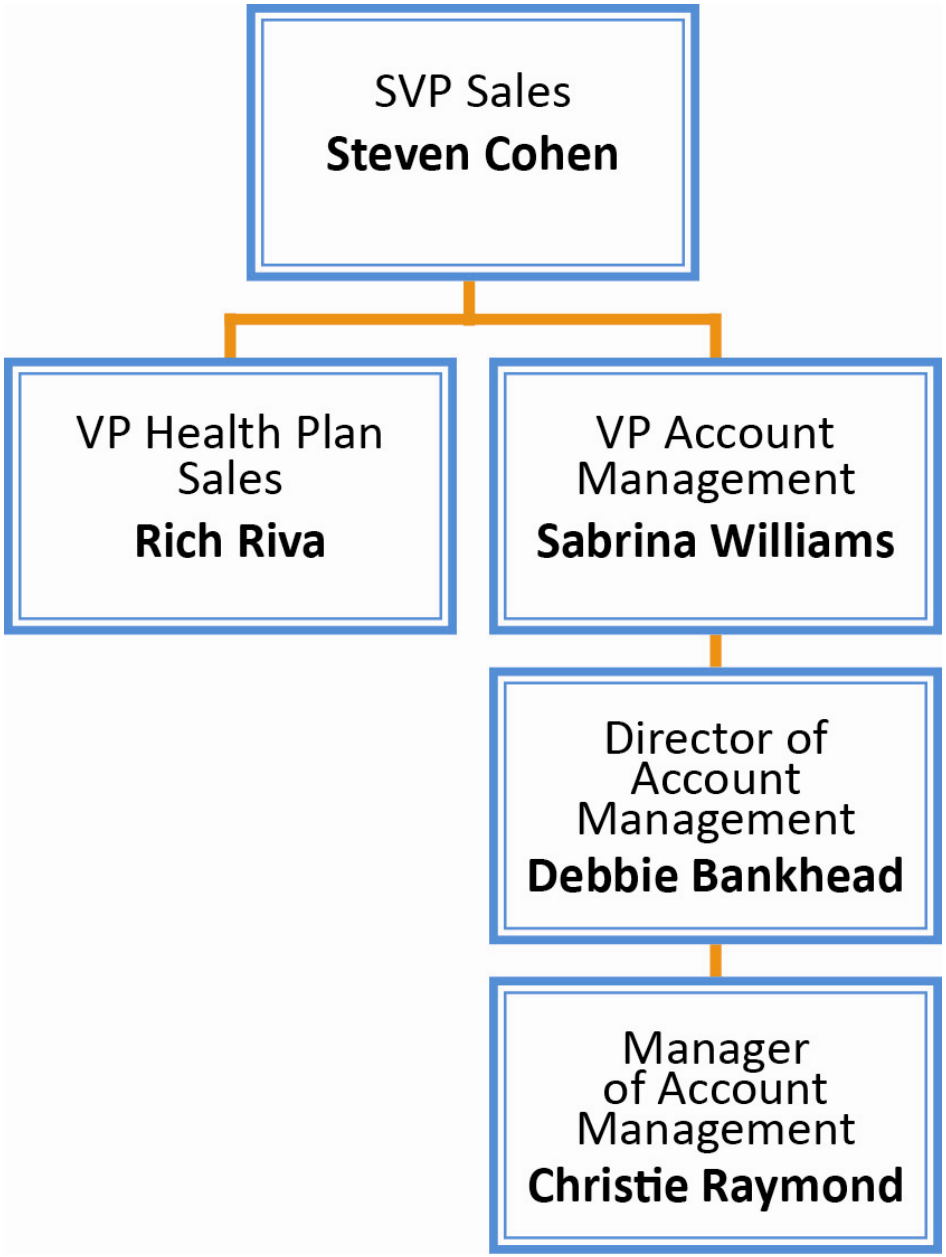
CVS-CareMark Organizational Chart



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CVS-CAREMARK PROPOSED STAFF RESUMES

Jennifer Hendrix

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Caremark		
☐ **Contractor**		√ **Subcontractor**	
Name:	Jennifer Hendrix, PharmD, BCPP	☐ **Key Personnel**	
Classification:	Director of Strategic Accounts, Healthplans	**# of Years in Classification:**	4
Brief Summary: of Experience:	Jennifer Hendrix is a registered pharmacist with board certification in psychiatry. She has worked in managed care and pharmacy benefit management for the last 12 years.		
# of Years with Firm:	4		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	7.2008 – Present **Caremark** One CVS Drive Woonsocket, Rhode Island 02895 P: 623-444-4274 jennifer.hendrix@caremark.com *Director of Strategic Accounts, Healthplans* Jennifer Hendrix has ownership of ensuring contractual requirements and service expectations are met for CVS Caremark clients as well as go-forward expansion strategy support.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	2005-2008, 2002-2004 **ValueOptions** 444 N. 44th St. Phoenix, AZ 85018 P: 602-264-3797 *Director of Clinical Pharmacy* Jennifer Hendrix had responsibility for clinical pharmacy, prior authorization, formulary management, and cost saving strategies for a capitated behavioral health managed care organization

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	2004-2005 **Bristol Myers Squibb** 1 Squibb Dr New Brunswick, NJ 08903 P: 800-332-2056 *Neuroscience Medical Science Liaison* Jennifer Hendrix maintained relationships with key opinion leaders in the neuroscience field and ensured understanding of the leading industry literature.

EDUCATION

Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	St. Louis College of Pharmacy St. Louis Missouri Bachelors of Science Grand Rio College of Pharmacy Albuquerque New Mexico Pharmacy Degree

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Rich Riva, VP of HealthPlans Caremark P: 614-264-0789 F: N/A Rich.riva@caremark.com Ryan Kuehn, Area Director, Medicaid RxAmerica P: 801-961-6115 F: N/A Ryan.kuehn@rxamerica.com Steve Cohan, SVP of HealthPlans Caremark P: 401-770-7460 F: N/A Steve.cohan@caremark.com

Christie Raymond

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Caremark		
☐ **Contractor**		√ **Subcontractor**	
Name:	Christie Raymond	☐ **Key Personnel**	
Classification:	Manager, Account Management	**# of Years in Classification:**	3
Brief Summary of Experience:	Ms. Raymond provides the field sales forces with oversight and expertise regarding exceptional client needs or issues, problem resolution, and plan design changes or enhancements.		
# of Years with Firm:	10		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	11.2002 - Present **Caremark** One CVS Drive Woonsocket, Rhode Island 02895 P: 480-614-7966 Christie.Raymond@caremark.com *Manager, Account Management* • Develops strategies and processes for the penetration and growth of business • Identifies opportunities for integration of CVS Caremark services • Ensures the ongoing development and maintenance of effective regional CVS Caremark sales forces

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Arizona State Phoenix Arizona Bachelor's Degree, Inter-Disciplinary, Business Management

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Debbie Bankhead, Director, HP CST Caremark P: 480-314-8863 F: N/A Debbie.bankhead@caremark.com Sabrina Williams, VP, HP CST Caremark P: 480-314-8545

	F: N/A Sabrina.williams@caremark.com Ryan Kuehn, Area Director, Medicaid RxAmerica P: 801-961-6115 F: N/A Ryan.kuehn@rxamerica.com

State of Illinois

Department of Financial and Professional Regulation

Division of Professional Regulation

LICENSE NO.
054.015388
051.289996

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES:
03/31/2014

LICENSED PHARMACY
COMMUNITY

CAREMARK ILLINOIS MAIL PHARMACY LLC
DBA CVS CAREMARK
JASON R PERRY
800 BIERMANN CT STE A
MOUNT PROSPECT, IL 60056

BRENT E. ADAMS
SECRETARY

JAY STEWART
DIRECTOR

The official status of this license can be verified at www.idfpr.com

6530504

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For further reference, the Department is now providing a personal customer identification "Contact Number" which you may use in lieu of your social security number or FEIN number when contacting the Department. Your number is: 448322

State of Illinois
LICENSE NO. **Department of Financial and Professional Regulation**
Division of Professional Regulation

****** VOID ******

****** VOID ******

****** VOID ******

EXPIRES:

BRENT E. ADAMS
SECRETARY

JAY STEWART
DIRECTOR

The official status of this license can be verified at www.idfpr.com

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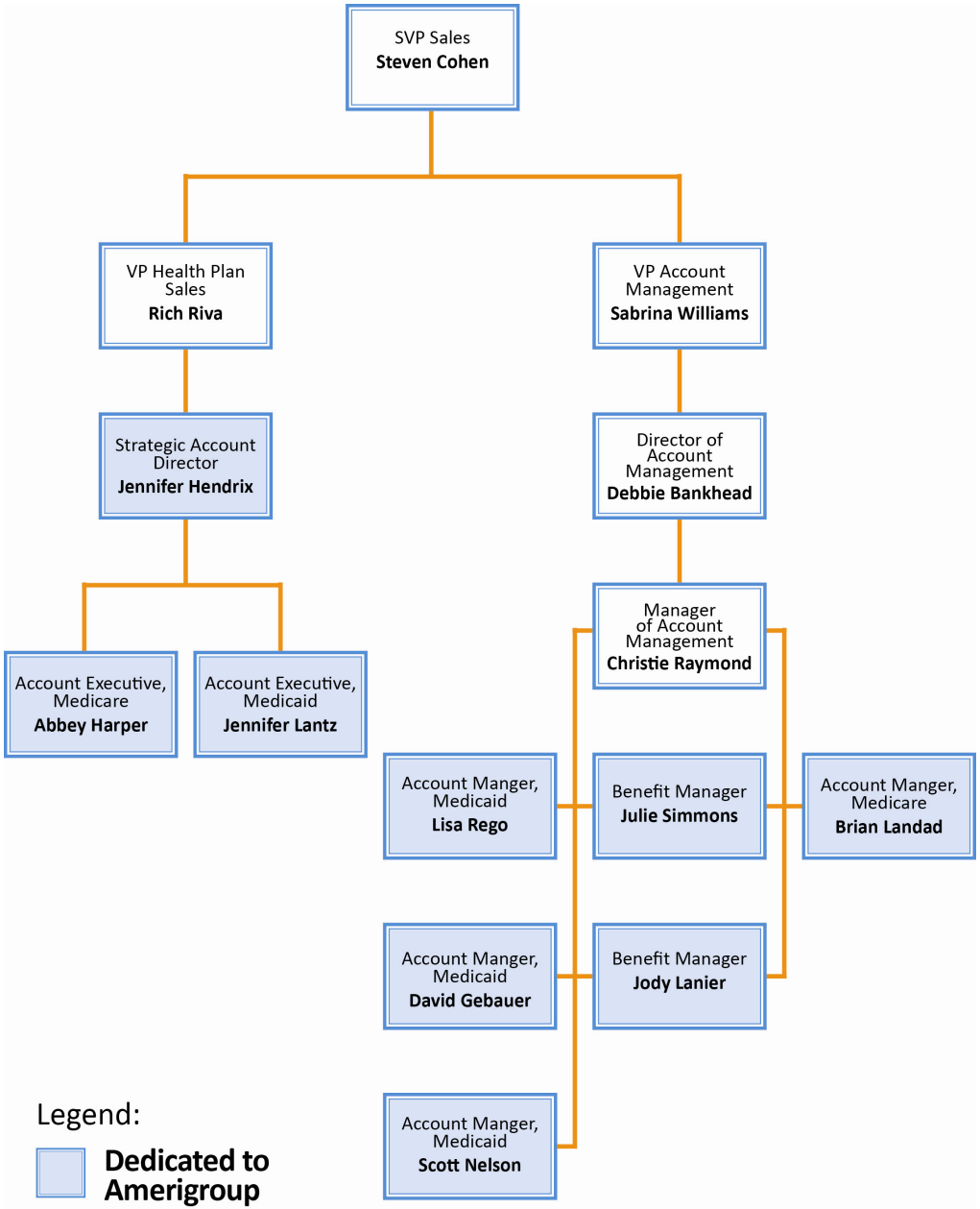
CVS-CareMark Organizational Chart by Functional Area



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eyeQuest	
Provision of vision care services	
5.1.1	
Company name:	DentaQuest, LLC (eyeQuest)
Ownership (sole proprietor, partnership, etc.):	Limited Liability Company
State of incorporation:	Delaware
Date of incorporation:	November 13, 2003
# of years in business:	Nine
List of top officers:	▪ Fay Donohue, President and Chief Executive Officer ▪ Steve Pollock, Chief Operating Officer ▪ Jim Collins, Chief Financial Officer ▪ Myra Green, Senior VP, Legal Counsel ▪ Robert Lynn, Senior VP, Sales and Marketing ▪ Dennis Leonard, Chief Sales Officer
Location of company headquarters:	465 Medford St. Boston, MA 02129-1454
Location(s) of the company offices:	Austin, TX Boston, MA Calverton, MD Columbia, SC Coral Gables, FL Mequon, WI
Location(s) of the office that will provide the services described in this RFP:	Austin, TX Boston, MA Mequon, WI
Number of employees locally with the expertise to support the requirements identified in this RFP:	Seven vision employees and two client service members will support this account.
Number of employees nationally with the expertise to support the requirements in this RFP:	1,200
Location(s) from which employees will be assigned for this project:	Austin, TX Boston, MA Mequon, WI
5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.	
eyeQuest understands and complies with this requirement.	
5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.	

eyeQuest
Provision of vision care services
Is “Legal Entity Name” the same name as vendor is doing business as? If “No”, provide explanation.
License Number: 528207 No. The legal entity name is DentaQuest, LLC.
5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.
eyeQuest understands and complies with this requirement.
5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency? If “Yes”, complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified. A. Name of State Agency? B. State Agency Contact name? Date when services were performed? C. Type of Duties Performed? D. Total Dollar Value of the contract?
No
5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?
No
5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor’s ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If “Yes”, please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding: A. Date of Alleged Contract failure or breach? B. Description of failure or breach or litigation including the products or services involved? C. Amount in Controversy? D. Resolution or current status of dispute? E. Has the matter involved a court case? F. Status of litigation?
None
5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of

eyeQuest

Provision of vision care services

Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Yes, eyeQuest possesses the appropriate insurance protections.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

DentaQuest, parent company of eyeQuest, is the nation's leading administrator of government-sponsored dental programs, serving more than 15 million Medicaid, CHIP, and Medicare members in 26 states. The company administers dental programs on behalf of 10 state agencies and more than 70 health plans.

eyeQuest, DentaQuest's vision and eye care services product, serves more than 500,000 health plan members in 31 states. Operating since 2007, eyeQuest offers a full range of vision and eye care services. It additionally offers an integrated vision/medical program, including a surgical component.

With a nationwide network of more than 5,000 professionals including independent and retail providers, eyeQuest is equipped to administer vision programs in both commercial and government business sectors.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

In 2001, Dental Service of Massachusetts (DSM) contracted with DentaQuest to provide the total suite of administrative services to support its commercial dental business in Massachusetts. DSM is the largest dental carrier in Massachusetts with approximately 50% of the dental benefits market share (based on amount of claims processed each year). It administers benefits to approximately 5,000 groups and a growing individual product segment. DentaQuest provides DSM with sales, client services, underwriting and financial management, customer service, network recruitment, enrollment, claims processing, information technology, utilization and review, fraud and abuse, marketing communications and advertising, product development, management services (including the development and management of dental disease management programs), and legal services. Fay Donohue is the COO of DSM.

The government division of DentaQuest, formerly known as Doral, was established in 1993 for the sole purpose of administering dental benefits within the government business sector.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

eyeQuest

Provision of vision care services

DentaQuest is not a resident of Nevada. Its corporate headquarters is located in Boston, MA. Massachusetts does not apply a preference that would affect bidders and vendors located in Nevada.

D. The location of disaster recovery back-up site.

DentaQuest's business continuity plan outlines the procedures and management actions for disasters, with a goal of restoring operations within 72 hours. The plan outlines a recovery effort from the onset of the disruption to the normalization of business operations. DentaQuest conducts testing of its disaster recovery operations to ensure system recovery, regardless of the nature of the threat.

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Megan Ryczek, National Executive Director

(262) 834-3736

megan.ryczek@dentaquest.com.

F. The size of organization in assets, revenue and people.

Employees: 1,200
Assets: $214 million

- Revenue: $330 million

G. The organizational chart of your senior management by function including key personnel.

See Attachment 5.1.9.1.G for eyeQuest's organizational chart.

H. The areas of specialization.

eyeQuest specializes in the administration of government-sponsored vision programs. Its corporate parent, DentaQuest, provides group and individual dental plans.

I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.

eyeQuest is a leading vision benefits management company serving members in 13 states, with an annual revenue of $330 million. It manages government-sponsored benefit programs and employer- and union-sponsored benefit plans. The vision benefit plans include vision Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and indemnity plans and discount plans. eyeQuest provides a broad range of management services to its customers, including sales and marketing, underwriting, enrollment, vision provider network management, customer service and claims processing.

J. The corporate philosophy and mission statement.

eyeQuest's mission is to deliver value to its clients, members, and providers with performance excellence second to none and improve the vision and eye health of members.

K. A description of any plans for future growth and development of your organization.

eyeQuest is positioned for growth in both commercial and government business sectors as health reform measures unfold. It continues to develop products that will assist health plans in capturing

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Provision of vision care services

membership opportunities in the new healthcare marketplace.

L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

In 2012, DentaQuest, as the parent company of eyeQuest, expanded into Texas where it administers dental benefits to more than two million Medicaid and CHIP recipients. In 2013, DentaQuest will begin administering Hawaii's statewide Medicaid dental program covering more than 100,000 lives.

DentaQuest has implemented hundreds of programs since its inception in 1993, including nine statewide Medicaid programs. Many of the implementations have involved Medicaid Management Information Systems (MMIS) interface.

eyeQuest's implementation team is accustomed to navigating the long list of tasks associated with program implementations and encourages client participation in the process. eyeQuest's time-tested implementation process, which involves a cross-functional team of experts, promotes efficiency and the achievement of timeline goals.

5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

20 years of experience in Medicaid and CHIP programs. See details below for each subsection.

5.1.10.1 Experience

A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:

1. Managing a network of Medicaid Providers;

eyeQuest's Nevada vision network consists of 133 general practices, equating to one practice per 643 members, exceeding the industry standard. eyeQuest's network is compliant with Amerigroup's access standards: all urban members have access to a provider within 15 miles of their home, and all rural members have access to a provider within 30 miles.

eyeQuest is an informed business partner, equipped with the tools to make participating in Medicaid programs easy and profitable. eyeQuest offers:

- Real-time claim processing, which means providers get paid quickly and funds can deposit directly into provider bank accounts
- Responsive service from the customer care center, which keeps provider offices running at peak efficiency
- Annual satisfaction surveys, which give providers an opportunity to make their voices heard

eyeQuest's website makes it easy for providers to participate in its programs. Vision professionals logging into eyeQuest's HIPAA-compliant provider website can accomplish administrative tasks quickly and easily, including:

- Eligibility verification
- Medical prior approval

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- Claim submission
- Prescription orders (including a "smart form" that makes ordering easy)
- Authorization status
- Medical prior approval status
- Claim status
- Order status
- Access to the Office Reference Manual

2. Managed care programs for Medicaid recipients;

eyeQuest contracts with more than 70 health plans to administer managed care programs for Medicaid recipients. With 20 years' experience in administering Medicaid and CHIP programs, eyeQuest understands the importance of complying with state regulations and client requirements.

The needs of the Medicaid population differ greatly from those served by commercial carriers. Access to care, language proficiency, transportation challenges, and the need for program materials reflecting the varied backgrounds of members represent just some of the issues attending Medicaid Program administration. eyeQuest is accustomed to dealing with these issues to ensure every member benefits from a high quality vision experience.

eyeQuest is familiar with the barriers faced by vision providers participating in government-sponsored programs. One by one, eyeQuest has eliminated these barriers through advanced technology service improvements and by giving providers a say in how eyeQuest conducts business with them.

3. Administering Medicaid utilization and case management programs;

eyeQuest's utilization management (UM) program ensures members receive medically necessary care defined under state guidelines. It complies with recognized UM standards as they apply to vision care through such organizations as NCQA, URAC, and federal and state standards including the Department of Labor's Employee Retirement Income Security Act (ERISA) regulations.

eyeQuest employs optometrists and ophthalmologists to review claims and authorizations for medical necessity. Its billing algorithms take into account the provider, practice setting, patient diagnosis (International Classification of Diseases [ICD] code), patient age and billed service code (Current Procedural Terminology [CPT®)]. These measures permit eyeQuest to limit excessive services without restricting the member's access to care.

For example, pachymetry (CPT-76514), the measurement of the thickness of the cornea (the front surface of the eye), will be a once-in-a-lifetime service for adults with a glaucoma/ glaucoma suspect diagnosis, but will be available more frequently when monitoring active corneal disease. This approach will provide better patient care than a rigid limitation on episodes of care across the board.

Other conditions for which this type of algorithm will be used include gonioscopy (92020), visual fields (92083), retinal photography (92250) and posterior segment scanning (92135).

Prior Authorizations

Providers may submit prior authorizations via mail, fax, or eyeQuest's free website. Operations employees initially review requests to determine whether they comply with contracted service codes.

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An optometrist or ophthalmologist determines surgical cases and denied clinical and medical requests. eyeQuest determines non-urgent requests in accordance with NCQA, URAC, and any applicable federal or state regulations.

In general, members have coverage for one examination and pair of eyeglasses or contact lenses each year. Under this benefit set, eyeQuest would require prior authorization for replacement eyeglasses (Medicaid only), second and successive routine examinations, and all medically necessary contact lenses. The approval criteria and limitations are in line with contract requirements and applicable Medicaid/Medicare regulations.

4. Medicaid claims processing and adjudication

eyeQuest's HIPAA-compliant operating system is a user-definable rules-based engine that enables auto-adjudication of claims in real time. This flexible, parameter-driven program has an open architecture to accommodate the full spectrum of vision care plan designs and benefit levels as well as multiple line items for each claim. It permits the vision team real-time access to utilization data. eyeQuest's system supports a naturally integrated workflow of all operations to:

- Expedite benefit administration and transaction processing
- Deliver a better than 99% accuracy rate in its auto-adjudication claims processing

The system's claims processing methodology accepts claims data as input and determines the payment amount for each claim. It interrogates data submitted to a relational database during the final adjudication and payment of claims. For example, the system compares claim data submitted to the database against the plan design benefit limit data. The system determines whether the service is covered and calculates the member's responsibility such as co-pays and allowances.

In Nevada, eyeQuest has provided superior claims processing performance in 2011 including:

- Paid 100 percent of claims (52,760) within 30 days, exceeding the 90 percent standard
- Pended zero claims
- Denied 269 of 52,760 claims (0.5%).
- Maintained claim resubmission rate of 0.1%.

5. Project management; and

eyeQuest's implementation team has nearly 20 years' experience implementing government-sponsored programs. Given that eyeQuest is the incumbent, no implementation process is necessary. However, eyeQuest's project management team is available should the Nevada Medicaid program undergo significant changes.

eyeQuest uses a Microsoft Project Plan to track the progress of implementations. The project plan is customizable to meet program needs related to type, size, timeline, and scope of services. eyeQuest can easily modify the process to remove tasks related to administrative services that the client maintains. Regardless of task delegation, eyeQuest's implementation methodology is the same.

6. Qualifications of key personnel.

eyeQuest operates under the clinical direction of Dr. John Davis, whose 30 years of experience in both clinical and executive management positions supports the continued growth of eyeQuest's vision

eyeQuest

Provision of vision care services

product. Dr. Davis is affiliated with the American Optometric Association and was a diplomat for the American Board of Quality Assurance and Utilization Review Physicians. He was also an examiner for the National Board of Examiners in Optometry.

The following clinical professionals support Dr. Davis in the administration of eyeQuest's vision programs. Their combined knowledge supports consistency in the provision of vision and eye care services.

Jean Ramsey, MD, MPH, FAAO, Ophthalmology Consultant

- Associate professor of ophthalmology and pediatrics, Boston University School of Medicine; Ophthalmology Residency and Fellowship in pediatric ophthalmology at New England Medical Center, Boston

Dan Townsend, MD, FAAO, Ophthalmology Consultant

- Mayo Medical School, Ophthalmology Residency and Fellowship in oculoplastic/orbital diseases and surgery at Massachusetts Eye and Ear Infirmary, Harvard University

Concetta Daurio, OD, MBA, FAAO, Optometric Consultant

- Graduate of New England College of Optometry; Chief of Optometry at Harvard Vanguard Medical Associates

Vision Director Vidya Baliga manages the operational aspects of eyeQuest's programs. She assumed these responsibilities in 2011. Since that time, she has expanded her team and implemented a host of initiatives to improve the efficiency of the operational unit.

B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.

In conjunction with Amerigroup, eyeQuest implemented an Adult Diabetic Member Outreach program to improve health outcomes. It involved providers reaching out to members to schedule an appointment and provide an adult fundus eye exam. As an incentive, Amerigroup pays the provider an additional $25 above its contracted reimbursement for an eye exam.

C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

eyeQuest invests in treatment protocols to maximize the eye health outcomes of its members.

Diabetes and Vision Care Quality Initiative

Diabetes can have a devastating effect on both a member's vision and overall health. The primary objective of eyeQuest's Diabetes and Vision Health Quality Initiative, which has been implemented as part of the current Amerigroup program, is to identify retinopathy, which is often indicative of secondary issues in the kidneys, heart, and brain. Identifying retinopathy in its early stages can:

- Significantly reduce medical costs
- Preserve the member's vision
- Ensure members receive treatment for diabetes-related medical issues

The components of this initiative include:

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- Dilated fundus evaluation (DFE)
- An enhanced benefit design in which all diabetics would be eligible for an annual eye examination, regardless of underlying coverage
- Data collection to identify diabetic members and flag them for enhanced eligibility
- Collection of CPT and ICD-9 data from providers, including up to four diagnostic codes. Vision providers typically include only vision diagnostics, such as hyperopic or myopia, which causes loss of a valuable source of data relating to systemic disease. By requiring this additional data, eyeQuest maximizes the opportunity to identify members who may be diabetic.
- Member education pertaining to the need for an annual examination, DFE, and the potential impact of diabetes shared with members through a variety of channels
- Providers receive educational materials supporting the need for enhanced services to diabetics, including DFE. eyeQuest notifies the provider when eligibility requests are made regarding the patient's diabetic status. This sentinel effect supports optimal clinical outcomes.

PCP Chart Markers

After vision providers conduct a DFE, PCPs review the results to determine the best course of treatment for diabetic patients. Amerigroup provides eyeQuest a list of diabetic members' PCPs. Following exams, eyeQuest sends the PCP a notice to include in the member's medical record.

eyeQuest encourages providers to provide diagnosis results to both eyeQuest and the PCP. eyeQuest uses these results to conduct disease management studies.

Disease Management Studies

As a complement to eyeQuest's quality initiative, its quality improvement program includes annual disease management studies. Examples of these studies include:

- Cataract outcomes assessment
- Early recognition of diabetic macular edema

The goal of these studies is to evaluate the effectiveness of the delivery system with regard to clinical outcomes.

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

Since the inception of DentaQuest's vision product in 2007, eyeQuest has administered Medicaid vision programs on behalf of health plans contracting with state agencies. Today, eyeQuest manages vision programs on behalf of 12 health plan clients in 13 states, and is familiar with the state and federal requirements attending the administration of Medicaid programs. The high level of performance eyeQuest has achieved in Nevada on behalf of Amerigroup testifies to its ability to accommodate Nevada Medicaid program requirements.

In addition to providing vision services through its vision product, eyeQuest, DentaQuest administers dental programs directly with 10 state agencies and in a subcontracting role with 70 health plans. Today it serves more than 15 million government program recipients in 26 states.

Having administered government-sponsored benefit programs since 1993, the company is deeply familiar with federal and state program requirements governing Medicaid, Medicare, and CHIP

eyeQuest
Provision of vision care services
programs. Its system guards against fraud and abuse, one of the largest costs associated with Medicaid programs.
E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.
See Appendix 5.1.10.1.E for the resumes of eyeQuest's key employees.
F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area: 1. Information Systems 2. Utilization/Case Management 3. Claims Payment 4.Quality Improvement and Reporting (i.e. HEDIS, CMS) 5. Health education 6. Data / coding 7. Contract negotiations, Network recruiters 8. Encounter data 9. Other staff as needed
1. Information Systems: Greg Juedes 2. Utilization Management: Dr. John Davis 3. Claims Payment: Mary Alverson 4. Quality Improvement: Dr. John Davis 5. Health education: Dr. John Davis 6. Data coding: Greg Juedes 7. Contract Negotiations: Deseray Backman 8. Encounter Data: Greg Juedes
G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.
This can be found in the eyeQuest Attachments Tab.
H. List any bilingual staff, the area to which they are assigned and the languages spoken.
eyeQuest contracts with Certified Languages International to accommodate non-English speaking members. This professional language company specializes in telephone interpreter services and can accommodate more than 150 languages. Representatives have experience in medical and insurance terminology.
I. List any associations or organizations to which the organization belongs.
eyeQuest belongs to the National Association of Specialty Health Organizations.

eyeQuest
Provision of vision care services
5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included. **5.1.11.1** Medical Services A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.
Not applicable
B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.
Not applicable
C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.
Not applicable
D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.
Not applicable
E. Describe the roll and responsibilities of your case managers.
Not applicable
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Not applicable
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Not applicable
H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Not applicable
I. Provide your policies and procedures for emergency and post stabilization services.
Not applicable
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable

eyeQuest

Provision of vision care services
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
eyeQuest maintains a compliant network in both counties. Members living in urban and rural areas have, on average, three vision providers within 3.4 miles of their homes.
B. Provide a sample of all base network provider contracts.
See Attachment 5.1.11.4 B for eyeQuest's sample provider contract.
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
While eyeQuest currently does not have Essential Community Providers in its network, the company is open to accepting applications from these groups.
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?
eyeQuest monitors access to care to identify areas that may require additional recruitment. It uses the following reports to monitor network adequacy: ▪ GeoAccess®: This report provides a detailed overview of eyeQuest's network. It includes the number of members who have access to care in the required mileage criteria as well as the average distances to the three closest provider options. ▪ Provider status: This report shows the number of providers accepting new patients (number with open panels) and the number of providers accepting existing patients only (number with restricted panels or existing patients only). ▪ Grievance log: The grievance report notes member grievances related to accessing care. Should DentaQuest notice access issues in certain areas, it will analyze the provider network in those areas to determine if recruitment is necessary.
E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.

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Provision of vision care services

Monitoring Provider Activities

Appointment availability surveys

Each quarter, eyeQuest surveys the network to assess appointment availability and turnaround time for eyewear.

eyeQuest surveyed 54 locations during the third quarter of 2012. The survey results are as follows:

- All providers offered appointments within the required timeframe of 28 days.
- 98% of providers were compliant with the eyewear turnaround time of five business days.

Utilization review

eyeQuest monitors quality of care through its utilization review program. In 2011 and 2012 to date, there have been no instances of fraud or abuse.

Complaints and grievances

Members have the right to submit complaints regarding quality of care or about their experience. In 2011 and 2012 to date, there have been no member complaints or grievances.

Provider Relations

Nevada providers are very familiar with eyeQuest's provider relations representative, Deseray Backman. She works on a first-name basis with most of the providers in the network and has been recognized both internally and externally for her excellent customer service ethic. Ms. Backman is available during normal business hours to answer provider questions.

Provider Contracting

eyeQuest providers are credentialed in accordance with NCQA standards. eyeQuest conducts a thorough review of each provider's practice, including an evaluation of the following:

- Academic background
- Work experience
- Continuing education
- Office equipment
- Hours of operation
- Services provided
- Handicapped accessibility
- Languages spoken

Providers must supply the following information upon credentialing:

- State licensure (must be active and in good standing)
- Certification to use diagnostic pharmaceutical agents (optometrists only)
- Certification to use therapeutic pharmaceutical agents (optometrists only; for programs that include medical services)

Insurance documentation

- Each doctor must provide evidence of coverage indicating malpractice insurance in the amount of

eyeQuest

Provision of vision care services

$1 million per incident and $3 million in aggregate (minimums) or the community standard.

- Applications are subject to the Credentialing Committee's review of any malpractice, professional discipline history, or felony convictions.
- Providers must complete a professional background document which demonstrates appropriate pre- and post-professional education obtained at an accredited college of optometry, and they must provide professional employment history including professional memberships.

Office information

- Office location and equipment
- Hours of operation
- Range of services
- Credentials of support employees
- Languages spoken
- Handicapped accessibility
- Statement attesting to a lack of impairment due to chemical or substance abuse

Policies and Procedures

Nevada providers have access to the Office Reference Manual, which provides them with the information they need to manage their eyeQuest patients. It includes information such as how to submit appeals or grievances and clinical criteria used to make prior authorization determinations

F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.

In conjunction with Amerigroup, eyeQuest implemented an Adult Diabetic Member Outreach program to improve health outcomes. It involved providers reaching out to members to schedule an appointment and provide an adult fundus eye exam. As an incentive, Amerigroup pays the provider an additional $25 above the contracted reimbursement for an eye exam.

G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.

eyeQuest subcontracts with Classic Optical, a full-service central contract laboratory. Classic has consistently been rated one of the top performing laboratories in the nation. Classic is equipped with the latest optical manufacturing equipment to fabricate the full range of ophthalmic lenses.

Classic maintains standards for the industry set by the American National Standards Institute (ANSI) Z.80, which specify manufacturing requirements for ophthalmic frames and lenses. The requirements include compliance with Federal Regulation 21 CFR for lens hardening. eyeQuest's quality program encompasses onsite monitoring of the laboratory and includes inspection of finished eyeglasses.

Classic produces several thousand prescription eyeglasses daily. All work meets applicable safety regulations, codes, and laws including Occupational Safety and Health Administration (OSHA) and ANSI guidelines.

H. The National Provider Identifier (NPI) is the standard unique health identifier for health care

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Provision of vision care services
providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?
eyeQuest complies with National Provider Identifier (NPI) requirements.
5.1.11.5 Quality Assurance A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.
Not applicable
B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?
Not applicable
C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?
Not applicable
5.1.11.6 Fiscal Requirements A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?
eyeQuest has a solid track record of paying timely claims to its vision providers in Nevada. eyeQuest adheres to State and federal requirements pertaining to claim payment timelines in Nevada and other markets as a result of its efficient claims payment process. Its system accommodates the complexities of government-sponsored benefit programs, and its flexibility permits eyeQuest to meet the unique requirements of each state.
B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?
In 2011, eyeQuest paid 100% of claims (52,760) within 30 days, exceeding the 90% standard. No claims were pended in 2011. In 2011, eyeQuest denied 269 of 52,760 claims (0.5%). In 2011, eyeQuest's claim resubmission rate was 0.1%.
1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.
Not applicable
C. Describe your plan to identify and report suspected provider and recipient fraud.
The main focus of eyeQuest's utilization review program is reviewing claims data for aberrant

eyeQuest

Provision of vision care services

utilization and billing patterns. eyeQuest's analysis focuses on repetitive behavior patterns because eyeQuest found that individuals perpetrating fraud tend to repeat their behavior. Review and analysis of these reports allows eyeQuest to do the following:

- Identify unusual treatment and billing patterns
- Compare providers to their peers to establish a community standard
- Identify providers with certain claim submission patterns
- Identify member treatment with claim submissions

D. Describe and submit your policies and procedures for determining and collecting patient liability.

Not applicable

5.1.11.7 Grievances, Appeals and Fair Hearings

A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

Upon receipt of a complaint or grievance, the following data is captured:

- Member name
- Member ID
- Product ID
- Date due
- Source type
- Issue description
- Date received
- Member DOB
- Office involved
- Nature of complaint
- Resolution
- Resolution date
- Time received
- Product
- User ID
- Office address
- Issue type

After logging the case, eyeQuest sends acknowledgement correspondence within three business days. The Complaints and Grievances Specialist begins researching the case and coordinating with various departments through resolution. When necessary, eyeQuest may request records from the provider.

B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

eyeQuest experiences a very low incidence of complaints, grievances, and appeals. In fact, it has not received any member complaints, grievances, or appeals in 2012 for Amerigroup. Last year, eyeQuest received one member appeal, which was resolved within the required timeframe.

eyeQuest's standards for Amerigroup Nevada are as follows:

- Resolve member clinical appeals in 10 business days.
- Have a less than 1% incidence of member clinical appeals.

5.1.11.8 Operational Requirements

Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed

eyeQuest
Provision of vision care services
contract and lines of authority within the corporate structure.
See Appendix 5.1.11.8 for eyeQuest's organizational chart.
5.1.11.9 Implementation A. If you currently do not have an established network, what time frame and approach will you use to build a network?
eyeQuest has an established network in place in Nevada.
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Not applicable (eyeQuest is established in Nevada)
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
eyeQuest administers the routine vision benefit on behalf of Amerigroup and can accommodate all State reporting requirements.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
eyeQuest provides compatible interfaces with existing and proposed information systems.
5.1.11.12 HIPAA Compliance A. Describe your status, resources, and approach to HIPAA compliance.
eyeQuest's legal team ensures DentaQuest/eyeQuest is HIPAA-compliant. eyeQuest offers several secure data transfer methods including secure socket layer (SSL) file transfer protocol (FTP) and individual Pretty Good Privacy (PGP) file encryption. Data can push to eyeQuest's websites or pull from the client's file transfer areas. All websites and FTP areas are secured with 128-bit encryption and comply with HIPAA security and privacy requirements. DentaQuest trains employees annually in HIPAA and all must comply with company standards and security protocols including those governing e-mail transmissions, data transmissions, and PC security. All DentaQuest employees, temporary employees, and consultants sign a confidentiality policy upon hire. eyeQuest also conducts annual training for all employees pertaining to confidentially, HIPAA regulations, and fraud and abuse detection. Employees must successfully complete testing in each area.
B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.
eyeQuest's HIPAA-compliant operating system is a rules-based engine that enables auto-adjudication of claims in real time. This flexible, parameter-driven program has an open architecture to

eyeQuest
Provision of vision care services
accommodate the full spectrum of vision care plan designs and benefit levels as well as multiple line items for each claim. Most clients require regular utilization reporting in specified or mandated technical formats. eyeQuest's flexible system facilitates the mapping of outbound utilization data interchange files in proprietary formats as well as in HIPAA-standard formats such as the ANSI 837P claim format. It compiles data based on contract requirements for each data interchange and provides a wealth of transaction logging and file statistics. 837 files transmit to clients via many different file transfer protocols. The most often used is FTP, but eyeQuest also uses Connect: Direct with several clients.
5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial. 5.1.12.1 Dun and Bradstreet Number
DentaQuest/eyeQuest is not rated by Dun and Bradstreet.
5.1.12.2 Federal Tax Identification Number
DentaQuest/eyeQuest's TIN is 20-0390099.
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement
See Appendix 5.1.12.3.

5.3 BUSINESS REFERENCES

eyeQuest Reference Information

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding eyeQuest directly to the Purchasing Division.

Table 5.3-1. eyeQuest Reference 1

Reference #:	1		
Company Name:	eyeQuest		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	James Christian Vice President, Network Development and DC HealthCare Alliance DC Chartered Health Plan		
Street Address:	1025 15th Street NW		
City, State, Zip	Washington, DC 20005		
Phone, including area code:	(202) 216-2304		
Facsimile, including area code:	N/A		
Email address:	jchristian@chartered-health.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Medicaid managed care services for families, children, and individuals with disabilities for more than 118,000 members in the District of Columbia.		
Original Project/Contract Start Date:	07/01/2010		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	DentaQuest administers approximately 118,000 members		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing since DentaQuest is still under contract		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

Table 5.3-2. eyeQuest Reference 2

Reference #:	2		
Company Name:	eyeQuest		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	Maura Bordas Senior Vice President, Community Programs HHC Choices Health Plan, LLC		
Street Address:	2100 Bartow Ave		
City, State, Zip	Bronx, NY 10475		
Phone, including area code:	(718) 678-1511		
Facsimile, including area code:	N/A		
Email address:	mbordas@hhcinc.org		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	DentaQuest provides long-term care managed services for adults in and around the New York City area.		
Original Project/Contract Start Date:	04/01/2012		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	DentaQuest administers approximately 2,000 members		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

Table 5.3-3. eyeQuest Reference 3

Reference #:	3		
Company Name:	eyeQuest		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	Nataliya Averyanova Asst. Vice President, Government Affairs VillageCare MAX		
Street Address:	154 Christopher St		
City, State, Zip	New York, NY 10014		
Phone, including area code:	(212) 337-5750		
Facsimile, including area code:	N/A		
Email address:	nataliyaa@villagecare.org		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	DentaQuest provides long-term care managed services for adults in and around the New York City area.		
Original Project/Contract Start Date:	07/01/2012		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	DentaQuest administers approximately 1,000 members		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Project is ongoing		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Project is ongoing		

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

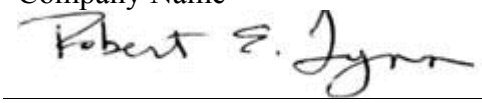
YES X I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

DentaQuest LLC

Company Name



Signature

Robert Lynn — Print Name

11/1/12 — Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

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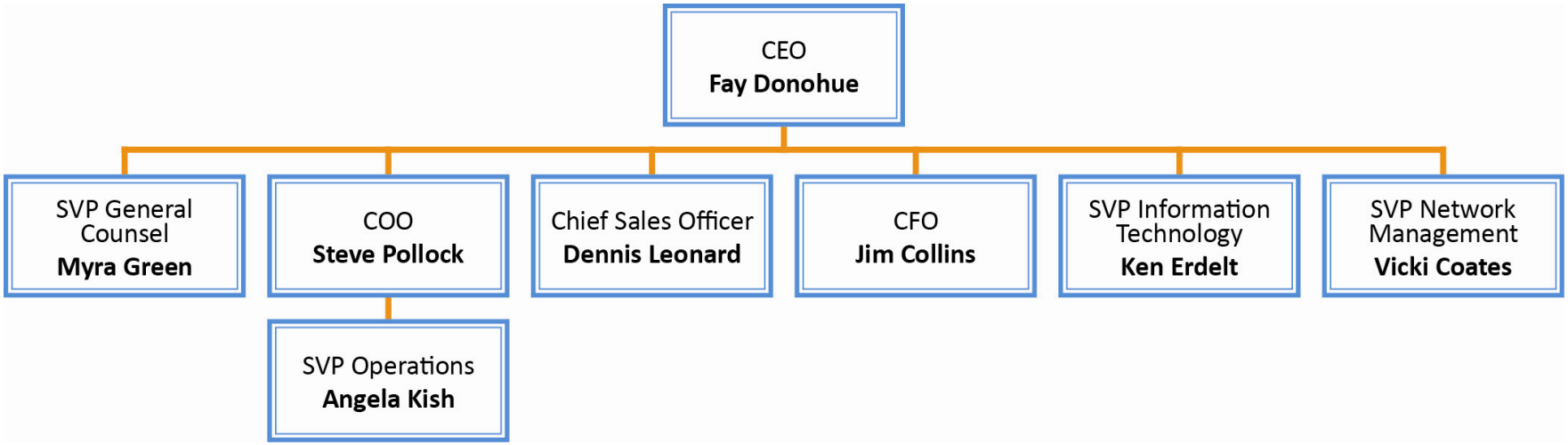
eyeQuest Organizational Chart



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EYEQUEST PROPOSED STAFF RESUMES

Brett Bostrack

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	eyeQuest		
☐ **Contractor**		**X Subcontractor**	
Name:	Brett Bostrack	☐ **Key Personnel**	
Classification:	Regional Vice President	**# of Years in Classification:**	1
Brief Summary of Experience:	Strategic thinker and succinct communicator with history of building strong client relationships. More than ten years of progressive leadership of key business accounts. Exceptional market insight with the ability to extract or determine key information and prepare effective response. Resourceful problem-solver with consistent track record for managing P&L and driving growth.		
# of Years with Firm:	11		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	03.2011 - Present **eyeQuest** 12121 N Corporate Parkway Mequon, WI 53092 P: 262-834-3578 Brett.Bostrack@dentaquest.com *Regional Vice President* • Responsible for direction and management of regional Medicaid, CHIP, and Medicare managed care accounts		
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	09.2008 – 02.2011 **eyeQuest** 12121 N Corporate Parkway Mequon, WI 53092 P: 262-834-3578 Bret.Bostrack@dentaquest.com *Director, Client Relations* • Developed effective professional relationships with key stakeholders of private and public sector clients in order to retain accounts, expand business within existing plans and geographic		

	regions, and increase revenue • Guided clients through critical contracting, compliance, financial and operational business issues within a highly regulated and financially restrictive Medicaid environment.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	04.2007 – 09.2008 **eyeQuest** 12121 N Corporate Parkway Mequon, WI 53092 P: 262-834-3578 Bret.Bostrack@dentaquest.com *Director, Cost Management* • Developed and implemented strategies and solutions that effectively managed dental program costs to achieve financial objectives • Communicated financial performance audiences with wide-ranging financial acumen
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Luther College Decorah Iowa Bachelor's Degree
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Veronica Piotrowski Director of Communications and Development The University of Arizona Health Plans 2502 E. University Suite 125 Phoenix, AZ 85034 P: (602) 344-8340 F: (602) 344-8371 veronica.piotrowski@uahealth.com Nick Curran Principal Executive Search Partners 322 East Michigan Street, Suite 502 Milwaukee, WI 53202 P: (414) 278-9778 , x.223 F: (414) 270-4520 nick@espwi.com Lourdes Rivas COO Better Health Plans 1701 Ponce de Leon Blvd Coral Gables, FL 33134 P: (786) 441-4730 F: N/A LRivas@simplyhealthcareplans.com

John Davis

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	eyeQuest		
☐ **Contractor**		**X Subcontractor**	
Name:	John Davis, O.D.		☐ **Key Personnel**
Classification:	Clinical Vision Director	**# of Years in Classification:**	≤1
Brief Summary of Experience:	Over 24 years of managed vision care experience. Founder and former CEO of a network management company where he oversaw the development and management of a multi-state, vertically integrated eye care delivery system. Mr. Dav is a Specialist in the formulation and implementation of QA/UR policies and procedures for integrated eye care networks. John Davis is a Doctor of Optometry with more than 29 years of hospital and private practice-based clinical experience.		
# of Years with Firm:	≤1		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***04/2012 to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	10.2011 – Present **eyeQuest** 465 Medford Street Boston, Massachusetts 02129 P: 954-226-0851 John.Davis@dentaquest.com *Clinical Vision Director* • Manages the clinical aspects of the Amerigroup Nevada vision program • Coordinates the activities of EyeQuest's clinical consultants • Oversees the performance of utilization management, utilization review and quality assurance departments
Required Information: ***Vendor Name: Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	09.2004 – 10.2011 **OptiCare Managed Vision (CENTENE)** *Vice President, Managed Care* • Primary duties included business development for new managed care business and interpretation and coordination of specific benefits to be delivered • Provided ongoing program support including Policy development and quality assurance and utilization management analysis

Required Information:	
MMYYYY to MMYYYY:	12/1988- 09/2004
Vendor Name:	**Ocucare Systems, Inc.**
Client Name:	**(sold to Centene predecessor in 2004)**
Client Contact Name:	
Client Address, Phone Number, Email:	
Role in Contract/Project:	*Position*
Details and Duration of Contract/Project:	• Multiple roles from Director of Provider Relations to President and CEO • Involved and intimate in all aspects of this specialty services network management and eye care delivery system
EDUCATION	
Institution Name:	New England College of Optometry
City:	Boston
State:	Massachusetts
Degree/Achievement:	
Certifications:	Florida State University Tallahassee Florida Bachelor's Degree
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Jay Myers Director of Provider Services Opticare P: (252) 451-2217 F: N/A jmyers@opticare.net Marigene McHale Market Director P: (216) 544-3501 F: N/A marigenemchale@cox.net David Freer Principle, Medical Consultants P: (407) 721-7648 F: N/A Drfreer2000@yahoo.com

Vidya Baliga

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	eyeQuest		
☐ **Contractor**		**X Subcontractor**	
Name:	Vidya Baliga		☐ **Key Personnel**
Classification:	Vision Operations Director	**# of Years in Classification:**	1
Brief Summary: of Experience:	Vidya Baliga has been a key contributor to driving change within organizations with a mission of excellence in serving its customers and a vision for growth and innovation.		
# of Years with Firm:	1		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information:	11.2011 - Present
MMYYYY to Present:	
Vendor Name:	**eyeQuest**
Client Name:	3835 West Green Tree Road
Client Contact Name:	Milwaukee, WI 53209
Client Address, Phone Number, Email:	P: 800-417-7140, ext. 73397 Vidya.Baliga@dentaquest.com
Role in Contract/Project:	*Vision Operations Director*
Details and Duration of Contract/Project:	• Oversees contractual and regulatory compliance pertaining to operational and network requirements Related accomplishments include: • Expanded operations staff to accommodate the needs of our growing client base • Introduced automated processes to increase operational efficiency • Increased the technical knowledge of her staff through ongoing training sessions • Improved the audit process to gauge the quality of our performance • Introduced a new quality assurance method
Required Information:	07.2011 – 11.2011
MMYYYY to MMYYYY:	
Vendor Name:	**Genesis10**
Client Name:	828 North Broadway
Client Contact Name:	Milwaukee, WI 53202
Client Address, Phone Number, Email:	P: 414-221-1707 vbaliga@genesis10.com
Role in Contract/Project:	*Position Business Analyst*
Details and Duration of Contract/Project:	• Worked on an Assortment Management program at a rapidly growing, leading retail company

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	11.2007 – 06.2011 **Safenet Consulting, Inc.** 10700 Research Drive, Suite 170 Wauwatosa, WI 53226 P: 877-271-5373 vbaliga@safenetconsulting.com *Business Analyst, Consulting at DentaQuest* • Worked on Business Transformation program • Implemented dental processing systems for the enterprise • Focused on design improvement of claims operations
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Calcutta University Kolkata, West Bengal, India Bachelor's of Science, Honors Economics Ranked 3rd in class
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Robert M. Ryan CEO Peracs, LLC P: (888) PERACS.5 x702 (888-737-2275) F: (646) 417-8246 Email: robert.ryan@peracs.com Claude Dance Executive Vice President of Sales & Marketing Sharps Compliance, Inc. P: (800) 772-5657 F: (713) 660-3575 cdance@sharpsinc.com Rachael Yerges VP Client Services - GENCO Pharmaceutical Services GENCO ATC, PRODUCT LIFECYCLE LOGISTICS P: (414) 459-8395 F: (412) 820-3689 rachael.yerges@gencoatc.com

Nevada License Certification

Scott J. Kipper, Commissioner of Insurance

Nevada Division of Insurance

DENTAQUEST LLC
12121 CORPORATE PKWY
MEQUON WI 53092-3332

Date: July 09, 2012

The entity or individual shown above is licensed as follows:

DENTAQUEST, LLC

License Type	Qualification	Effective Date	Expiration Date	License Number
Non-Res. Third Party Admin.		10-01-2009	02-01-2014	579720
	TPA1 -Life/Health Insurance	10-01-2009		
Utilization Review		08-09-2011	03-01-2013	528207

Nevada License Certification

This letter certifies that on the date it was produced the referenced licensee was actively licensed by the Nevada Division of Insurance for the license type indicated. The licensee was in good standing unless otherwise indicated.

All agents, brokers and consultants must complete prelicensing education and pass a written examination prior to being licensed. 30 hours of continuing education is required at renewal.

This is an official certification issued by the State of Nevada and is valid without signature and seal.

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VISION PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT is made between DentaQuest, LLC d/b/a eyeQuest (hereinafter referred to as "eyeQuest") and _____
(Business Name as it appears on W-9)
(hereinafter referred to as "Provider") and is effective as of date executed by eyeQuest ("Effective Date").

WHEREAS, eyeQuest is a company that arranges for the delivery of vision services to Members of prepaid healthcare plans, employer groups and other organizations contracting with eyeQuest; and

WHEREAS, Provider, has an unrestricted license to practice optometry, ophthalmology or opticianry in the state in which services are to be provided and desires to provide vision services pursuant to the terms and conditions of this Agreement;

NOW, THEREFORE, in consideration of the above and the promises hereinafter contained, the parties hereby agree as follows:

1. Definitions

(a) "Agreement" means this Agreement between eyeQuest and Provider, including all attachments hereto.

(b) "Appeal" is a request from a Member for a reversal of a denial by eyeQuest to provide a service prescribed for the Member by an appropriately qualified practitioner.

(c) "Complaint" is a dispute or objection regarding a Participating Provider or the coverage, operations or management policies of eyeQuest or Plan, which has not been resolved by eyeQuest or Plan and has been filed with the applicable Department. The term does not include a Grievance.

(d) "Covered Services" is a vision service or supply that satisfies all of the following criteria:
1. provided or arranged by a Participating Provider to a Member;
2. authorized by eyeQuest in accordance with the Plan Certificate or requirements;
3. submitted to eyeQuest according to eyeQuest's filing requirements; and
4. limited to the most professionally recognized standards of vision practice within the service area and applicable polices and procedures.

(e) "Encounter Data" means information of any vision services provided to Member.

(f) "Emergency Covered Service" means any health care service provided to a Member after sudden onset of a condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect absence of immediate attention to result in:

1. placing the health of the Member, or with respect to a pregnant women, the health of the women or her unborn child, in serious jeopardy;
2. serious impairment of bodily functions; or
3. serious dysfunction of any bodily organ or part. Emergency transportation and related emergency services constitute an emergency service.

(g) "Grievance" is a request by a Member or Participating Provider, with written consent by the Member, to have Plan or eyeQuest reconsider a decision solely concerning Medical Necessity and appropriateness of the service. If Plan is unable to resolve the matter, Grievance may be filed regarding a decision that:

1. disapproves of full or partial payment for requested service;
2. approves provision of a requested service for lesser scope or duration than requested; or
3. disapproves payment for provision of a requested service but approves payment for provision of an alternative service. The term does not include a Complaint.

(h) "Medically Necessary" means determinations of medical necessity for covered care and services, whether made on a prior authorization, concurrent review or post-utilization basis, shall be in writing and compensable under Medical Assistance. eyeQuest shall base its determination on information provided by the Member, the Member's family/caretaker and the Participating Provider as well as any other program and agencies that have evaluated the Member. Satisfaction of any one of the following standards will result in authorization of the service:

1. The service or benefit will, or is reasonably expected to, prevent the onset of illness, condition or disability.
2. The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
3. The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

(i) "Member" means any individual who is eligible to receive Covered Services pursuant to a contract and the eligible dependents of such individuals.

(j) "Participating Provider" is a vision professional or facility or other entity, including Provider, that has entered into a written agreement with eyeQuest, directly or through another entity, to provide vision services to selected groups of Members.

(k) "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members.

(l) "Plan Certificate" means the document that outlines the benefits available to Members.

(m) "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with eyeQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

(n) "Individual Provider" is a vision professional, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider.

2. Obligations of eyeQuest

(a) Operations. eyeQuest shall conduct the day-to-day administrative operations of eyeQuest, including but not limited to: negotiating contracts and provider agreements with Providers, making benefit determinations; conducting actuarial analyses; processing claims; regulatory compliance and reporting; and marketing eyeQuest.

(b) Directories. eyeQuest shall maintain a listing of Participating Providers and may include Provider's participation in Plan's network in provider directories and/or other publications intended for use of Members, subject to approval by Plan, which may include but are not limited to: name, address, office hours, telephone number, services provided and license type.

(c) Benefit Changes. eyeQuest shall notify Provider of changes in benefit provisions offered by the Plan.

(d) Quality Improvement. eyeQuest shall operate, at its own expense, quality assurance, utilization review and Member grievance programs.

(e) Payment Processing. eyeQuest shall transmit payments to Provider in accordance with the terms and conditions of this Agreement, or as may otherwise be agreed upon between the parties in writing.

(f) Regulatory Compliance. eyeQuest shall establish and enforce policies and procedures designed to ensure continued compliance with State and Federal regulations.

(g) Access to Care. eyeQuest shall conduct its administrative operations in a manner that does not encourage Provider to jeopardize Member's access to care or the appropriate delivery of Covered Services to Members.

(h) Treatment Alternatives. The provider has the right to discuss appropriate treatment alternatives and to discuss medically necessary care with the patient without being sanctioned.

3. Provider Obligations

(a) Provision of Services. Provider shall render to Members all Covered Services and continue to provide Covered Services to Members. After the date of termination from participation, upon the request of eyeQuest, Provider shall continue to provide Covered Services to Members for a period not to exceed ninety (90) days during which time period payment will be made pursuant to Attachment A for Covered Services provided. Participating Provider shall not deny services to a Covered Person who is only eligible for fee-for-service ("FFS") Medical Assistance. For newly eligible Covered Persons who fall into a FFS eligibility window prior to the effective date of Plan enrollment, Participating Provider is prohibited from denying services to a Covered Person during this FFS window.

(b) Submission of Claims. Provider shall submit claims for vision services to eyeQuest in a manner and format prescribed by eyeQuest. Provider understands that failure to submit claims or failure to submit requested documentation within 90 days will result in loss of reimbursement for services provided. Provider shall submit claims electronically to eyeQuest. If unable to submit claims electronically, paper claims must be submitted on a standard claim form or a format that has been approved by eyeQuest in advance.

(c) Non-discrimination. Provider shall not discriminate in the treatment or quality of services provided to Members on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, Vietnam-era veteran's status, ancestry, health status or need for health services of such Members and without regard to source of payments made for health services rendered to such Members. Provider shall make their services accessible to Members during the same hours and with the same intensity as they do to non-Members.

Provider agrees to comply with all applicable federal and state laws relating to nondiscrimination and equal employment opportunity, including the Civil Rights Act of 1964, regulations issued pursuant to that Act and provision of Executive Order 11246 dated September 26, 1965. Provider agrees to provide physical and program accessibility of vision services to persons with physical and sensory disabilities pursuant to Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by any applicable DHFS regulations (45 C.F.R. Part 84) of CMS regulation (42 C.F.R. Parts 417 and 434) and all guidelines and interpretations issued pursuant thereto.

(d) Policies and Procedures. Provider agrees to comply with any and all policies, rules and regulations of eyeQuest as they may exist from time to time including, but not limited to, claims processing, credentialing, quality or cost containment standards established by eyeQuest and Plans.

Provider agrees to refer patients that require covered specialty services that Provider does not perform, only to vision specialists designated by eyeQuest.

(e) Records. Provider agrees to:

1. Maintain adequate vision/medical, financial and administrative records related to covered vision services rendered by Provider in accordance with federal and state law.
2. Safeguard all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provider to or obtained by or through Provider's performance under this Agreement, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of his/her obligations and securement of his/her rights under this Agreement. Neither eyeQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure. Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with eyeQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws. Provider and eyeQuest acknowledge that the activities conducted to perform the obligations undertaken in this Agreement are or may be subject to HIPAA as well as the regulations promulgated to implement HIPAA. Provider and eyeQuest agree to conduct their respective activities, as described herein, in accordance with the applicable provisions of HIPAA and such implementing regulations. Provider and eyeQuest further agree that, to the extent HIPAA or such implementing regulations require amendments(s) hereto, Provider and eyeQuest shall conduct good faith negotiations to amend this Agreement. Provider shall maintain adequate vision/medical, financial and administrative records related to covered vision services rendered by Provider in accordance with federal and state law.
3. To cooperate and provide Plan, eyeQuest, government agencies and any external review organizations ("Oversight Entities") with access to each Member's vision records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member complaints or grievances or as otherwise is necessary or appropriate
4. To provide such information and data, including, but not limited to, encounter, utilization, referral and other data, that Oversight Entities may require.
5. To provide, at no cost to the Member or the Member's new or different vision provider, all Member's vision/medical records. Upon written request by a Member, Provider agrees to transfer the information in such Member's health care records to the person specified by the Member at no charge.
6. That any and all Member records will be maintained for a period not less than seven (7) years, or minimum required by state, following the termination of this Agreement or, if such records are under review or audit, until such review or audit is complete.
7. That all records shall be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of Oversight Entities at no cost to the requesting entity.
8. Upon termination of this Agreement for any reason, to make available to any Oversight Entities, in a useable form, all records, whether vision/medical or financial, related to Provider's activities undertaken pursuant to the terms of this Agreement at no cost to the requesting entity.
9. That any Oversight Entities, including but not limited to DSS, the Attorney General of the State, the state fraud agency, the United States Department of Health and Human Services ("HHS"), the Comptroller General of the United States, and/or their duly authorized representatives shall have access to any books, documents, papers and records which are related to this Agreement for the purpose of making audit,

examination, excerpts and transcriptions; provided, however, that those records detailing health care status and/or treatment of specific Members eligible for coverage of health care/vision services under Title XVIII of the Social Security Act need not be made available to the Comptroller General of the United States.

10. That Provider shall allow duly authorized agents or representatives of Oversight Entities, during normal business hours, access to Provider's premises to inspect, audit, monitor or otherwise evaluate the performance of Provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this paragraph, Provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate personnel conducting the audit or inspections effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information so obtained will be accorded confidential treatment as provided under applicable law. Oversight Entities and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Agreement.

(f) Authority of Provider. Provider represents and warrants that it has full authority to bind those providers listed as Individual Providers to the terms and conditions of this Agreement.

(g) Insurance. Provider shall procure and maintain at their own cost, liability insurance with limits as required by professional industry standards. Provider shall provide evidence of such coverage to eyeQuest upon the execution of this Agreement and thereafter as requested by eyeQuest.

(h) Medicaid Number. Provider shall have his/her own distinct state Medicaid number.

(i) Appointment Status. Provider shall ensure Members are offered appointments according to state requirements; Emergency care appointments must be available at all times. Urgent care appointments must be available within three (3) calendar days. Routine care appointments must be available within thirty (30) calendar days. In office wait time shall not exceed one (1) hour if an appointment is made.

4. Professional Requirements

(a) Licensure. Provider and employees or agents rendering services to Members shall be appropriately licensed to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing. Provider shall provide eyeQuest a copy of said license(s) upon execution of this Agreement and as required thereafter.

(b) Restriction of Licensure. Provider shall notify eyeQuest within two (2) business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts Provider's ability to practice.

(c) Professional Training. Provider and all employees or agents rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality vision patient care.

(d) Professional Standards. Provider and employees or agents rendering services to Members shall provide vision care which meets or exceeds the standard of care for vision providers in the region and shall comply with all standards for providers as established by any state or federal law or regulation.

(e) Continuing Education. Provider and employees or agents rendering services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

(f) Regulatory Compliance. Provider must meet the minimum requirements for participation in the Medicaid program as provided by the State. Provider warrants and represents that it is eligible and qualified to participate in federal and state health care programs, including the State's Medicaid Program, and shall immediately notify eyeQuest in writing upon becoming aware of any cause of action or proceeding which could result in the termination of Provider's eligibility or qualification to participate in such program.

5. Payment Arrangement

(a) Compensation. Upon receipt of payment from Plan, eyeQuest shall pay Provider according to Attachment A for eligible Medicaid Members. Participating Provider acknowledges that payments made to Participating Provider are derived from federal and state funds and that Participating Provider shall be held civilly and/or criminally liable to both Plan and State in the event of non-performance, misrepresentations, fraud or abuse of services rendered to Covered Persons. Provider agrees to accept electronic payment and electronic remittances if/when available.

(b) Hold Harmless. Provider agrees and warrants that in no event, including, but not limited to, nonpayment by eyeQuest or Plan, eyeQuest or Plan insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Member or persons acting on their behalf for providing Covered Services. This provision does not prohibit Provider from seeking to collect co-insurance, co-payments or deductibles from Members or fees for non-covered services delivered on a fee-for service basis to Members as well as services received by ineligible persons in accordance with the terms of the applicable Plan Certificate. Provider agrees that they shall hold the Members harmless and shall not bill the Member for non-covered services if the services are not covered as a result of any error or omission by Provider.

Provider also agrees that this hold harmless and warranty provision herein shall:

1. survive the termination of the Agreement regardless of the cause giving rise to termination, and
2. supersede any oral or written contract agreement heretofore entered into between Provider, eyeQuest, Plan and Members or designees.

Provider also agrees to hold Plan, the State, Members and the state agencies financially harmless from unpaid claims for Covered Services and not seek payment from the State, Members or state agencies, if eyeQuest will not pay for Covered Services performed by Provider under this Agreement.

(c) Co-payment Limits and Member Charges For Noncovered Services. No deductibles or co-payments are permitted for Medicaid Covered Services. A provider shall be permitted to charge an eligible Member for goods or services which are not covered only if the Member knowingly elects to receive the goods or services and enters into an agreement in writing to pay for such goods or services prior to receiving them. For purposes of this section non-covered services are services not covered under the Medicaid state plan, services which are provided in the absence of appropriate authorization and services which are provided out-of-network unless otherwise specified in the contract, policy or regulation (e.g., family planning, mental health or emergency room services).

(d) Coordination of Benefits. Provider shall notify eyeQuest whenever he/she has reason to believe a Member may be entitled to coverage under any other health benefit plan and shall assist eyeQuest in obtaining information for the coordination of benefits when a Member holds other coverage. If a Member is also covered by another vision plan, and eyeQuest determines it is the primary carrier, the Provider agrees that eyeQuest's obligation to Provider will not exceed the compensation described in this Agreement for the Covered Services in question. If a Member is also covered by another health benefit plan and eyeQuest determines that it is the secondary carrier, the Provider agrees that

eyeQuest's obligation shall not exceed the compensation described in the Agreement for the Covered Services in question and that Provider will refund (reduced by any payments the Member may have made to Provider) the aggregate compensation Provider received from the other health benefits plan for the Covered Services in question.

(e) Other Coverage. Provider agrees that payment defined in Attachment A shall be his/her sole compensation for rendering Covered Services to Members.

(f) Missed Appointment. Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or persons acting on their behalf for missed appointments. Provider shall not be required to accept or continue treatment of a Member with whom Provider feels he/she cannot establish and/or maintain a professional relationship, or is beyond the scope of Provider's expertise or ability.

(g) Plan Reimbursement. Compensation of Provider by eyeQuest is subject to, and dependent upon, eyeQuest's receipt of proper claims payment from Plan. In the event of nonpayment by Plan, eyeQuest reserves the right to withhold or recover payment to Provider for all claims not paid by Plan. Once eyeQuest has received the outstanding amount for such claims from Plan, eyeQuest will reimburse Provider according to the terms of this Agreement.

It is understood and agreed that Provider shall look solely to eyeQuest for compensation for Covered Services rendered hereunder to Members. Neither Provider nor any affiliate of Provider shall bill, charge or make any other claim against Members, Plan or the State or any of its regulatory agencies including, for such services except as specifically provided in this Agreement.

(h) Advance Deposits. Provider shall not require advance deposits for Covered Services from any Member who provides proof of identity and coverage under the Member Handbook. However, Members may be required to pay Co-payment amounts for certain Covered Services. The collection of Member Co-payments shall be the responsibility of Provider. Non-Covered Services are also collectible from the Member by the Provider.

(i) Prohibition on Waiver of Member's Financial Responsibility. Provider shall not, as a matter of business practice, waive Co-payment amounts due from Members for Covered Services provided.

6. Quality Management

(a) Cooperation with Quality Programs. Provider shall cooperate with and participate in the utilization review, quality assurance, credentialing, grievance, peer review, claims processing, and audit procedures of eyeQuest, and shall comply with all final determinations rendered by such procedures.

(b) Re-credentialing. Provider shall cooperate with the re-evaluation of their credentials at such intervals, as eyeQuest shall determine, but not more frequently than every three years. Such evaluation may take into account a review of Provider's past performance and practice patterns, and a review of vision records and evaluations pertaining to Provider's participation in the delivery of vision care.

(c) Audit of Records. eyeQuest, Plan and all applicable state and federal agencies shall have access at reasonable times and upon demand, to inspect the books, records and papers of Provider for the purpose of auditing and evaluating and determining on a concurrent or retrospective basis the necessity or appropriateness of health services provided to Members. eyeQuest, Plan or state and federal agencies or their designees shall also have the right to inspect, upon demand and at reasonable times, Provider's facilities pursuant to quality management programs or peer review programs. Provider shall provide copies of medical records to eyeQuest, Plan or state and federal agencies or their designees upon request. Copying and delivery expenses associated with compliance with this Agreement shall be the responsibility of Provider.

(d) Plan and Regulatory Agency Oversight. The Provider acknowledges and agrees that nothing in the Agreement shall be construed to limit: (a) the authority of the Plan to ensure the Provider's participation in and compliance with Plan's quality assurance, utilization management, member grievance and other systems and procedures; (b) any applicable regulatory agency's authority to monitor the effectiveness of such systems and procedures; or (c) Plan's authority to sanction or terminate a Provider found to be providing inadequate or poor quality care or failing to comply with Plan's systems, standards or procedures.

The Provider acknowledges and agrees that any delegation under a contract of quality assurance, utilization management, credentialing, provider relations and other vision management programs, shall be subject to Plan's oversight and monitoring of eyeQuest's performance. The Provider further acknowledges and agrees that Plan, upon the failure of eyeQuest to properly implement and administer such systems or to take prompt corrective action after identifying quality, member satisfaction or other problems, may terminate the contract and that, as a result of such termination, the Provider's participation in Plan may also be terminated.

7. Independent Contractors

(a) Professional Relationship. Provider is an independent contractor and is responsible for maintaining a professional relationship with Members. Provider is responsible for his/her own acts or omissions in his/her professional practice, as well as those acts or omissions of his/her employees and agents. No action by eyeQuest has or is intended to have the effect of infringing upon Provider's care and treatment of the Member, including without limitation all decisions with respect to administration, treatment or discharge of such Member.

(b) Appropriate Treatment. eyeQuest allows open Provider-Member communication regarding appropriate treatment alternatives. Provider will not be penalized for discussing Medically Necessary or appropriate patient care. A determination by eyeQuest that a particular course of treatment is not a Covered Service does not relieve Provider from providing or recommending such care to Members as he/she deems to be appropriate, and that determination may not be considered to be a medical determination made by eyeQuest.

8. Individual Provider

(a) Individual Provider Approval. Provider shall supply all information requested by eyeQuest for the purpose of credentialing Individual Provider, and Individual Provider must be approved for participation by eyeQuest in writing before rendering Covered Services to Members.

(b) Rights and Obligations. Individual Provider shall have the rights and obligations provided in the Agreement which are applicable to Provider, and understands that certain provisions of the Agreement shall also be individually binding on Individual Provider, and that eyeQuest may require performance of all provisions by Individual Provider. Individual Provider also understands that eyeQuest and Provider may amend the Agreement without right of review by or approval of Individual Provider.

(c) Reimbursement by Provider. Individual Provider agrees to look solely to Provider for reimbursement of Covered Services, where Provider is designated as payee pursuant to Agreement, as applicable.

9. Term and Termination

(a) Term. This Agreement shall begin on the Effective Date and shall end one (1) year from such date. Thereafter, this agreement shall automatically renew for successive one (1) year periods unless either party provides notice of its intent not to renew.

(b) Termination. This Agreement may be terminated as follows:

i. By eyeQuest upon 30 days prior written notice without cause.

ii. By Provider upon 90 days prior written notice without cause.

iii. By either party, in the event of a material breach of this Agreement by the other party, upon 60 days prior written notice to the other party.

iv. Upon the occurrence of any of the following events with respect to Provider, eyeQuest has the option to immediately terminate Provider's designation as a Participating Provider:

1. the death of Provider ;
2. the loss or suspension of the license of Provider;
3. the loss or suspension of Provider's drug enforcement administration license, or the loss of Provider's unrestricted prescribing privileges;
4. the loss of Provider's liability insurance;
5. the Provider being restricted from receiving payments from Medicare or Medicaid;
6. the Provider is convicted of any felony;
7. the Provider is convicted of any offense involving eyeQuest or Plan;
8. the failure of the Provider to meet any quality assurance, credentialing, or grievance program requirements of eyeQuest, Plan or any state or federal regulatory agency or their designees;
9. the Provider intentionally and purposefully does not comply with the referral and notification requirements of eyeQuest, Plan or any state or federal regulatory agency or their designees;
10. the Provider fails to cooperate with eyeQuest in the provision of cost-effective, quality services to Members;
11. the Provider is found to be harming Members; or
12. any adverse regulatory finding with respect to Provider.

(c) Effect of Termination. In the event of termination of this Agreement, Provider agrees to complete any treatment in progress and/or assist in the orderly transfer of Members to another provider, as requested by eyeQuest. Provider must provide timely notification to all Members affected by Provider's termination.

10. Miscellaneous

(a) Non-exclusivity. This Agreement is not an exclusive contract and eyeQuest may contract with other providers of vision services. Provider may contract with other vision plans. This Agreement shall be regarded as confidential and its terms or contents shall not be disclosed to any other party unless agreed to in writing by eyeQuest; except, however, Provider may disclose the contents of this Agreement to the legal representative of Provider without the consent of eyeQuest. No employee of a Participating Provider shall be limited from disclosing information pertaining to the MA Program.

(b) Amendment or Restated Agreement. eyeQuest may amend or restate this Agreement by sending a copy of the amendment or restated agreement to Provider at least 30 days prior to its effective date. If Provider does not object to such amendment or restated agreement in writing within such 30-day notice period, Provider shall be deemed to have accepted the proposed amendment or restated agreement as of the end of the 30-day notice period. In the event Provider objects within the 30-day notice period, by providing written notice to eyeQuest, the parties shall confer in good faith to reach agreement. If such agreement cannot be reached, eyeQuest may terminate this Agreement.

(c) Change in Status. Provider understands that any and all changes in the Provider's legal and contractual relationship to and with Provider's clinic partners, who are also party to this Agreement must be communicated in writing to eyeQuest, or eyeQuest may elect to immediately

terminate this Agreement. Provider also agrees to provide eyeQuest with 30 days advance written notice of any closure of their practice to additional Members, or new location at which Provider anticipates seeing Members.

(d) Waiver of Breach. The waiver by either party of a breach of violation of any provision of the Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.

(e) Governing Law. This Agreement shall be governed in all respects by the laws of the state in which services are provided.

(f) Responsibility for Actions. Each party shall be responsible for any and all claims, liabilities, damages, or judgments that may arise as a result of its own negligence or intentional wrongdoing.

(g) Severability. The invalidity or unenforceability of any term of condition shall in no way affect the validity or enforceability of the remainder of this Agreement.

(h) Arbitration. If a dispute regarding payment arises between the parties involving a contention by one party that the other has failed to perform its obligations and responsibilities under this Agreement, then the party making such contention shall promptly give notice to the other. Such notice shall set forth in detail, the basis for the party's contention, and shall be sent by Certified Mail-Return Receipt Requested. The other party shall within thirty (30) calendar days of receipt of the notice provide a written response seeking to satisfy the party that gave notice regarding the matters as to which notice was given. Following such response, or the failure of the second party to respond to the compliant of the first party within thirty (30) calendar days, if the party that gave notice of dissatisfaction remains dissatisfied, then the party shall so notify the other party and the matter shall be promptly submitted to inexpensive and binding arbitration.

(i) Assignment. eyeQuest may assign this Agreement immediately upon written notice to Provider. Provider must obtain eyeQuest's prior written consent to assign this Agreement.

(j) Notice. Any notices required to be given pursuant to the terms and provision hereof shall be sent by mail, addressed to eyeQuest at:

eyeQuest
Attn: Provider Information
12121 N. Corporate Parkway
Mequon, WI 53092

and to the Provider at the address stated herein or as he/she may otherwise notify eyeQuest in writing.

(k) Form. All words used herein in the singular number shall extend to and include the plural. All words used in the plural numbers shall extend to and include the singular. All words used in any gender shall extend to and include all genders.

(l) Entire Agreement. This Agreement, together with all subordinate and other documents and exhibits incorporated herein, constitutes the final and entire expression of the Agreement between the parties with respect to the subject matter contained herein and expressly supercedes all prior and contemporaneous representations, statements, drafts, correspondence or similar understanding or documents.

(m) Errors. eyeQuest shall make every effort to maintain accurate information; however, eyeQuest shall not be held liable for any damages directly or indirectly due to typographical errors. The Provider agrees to immediately notify eyeQuest of any errors.

(n) Member Bill of Rights

1. **The Right to Information.** Members have the right to receive accurate, easily understood information to assist them in making informed decisions about their health plans, facilities and professionals.

2. **The Right to Choose.** Members have the right to a choice of health care providers that is sufficient to assure access to appropriate high-quality health care including giving women access to qualified specialists and giving Members with serious medical conditions and chronic illnesses access to specialists.

3. **Access to Emergency Services.** Members have the right to access emergency health services when and where the need arises. Health plans should provide payment when a Member presents himself/herself to any emergency department with acute symptoms of sufficient severity "including severe pain" that a "prudent layperson" could reasonably expect the absence of medical attention to result in placing that consumer's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

4. **Being a Full Partner in Health Care Decisions.** Members have the right to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators. Additionally, provider contracts should not contain any so-called "gag clauses" that restrict health professionals' ability to discuss and advise Members on medically necessary treatment options.

5. **Care With out Discrimination.** Members have the right to considerate, respectful care from all members of the health care industry at all times and under all circumstances. Members must not be discriminated against in the marketing or enrollment or in the provision of health care services, consistent with the benefits covered in their policy and/or as required by law, based on race, ethnicity, national origin, religion, sex, age, current or anticipated mental or physical disability, sexual orientation, genetic information, or source of payment.

6. **The Right to Privacy**. Members have the right to communicate with health care providers in confidence and to have the confidentiality of their individually-identifiable health care information protected, as reasonably necessary and appropriate. Members also have the right to review and copy their own medical records and request amendments to their records.

7. **The Right to Speedy Complaint Resolution.** Members have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

8. **Taking on New Responsibilities.** In a health care system that affords Members rights and protections, Members must also take greater responsibility for maintaining good health.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date written below:

DentaQuest, LLC

Entity Name & Address

_____

_____

Tax ID: _____

Phone: _____

_____

BY: _____ BY: _____
(Signature) Steven J. Pollock
President

DATE: ___/ _____/_____ DATE: _____/ _____/_____

INDIVIDUAL PROVIDERS
(Please type or print)

Please list the name of all individuals providing vision services under the terms of this Agreement.

_____ _____
Individual Provider Individual Provider

_____ _____
Individual Provider Individual Provider

_____ _____
Individual Provider Individual Provider

ATTACHMENT A
Vision Reimbursement

4.00 Timing of Reimbursement Payments

4.01 eyeQuest shall pay Provider within thirty (30) calendar days of receipt of clean claims for vision services rendered to Members. Provider agrees to accept electronic payment and electronic remittances if/when available.

Provider reimbursement requires receipt of a clean claim. A claim shall be considered clean only if the claim requires no further information, documentation, adjustment or alteration by Provider to be adjudicated by eyeQuest. Any dispute regarding payment shall be deemed waived unless Provider submits written notification of the reasons for the dispute within sixty (60) days of receipt of the payment, statement of denial or adjustment.

4.02 Provider shall utilize Plan designated laboratory for fabrication of frames (V2020) and all lenses (V2100 - V2321).

Attachment A-1
Schedule of Allowable Fees
**** Please refer to your Office Reference Manual for covered procedures ****

Procedure Code	Description	Fee
Eye Examination		
92002	Exam New Patient (Intermediate)	$60.00
92004	Exam New Patient	$60.00
92012	Exam Existing Patient (Intermediate)	$60.00
92014	Exam Existing Patient	$60.00
Spectacle Frames and Lenses		
V2020	Vision Svcs Frames Purchases	Included
V2025	Vision Svcs Frames Deluxe	$20.00
M2025	Member's Frame	Included
V2100	Lens Sphere Single Plano 4.0	Included
V2101	Single Vision Sphere 4.12-7.00	Included
V2102	Single Vision Sphere 7.12-20.00	Included
V2103	Sphcyl 4.00D/12-2.00D	Included
V2104	Sphcyl 4.00D/2. 12-4D	Included
V2105	Sphcyl 4.00D/4.25-6D	Included
V2106	Sphcyl 4.00D/>6.00D	Included
V2107	Sphcyl 4.25D/12-2D	Included
V2108	Sphcyl 4.25D/2.12-4D	Included
V2109	Sphcyl 4.25D/4.25-6D	Included
V21 10	Sphcyl 4.25D/OVER 6D	Included
V21 11	Sphcyl 7.25D/.25-2.25	Included
V21 12	Sphcyl 7.25D/2.25-4D	Included
V21 13	Sphcyl 7.25D/4.25-6D	Included
V21 14	Sphcyl OVER 12.00D	Included
V21 15	Lens Lenticular Bifocal	Included
V21 18	Lens Aniseikonic Single	Included
V2121	Lenticular Lens, Single	Included
V2200	Lens Sphere Bifoc Plano 4.00D	Included
V2201	Lens Sphere Bifocal 4.12-7.0	Included
V2202	Lens Sphere Bifocal 7.12-20.	Included
V2203	Lens Sphcyl Bifocal 4.00D/.1	Included
V2204	Lens Sphcyl Bifocal 4.00D/2. 1	Included
V2205	Lens Sphcyl Bifocal 4.00D/4.2	Included
V2206	Lens Sphcyl Bifocal 4.00D/OVE	Included
V2207	Lens Sphcyl Bifocal 4.25/7D/.	Included
V2208	Lens Sphcyl Bifocal 4.25-7/2.	Included
V2209	Lens Sphcyl Bifocal 4.25-7/4.	Included
V2210	Lens Sphcyl Bifocal 4.25-7/OV	Included
V221 1	Lens Sphcyl Bifo 7.25-12/.25-	Included
V2212	Lens Sphcyl Bifo 7.25-12/2.2	Included
V2213	Lens Sphcyl Bifo 7.25-12/4.2	Included
V2214	Lens Sphcyl Bifo Over 12.	Included
V2215	Lens Lenticular Bifocal	Included
V2218	Lens Aniseikonic Bifocal	Included
V2219	Lens Bifocal Seg Width Over	Included
V2220	Lens Bifocal Add Over 3.25D	Included
V2221	Lenticular Lens, Bifocal	Included
V2300	Lens Sphere Trifocal 4.00D	Included
V2301	Lens Sphere Trifocal 4.12-7.	Included
V2302	Lens Sphere Trifocal 7.12-20	Included
V2303	Lens Sphcyl Trifocal 4.0/.12-	Included
V2304	Lens Sphcyl Trifocal 4.0/2.25	Included

Spectacle Frames and Lenses Continued		
V2305	Lens Sphcyl Trifocal 4.0/4..25	Included
V2306	Lens Sphcyl Trifocal 4.00/>6	Included
V2307	Lens Sphcyl Trifocal 4.25-7/.	Included
V2308	Lens Sphcyl Trifocal 4.25-7/2.	Included
V2309	Lens Sphcyl Trifocal 4.25-7/4.	Included
V2310	Lens Sphcyl Trifocal 4.25-7/>6	Included
V2311	Lens Sphcyl Trifo 7.25-12/.25-	Included
V2312	Lens Sphcyl Trifo 7.25-12/2.25	Included
V2313	Lens Sphcyl Trifo 7.25-12/4.25	Included
V2314	Lens Sphcyl Trifocal Over 12	Included
V2315	Lens Lenticular Trifocal	Included
V2318	Lens Aniseikonic Trifocal	Included
V2319	Lens Trifocal Seg Width >28	Included
V2320	Lens Trifocal Add Over 3.25D	Included
V2321	Lenticular Lens, Trifocal	Included
Dispensing Services * Dispensing is paid at $12.50 when member chooses a deluxe frame (V2025)		
92340	Fitting of Spectacles	$20.00
92341	Fitting of Spectacles	$2.00
92342	Fitting of Spectacles	$20.00
Contact Lens Fitting*	*Medically necessary only, with prior approval	
92310	Contact Lens Fitting	$72.62
92311	Contact Lens Fitting	$72.00
92312	Contact Lens Fitting	$77.54
92313	Contact Lens Fitting	$68.00
Contact Lens*	*Medically necessary only, with prior approval	
V2500	Contact Lens PMMA Spherical	$70.52
V2501	Contact Lens PMMA-Toric/Prism	$110.91
V2502	Contact Lens PMMA, Bifocal	$162.28
V2510	Contact Gas Permeable Sphericl	$94.80
V2511	Contact Toric Prism Ballast	$153.22
V2512	Contact Lens Gas Permbl Bifocl	$177.88
V2513	Contact Lens Extended Wear	$163.20
V2520	Contact Lens Hydrophilic	$83.64
V2521	Contact lens Hydrophilic toric	$145.61
V2522	Contact Lens Hydrophilic, Bifocal	$188.95
V2523	Contact lens Hydrophilic extend	$120.76
V2530	Contact Lens Scleral	$178.66
V2531	Contact Lens Scleral Gas Permeable	$426.30

ATTACHMENT FOR
STATE OF NEVADA MEDICAID REQUIREMENTS

1. Definitions

(a) "DHCFP" means the Nevada Division of Health Care Financing and Policy.

(b) "DHCFP Contract" means the contract relationship for the Nevada Medicaid Program and the contract or relationship for the Nevada Medicaid and SCHIP Programs between the Plan and Nevada Division of Health Care Financing and Policy ("DHCFP") for the provision of medical services to Members and shall include all DHCFP regulation.

2. Provider Obligations

(a) DHCFP Contract. Provider acknowledges that Plan has entered into a contract with the DEPARTMENT OF HUMAN RESOURCES, DIVISION OF HEALTHCARE FINANCING AND POLICY, NEVADA MEDICAID ("DHCFP") to provide managed care services to eligible Medicaid enrollees ("the DHCFP Contract") and agrees that the terms and conditions of the DHCFP Contract are hereby incorporated by reference in this Agreement. The DHCFP Contract will be provided to Provider upon request. Provider further agrees to abide by all DHCFP Performance Standards set forth below under Section 11. DHCFP Performance Standards and in the DHCFP Contract. Provider agrees it will reimburse Plan for any liquidated damages assessed against Plan for failure by Provider to comply with the DHCFP Performance Standards or the minimum standards set forth in the DHCFP Contract which can be traced to the failure of Provider to comply with the DHCFP Performance Standards or the minimum standards set forth in the DHCFP Contract. To the extent applicable, Provider agrees to submit valid Encounter Data.

3. DHCFP Performance Standards and Required Provisions

(a) Medical records must be maintained in accordance with standard XII of the "Guidelines for Internal Quality Assurance Programs" as set forth in the HCFA Medicaid Guidelines. The Records shall be available for review by duly authorized representatives of DHCFP and CMS upon request.

(b) Provider certifies that it does not currently have, pursuant to 42 USC § 1396a(p) and 42 CFR § 434.80 regarding any contractor, any person or entity with direct or indirect ownership interest or control of five percent (5%) or more in the Provider, any officer, director, agent, contractor or managing employee of the Provider, who has been convicted of any offense or received certain sanctions described in 42 USC § 1 320a-7(a) and (b) and 42 CFR 455.100 through 455.106 that is excluded or could be excluded, or that has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from any federal program and any individual or entity excluded from Medicare or Medicaid participation, or debarred, suspended, or excluded from any federal program that the Provider employs or contracts with directly or indirectly. Provider shall investigate and promptly, fully disclose to DHCFP the existence of any and all above referenced convictions and sanctions by the relevant persons and entities listed above, regardless of any opinion whether or not the entity or person could be excluded in accordance with 42 CFR 455.104. Such offense or sanction includes but is not limited to any debarment or suspension as a federal contractor under 28 CFR Part 67 or other exclusions contained in 42 USC § 1 320a-7, inclusive.

(c) Provider must comply with all applicable federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities act; the Equal Employment Opportunity Act (Executive

Orders 11246 and 11375); the Copeland Anti-Kickback Act (18 USC 874 and 70 USC 276c); the Davis Bacon Act, as amended (40 USC 276a to a7); Contract Work Hours and Safety Standards Act (40 USC 327-333); Rights to Inventions Made Under a Contract or Agreement; Clean Air Act (42 USC 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 USC 1251 et seq.; Byrd Anti-Lobbying Amendment (31 USC 1352); and Debarment and Suspension (Executive Orders 12549 and 12689); Energy Policy and Conservation Act.

(d) Provider must also not discriminate against recipients based on the same civil rights identifiers mentioned above. Non-discrimination notices must be posted to inform recipients and employees of the Provider's non-discrimination policies and practices.

(e) In connection with the performance of work under this contract, Provider agrees not to discriminate against any employee or offer for employment because of race, national origin, creed, color, sex, religion, age, physical or mental disability.

Provider agrees the books, records (written, electronic, computer related or otherwise), actuarial reports, financial statements, medical records, quality assurance data using the data and information set that the Secretary has specified for use under Part C of Title XVII, or such alternative data as the Secretary approves in consultation with the State, facilities and accounting procedures and practices of Provider relevant to this contract, shall be subject to inspection, examination, copying and audit during regular business hours, at various but necessary times by DHCFP or its contracted examiner(s), the State of Nevada Division of Insurance division or its contracted examiner(s), the State Board of Health and the State Health Division or its contracted examiner(s), the Attorney General of Nevada or the State Legislative Auditor, the Controller General of the United States, the United States General Accounting Office, the Centers of Medicare and Medicaid Services (CMS), or any authorized representative of these entities, or any other person or entity allowed by law, for the purposes of assuring financial solvency, determining amounts payable, assuring availability, accessibility and quality assurance standards, facilitating resolution of disputes arising under the contract and investigation of any suspected Medicaid fraud or abuse by Provider or recipient.

Provider agrees to the following terms and conditions as they pertain to services rendered to Members enrolled in an applicable Medicare Advantage Plan. Since the Agreement between Provider and Payor, in whole or in part, relates to services provided to Medicare Advantage Members, you are required by Centers for Medicare and Medicaid Services ("CMS"), contracted Plan, and Payor, to agree to and comply with the following requirements.

For purposes of this Medicare Requirements Attachment, reference to "Provider" means the individual or entity identified as a named party to the Agreement, its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities performing services related to the Agreement. Provider acknowledges that the requirements contained in this Attachment shall apply equally to the above referenced individuals or entities and that Provider's agreements with such individuals or entities shall contain the applicable Medicare requirements set forth in this Attachment. In the event of a conflict between any provision in this Attachment and such agreement, this Attachment will control.

Except as specifically amended hereby, the terms and conditions of the Agreement remain the same. In the event of a conflict between the Agreement and this Attachment, this Attachment will control with respect to Members of Medicare Advantage Plans.

1. **Compliance with Law.** Provider acknowledges that payment received for providing Covered Services to Members under the Agreement, in whole or in part, are deemed to be federal funds subject to all laws and regulations applicable to recipients of federal funds. As such, Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Plan and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation: (1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (2) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164. [42 C.F.R. § 422.504(h)].

2. **Medicare Advantage Member Privacy and Confidentiality.** Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the Medicare Contract regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated thereunder, (2) 42 C.F.R. § 422.504(a)(13), and (3) 42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable state and/or federal law or pursuant to court orders or subpoenas.

3. **Audits; Access to and Maintenance of Records.** Provider shall permit inspection, evaluation and audit directly by Payor, Plan, the Department of Health and Human Services (DHHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the DHHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s)

indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Payor, Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Members to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Payor, Plan and/or CMS with timely access to records, information and data necessary for: (1) Plan to meets its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Plan under the Medicare Contract. [42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v).]

In accordance with applicable law: (1) nothing in this agreement or any other agreement shall be construed to limit: (a) the authority of Payor or the Plan to ensure participation in and compliance with its quality assurance, utilization management, member grievance and other systems and procedures; (b) the DHHS' authority to monitor the effectiveness of the Plan's systems and procedures, or to require the Plan to take prompt corrective action regarding quality of care or Member appeals, grievances and complaints; (c) Payor or Plan's authority to sanction or terminate a provider found to be providing inadequate or poor quality care or failing to comply with Payor or Plan's systems, standards or procedures; and (2) Provider shall participate and abide by the decisions of Payor and/or Plan's medical policy, quality assurance, medical management, utilization review, member grievance and Medicare's appeal system.

Where applicable, Provider will participate in the collection and submission of data to CMS which includes, but is not limited to the following: (a) impatient hospital data for discharges; (b) physician, outpatient hospital skilled nursing facility and home health agency data; and (c) all other data CMS deems necessary. Provider shall certify the accuracy of he data that is collected and submitted to CMS where applicable.

4. **Prompt Payment of Claims.** Payor and/or Plan and/or Provider, as applicable, agree to process and pay or deny claims for Covered Services within thirty (30) calendar days of receipt of such claims in accordance with the Agreement. [42 C.F.R. § 422.520(b).]

5. **Hold Harmless of Members**. Provider hereby agrees: (i) that in no event, including but not limited to, nonpayment by Payor or Plan, Payor or Plan's determination that services were not Medically Necessary, Payor or Plan insolvency, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member for amounts that are the legal obligation of Payor or Plan; and (ii) that Members shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Members; (b) shall survive the termination of this Agreement regardless of the cause giving rise to termination, and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members, or persons acting on behalf of a Member. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i).]

Provider may notify a Member that certain medical services have been determined to be non-Covered Services according to the terms of the Plan and may, if the Member desires, make independent financial arrangements in advance, with written documentation thereof, and collect from such Member for such non-Covered Services. In the event that any charges for services which are determined to be non-Covered Services are billed by Provider to Payor, Plan or to a Member who has not agreed in advance in writing to independent financial arrangements and payment is made by Payor, Plan or Member, Provider shall immediately, upon request by Payor, Plan and/or Member, refund to Payor, Plan or Member the full amount collected by Provider attributable to non-Covered Service.

As required by 42 C.F.R. § 1001.952(m)(1)(i), in the case of services furnished to Members, Provider shall not claim payment in any form from CMS or from any other agency of the United States or from any state for items and services furnished in accordance with the Agreement, except as may be approved by CMS or a State agency, nor shall Provider otherwise engage in any shifting of costs or seek increased payments from the Medicare Advantage Program or any State health care program as a result of furnishing such services to Members.

6. **Accountability.** Payor and Provider hereby acknowledge and agree that Plan shall oversee the provision of services by Provider and Payor and shall be accountable under the Plan's Medicare Contract for services provided to Members under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Provider under the Agreement. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii).]

7. **Delegated Activities.** Provider acknowledges and agrees that to the extent Payor, in its sole discretion, elects to delegate any administrative activities or functions to Provider, Provider understands and agrees that: (i) Provider may not delegate, transfer or assign any of Provider's obligations under the Agreement and/or any separate delegation agreement without Payor's prior written consent; and (ii) Provider must demonstrate, to Payor's satisfaction, Provider's ability to perform the activities to be delegated and the parties will set out in writing: (1) the specific activities or functions to be delegated and performed by Provider; (2) any reporting responsibilities and obligations pursuant to Payor's or Plan's policies and procedures and/or the requirements of the Medicare Contract; (3) monitoring and oversight activities by Payor or Plan including without limitation review and approval by Payor or Plan of Provider's credentialing process, as applicable, and audit of such process on an ongoing basis; and (4) corrective action measures, up to and including termination or revocation of the delegated activities or functions and reporting responsibilities if CMS or Payor or Health Plan determines that such activities have not been performed satisfactorily. [42 C.F.R. § 422.504(i)(3)(iii); 422.504(i)(4)(i)-(v).]

The parties agree, notwithstanding anything set forth in the Agreement, that the Plan oversees and is accountable to CMS for any functions or responsibilities that are described in the CMS regulations.

8. **Compliance with Payor and Health Plan Policies and Procedures.** Provider shall comply with all policies and procedures of Payor and Plan including, without limitation, written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) provider consideration of Member input into Provider's proposed treatment plan; and (d) Plan's compliance program which encourages effective communication between Provider and Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. The aforementioned policies and procedures are identified in Payor and Plan Provider Manuals which are incorporated herein by reference and may be amended from time to time by Payor or Plan. [42 C.F.R. § 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

Provider shall report in writing to Plan within thirty calendar days of Provider's knowledge any and all civil judgments and "other adjudicated actions or decisions" against Provider related to the delivery of any health care item or service (regardless of whether the civil judgment or other adjudicated action or decision is the subject of a pending appeal). "Other adjudicated actions or decisions" means formal or official final actions taken against a health care provider by a federal or state governmental agency or a health plan, which include the availability of a due process mechanism, and are based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service. An action taken following adequate notice and hearing requirement that meets the standards of due process set out in section 412(b) of the Health Care Quality Improvement Act (42 U.S.C. § 11112(b)) also would qualify as a reportable action under this definition. The fact that Provider elects not to use the due process mechanism provided by the authority bringing the action is immaterial, as long as such a process is available to the subject before the adjudicated action or decision is made final.

9. **Continuation of Benefits.** Provider agrees that except in instances of immediate termination by Payor or Plan for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Provider will continue to provide Covered Services to Members as indicated below and to cooperate with Payor or Plan to transition Members to other participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of the Medicare Contract, Payor's or Plan's accrediting bodies and applicable law and regulation, Provider will continue to provide Covered Services to Members after the expiration or termination of the Agreement, whether by virtue of insolvency or cessation of operations of Payor or Health Plan, or otherwise: (i) for those Members who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Members through the date of the applicable Medicare Contract for which payments have been made by CMS to Payor or Plan; and (iii) for those Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g)(2) & (3).]

10. **Physician Incentive Plans.** The parties agree: (i) that nothing contained in the Agreement nor any payment made by Payor or Plan to Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Members; and (ii) that any incentive plans between Payor or Plan and Provider and/or between Provider and its employed or contracted physicians and other health care practitioners and/or providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract. Upon request, Provider agrees to disclose to Payor or Plan the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule or regulation. [42 C.F.R. § 422.208.]

11. **Termination.** Notwithstanding any provision regarding termination, no termination of this Agreement without cause or requested by Provider shall be effective unless made in advance in writing to Payor, not less than ninety (90) days prior to the anniversary date of the Agreement. Payor, the Plan or its designee may terminate Provider from this Product upon ninety (90) days advance written notice to Provider. If in Payor or Plan's judgment, Provider has failed to cooperate with and abide by the decisions of Payor or Plan's medical policy, quality assurance, medical management, utilization review, member grievance and Medicare's appeal systems, or is found to be harming Members, or if the continuation or participation negatively effects patient care, Provider's participation in this Product may be terminated. Nothing set forth herein shall limit the ability of the Plan to delegate all or a portion of these functions. Payor or Plan hereby agrees to provide notice to Provider when Payor or Plan denies, suspends, or terminates the Agreement with Provider and include: (a) the reason for the action, (b) the standards and profiling data Payor or Plan used to evaluate Provider, (c) the numbers and mix of health care professionals needed for Payor or Plan to provide adequate access to services, and (d) Provider's right to appeal the action and the timing for requesting a hearing.

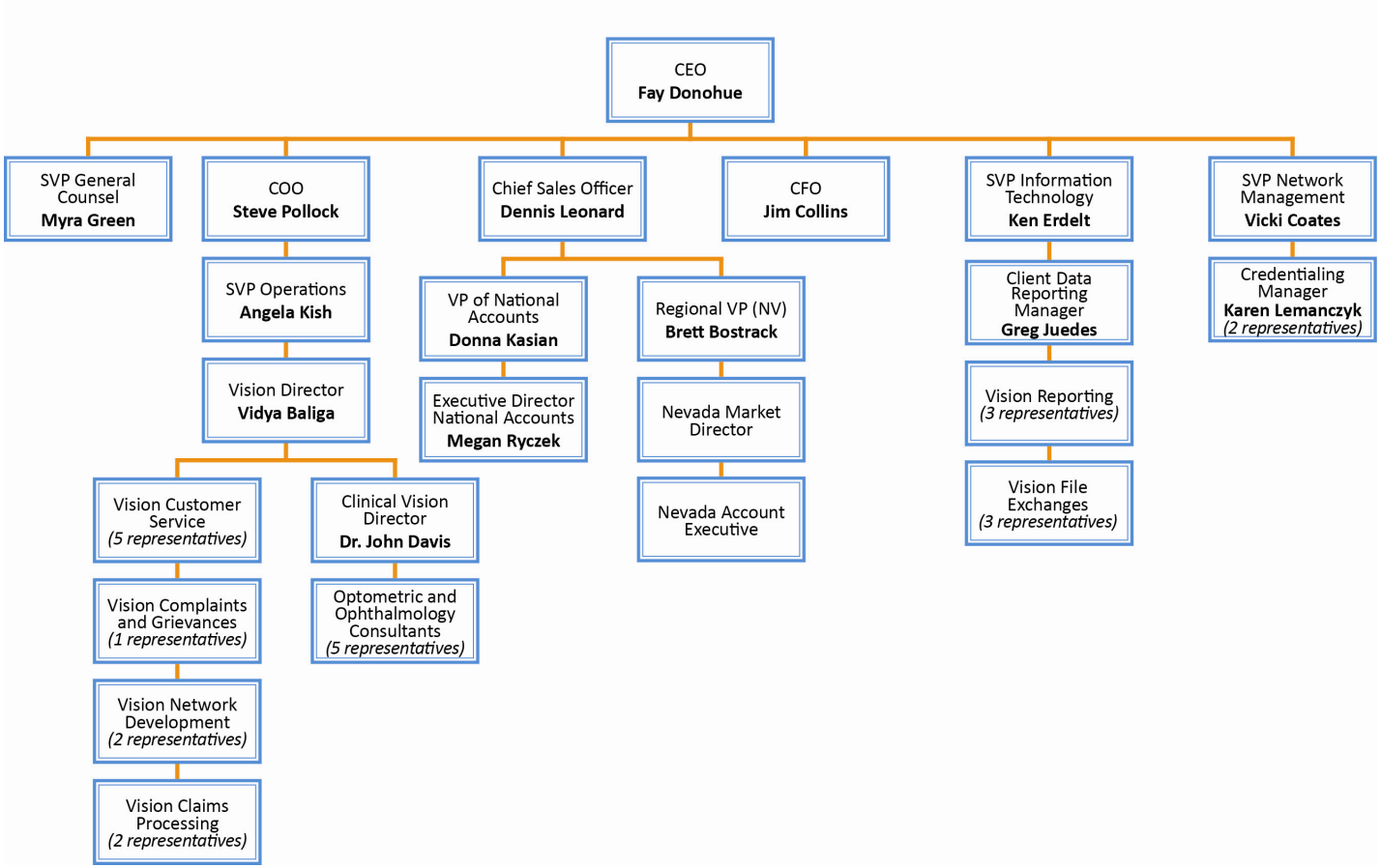
12. **Treatment Standards.** Provider agrees to provide, in a manner consistent with professionally recognized standards of health care, all benefits covered by the Plan. Provider shall provide Covered Services to Members in accordance with the same standards and within the same time frames as generally provided by Provider to other patients that are not Members and to not differentiate or discriminate in the treatment of or in the quality of services delivered to Members on the basis of age, race, color, national origin, religion, handicap, ancestry or marital status, any factor that is related to health status, or participation in the Medicare Program. Factors related to health status include, but are not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (g) disability.

14. **Credentialing.** To participate in any product offered to Medicare Members, Provider must meet the credentialing standard established by Payor and Plan.

15. **Exclusion.** Provider shall not employ or contract for the provision of health care, utilization review, medical social work, or administrative services with any individual excluded from participation in Medicare under section 1128 and 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider relating to the furnishing of these services to Members. Providers that are facilities, including Participating Hospitals, must be Medicare certified. All other Providers must be Medicare participating providers. Participating Providers shall notify Payor upon any change in such status.

16. **Initial Assessment**. As applicable, Provider shall cooperate with Plan in furnishing an initial assessment of new Members' heath care needs within 90 days of their enrollment.

eyeQuest Organizational Chart by Functional Area



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National Imaging Associates (NIA)

Administration of radiological and imaging services

5.1.1

Company name:	National Imaging Associates, Inc. (NIA)
Ownership (sole proprietor, partnership, etc.):	Corporation—Indirect, wholly owned subsidiary of Magellan Health Services, Inc.
State of incorporation:	Delaware
Date of incorporation:	1996
# of years in business:	17 years (since 1995)
List of top officers:	▪ Tina Blasi, CEO ▪ René Lerer, MD, Executive Vice President ▪ Thomas Dehn, MD, FACR, Chief Medical Officer ▪ Daniel Gregoire, Vice President, Secretary ▪ Jonathan Rubin, Vice President, Treasurer ▪ Linton Newlin, Vice President, Assistant Secretary ▪ Dennis Lazaroff, Vice President ▪ Margie Smith, Assistant Secretary ▪ John DiBernardi, Assistant Secretary
Location of company headquarters:	6950 Columbia Gateway Dr. Columbia, MD 21046
Location(s) of the company offices: Location(s) of the office that will provide the services described in this RFP:	NIA has customer care centers in St. Louis, MO; Phoenix, AZ; and Rancho Cordova, CA. For the radiology benefits management (RBM) program, NIA employees will support the State of Nevada comprehensively through several locations as follows: ▪ St. Louis, MO National Operations/Call Center: Prior Authorization/Utilization Management (UM) services ▪ California: Network support resources, including provider services, training, orientation, and service California, Missouri, Pennsylvania, Virginia: Comprehensive (Medicaid experienced) NIA account service team (comprising a Senior Account Manager, Radiologist Medical Director, a Senior Analytics Director, and a Client Service Lead).
Number of employees locally with the expertise to support the requirements identified in this RFP:	NIA's Provider Services team will be very involved with this account. Tina Kaplan, NIA's VP, Provider Relations, will oversee all provider training and orientation activities. Kevin Apgar, NIA's senior Provider Relations Manager for Nevada since 2001, will lead these activities and ensure that all Nevada providers understand the parameters of the RBM program and have the tools needed to participate with the program effectively. Ms. Kaplan and Mr. Apgar also will provide education and training to all health plan personnel and State of Nevada Medicaid personnel as needed.

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Administration of radiological and imaging services

Number of employees nationally with the expertise to support the requirements in this RFP:	NIA has 446 employees nationally and brings the State tremendous experience with a Medicaid presence in 31 national markets and serving more than six million Medicaid recipients nationally. Locally, NIA currently works with one Nevada payer and provides services to 85,000 Medicaid members. The number of employees that will be aligned to supporting the State of Nevada Medicaid account will be extensive and generally would represent a wide range of staffing across multiple business areas including the following: ▪ National Operations/Call Center (clinical and operational hub): 126 employees ▪ Provider Relations/Servicing: Two employees ▪ Network Development: Two employees ▪ Account Service Team: Five employees ▪ Executive Oversight: Two employees
Location(s) from which employees will be assigned for this project:	The employees designated to serve the State of Nevada are located in Missouri, California, Pennsylvania, and Virginia.

5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

NIA understands and complies with this requirement.

5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Is "Legal Entity Name" the same name as vendor is doing business as?

If "No", provide explanation.

License Number:16233. Yes, the legal name is National Imaging Associates, Inc. (NIA).

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

NIA understands and acknowledges this requirement.

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

A. Name of State Agency?

B. State Agency Contact name? Date when services were performed?

National Imaging Associates (NIA)

Administration of radiological and imaging services

C. Type of Duties Performed?

D. Total Dollar Value of the contract?

No

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

No

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

No

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Yes, NIA has all the appropriate insurance requirements as specified in Attachment E as applicable.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

As of June 30, 2012, NIA serves 6.1 million Medicaid lives, representing approximately 35% of NIA's book of business. NIA serves nearly 85,000 of those lives in the State of Nevada. Approximately one million lives (6%) of NIA's business is in serving Medicare lives, with the remaining 10.2 million (59%) commercial.

As a recognized leader in the Radiology Benefits Management space, NIA has provided innovative clinical solutions to payers since 1995, partnering with more than 51 national and regional customers

National Imaging Associates (NIA)

Administration of radiological and imaging services

and serving more than 17 million lives in 26 states. In 2008, NIA began partnering with Amerigroup Nevada to provide RBM services for the State of Nevada (Medicaid).

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

NIA has a proven track record in delivering clinically effective, quality focused, and financially viable programs. NIA offers a comprehensive range of programs and strategies focused on addressing the many challenges in the outpatient imaging arena (costs, quality, provider performance, patient safety) including advanced imaging, obstetrical ultrasound, pain management, and emergency department imaging.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

NIA was founded in 1995 as a division of Corning Life Sciences, Inc. NIA became an independent entity in 1996. On January 31, 2006, Magellan Health Services, Inc. (Magellan) purchased NIA from its shareholders, making NIA an indirect, wholly owned subsidiary of Magellan. Headquartered in Avon, Connecticut, Magellan, the country's leading diversified health services organization is a publicly traded, for-profit corporation that registers its stock with the US Securities and Exchange Commission and trades actively on the NASDAQ Stock Market under the ticker symbol MGLN.

Originally founded to provide radiology benefits management for advanced imaging modalities, NIA has since expanded its program offerings to include a more comprehensive suite of programs and solutions that address customer cost-of-care challenges. These solutions include the management of cardiac, oncology, pain, obstetrical ultrasounds, emergency department imaging, and genetic testing.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

NIA is a Delaware corporation. The State of Delaware does not apply procurement preferences that are not available to the State of Nevada.

D. The location of disaster recovery back-up site.

NIA uses Iron Mountain for daily data backup and offsite storage of data recovery media. If NIA declares a disaster, NIA delivers those media to its designated hot site, SunGard Recovery Services, in Philadelphia, PA.

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Darlene Burton, Senior Vice President, Business Partnerships

National Imaging Associates, Inc.

6950 Columbia Gateway Dr.

National Imaging Associates (NIA)

Administration of radiological and imaging services

Columbia, MD 21046

(410)-953-1211

dmburton@magellanhealth.com

F. The size of organization in assets, revenue and people.

Assets: Magellan's total assets as of June 30, 2012 totaled $1.409 billion, which includes unrestricted cash and investments of $239.5 million. NIA does not disclose asset information by business segment. This information is in agreement with Form 10-Q for the quarterly period ended June 30, 2012. The Form 10-Q for the quarterly period ended September 30, 2012 became available at the end of October, 2012.

Revenue: Through June 30, 2012, Magellan Health Services, parent of NIA, reported year-to-date net revenue of $1.579 billion. NIA's reported segment is $165.7 million.

People: Per Magellan's Form 10-K for the year ended December 31, 2011, Magellan had approximately 4,800 full- and part-time employees. This disclosure is made annually. NIA has approximately 446 employees.

G. The organizational chart of your senior management by function including key personnel.

See Attachment 5.1.11.8 for NIA's organizational chart.

H. The areas of specialization.

Areas of specialization include providing management solutions for high cost-of-care areas of outpatient imaging including advanced imaging, cardiac imaging, non-advanced imaging, obstetrical ultrasound, and pain management. NIA's solutions include a myriad of customized strategies ranging from clinical strategies (utilization management, validation of records, ordering/imaging request trends), provider assessment (accreditation, adherence to quality processes), and ongoing provider profiling.

I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.

NIA's annual net revenue for radiology benefits management services was $1.4 million in 2010 and $1.5 million in 2011.

J. The corporate philosophy and mission statement.

NIA's corporate philosophy is to deliver products and services that are built on a strong foundation of clinical integrity. NIA helps ensure that patients receive timely referrals to appropriate levels of needed care, prevents authorization of unnecessary procedures, and avoids the waste of customer or public money.

NIA's mission is to deliver innovative, clinically driven specialty management programs that create value for its customers and improve the overall health care experience for consumers.

K. A description of any plans for future growth and development of your organization.

NIA has built its reputation on staying on effective program development. Product Innovation is a core competency for NIA and is the result of a proven model that incorporates the voice of the customer,

National Imaging Associates (NIA)

Administration of radiological and imaging services

robust empirical modeling and informatics, and clinical rigor and expertise. NIA is committed fully to providing innovative utilization management solutions and deploys a dedicated Product Innovation team, led by a senior vice president who reports directly to NIA's CEO.

NIA's Product Innovation Strategy, which begins with the identification of high-growth areas of healthcare through environmental scans, customer feedback, consultation with diverse medical experts, and analysis of NIA's expansive data mart and other data. NIA consults with industry experts including specialty physicians, specialized coding and billing experts, and professional societies to determine NIA's ability to affect cost and quality for these areas. NIA builds each of its products on a foundation of the highest clinical integrity, and the company incorporates feedback and clinically sound programmatic elements that minimize disruption to provider workflows, while ensuring that recipients receive the most clinically appropriate care.

L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

Founded in 1995 as an RBM pioneer, NIA continues to expand both in terms of its product portfolio and the markets it serves. From its foundation in managing advanced imaging, NIA has expanded to offer its customers solutions in cardiac services, radiation oncology, ultrasound, and emergency department imaging. NIA always has served commercial as well as managed Medicaid and Medicare lines of business, although Medicaid continues to grow as the health care landscape changes and states and Medicaid plans recognize the value of NIA' services. NIA continues to seek expansion in Medicaid state program partnerships.

5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

16 years

5.1.10.1 Experience

A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:

1. Managing a network of Medicaid Providers;

NIA has developed a number of Medicaid imaging networks in states across the country, including Nevada, Florida, Georgia, Illinois, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, and South Carolina. In addition to competitive contracting, NIA has a strong provider servicing presence in these states to provide the necessary support and service needed in managing a delivery system.

For the State of Nevada, NIA is very familiar with the provider community, has an experienced Network Contracting and Provider Service team in place to support the State, and has conducted many provider training sessions with offices and hospitals.

Current Activities in Nevada

Since 2003, NIA has performed extensive provider outreach and education to Nevada providers including the following:

National Imaging Associates (NIA)

Administration of radiological and imaging services

- Nevada provider outreach and education calls (ordering and imaging providers/staff): 300
- Imaging Nevada provider on-site visits: 54
- Nevada ordering provider on-site visits: 34
- Nevada provider-office Town Hall Sessions conducted with more than 400 Nevada ordering, imaging, and hospital providers in attendance: Eight

2. Managed care programs for Medicaid recipients;

For more than a decade, NIA has been providing customized management solutions to customers that serve Medicaid populations. Recognized as a national leader in the RBM industry, NIA currently partners with 27 Medicaid customers and provides services to more than 6 million Medicaid recipients nationally.

In 2000, NIA implemented its first Medicaid customer partnership with Gateway Health Plan in Pittsburgh, PA. Since that time, NIA has continued to build a strong foundation of Medicaid customers. Today, NIA has a Medicaid presence across the country, including in the State of Nevada. NIA has been an RBM vendor for State of Nevada Medicaid with Amerigroup since 2009.

3. Administering Medicaid utilization and case management programs;

NIA brings extensive expertise in administering utilization management services ad currently administers utilization management programs for 51 commercial and state agency customers covering 17.28 million lives across 26 states, as of June 30, 2012. Of those lives, 6.08 million reflect Medicaid, 1.0 million reflect Medicare, and 10.2 million reflect commercial lives.

The company has been successful in developing focused utilization management solutions to address the diverse needs of Temporary Assistance for Needy Families (TANF); CHIP; Supplemental Security Income (SSI); and Aged, Blind, and Disabled (ABD) Medicaid populations, among others. NIA has worked with these underserved populations far longer than any other RBM organization and understands the age-related, geographic, and socio-economic challenges faced in the healthcare arena. Many recipients share the common denominator of anxiety, which is known to double non-mental healthcare utilization. This especially is reflected in the demand for lumbar (back-pain) magnetic resonance imaging (MRI) and brain (headache) MRI. This in-depth understanding of the social and clinical challenges in serving the Medicaid population manifests in a holistic approach that includes a number of NIA Physician reviewers with specific psychosocial competence. Additionally, NIA's attention to radiation exposure, especially in the female and younger populations, speaks to a sincere quality concern beyond mere economic issues.

4. Medicaid claims processing and adjudication

NIA brings a myriad of advanced imaging claims review and editing expertise for its customers, which helps achieve savings. From claims authorization matching to application of industry claim edits and Multiple Procedure Discounts (MPD), NIA provides this expertise for its customers. NIA also has a tremendous amount of operational expertise in reviewing claims and currently reviews approximately 70,000 per month.

Under this subcontractor agreement, NIA will not be reviewing, processing, or paying claims for the State of Nevada.

5. Project management; and

National Imaging Associates (NIA)

Administration of radiological and imaging services

NIA's Implementation team has a strong track record of successfully implementing more than 90 customer programs. The team has demonstrated success and very high satisfaction rates with the implementations of Medicaid plans using a proven implementation methodology and approach. The key to NIA's success is its ability to leverage proven project management tools. Early on, during NIA's implementation period, the team works collaboratively with the customer to understand key business requirements and important market nuances for developing the detailed business requirements and non-standard customer procedures. This ensures that the precise information relating to timeframes, clinical criteria and algorithms and all customer-specific business rules are loaded into the NIA platform system and ensure a flawless launch of the program.

The following best practices guide NIA's customer implementation process:

- Effective project work plan that serves as the roadmap for all implementation activity and ensures adherence to best practices, key dates, and milestones
- Formal project management status reporting and issue tracking
- Pairing of SMEs in cross-functional teams to ensure identification and integration of requirements

Account Management Services

- NIA's Director of Account Management, Ami Camardo, will be the designated account manager and will be involved with the State's implementation from day one. She will have ongoing responsibility for the relationship with Amerigroup and the State. She will be accountable for performing all aspects of defined account management activities and will have the main responsibility for ensuring that NIA continuously meets all program goals and objectives. Ms. Camardo also will be responsible for documenting ongoing issues and trends for the State and managing critical customer reporting, dashboards, and performance.

6. Qualifications of key personnel.

See Resume attachment, NIA Attachment 5.1.10.1. The following key personnel resumes are included under Attachment 5.1.10.1.E NIA Resumes

- Michael Pentecost, MD, FACR, Associate Chief Medical Officer
- Laurel Douty, Senior VP, Clinical Operations
- Annalisa Cooper, Senior VP, Client Services
- Ami Camardo, Director, Account Management
- Debra Guerino, VP, Implementation
- Marsha Marsh, VP, Call Center Operations
- Vonda LeDay, VP, Quality Operations
- Philip Rose, Director, Client Analytics

B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.

NIA uses its standards of performance to customize the ordering process for providers. Because NIA bases its management on a specific point in time as opposed to targeted health outcomes, NIA believes this is the best way to measure provider performance. NIA uses its extensive data warehouse as well as

National Imaging Associates (NIA)

Administration of radiological and imaging services

industry-accepted standards such as the CMS efficiency measures to measure provider performance. NIA offers those providers who order consistently within the guidelines a streamlined process to ease the administrative burden of prior authorization.

The outcomes of an RBM program depend on many factors. These are NIA's best practices in asserting some control over some of these factors, such as prior authorization, facility site selection (hospital versus office services), and provider assessment. Not included are other factors, such as pre-existing management approaches, plan benefit designs, the age/sex balance of the population, the plan's provider rates, and supply of the market's imaging providers.

While circumstances may differ for each customer, NIA's programs have proven to accomplish the following:

- Curtail the explosive growth in advanced, high-cost diagnostic imaging services caused by the ordering of inappropriate imaging
- Improve quality by supporting providers in their clinical decision-making regarding the most appropriate use of diagnostic imaging and avoiding unnecessary and potentially harmful exposure to patients to ionizing radiation
- Increase provider satisfaction with a utilization management program that is delivered effectively and efficiently. as demonstrated by NIA's call center service standards and extremely low rate of overturned determinations
- Measure the performance of imaging providers in the community (using efficiency measures) against industry-accepted standards used by CMS and the impact of the program on changing over utilization compared to accepted benchmarks
- Compare physician-ordering behaviors across modality, line of business, and area of the country to identify high-performing providers who order within the guidelines and providers who frequently order outside the guidelines

C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

Since its inception, NIA has invested in strategies that promote clinical excellence, provider engagement, and innovation. NIA has developed successful clinical programs that leverage clinical efficiencies, incorporate best practices, and create new capabilities for the future. The company has created long-term, positive relationships with national, regional, and local health plans and government agencies, adding value through aggressively managing costs, engaging recipients in the decision-making process, and delivering new and innovative solutions on an ongoing basis.

For example, a critical part of NIA's utilization management services is to ensure completion of accepted medical processes prior to imaging. This may include conservative therapy, other low-tech testing, laboratory work, or even alternative advanced imaging. The key focus is the "right test" at the "right time." NIA's trained clinical teams help ordering providers' offices understand the guidelines NIA applies and have the skills and knowledge to support guideline education as part of the process.

- NIA aims to make the clinical process as efficient as possible for the ordering providers in a customer's network by providing technology tools that streamline the process. NIA bases its proprietary algorithms on the clinical information necessary to approve or quickly pass the case on for additional review. NIA bases its nurse and physician scorecards on whether nurse and physician

National Imaging Associates (NIA)

Administration of radiological and imaging services

reviewers made the right decision—whether that is an approval or, in the case of a physician, a denial. This ensures that NIA's nurses are approving cases, if at all possible, at their level without elevating to the physician level.

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

NIA has a diverse book of business, which includes proven Medicaid experience and a strong understanding of state regulatory requirements for the Medicaid population. NIA has sound clinical knowledge of the diverse populations within the Medicaid segment (ABD, TANF, SSI, CHIP) and of the solutions that have been effective in addressing high utilization, high unit cost, high hospital facility usage, and potential patient exposure to radiation.

NIA's comprehensive scope of services for Medicaid populations includes such critical components as the following:

- Utilization management process that increases quality while reducing costs
- Successful call center operations that work fluidly with the client systems
- One-on-one consultative approach with a broad team of NIA physicians to orient and educate providers on NIA's appropriateness criteria
- Extensive provider outreach, communication, and a myriad of Web-based provider tools
- Radiation awareness program (focused on maternal and pediatric health)
- Streamlined program for processing appeals
- Industry-leading information technology team that works closely with each customer, defining critical interfaces and data pathways
- Suite of web-based provider tools and reporting websites
- Inclusive set of customized web-based reports and data analytics

E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

Please refer to NIA Attachment 5.1.10.1 to view résumés for some of the following key NIA personnel, who will be responsible for performance of any contract with Amerigroup resulting from this RFP:

- Michael Pentecost, MD, FACR, Associate Chief Medical Officer
- Laurel Douty, Senior VP, Clinical Operations
- Annalisa Cooper, Senior VP, Client Services
- Ami Camardo, Director, Account Management
- Debra Guerino, VP, Implementation
- Marsha Marsh, VP, Call Center Operations
- Vonda LeDay, VP, Quality Operations
- Philip Rose, Director, Client Analytics

National Imaging Associates (NIA)

Administration of radiological and imaging services

F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:

1. Information Systems
2. Utilization/Case Management
3. Claims Payment
4. Quality Improvement and Reporting (i.e. HEDIS, CMS)
5. Health education
6. Data / coding
7. Contract negotiations, Network recruiters
8. Encounter data
9. Other staff as needed

1. Information Systems

   Data Setup in NIA's System: Cathy Soucy, Senior Manager of Analysis and Programming

   Configuration of the State's setup in NIA's Clinical System: Lynette Ledesma, Senior IT Director
2. Utilization Management

   Clinical Utilization Management Oversight: Janet Maurer, MD, Medical Director

   Clinical Utilization Management: Brian Zimmerman, MD, Clinical Advisor
3. Claims Payment: Not applicable
4. Quality Improvement and Reporting

   Quality Improvement: Joann Albright, Magellan Senior VP, QI Outcomes and Research

   Reporting William Henderson, Senior VP, Client Analytics

   Compliance: LaNell Collins, National Compliance Officer
5. Health education: Not applicable
6. Data coding: Not applicable
7. Contract Negotiation: Not applicable
8. Encounter Data

   Establishment of Data Interfaces: Jennifer Millichamp, Supervisor of Analysis and Programming
9. Other

   Provider Relations: Tina Kaplan, VP, Provider Relations and Education; Kevin Apgar, Provider Relations Manager

   Clinical Services: Janet Maurer, MD, Medical Director; Brian Zimmerman, MD, Clinical Advisor

   Account Management: Tammy Goff, Senior Account Executive

   Operations: Kevin Frederick, Operations Hub Director

G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.

Please refer to NIA Attachment 5.1.10.1 for a copy of NIA's license to engage in the business of insurance in the State of Nevada in the capacity of Utilization Review. NIA does not operate as an HMO

National Imaging Associates (NIA)

Administration of radiological and imaging services

in Nevada.

H. List any bilingual staff, the area to which they are assigned and the languages spoken.

NIA contracts with Pacific Interpreters, its partner organization, to provide interpretation in more than 180 languages. For example, Pacific Interpreters employs interpreters who can converse in languages commonly spoken in Nevada, such as Spanish, Tagalog, Chinese, French, German, Korean, Italian, Japanese, Vietnamese, and Thai. This ensures that all non-English-speaking providers and members have equal access to the same level of services as those who do speak English.
Should NIA employees encounter a member or provider who speaks a language other than English, they quickly contact the Pacific Interpreters service. If NIA's intake employees do not recognize the language, the Pacific Interpreters operator helps to identify it and conferences in an interpreter within seconds. Pacific Interpreters is available to members, providers, and NIA employees during regular call center hours. Pacific Interpreters employs only skilled and professional interpreters who are specially trained in customer service and who exhibit cultural sensitivity in their handling of medical, financial, insurance, legal, and emergency services terminology.

I. List any associations or organizations to which the organization belongs.

Not applicable

5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

5.1.11.1 Medical Services

A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

Together, NIA and Amerigroup will evaluate State of Nevada program data received throughout the advanced imaging authorization process and develop an ongoing opportunity assessment for future cost and quality initiatives that the State could undertake. Generally, when NIA first implements a radiology benefits management (RBM) program, it requires approximately 100 days of authorization/claim activity to capture trends and provider profiling. Through a formal customer interface meeting, Amerigroup will present these imaging-specific program and savings opportunities.

As the RBM vendor, NIA also has a comprehensive technology assessment process, given the continual changes in the use of imaging equipment. NIA brings forward any changes in the use of imaging equipment to its customers for review and determination of benefit coverage. NIA's Medical Directors continually examine peer-reviewed literature and society guidelines including the National Comprehensive Cancer Network (NCCN) recommendations.

B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.

NIA uses internally developed proprietary guidelines.

The criteria are one of the industry's most comprehensive, evidence-based sets of clinical criteria. NIA

National Imaging Associates (NIA)

Administration of radiological and imaging services

clinicians developed the criteria through an extensive process of innovation and refinement and structured all guidelines on their analysis of public, peer-reviewed articles; health plan medical policies; CMS policies; and specialty physician reviews, professional society guideline statements, and other rigorous reviews of scientific documents.

NIA elected to develop proprietary guidelines due to the absence of high quality, commercially available guidelines. NIA adjusts all of its guidelines for age and gender. So, for example, a request for a brain CT for an adolescent or young female likely will result in a recommendation to substitute a brain MRI due to the dangers of radiation exposure.

C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.

Yes. All revisions are the result of a scientific process of clinical consensus, approved by the NIA Associate Chief Medical Officer, Michael Pentecost, MD, FACR., and the NIA Clinical Guideline Work Group. NIA's Clinical Department reviews its clinical guidelines at least annually, but typically far more frequently on an ad hoc basis, particularly those guidelines that relate to new technologies. The guideline review and revision process occurs over the course of the year, and the formal annual review completes by late summer or early fall of each year. This allows NIA enough time to notify customers, demonstrate compliance with specific state notification requirements, and make parallel algorithm changes. NIA implements the annually revised guidelines in January.

D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.

NIA may approve out-of-network services on advanced radiology procedures according to the State of Nevada's benefit policies. NIA only can render approval for advanced radiology procedures performed out-of-network after appropriate coordination with Amerigroup.

E. Describe the roll and responsibilities of your case managers.

Not applicable

F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.

Not applicable

G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?

Not applicable

H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.

Not applicable

I. Provide your policies and procedures for emergency and post stabilization services.

NIA's policy is that a member or a member's healthcare provider is never required to inform or contact NIA prior to the provision of emergency care, including emergency treatment. Accordingly, NIA can

National Imaging Associates (NIA)

Administration of radiological and imaging services
provide a retrospective authorization process for accommodating clinically urgent, medically necessary imaging procedures outside of a hospital emergency department. The NIA program focuses on managing elective, non-emergent outpatient exams. NIA does not manage imaging performed for patients in an inpatient setting or for those who present in the emergency department or are on observation status. Post-stabilization services are not applicable to NIA's function as a radiology benefits manager.
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
Not applicable
B. Provide a sample of all base network provider contracts.
Not applicable
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
Not applicable
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?
Not applicable
E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.
Not applicable
F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s)

National Imaging Associates (NIA)

Administration of radiological and imaging services

you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.

Not applicable

G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.

NIA currently does not have, or intend to have, sole source subcontracts.

H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?

NIA is in full compliance with NPI. Before activation within the provider network, NIA collects the NPI from every provider and then primary-source verifies it through the National Plan and Provider Enumeration System (NPPES) website. NIA stores the NPI in its provider data repository and extracts it for inclusion in all outgoing transactions and reports. Additionally, NIA re-verifies every provider's NPI as accurate and up to date every three years in conjunction with its re-credentialing process.

5.1.11.5 Quality Assurance

A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.

NIA's internal Quality Improvement (QI) program includes the objective and systematic monitoring of the quality and safety of advanced radiology services provided to a payer's enrollees and participants. NIA's QI program accomplishes its mission and promotes its vision through the implementation of an outcomes-oriented, continuous quality improvement program. To support this approach, NIA uses a written, internal QI program description as a dynamic document that responds to the voices of all stakeholders, offers flexibility in its actions, and can readily adapt as conditions warrant. NIA maintains this program throughout the year and prepares a revised version each year. NIA's process promotes continuous quality improvement, while it supports and enhances the integration of quality and accountability within operations and in the delivery of services and care for members. NIA's approach leads to systems evolution and the development of a culture of quality.

NIA has developed a QI program description that will serve the following purposes and compliance with the State's quality standards:

- Promote the performance of consistent, appropriate, and timely utilization of outpatient diagnostic imaging
- Help ensure provider conformance with the appropriate use of diagnostic imaging technology through the implementation of a prior authorization process
- Assist Amerigroup and the State in the reviews of potential over- and under-utilization when identified through the NIA analytic process
- Monitor the program's surveys to provide a high level of consistent services to the State, its members, and the Nevada provider community

National Imaging Associates (NIA)

Administration of radiological and imaging services

B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

NIA takes the following steps to assure quality performance:

- Conducts daily and weekly internal audits of health plan-specific and timeliness reports and annual audits of focused utilization management service activities
- Conducts regular case audits to evaluate the quality of employee services
- Reviews and updates clinical criteria annually, or more frequently as needed
- Maintains response process for member/provider complaints/appeals
- Reports monthly on core indicators for benchmarking and comparisons
- Participates in evaluating new technology or new technology applications
- Ensures consistent use of medical necessity criteria through Inter-Rater Reliability conducted on all utilization management staff members rendering decisions
- Updates and approves the annual Quality Program Description (annual quality goals) and Quality Work Plan (scheduled activities and indicators)
- Maintains processes to address specific provider incidents, including corrective actions, and changes of network status
- Conducts provider performance reviews (profiling) that is utilization directed quality focused, and based on national guidelines; offers an opportunity for measurable improvement through recommended action plans
- Documents, tracks, and addresses all reported quality of care concerns
- Analyzes satisfaction data; identifies/implements appropriate interventions
- Uses recording tools to monitor calls, capturing the audio and screen flow of calls to improve the audit process and provide coaching opportunities
- Visits high volume providers to evaluate service settings
- Maintains URAC UM accreditation and NCQA utilization management certification

C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

The design of NIA's platform and process precludes the collection of HEDIS information during the front-end process. However, NIA can provide retrospective clinical information and provider practice information to support some imaging-related HEDIS outcomes such as mammography recall and radiation exposure.

To integrate the knowledge inherent in its guidelines to the clinical practice of prior authorization, NIA embeds its highly effective algorithms and customer- and state-specific business rules into Informa, NIA's browser-based clinical system, used by its Customer Care Associates at NIA's call center and by providers through the RadMD.com website. NIA also includes requirements specific to its customers regarding timeliness and turnaround times.

National Imaging Associates (NIA)

Administration of radiological and imaging services

5.1.11.6 Fiscal Requirements

A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?

Not applicable

B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?

Not applicable

1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.

Not applicable

C. Describe your plan to identify and report suspected provider and recipient fraud.

Not applicable

D. Describe and submit your policies and procedures for determining and collecting patient liability.

Not applicable

5.1.11.7 Grievances, Appeals and Fair Hearings

A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

NIA is not delegated to perform enrollee complaints/grievances and does not manage access to State Fair Hearings. However, NIA does perform investigations on complaints and will send its responses to Amerigroup within 30 days. Amerigroup then will respond to the complainant. NIA will support Amerigroup as needed in Fair Hearings.

B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

NIA does not have any performance standards on grievances, appeals, or provider disputes. NIA does monitor the frequency and trends of the events and would take action if appreciable changes are noted. NIA also monitors overturned appeals.

5.1.11.8 Operational Requirements

Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.

See NIA Attachment 5.1.11.8 for the NIA organizational chart.

National Imaging Associates (NIA)

Administration of radiological and imaging services
5.1.11.9 Implementation A. If you currently do not have an established network, what time frame and approach will you use to build a network?
Not applicable
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
See NIA Attachment 5.1.11.9.
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
NIA is prepared to produce reports listed in Attachment I Forms and Reporting Guide where appropriate.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
NIA understands that secure file transfer capability is of paramount importance to its customers. The company has extensive experience in establishing data interfaces between it systems and those of its customers' internal data systems, including Amerigroup, but also those used by those services that support its customers and providers, such as external database facilities and clearinghouses. NIA has developed and tested all the HIPAA-compliant transactions (including the components for COB), and NIA supports Electronic Data Interface (EDI), FTP, SOAP/XML, and Network Data Mover (NDM). Business-to-Business Virtual Private Network (VPN) is NIA's preferred process for transmitting and receiving files. NIA accepts and transmits data as often as required by the customer.
5.1.11.12 HIPAA Compliance A. Describe your status, resources, and approach to HIPAA compliance.
NIA is fully compliant with the HIPAA Standards for privacy, electronic transactions, and security.
B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.
Not applicable
5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial. 5.1.12.1 Dun and Bradstreet Number
Magellan Health Services, Inc.: 04-969-3732
5.1.12.2 Federal Tax Identification Number

National Imaging Associates (NIA)
Administration of radiological and imaging services
National Imaging Associates, Inc.: 22-3428367
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement
See NIA Attachment 5.1.12.3.

5.3 BUSINESS REFERENCES

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding National Imaging Associates directly to the Purchasing Division.

Table 5.3-1. National Imaging Associates Reference 1

Reference #:	1		
Company Name:	National Imaging Associates		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Radiology Benefit Management Services		
Primary Contact Information			
Name:	Terra Swiggett Horizon New Jersey Health		
Street Address:	210 Silva St		
City, State, Zip	West Trenton, NJ 08628		
Phone, including area code:	(609) 718-9511		
Facsimile, including area code:	(609) 671-0584		
Email address:	Terra_Swiggett@horizonNJhealth.com		
Alternate Contact Information			
Name:	Valerie Moses		
Street Address:	210 Silva St		
City, State, Zip	West Trenton, NJ 08628		
Phone, including area code:	(609) 718-9724		
Facsimile, including area code:	(609) 671-0584		
Email address:	Valerie_Moses@horizonNJhealth.com		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	NIA provides radiology benefit management services (CT, MI, PET, Nuclear Cardiology)		
Original Project/Contract Start Date:	06/2006		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is confidential information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Contract is ongoing, and all tasks to date have been completed on time		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes		

Table 5.3-2. National Imaging Associates Reference 2

Reference #:	2		
Company Name:	National Imaging Associates		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Radiology Benefit Management Services		
Primary Contact Information			
Name:	Rachel Wiehagen Gateway Health Plan		
Street Address:	600 Grant St		
City, State, Zip	Pittsburgh, PA 15219		
Phone, including area code:	(412) 255-7137		
Facsimile, including area code:	(412) 255-4260		
Email address:	RWiehagen@gatewayhealthplan.com		
Alternate Contact Information			
Name:	Loretta Adams		
Street Address:	600 Grant St		
City, State, Zip	Pittsburgh, PA 15219		
Phone, including area code:	(412) 255-4530		
Facsimile, including area code:	(412) 255-4300		
Email address:	ladams@gatewaygealthplan.com		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	NIA provides radiology benefit management services (CT, MR, PET, Nuclear Cardiology)		
Original Project/Contract Start Date:	01/2000		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is confidential information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Contract is ongoing, and all tasks to date have been completed on time		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes		

Table 5.3-3. National Imaging Associates Reference 3

Reference #:	3		
Company Name:	National Imaging Associates		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Radiology Benefit Management Services		
Primary Contact Information			
Name:	Jolene H. Calla Esq. Pennsylvania Medical Assistance		
Street Address:	P.O. Box 2675		
City, State, Zip	Harrisburg, PA 17105		
Phone, including area code:	(717) 772-6174		
Facsimile, including area code:	(717) 772-6179		
Email address:	jcalla@state.pa.us		
Alternate Contact Information			
Name:	Marlana T. Thieler		
Street Address:	P.O. Box 2675		
City, State, Zip	Harrisburg, PA 17105		
Phone, including area code:	(717) 772-6091		
Facsimile, including area code:	(717) 772-6179		
Email address:	mthieler@state.pa.us		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	NIA provides radiology benefit management services (CT, MR, PET, Nuclear Cardiology)		
Original Project/Contract Start Date:	07/2008		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	Contract value is confidential information		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Contract is ongoing, and all tasks to date have been completed on time		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes		

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

YES X I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

National Imaging Associates, Inc. (NIA)
Company Name

Darlene M. Burton
Signature

Darlene M. Burton, SVP, Business Partnerships
Print Name

October 31, 2012
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

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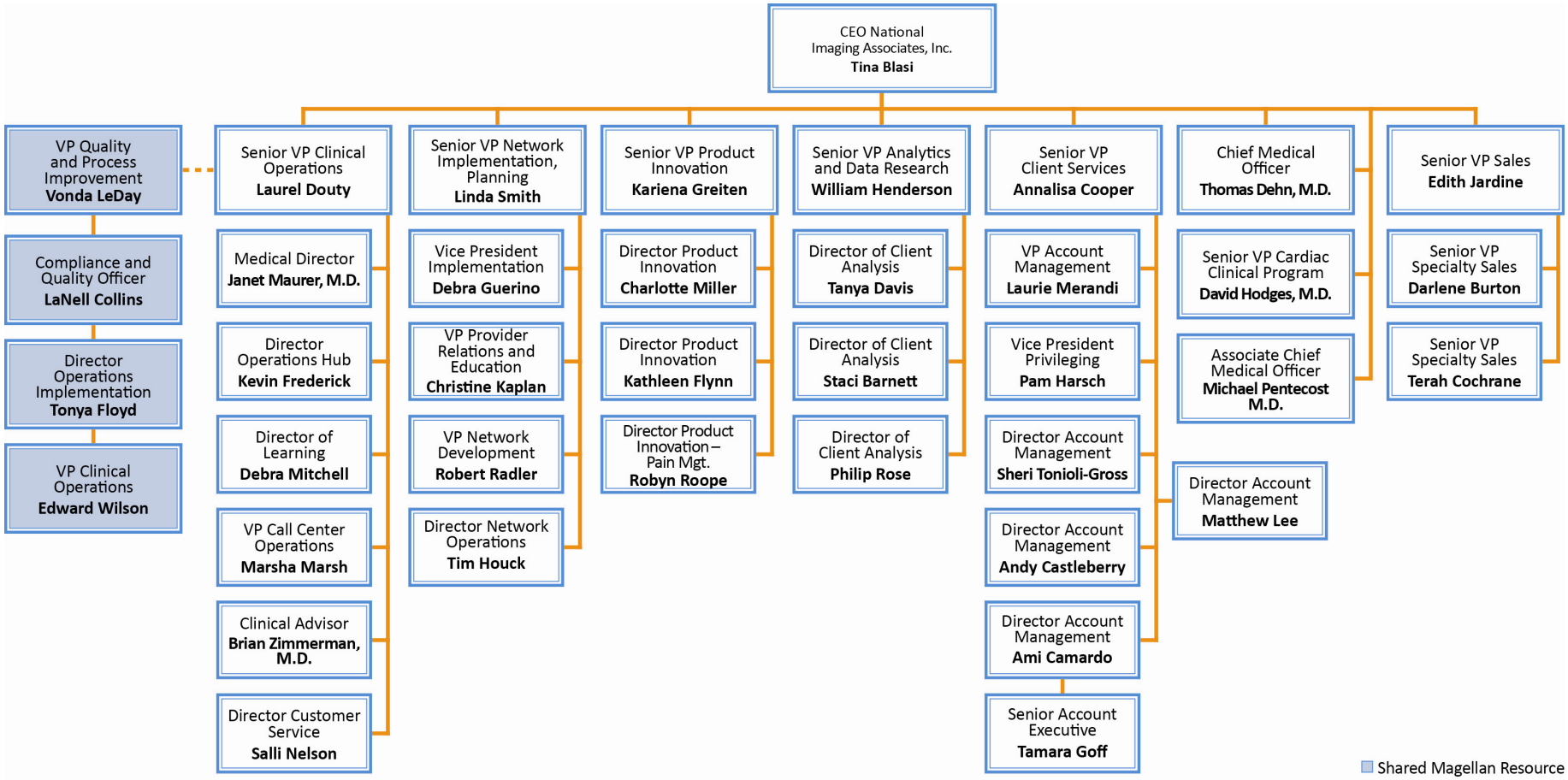
National Imaging Associates Organizational Chart



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NATIONAL IMAGING ASSOCIATES PROPOSED STAFF RESUMES

Annalisa Cooper

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	National Imaging Associates (NIA)		
☐ **Contractor**		**X Subcontractor**	
Name:	Annalisa Cooper	☐ **Key Personnel**	
Classification:	SVP, Client Services	**# of Years in Classification:**	5
Brief Summary of Experience:	Ms. Cooper has been in the health care industry for more than 20 years. With extensive health care experience in operational management, customer service, and satisfaction, as well as sales and business development, Ms. Cooper is a resourceful and innovative leader.		
# of Years with Firm:	5		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	01.2007 - Present **National Imaging Associates (NIA)** 6950 Columbia Gateway Drive Columbia, Maryland 21046 P: 410-953-1060 Acooper@magellanhealth.com *Senior Vice President, Client Services* • Serves as senior lead for a large, national health plan • Manages the account team dedicated to the national health plan		
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of***	1999 – 2007 **WellPoint, Inc./Lumenos** 120 Monument Circle Indianapolis, IN 46204 P: 317-488-6000 www.wellpoint.com *Vice President* • Led account management, customer service, eligibility, and claims		

Contract/Project:	operations for a startup company that became one of the largest consumer-driven health plans in the nation.
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	1999-2007 **Value Behavioral Health/ValueOptions** 240 Corporate Blvd Norfolk, Virginia 23502 P: 757-459-5100 www.valueoptions.com *Executive Vice President* • Maintained full responsibility for Profit and Loss Statement • Directed the financial, administrative, and client management for the commercial division
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Johns Hopkins University Baltimore Maryland Masters Degree, Science University of Maryland College Park Maryland Bachelors Degree, Science
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Gary Strong Director, National Contracting Centene Corporation P: 314-725-4477 F: N/A gstrong@centene.com Tina Shabanian Director, Networks Blue Shield of California P: 818-228-2547 F: N/A Tina.Shabanian@blueshieldca.com Julie C. Bryant Manager, National Network Operations Coventry Health Care, Inc. P: 434-951-2435 F: 434-951-2555 JCBryant@cvty.com

Laurel Douty

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	National Imaging Associates (NIA)		
☐ **Contractor**		**X Subcontractor**	
Name:	Laurel Douty	☐ **Key Personnel**	
Classification:	SVP, Clinical Operations	**# of Years in Classification:**	4
Brief Summary of Experience:	Laurel Douty is a creative thinker with proven success in the development of strategic business solutions and products.		
# of Years with Firm:	4		
RELEVANT PROFESSIONAL EXPERIENCE			
Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	01.2008 – Present **National Imaging Associates (NIA)** 6950 Columbia Gateway Drive Columbia, Maryland 21046 P: 817-475-9501 LDDouty@magellanhealth.com *Senior Vice President, Clinical Operations* • Provides strategic direction and oversight of operations related to all clinical programs		
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	03.2004 – 08.2007 **WellPoint, Inc./Lumenos** 120 Monument Circle Indianapolis, IN 46204 P: 317-488-6000 www.wellpoint.com *Vice President, Consumer Sales and Engagement* • Created a consumer engagement product design to transform the way consumer viewed their role in the health care process • Participated on the team that helped facilitate the integration of the Lumenos consumer-driven health plans within the WellPoint infrastructure		
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:***	01.2000-03.2004 **Baylor Health Care System** 3500 Gaston Avenue Dallas, TX 75246 P: 800-422-9567 www.baylorhealth.com		

Role in Contract/Project: Details and Duration of Contract/Project:	*Vice President, Total Compensation, Director, Compensation and Benefits, Director, Benefits* • Strategic leadership of the design and delivery of benefits, compensation, and human resource systems for 15,000 employees at over 275 business locations • Created new human resources business strategy to align pay and benefit packages with the critical recruiting and retention needs • Designed and implemented new health and wellness program that resulted in lower health care costs, higher program participation and a healthier workforce • Managed all employee communication and engagement activities including change management, benefit and compensation information, and culture initiatives • Created new compensation structure for job ranges, merit pay, incentive programs, and pay differentials based on business variables such as turnover, vacancies, and growth needs • Worked with Board of Trustees to design an executive pay and incentive program that addressed both short-term and long-term business objectives

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	University of Texas, Arlington Arlington Texas Bachelor's Degree Leadership Texas Graduate, Menttium 100 Graduate

REFERENCES		
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Gary Strong Director, National Contracting Centene Corporation P: 314-725-4477 F: N/A gstrong@centene.com Andrea Yanopoulos Project Manager AvMed Health Plans P: 434-951-2435 F: N/A Andrea.Yanopoulos@avmed.org	Teresa Willard Consultant, Provider Network Management Geisinger Health Plan P: 570-271-5103 F: N/A Twillard@thehealthplan.com

Michael Pentecost, MD, FACR

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	National Imaging Associates (NIA)		
☐ **Contractor**		**X Subcontractor**	
Name:	Michael Pentecost, MD, FACR	☐ **Key Personnel**	
Classification:	Associate Chief Medical Officer	**# of Years in Classification:**	4
Brief Summary of Experience:	Michael Pentecost is a proven leader with extensive experience in radiology.		
# of Years with Firm:	4		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	02.2008 – Present **National Imaging Associates (NIA)** 6950 Columbia Gateway Drive Columbia, Maryland 21046 P: 410-206-8702 MJPentecost@magellanhealth.com *Associate Chief Medical Officer, NIA* • As Associate Chief Clinical Officer, Michael Pentecost, M.D., oversees clinical operations for NIA. This includes all clinical-based call center activities, utilization management functions, and maintenance of CPT/HCPCS coding logic. Dr. Pentecost also is responsible for ongoing clinical interface with health plan clients
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	07.2005 – 02.2008 **Kaiser Permanente** **Mid-Atlantic Permanente Medical Group** 2101 E Jefferson Street Rockville, MD 20852-4908 P: 301-816-6520 www.healthy.kaiserpermanente.org *Chief of Radiology* • Served as Chief of Radiology for the Medical Group • Oversaw Institute for Health Policy in Radiology

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	03.1996 – 07.2005 **Georgetown University** 37th and O Streets, N.W. Washington, DC 20057 P: 202-687-0100 www.georgetown.edu *Professor and Chair of Radiology* • Served as Chair of the Department of Radiology for Georgetown University Medical School and continues to teach as a full professor at the University
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Tulane University School of Medicine New Orleans Louisiana Doctor of Medicine Licensure: California, District of Columbia, Maryland, Virginia Tulane University New Orleans Louisiana B.S. Mathematics
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Virginia Calega, M.D. Vice President Medical Management and Policy Highmark Healthy High 5 P: 412-544-3861 F: 412-544-2950 virginia.calega@highmark.com Scott Spradlin, M.D. Vice President, Medical Affairs Coventry Health Care of MO P: 800-743-3901 F: 314-453-1958 SSpradlin@cvty.com Terry Torbeck, M.D. Vice President, Senior Medical Director CareSource P: 937-531-2220 F: N/A Terry.Torbeck@csmg-online.com

NATIONAL IMAGING ASSOCIATES
6950 COLUMBIA GATEWAY DR 400
COLUMBIA MD 21046

Scott Kipper, Commissioner of Insurance

NATIONAL IMAGING ASSOCIATES

License Number 16233

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

		Effective Date:	Expiration Date:
License Type:	Utilization Review	10-22-2002	03-01-2013

Qualifications:

Licensees must notify the Division of any change of address within 30 days of the change. You are subject to revocation for noncompliance.
Individuals – If you are affiliated to a business entity it will not print on the license. Individuals must be properly affiliated to the business entity's license prior to transacting insurance on the entity's behalf. The individual and the business entity are responsible for maintaining the affiliation.

A producer of insurance acting as an agent of the insurer must be appointed by the insurer prior to transacting insurance.

This license must be conspicuously displayed in your place of business that is open to the public.

NATIONAL IMAGING ASSOCIATES

License Number 16233
National Producer ID

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

LICENSE TYPE	EFFECTIVE DATE
Utilization Review	10-22-2002
QUALIFICATIONS	**EXPIRATION DATE**
	03-01-2013

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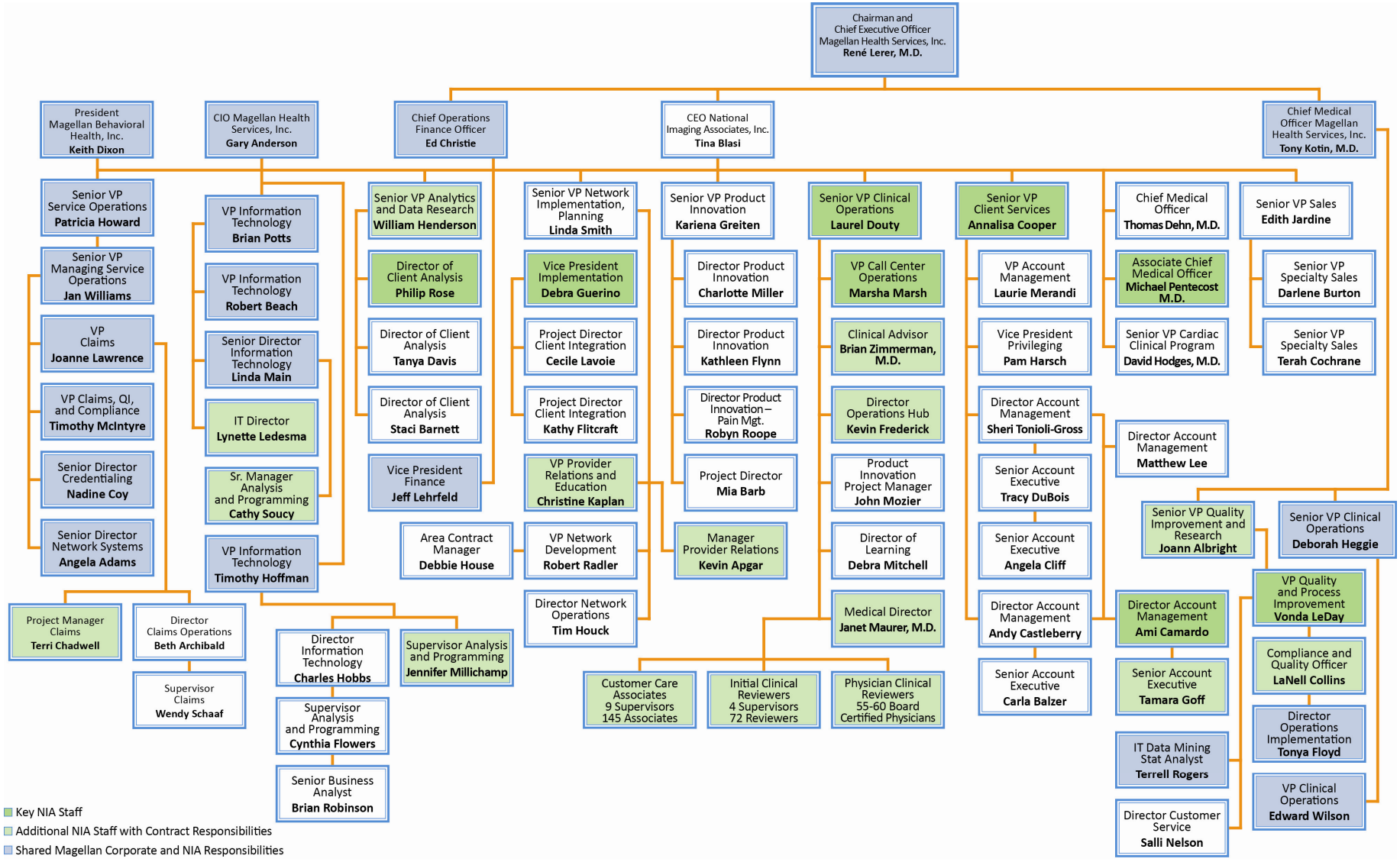
National Imaging Associates Organizational Chart by Functional Area



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Scion Dental

Provision of dental services	
5.1.1	
Company name:	Scion Dental, Inc.
Ownership (sole proprietor, partnership, etc.):	C-Corporation
State of incorporation:	Delaware
Date of incorporation:	April 4, 2009
# of years in business:	3.5
List of top officers:	▪ Craig Kasten, Chairman of the Board ▪ Greg Borca, Chief Executive Officer ▪ Darrin Haehle, Chief Information Officer ▪ Lisa Sweeney, Chief Financial Officer ▪ Michelle Spencer, Chief Operating Officer
Location of company headquarters:	10201 N. Port Washington Rd. Mequon, WI 53092
Location(s) of the company offices: Location(s) of the office that will provide the services described in this RFP:	10201 N. Port Washington Rd. Mequon, WI 53092 N92 W14612 Anthony Ave. Menomonee Falls, WI 53051
Number of employees locally with the expertise to support the requirements identified in this RFP:	One in Nevada: Kevin Johnston, Las Vegas Market Director
Number of employees nationally with the expertise to support the requirements in this RFP:	Approximately 200
Location(s) from which employees will be assigned for this project:	N92 W14612 Anthony Ave. Menomonee Falls, WI 53051 And also one local Las Vegas, Nevada Provider Relations Representative
5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.	
Scion Dental understands and complies with this requirement.	
5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us. Is "Legal Entity Name" the same name as vendor is doing business as?	

Scion Dental

Provision of dental services

If "No", provide explanation.

Legal Entity Name: Scion Dental of Nevada, LLC

No, Scion Dental of Nevada, LLC is a subsidiary of Scion Dental, Inc.

Scion Dental of Nevada, LLC is in good standing, and has been doing business in Nevada since 2010, as Amerigroup of Nevada's dental vendor/subcontractor.

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

Scion understands this requirement and is in good standing for all licensing requirements.

- License Number: 656460

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

A. Name of State Agency?

B. State Agency Contact name? Date when services were performed?

C. Type of Duties Performed?

D. Total Dollar Value of the contract?

No, Scion has never been engaged under contract by any State of Nevada agency.

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

No, Scion is not employed with the State of Nevada or any of its agencies, nor does it have any employees that are employed with the State of Nevada or any of its agencies.

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

No, Scion is not involved in any ongoing or contract failures, contract breaches, civil or criminal litigation that would impact its ability to perform fulfill its obligations if Amerigroup is awarded as a

Scion Dental

Provision of dental services

winner of this RFP.

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Yes, Scion has the insurance requirements as specified in Attachment E.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Scion Dental is the pioneer of Medicaid dental management, having been dedicated to improving government dental programs for nearly 20 years. The Scion ownership team and many of the management team founded Doral Dental in 1992 and grew it to more than 6,500,000 members. During this time, Scion introduced a variety of industry innovations, improving Medicaid dental programs across the country.

In 2004, Doral Dental was sold to DentaQuest of Boston, MA. At the time of the sale, Scion maintained ownership of Doral's technology as well as the external company and staff which developed it - Wonderbox Technologies. During a five year non-compete period, Scion continued developing the Enterprise System technology and became the dental industry leader by selling it on an administrative services provider (ASP) basis to other insurers, some of which are quite prominent.

That opportunity arrived in 2009, as Scion Dental was formed, once again marrying a talented and experienced leadership team with the leading technology in the industry. Scion Dental has quickly become a national leader, growing rapidly with new implementations every month. Scion will cover approximately 4.9 million Medicaid members by January 1, 2013. Its performance delivers lower administration and benefit costs for MCO and state clients, while at the same time improving both the member and provider experience.

Scion Dental's Enterprise System includes access to the industry-leading Client Web Portal (CWP). The portal is available to authorized users, and subsequently configured by Scion to have secured rights. The portal is accessible 24/7 from any personal computer by using an Internet Explorer web browser. The portal allows secured access to Scion's data center and computing environment.

Through CWP, any client can access a variety of proven, industry-leading tools, including the Executive Dashboard. The Executive Dashboard is the most innovative government oversight and transparency tool available. Exploiting Microsoft SQL data cubing technology first introduced in 2008, Scion provides

Scion Dental

Provision of dental services

clients with real-time data on every meaningful operational and financial metric.

The Executive Dashboard has tabs which cover claims, authorizations, member services and financials. Each tab contains comprehensive, real-time information of activities within the client's dental program, including detailed charts and graphs, with every page exportable to Excel or other formats for instance analysis and sharing. Each tab also has drop-down lists to compare data by benefit plan (CHIP versus. Medicaid), region (one region compared to another region), and other options.

Also within CWP is the Enterprise Business Intelligence System (eBIS). eBIS is another web-based tool that serves as a data warehouse, accessing all historical paid claims data. The intuitive user interface has dozens of standard templates and the filter options produce thousands of variations of instant ad hoc reports, including provider profiling and cost trend reports.

Next, access to the Customer Service Module (CSM) is available through CWP. CSM is the internal tool that Scion employees use to record all provider and member interactions. By spring of 2013, CSM will record all calls from providers and members and deposit links within each CSM call record. Clients can access CSM on a read-only basis (to review all the data, but not modify or add anything) to have complete transparency to all provider and member interactions, including listening to the phone calls themselves. In the event of a provider or member complaint, the client can immediately access all the details of the situation without delay or difficulty.

Scion Dental has been providing dental administrative services to Medicaid recipients in the public sector since its inception in 2009. Scion has since grown to service approximately 4.2 million Medicaid recipients, and will serve approximately 4.9 million Medicaid recipients by January 1, 2013. Scion does not provide services to commercial members/private sector. Scion is a government dental administrative company that focuses in this niche. Scion has approximately 26 managed care clients, in which all of these are in the Medicaid/CHIP programs. Scion specifically has been providing dental services in the State of Nevada's program since October 2010, or just over two years.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

The owners and leaders of Scion Dental are pioneers of Medicaid dental management, as they have been dedicated to improving government dental programs for nearly 20 years. The Scion ownership team and many of the management team are the same people who founded Doral Dental in 1992 and grew it to over 6,500,000 Members. During this time, Scion introduced a variety of industry innovations, improving Medicaid dental programs across the country.

In 2004, Doral Dental was sold to DentaQuest in Boston, MA. At the time of sale, Scion maintained ownership of Doral's technology as well as the external company and staff which developed it - Wonderbox Technologies. During a five-year non-compete period, Scion continued developing the Enterprise System technology and became the dental industry leader by selling it on an ASP basis to other insurers, some of which are quite prominent. Also during this time, Scion reviewed past weaknesses, observations, and lessons to carefully improve the technology with a vision of once again incorporating a host of innovations.

That opportunity arrived in 2009, as Scion Dental was formed, again uniting a talented and experienced leadership team with the industry's leading technology. Scion Dental has quickly become a national leader, growing rapidly with new implementations every month. Scion delivers lower administration

Scion Dental
Provision of dental services
and benefit costs for MCO and state clients, while at the same time improving both the member and provider experience. In addition, Scion Dental, Inc. does not have a parent company. Scion Dental of Nevada, LLC is a single member LLC whose sole member is Scion Dental, Inc. It is treated as a disregarded entity for tax purposes. Please see attached document for the current company ownership including the ultimate parent organization and major shareholders/principals.
C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.
Scion is incorporated in Delaware, domiciled in Wisconsin, and foreign qualified in all 50 states.
D. The location of disaster recovery back-up site.
N92 W14612 Anthony Ave. Menomonee Falls, WI 53051
E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.
Mark K. Borca 10201 N. Port Washington Rd. Mequon, WI 53092 (262) 834-6115
F. The size of organization in assets, revenue and people.
Assets - $12 million. Revenue - $25 million. People - 200.
G. The organizational chart of your senior management by function including key personnel.
See Attachment 5.1.11.8 for Scion's organizational chart.
H. The areas of specialization.
Government program (Medicaid, CHIP, Medicare) dental management. Scion is not a commercial dental insurer, but rather only a government program dental administrator.
I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.
The revenues are $20 million (2010) and $25 million (2011). These figures are for Medicaid dental program management, which is the company's main product line and service.
J. The corporate philosophy and mission statement.
Improving dental program management through reduced administrative cost, improved member and provider experience, and technology innovations which drive unsurpassed transparency and oversight.
K. A description of any plans for future growth and development of your organization.

Scion Dental

Provision of dental services

Scion is a rapidly growing company. It currently administers dental programs and benefits for approximately 3.9 million Medicaid, CHIP, and Medicare members. By January 1, 2013, Scion will be administering dental programs and benefits for approximately 4.7 million Medicaid, CHIP, and Medicare members, which means Scion is in the process of implementing approximately 800,000 of these members in the next three months. There has never been an operational issue as a result of Scion's continued rapid growth. In addition, in 2013 there are some plans to increase staffing by approximately 30 to 40 employees while continuing to increase the membership and client base.

L. Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

Scion Dental has not added any business lines recently. However, Scion Dental continues to add membership, new clients, and new markets to its organization. In the past six months, Scion has added three clients and 550,000 members in three separate states. In the next four months, Scion will add approximately 650,000 members in two new states. Scion Dental has a very precise and scalable implementation approach, and can be used in any size market or state. Scion has a dedicated implementation team of five people who dedicate themselves to every aspect of the project. A detailed implementation plan identifies the active departments, the task/item owner, and a target date for each milestone. The timeline to implement a new market is 90 days, but can be much shorter in some scenarios. When Scion Dental entered the Nevada marketplace in 2010, it implemented this business in 57 days (August 4, 2010 and go-live on October 1, 2010).

5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

Scion Dental has been providing dental administrative services to Medicaid recipients in the public sector since its inception in 2009. Scion has since grown to service approximately 4.2 million Medicaid recipients, and will be at approximately 4.9 million Medicaid recipients on January 1, 2013. Scion does not provide services to commercial members/private sector. Scion is a government dental administrative company that focuses in this niche. Scion has approximately 26 managed care clients, in which all of these are in the Medicaid/CHIP programs. Scion specifically has been providing dental services in the State of Nevada's Medicaid program since October, 2010, or just over two years.

5.1.10.1 Experience

A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:

1. Managing a network of Medicaid Providers;

The owners and leaders of Scion Dental are the undisputed pioneers of Medicaid dental management, and have been dedicated to improving government dental programs for nearly 20 years. The Scion ownership team and many members of the management team founded Doral Dental in 1992 and grew it to more than 6,500,000 Members. During this time, Scion introduced a variety of industry innovations, improving Medicaid dental programs across the country.

In 2004, Doral Dental was sold to DentaQuest in Boston, MA. At the time of sale, Scion maintained

Scion Dental

Provision of dental services

ownership of Doral's technology as well as Wonderbox Technologies, the external company and employees which developed it. During a five-year non-compete period, Scion continued developing the Enterprise System technology and became the dental industry leader by selling it on an ASP basis to other insurers, some of which are quite prominent. Also during this time, Scion reviewed past weaknesses, observations, and lessons to carefully improve the technology with a vision of once again incorporating a host of innovations.

That opportunity arrived in 2009, as Scion Dental was formed, again uniting a talented and experienced leadership team with the industry's leading technology. Scion Dental has quickly become a national leader, growing rapidly with new implementations every month. Its performance delivers lower administration and benefit costs for MCO and state clients, while at the same time improving both the member and provider experience. Since that time, Scion has grown from no Medicaid members at its inception in April, 2009, to currently 4.2 million Medicaid members, to almost five million Medicaid members on January 1, 2013. This tremendous growth in less than four years shows the kind of experience and knowledge resident within Scion Dental. Scion has been operating in the Nevada market for more than two years with Amerigroup of Nevada.

2. Managed care programs for Medicaid recipients;

Scion Dental has been providing dental administrative services to Medicaid recipients in the public sector since its inception in 2009. It has since grown to serve approximately 4.2 million Medicaid recipients and will serve approximately 4.9 million Medicaid recipients by January 1, 2013. Scion does not provide services to commercial members/private sector. Scion is a government dental administrative company that focuses in this niche. Scion has approximately 26 managed care clients, in which all of these are in the Medicaid/CHIP programs. Scion specifically has been providing dental services in the State of Nevada's Medicaid program since October 2010, or just over two years.

3.Administering Medicaid utilization and case management programs;

Key employees have administered Medicaid utilization and case management programs for more than 20 years. The Chief Dental Officer provides guidance and oversight of these programs has and brings more than 20 years of experience in dental industry utilization management programs, with 10 of those years specifically focused on administering Medicaid utilization and case management programs. Additional clinical employees within the utilization management provide a high level of expertise in the appropriate administration of these programs. In addition, over a dozen outside dental consultants participate in the management program through both professional clinical review and program interface where appropriate. Most of these consultants have Medicaid dental experience. Finally, Scion Dental retains Nevada-based dental consultants as part of the utilization management process to provide professional clinical review and local input as to any unique Nevada provider components that may affect the utilization management and case management program process as it applies to the Nevada Medicaid program.

4. Medicaid claims processing and adjudication

Scion Dental has extensive experience in managed dental care. Scion Dental was established in April, 2009 and has been processing and adjudicating Medicaid claims since August, 2009. Before Scion Dental, the Scion Dental leadership team founded Doral Dental USA, one of America’s largest dental insurance companies with more than 90 percent of its business in Medicaid program management,

Scion Dental

Provision of dental services

until the sale of the company in 2004.

5. Project management; and

During the Implementation, Scion assigns a Project Manager (PM) to the implementation team, in addition to implementation specialists responsible to support the PM. The PM is responsible for planning and documenting a well-planned approach for the implementation from beginning to end. The PM will provide guidance to the team and confirm the tasks are successfully executed and the project goes live according to the plan. The PM approach is flexible, and Scion has experience using both the traditional waterfall approach and agile approach for the implementation.

6. Qualifications of key personnel.

Please see Appendix 5.1.10.1.E for Scion Dental's key employee resumes for:

- Craig Kasten, Chairman of the Board
- Gregory Borca, CEO
- Lisa Sweeney, CFO
- Darrin Haehle, Chief Information Officer
- Tom Conjurski, COO
- Dr. Fred Tye, Chief Dental Officer
- Mark Borca, VP, Sales
- Kevin Johnston, Market Director
- Jeanine Saer, Director of Administration
- Monica Clement, Director of Provider Services
- Carrie Klotzbach, Director of Utilization Management
- Beth Rabus, Director of Human Resources
- Miranda Richter, Appeals Manager

B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure of health care service delivery performance.

Scion Dental encourages providers to adopt tools that streamline administration, and is committed to collaborate with providers to structure financial incentives that drive its partners' quality goals. However, there is not yet clear consensus on dental quality metrics as for medical and behavioral health services. As the dental program evolves and matures, both Scion Dental and its partners will assess the data to establish benchmarks and identify opportunities to tie performance incentives to quality metrics. In the interim, current incentives drive improved efficiency and cost-effective service delivery.

In accordance with state laws, Scion Dental will never adopt any incentives that encourage restriction of quality of care to control costs.

Financial Incentives: Technology has driven substantial efficiency in healthcare, but many small dental practices lack the basic equipment, including computers, to benefit. To encourage provider adoption of

Scion Dental

Provision of dental services

technology, Scion Dental has, in other markets, invested in network providers to promote streamlined administration and efficiency, benefiting both Scion Dental and the dental office.

C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

Regarding the improvement of treatment protocols, Scion defines treatment protocols as the common practice patterns exercised by the local providers within the network. Because dentistry does not have a set of diagnostic codes to compare to treatment outcomes like medicine does, Scion relies on several components in which it has invested in as part of its UM programs. The development of standardized treatment protocols or decision algorithms for deciding on a particular treatment are reflected in the clinical criteria used in the authorization process. Because providers and Scion's clinical review teams use the same clinical criteria, there is a high level of consistency in the determination of medically necessary treatment through the authorization process. Relative to treatment protocols for those services not requiring prior authorization, Scion has developed several analytic tools to allow it to measure the average treatment patterns exercised by all providers in a local network and each provider individually. By these means, Scion is able to identify individual provider treatment protocols that may vary statically from their peers and work with these providers to evaluate the protocols that result in their treatment submissions.

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

Scion Dental concentrates on partnering with Medicaid MCOs to administer dental programs on behalf of their partners—in this case, DHCFP. Scion has a long-standing history in working with Medicaid MCOs to improve their HEDIS scores, increase overall access to care, eliminate any barriers to care, increase provider network, eliminate any member/provider complaints and grievances, and increase the value proposition for dental on behalf of Scion's MCO partners.

E. Provide the names, résumés, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

Please see Appendix 5.1.10.1.E for Scion Dental's key employee resumes for:

- Craig Kasten, Chairman of the Board
- Gregory Borca, CEO
- Lisa Sweeney, CFO
- Darrin Haehle, Chief Information Officer
- Tom Conjurski, COO
- Dr. Fred Tye, Chief Dental Officer
- Mark Borca, VP, Sales
- Kevin Johnston, Market Director
- Jeanine Saer, Director of Administration

Scion Dental

Provision of dental services

- Monica Clement, Director of Provider Services
- Carrie Klotzbach, Director of Utilization Management
- Beth Rabus, Director of Human Resources
- Miranda Richter, Appeals Manager

F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:

1. Information Systems
2. Utilization/Case Management
3. Claims Payment
4.Quality Improvement and Reporting (i.e. HEDIS, CMS)
5. Health education
6. Data / coding
7. Contract negotiations, Network recruiters
8. Encounter data
9. Other staff as needed

Jim Zeisler, Director of Client Information Services

Data Analysts

Mike Amborn, Troy Conway, Anushka Reddy, Nataliya Nenasheva, John Hanney, Christophe Tiako, Bhavna Bharadwaj, Wei Jiang, Thomas Lee, Yelena Yampolskaya, Jean Jurjevic

EDI Analysts

Ruslan Ahundov, Dan Wolf, EJ Buhrke, Artur Khachikyan, Tammie Van Ryzin, Karen Jakubowski

Operational Support

Ryan Moon

Utilization Case Management

Carrie Klotzbach, Manager of UM

Brenda Becker, Team Lead Dental Review Specialist

Jill Krause, Dental Review Specialist

Carie Wright, Dental Review Specialist

Jessica Fogl, Dental Review Specialist

Sheeba Gill, Dental Review Specialist

Karen Volden, Dental Review Specialist

Claims Payment

Jeanine Saer, Director of Administration

Dental Reimbursement Analysts

Wendy Ryder, Cheryl Jacob, Melissa Smith, and Danielle Roberts

Scion Dental

Provision of dental services

Michelle Spencer, Chief Quality Officer

Tom Conjurski, COO

Lisa Sweeney, CFO

Health education

Not applicable

Data/coding

Jim Zeisler, Director of Client Information Services

Data Analysts: Anushka Reddy, Nataliya Nenasheva, Bhavna Bharadwaj, Wei Jiang, Jean Jurjevic

Contract Negotiation Specialists

Not applicable

Encounter Data

Jim Zeisler, Director of Client Information Services

Data Analysts: Anushka Reddy, Nataliya Nenasheva, John Hanney, Christophe Tiako, Bhavna Bharadwaj, Wei Jiang

EDI Analysts: Artur Khachikyan, Tammie Van Ryzin, Karen Jakubowski

Others

Not applicable

G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.

See Attachment 5.1.10.1.G for our TPA license, renewal form, and utilization review license.

H. List any bilingual staff, the area to which they are assigned and the languages spoken.

Currently, six bilingual Customer Services Representatives: four Spanish, one Hmong, and one Arabic/French

I. List any associations or organizations to which the organization belongs.

None

5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

5.1.11.1 Medical Services

A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

The need to provide services beyond those required in the Vendor Covered Services section is determined through medical necessity evaluation for those members under the age of 21. The Dental Consultant reviews any such requests using criteria that would include, but are not limited to, the

Scion Dental

Provision of dental services

service requested:

- Meets generally accepted standards of dental practice
- Is appropriate to the identified dental condition and expected outcome
- Is appropriate for the intensity of the dental service and level of dental setting
- Is the lowest cost alternative that effectively address and treats the dental problem

B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.

A number of procedures require prior authorization approval before initiating treatment. Scion Dental reviews the provided documentation against dental clinical criteria for medical necessity before approving prior authorization requests. Scion Dental developed the dental clinical criteria used for medical necessity determinations from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. The medical review process begins with providing the required documentation and the clinical criteria that will generate a medical necessity approval. This information is made available to all providers through the online provider reference manual. In this way, all providers will know in advance the required documentation and the clinical criteria the documentation should show for an approval based on medical necessity. Upon receipt of the necessary documentation, dental employees will review the documentation using the same clinical criteria to determine approval or denial. If there is any instance of potential denial for not meeting medical necessity, Scion will refer the documentation to a Nevada-licensed dental consultant for final decision. Only a dental consultant can deny an authorization for not meeting the dental clinical criteria for medical necessity.

C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.

Each year, the Dental Peer Review Committee reviews, updates, and approves dental clinical criteria guidelines. This committee consists of independent dental consultants who are familiar with Medicaid dental programs, as well as the Nevada Dental Director and the Chief Dental Officer. The review incorporates additional State requirements or relevant criteria, as well as information on any industry-based criteria. Should there be substantial feedback from providers during the year on a particular criterion, the committee will also incorporate this information into the review process. Historical experience has shown that, unlike medical procedures, the dental clinical criteria for procedures evolve at a slower pace and therefore, annual review is adequate with the option for special meetings if circumstances warrant. The Nevada Dental Director and the Chief Dental Officer can implement minor modifications immediately if necessary to meet State-specific changes to ensure consistency in timing.

D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.

When a member requires dental services from a general dentist or dental specialist and one does not exist within an acceptable radius around the member's location, the member can visit an out-of-network provider for the requisite care. Scion will locate a provider willing to treat the member and

Scion Dental
Provision of dental services
monitor the member's care throughout treatment.
E. Describe the roll and responsibilities of your case managers.
Not applicable
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Not applicable
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Not applicable
H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Not applicable
I. Provide your policies and procedures for emergency and post stabilization services.
There will be instances in which prior authorization for a procedure will not be possible due to emergent conditions with the member. Should the member require a procedure under an emergency condition to relieve pain and suffering, the provider should provide treatment to alleviate the member's condition. When the provider sends the claim for reimbursement, the provider will include the same documentation that would be sent for the prior authorization process. This documentation will be subject to a retrospective review authorization process using the same dental clinical criteria as for the prior authorization process. As with the prior authorization process, only a Nevada-licensed dental consultant can issue a denial of a retrospective review authorization.
5.1.11.2 Enrollment: Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?

Scion Dental

Provision of dental services
Scion currently has a network in Clark and Washoe Counties consisting of 268 providers at 169 locations. Scion completes GeoAccess® reports monthly to monitor member access in these counties. When providers leave the network, Scion actively recruits additional providers to maintain network access or members.
B. Provide a sample of all base network provider contracts.
See Attachment 5.1.11.4 B for the Scion Dental provider services agreement.
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
Scion is committed to including all Federally Qualified Health Clinics (FQHC), metropolitan or county health departments, and accredited university-affiliated dental programs as part of the core provider network. In the event FQHCs with the capacity to deliver dental services are not used, Scion Dental will make the appropriate range of services available to the vulnerable populations. Scion Dental is also aware of all reimbursement-related requirements associated with the utilization of FQHCs.
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?
Scion performs availability surveys of one fourth of the network providers quarterly, ensuring that it surveys all providers at least annually.
E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.
Scion monitors network providers' activities regularly. Scion's Nevada-based Market Manager performs in-person visits to providers each quarterly to review utilization and compensation, changes to policies, addition of new providers, and response to provider disputes.
F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.
Not applicable
G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.
Not applicable
H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?
Scion has been and will continue to be in compliance and use NPI as the standard and unique health

Scion Dental

Provision of dental services

identifier for all dental providers.

5.1.11.5 Quality Assurance

A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.

Scion Dental holds itself to very high quality standards. To meet these standards, Scion takes a variety of Quality Assurance measures, starting with audits to ensure that each functional department meets any applicable internal and external standards. Scion then reports the results of the audits, along with each compliance standard, to the Quality Improvement and Compliance Committee for review each month.

In addition to audits to validate Scion's productivity, Scion Dental also uses additional methods to cover monitoring provider and member calls, as well as comparisons and validation checks on potential mailings. It also uses Native authorization algorithms and system edits on up-coding, duplications, and authorization matching to provide consistency and, when possible, stop problems before they start.

Scion Dental's policies, procedures, processes, and QI Program and Work Plan fully document these methods and procedures. Scion's official documents also acknowledge and define the structure of the various oversight committees that support the various departments in managing these efforts.

B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

Scion Dental's comprehensive quality and compliance structure consists of multiple committees that work in unison to fulfill all quality and compliance initiatives. The composition of this structure includes an Executive Committee, Quality Improvement (QI) Committee, Compliance Committee, Cost of Care Subcommittee, Credentialing Subcommittee, and Peer Review Subcommittee. All subcommittees work with each respective department/functional group to review and validate the fulfillment of all operational requirements. The subcommittees then report the productivity and compliance standards to the QI and Compliance Committee monthly for review.

C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

Wonderbox Technologies' Enterprise System allows Scion Dental to capture and maintain many characteristics of a client's membership and the membership's claims, including information about race/ethnicity, gender, languages, along with many other characteristics. To apply these characteristics to HEDIS reporting, Scion Dental works with its clientele to customize the information within the reports. Dental will partner with DHCFP to report the HEDIS information.

5.1.11.6 Fiscal Requirements

A. How will you ensure timely payment of claims in accordance with state and federal statutes and regulations?

Scion Dental recognizes the importance of timely and accurate claim payments. Scion Dental reviews the requirements of each state and federal statutes and develops a check run schedule to support that

Scion Dental

Provision of dental services

timely payment. In-place measurements and reporting metrics consistently and regularly monitor claim volumes, aging status, turnaround time, and adjudication results. In addition, current measurements oversee payment accuracy and claim entry accuracy. Scion Dental performs rigorous pre- and post-payment audits of claim payments and denials to verify the accuracy of the claims processing.

B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?

In 2011, Scion Dental had a 99.7% accuracy rate for clean claims paid within 30 days. Scion pays or denies all received clean claims. Scion Dental does not process unclean claims, but instead sends notification to the party that submitted the claim. Scion Dental also does not pend claims. Denial of claims percentage depends on correct provider submissions, but the current denial rate is under 10%.

1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.

See Appendix 5.1.11.6.1 for claims system management reports.

C. Describe your plan to identify and report suspected provider and recipient fraud.

Not applicable

D. Describe and submit your policies and procedures for determining and collecting patient liability.

Whenever possible, Scion Dental uses electronic eligibility files from clients to streamline and automate many of the activities involved with processing patient claims. Upon receipt, Scion Dental loads electronic files into the Enterprise System and applies accumulators (deductibles, co-pays) to calculate each patient's liability. Scion Dental then uses this information to aid in finalizing the Explanation of Benefits (EOB) each patient and provider receives. It is then the provider's responsibility to collect the patient liability for each submitted claim, as this is not within Scion Dental's scope of services.

In the event that Scion Dental is unable to use electronic eligibility files, it will then require manual collection and processing of eligibility information to complete each claim. To complete this manual process, Scion Dental adheres to the following internal policies and procedures (see Attached Policy & Procedures) to dictate how to use and process eligibility information during the manual process:

- CS-5500|Eligibility Verification and Enrollment Guidelines
- CS-2020|Claims and Billing
- CA-1010|Manual Processing of Claims with EOB Form.

Scion Dental audits both manual and electronic processing to ensure the highest quality in processing.

5.1.11.7 Grievances, Appeals and Fair Hearings

A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.

Scion Dental provides written notification to both the member and the member's dental care provider in the event of a denial for the request of dental services. Member denial notices contain clear and easy-to-understand language outlining the services that the dental provider requested and the reason that Scion Dental is denying coverage for said request. Scion Dental also includes a notice to the

Scion Dental

Provision of dental services

member explaining appeal rights, an appeal form, and a form for the member to request to continue benefits during the appeal or fair hearing process.

Each of these forms clearly explains to the member the time limitations of the member's rights, what the member can expect during the process, how to reach toll-free language interpreters or TTY/TTD services, and instructions on how to file an appeal/Fair Hearing request. Scion provides telephone numbers throughout its literature advising members to contact Amerigroup with any questions or if they need help understanding their rights or the appeal and Fair Hearing process. Members have 90 calendar days from the date of their denial notices to file an appeal.

Call center representatives document incoming verbal requests for appeals and grievances, then route them instantly to the Appeals and Grievances department through the Enterprise system. The Appeals Specialists receive an e-mail notification explaining the member's request and will follow up with the member as needed to process the appeal or grievance. After receiving the member's written confirmation of the request, the Appeals Specialist will work with an alternate dental consultant to review the member's request as well as the initial submission and denial information to reach a new determination. The member and the member's dental care provider receive written notification of the appeal outcome. This notification contains information on Fair Hearings and how to file a Fair Hearing request in the event the determination is not in favor of the member.

The appeals and grievances process is overseen by the Complaints, Appeals, and Grievances Manager. Monthly random audits ensure compliance and quality according to the established guidelines, policies, and procedures. The Quality Improvement Committee must review and approve any changes to policies or procedures before implementation. Each year, the responsible group or individual reviews and approves policies and procedures.

B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?

Scion Dental engages members and providers with outreach and education to reduce the number of appeals, grievances, and disputes. While Scion does not currently have a performance standard, it is open to discussing a mutually agreed-upon standard, if required.

5.1.11.8 Operational Requirements

Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.

Please see the attached organizational chart, Appendix 5.1.11.8, which shows that all functions delegated from any MCO client are retained within Scion Dental.

5.1.11.9 Implementation

A. If you currently do not have an established network, what time frame and approach will you use to build a network?

Scion has an established dental network of more than 200 providers in its current service area. If

Scion Dental

Provision of dental services
service area changes to include additional areas, Scion would contractually guarantee to build a compliant network in 30 days.
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Please see Attachment 5.1.11.9 Implementation Plan.
5.1.11.10 Reporting The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge
See reporting Attachment 5.1.11.10.
5.1.11.11 Information Systems and Technical Requirements Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.
Scion Dental has the ability to provide compatible interfaces with existing and proposed information systems.
5.1.11.12 HIPAA Compliance A. Describe your status, resources, and approach to HIPAA compliance.
Scion Dental operates with full compliance with the HIPAA and the HIPAA 5010 requirements. To reach this level of compliance, Scion Dental's Human Resource department works to train appropriate employees on the requirements of HIPAA and provides continued education throughout their employment with Scion Dental. After each employee completes training, Scion Dental then uses its Quality Assurance Initiatives and Quality Improvement Program and Work Plan to maintain consistent and compliant HIPAA-related behaviors throughout the company's functional areas. In the event of a breach or non-compliant matter, trained employees use a dedicated process to report such behavior to the Quality and Compliance Department of Scion Dental. This department reports directly to the Director of Quality and Compliance, who ensures the documentation and reporting of all breaches, violations, or non-compliant behavior.
B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.
Scion Dental produces encounter data and utilization reports in any format clients require. Scion Dental presents encounter files in a HIPAA-compliant 837D format by default, but can supply a proprietary file format on request. Scion Dental typically posts all reports and data extracts to a secure FTP site hosted by Scion Dental for client retrieval. If the client desires, Scion Dental can also transfer files to a secure site hosted by the client. Scion Dental uses the Enterprise System, a fully HIPAA-and HIPAA 5010-compliant system, to manage and process all claims and encounter activities.
5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial.

Scion Dental
Provision of dental services
5.1.12.1 Dun and Bradstreet Number
5772989
5.1.12.2 Federal Tax Identification Number
Scion Dental, Inc.: 26-4595216 Scion Dental of Nevada, LLC: 27-2521920
5.1.12.3 The last two (2) years and current year interim: A. Profit and Loss Statement B. Balance Statement
See Scion Attachment 5.1.12.3

5.3 BUSINESS REFERENCES

Scion Dental Reference Information

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Scion Dental directly to the Purchasing Division.

Table 5.3-1. Scion Dental Reference 1

Reference #:	1		
Company Name:	Scion Dental		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	Dr. Larry Paul Keystone Mercy Health Plan		
Street Address:	200 Stevens Dr. Building 200		
City, State, Zip	Philadelphia, PA 19113		
Phone, including area code:	(215) 937-7303		
Facsimile, including area code:	N/A		
Email address:	Larry.Paul@kmhp.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Scion is a dental vendor to Keystone Mercy Health Plan.		
Original Project/Contract Start Date:	06/01/2011		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	$3 million		
Final Project/Contract Date:	Evergreen		
Was project/contract completed in time originally allotted, and if not, why not?	Yes, contract started on time and within time allotted		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes, contract was within budget		

Table 5.3-2. Scion Dental Reference 2

Reference #:	2		
Company Name:	Scion Dental		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	Mr. Ethan Foxman Denex Dental		
Street Address:	111 Rockville Pike Suite 700		
City, State, Zip	Rockville, MD 20850		
Phone, including area code:	(240) 283-3514		
Facsimile, including area code:	(240) 283-3515		
Email address:	efoxman@denexdental.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Scion is Denex Dental's operating platform and vendor for various functions.		
Original Project/Contract Start Date:	04/01/2009		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	$1 million		
Final Project/Contract Date:	Current		
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the project was completed in time		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes, this was within the original budget		

Table 5.3-3. Scion Dental Reference 3

Reference #:	3		
Company Name:	Scion Dental		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	N/A		
Primary Contact Information			
Name:	Ms. Pollee Wilson, PMP CareSource		
Street Address:	P.O Box 8738		
City, State, Zip	Dayton, OH 45401		
Phone, including area code:	(937) 531-2841		
Facsimile, including area code:	(937) 396-3268		
Email address:	Pollee.Wilson@caresource.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Scion is a dental vendor of CareSource.		
Original Project/Contract Start Date:	10/16/2011		
Original Project/Contract End Date:	Current		
Original Project/Contract Value:	$2.5 million		
Final Project/Contract Date:	N/A		
Was project/contract completed in time originally allotted, and if not, why not?	Yes, the contract was completed in the original time allotted		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes, the contract was completed within the proposed budget		

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

YES X I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

SCION DENTAL
Company Name

Signature

GREGORY J. BORCA
Print Name

10/31/12
Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

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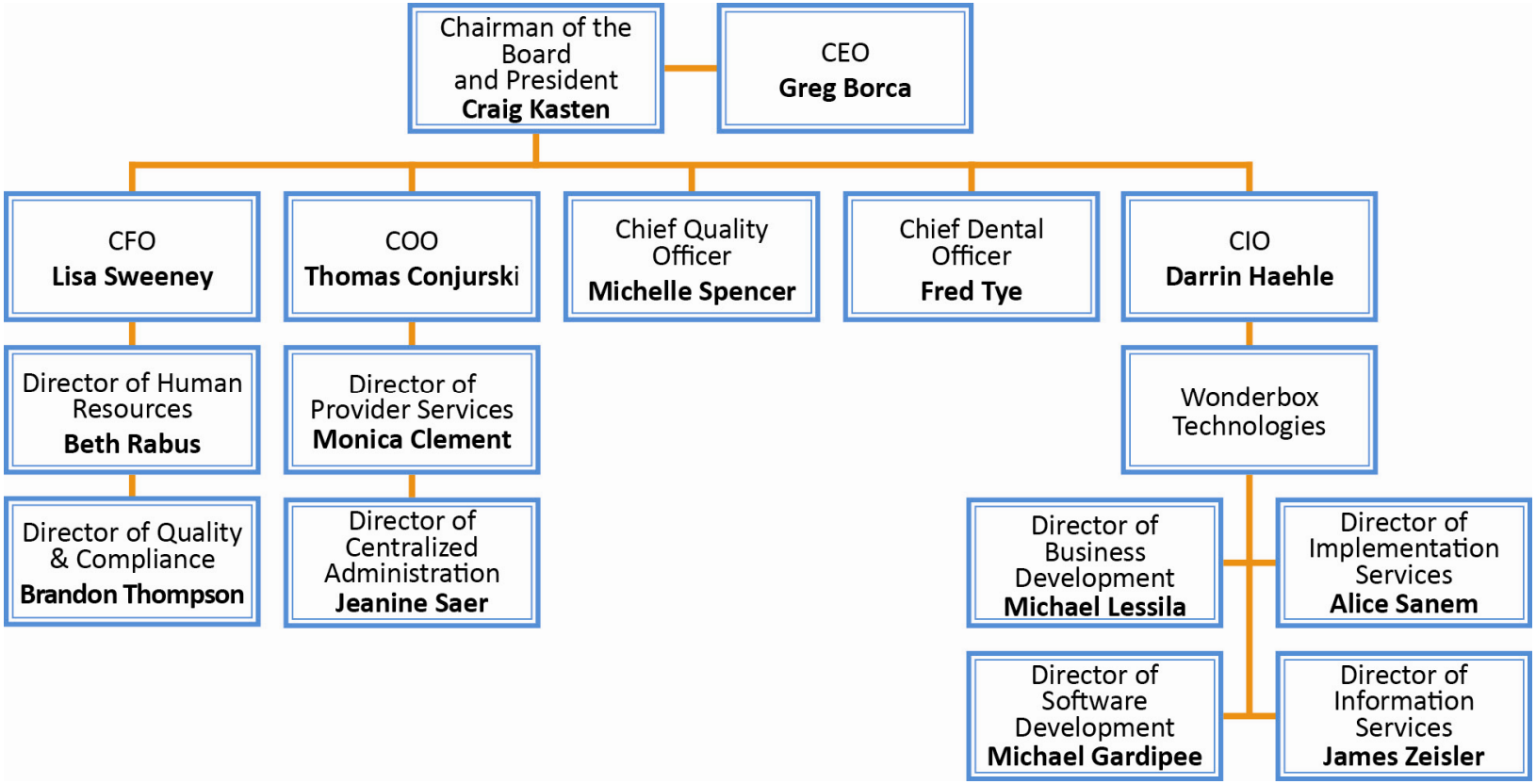
Scion Organizational Chart



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SCION PROPOSED STAFF RESUMES

Craig Kasten

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	SCION DENTAL, INC		
☐ **Contractor**		**X Subcontractor**	
Name:	Craig Kasten	☐ **Key Personnel**	
Classification:	Chairman of the Board	**# of Years in Classification:**	3
Brief Summary of Experience:	Mr. Kasten brings 25 years of experience in managed dental and health care to the company's industry pioneering operational strategies.		
# of Years with Firm:	3		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information:	
MMYYYY to Present:	04.2009 – Present
Vendor Name:	**Scion Dental, Inc**
Client Name:	10201 North Port Washington Road
Client Contact Name:	Mequon, WI 53092
Client Address, Phone Number, Email:	P: 262-834-4133 crkasten@wonderboxtech.com
Role in Contract/Project:	*Chairman of the Board*
Details and Duration of Contract/Project:	• Sets the focus and direction for the organization and its executives. • Partners with the executive team to create and implement the organization's strategic plan. • Oversees the creation and implementation of benefits administration for all Scion Dental clients.
MMYYYY to MMYYYY:	05.1998 – Present
Vendor Name:	**American Therapy Administrators LLC**
Client Name:	N92W14612 Anthony Ave
Client Contact Name:	Menomonee Falls, WI 53051
Client Address, Phone Number, Email:	P: 262-834-4133 crkasten@wonderboxtech.com
Role in Contract/Project:	*Owner/Manager*
Details and Duration of Contract/Project:	• Provided appropriate guidance to ensure organizational success.
MMYYYY to MMYYYY:	06.1997 – Present
Vendor Name:	**Vestica Healthcare LLC**
Client Name:	N92W14612 Anthony Ave
Client Contact Name:	Menomonee Falls, WI 53051
Client Address, Phone Number, Email:	P: 262-834-4133 crkasten@wonderboxtech.com

Role in Contract/Project: ***Details and Duration of Contract/Project:***	*Chairman of the board* • Provides direction and oversight to the executive team to ensure the organization is successful in the administration of healthcare solutions.
EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	University of Wisconsin Milwaukee Wisconsin Master's Degree, Business Administration Marquette University Milwaukee Wisconsin Bachelor of Arts, Accounting Certified Public Accountant
REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	John C Schaak Quarles & Brady LLP P: 414-277-5743 F: 414-271-3552 John.schaak@quarles.com Tommy Grabowski, President Vita Fitness & Physical Therapy P: 414-272-8482 F: 414-272-2880 tommyg@vitaphysicaltherapy.com Keven S. Hayhurst, Director Retirement Plan Solutions P: 262-641-0800 F: 262-641-0890 Keven@rplansolutions.com

Fred Tye

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	SCION DENTAL, INC		
☐ **Contractor**		**X Subcontractor**	
Name:	Fred Tye	☐ **Key Personnel**	
Classification:	Chief Dental Officer	**# of Years in Classification:**	3
Brief Summary of Experience:	Dr. Tye serves as a resource for all clinical interpretation and analysis and oversees utilization review and operational management skills.		
# of Years with Firm:	3		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	04.2009 – Present **Scion Dental, Inc.** N92 W14692 Anthony Avenue Menomonee Falls, WI 53051 P: 262-946-4555 ftye@sciondental.com *Chief Dental Officer* • Act as a strategic partner and provide oversight for all clinical functions within the organization.
MMYYYY to MMYYYY: ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	01.2008 – 04.2009 **Coventry Health Care** 6705 Rockledge Drive Bethesda, MD P: 240-283-3500 customerservice@gdsmd.com *Internal Consultant and Chief Dental Officer* • Development plan and execution of dental administration for an integrated health plan including product design and filings, utilization management, disruption analysis and network acquisition.
MMYYYY to MMYYYY: ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:***	10.2005 – 04.2007 **CIGNA Health** Bloomfield, CT P: 1-800-997-1654 www.cigna.com

Role in Contract/Project: ***Details and Duration of Contract/Project:***	*Assistant Vice-President of Network Field Operations* • Developed and executed focused PPO recruitment strategies to accommodate both regional and national sales strategies.

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	University of Illinois Urbana Illinois Bachelor of Arts, Chemistry with Psychology minor Loyola University School of Medicine Chicago Illinois Doctor of Dental Surgery JJ Kellogg Graduate School of Mgt Northwestern University Evanston Illinois Master of Business Administration, Health Management & Finance

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	Lee J. Chorley Senior Manager, Client Financial Administration Dearborn National P: 630.691-0303 F: 630.293.1760 Lchorley@dnoa.com David G. McLinden National Account Manager Delta Dental of Illinois P: 630-718-4746 F: 630-983-4246 dmclinden@deltadentalil.com Ronald Inge, DDS Vice President Professional Services/Dental Director Washington Dental Service P: 206-528-7329 F: 206-985-4738 ringe@deltadentalwa.com

SCION DENTAL INC
N92 W14612 ANTHONY AVE
MENOMONEE WI 53051

Scott Kipper, Commissioner of Insurance

SCION DENTAL INC

License Number 656460

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

		Effective Date:	Expiration Date:
License Type:	Utilization Review	07-01-2009	03-01-2013

Qualifications:

Licensees must notify the Division of any change of address within 30 days of the change. You are subject to revocation for noncompliance. Individuals – If you are affiliated to a business entity it will not print on the license. Individuals must be properly affiliated to the business entity's license prior to transacting insurance on the entity's behalf. The individual and the business entity are responsible for maintaining the affiliation.

A producer of insurance acting as an agent of the insurer must be appointed by the insurer prior to transacting insurance.

This license must be conspicuously displayed in your place of business that is open to the public.

SCION DENTAL INC

License Number 656460
National Producer ID

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

LICENSE TYPE	EFFECTIVE DATE
Utilization Review	07-01-2009
QUALIFICATIONS	**EXPIRATION DATE**
	03-01-2013

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Claims - All Plans

	Total Processed	Percentage Electronic (Web and EDI)	Turnaround Time – Receipt to Processed (SLA: <14 Business Days)	% Clean Electronic Processed <30 days (SLA: 90%)	% Clean Paper Processed <40 days (SLA: 90%)	% ALL Claims Processed <90 days (SLA: 99.5%)	Number of Adjustments Per 1,000 Claims	Auto Adjudication Percentage
September 2011	126,621	65.94%	8.86 Days	99.87%	99.96%	100.00%	11.86	98.11%
October 2011	107,771	70.12%	8.92 Days	99.98%	99.99%	100.00%	13.59	97.60%
November 2011	119,263	61.87%	9.5 Days	99.98%	99.99%	100.00%	13.40	96.16%
December 2011	153,552	62.29%	9.32 Days	99.95%	99.96%	100.00%	20.95	97.49%
January 2012	117,568	64.35%	8.8 Days	99.98%	100.00%	99.99%	24.39	98.27%
February 2012	133,693	64.16%	11.35 Days	98.93%	99.96%	99.30%	32.14	98.43%
March 2012	167,820	63.14%	9.65 Days	99.99%	100.00%	100.00%	21.79	98.52%
April 2012	128,124	65.75%	9.55 Days	100.00%	100.00%	100.00%	7.28	98.73%
May 2012	130,868	67.19%	9.69 Days	100.00%	100.00%	100.00%	4.81	98.77%
June 2012	153,221	66.83%	9.33 Days	100.00%	100.00%	100.00%	15.53	98.77%
July 2012	123,559	67.22%	8.86 Days	100.00%	99.99%	100.00%	10.15	98.74%
August 2012	168,305	65.66%	9.63 Days	100.00%	99.99%	100.00%	7.37	98.79%
September 2012	132,114	67.82%	9.22 Days	99.96%	100.00%	100.00%	5.03	98.84%

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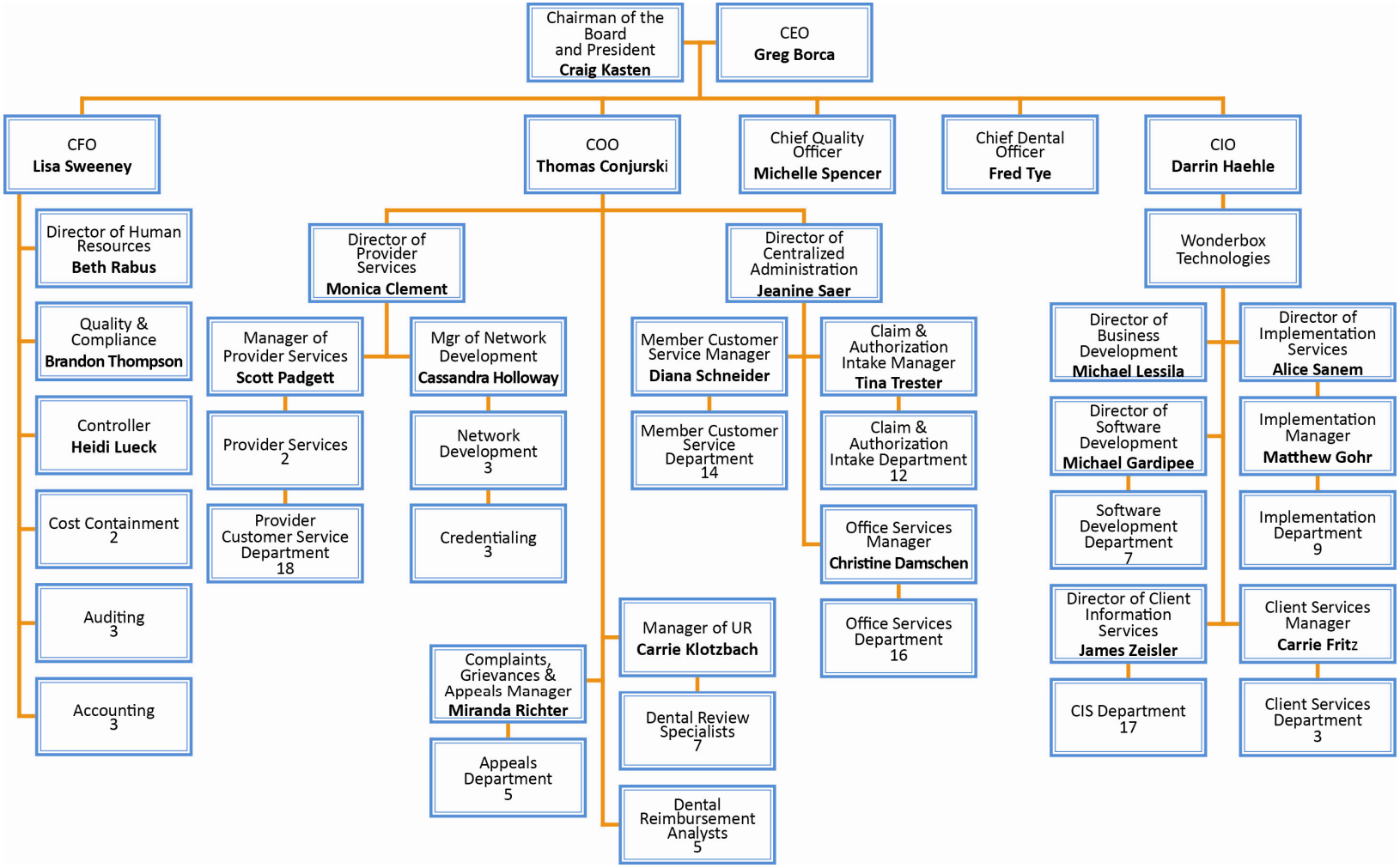
Scion Organizational Chart by Functional Area



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SCION DENTAL OF NEVADA, LLC

Provider Services Agreement

THIS PROVIDER SERVICES AGREEMENT (the "Agreement"), is made and entered into this %CONTRACT_DAY_OF_MONTH% day of %CONTRACT_MONTH_NAME%, %CONTRACT_YEAR%, by and between **SCION DENTAL OF NEVADA, LLC** ("SCION") and %PROVIDER_BUSINESS_NAME% ("PROVIDER").

WHEREAS, SCION is a company that has as its primary objective the creation of Practitioner panels whose participants agree to participate in and comply with the policies, procedures and reimbursement mechanisms established by SCION.

WHEREAS, SCION is a licensed insurer operating in the State of Nevada that has its primary object the delivery of healthcare benefits, including dental benefits, to Beneficiaries.

WHEREAS, SCION will offer to certain Payers the opportunity to enter into agreements for use of the Practitioners participating in the panel.

WHEREAS, SCION and PROVIDER mutually desire to enter into an agreement whereby PROVIDER shall arrange for the provision of certain health services to Beneficiaries of Payers (as defined below), in a manner that preserves and enhances patient dignity.

WHEREAS, SCION may at its sole discretion, retain SCION to arrange for and manage the provision of Covered Services to its Beneficiaries as set forth in the Plan Addendum to this Agreement.

NOW, THEREFORE, in consideration of the premises and mutual covenants herein contained and other good and valuable consideration, it is mutually covenanted and agreed by and between the parties hereto as follows:

Section 1 Definitions

1.1. **DHCFP**. The Division of Health Care Financing and Policy, an administrative agency of the State of Nevada, responsible for, among other things, administering the state Medicaid program. In the event this Agreement is for services rendered outside the State of Nevada, the reference to DHCFP shall be to the similar agency administering the state Medicaid program in that other jurisdiction.

1.2. **Beneficiary**. An eligible individual covered by Payer and/or enrolled under a Benefit Contract, and the eligible dependents of such individual who are enrolled under such Benefit Contract. In the event that a Payer has a government contract as defined in **Section 5.2** below, the definition of Beneficiary shall include enrolled individuals from such Contracts.

1.3. **Benefit Contract**. A benefit plan of health care coverage for Beneficiary (ies) that is sponsored, issued or administered by Payer and contains the terms and conditions of a Payer's coverage.

1.4. **CMS**. The Center for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare and Medicaid programs.

1.5. **Covered Services**. Those dental services to which Beneficiaries are entitled under the terms of the applicable Benefit Contract as determined by a Payer, the relevant portions of which may be made available upon request to PROVIDER by SCION-SCION or a Payer.

1.6. **Emergency**.

a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1) serious jeopardy to the health of a patient, including a pregnant woman or fetus; 2) serious impairment to bodily functions; and/or 3) serious dysfunction of any bodily organ or part; and

b) with respect to a pregnant woman: 1) that there is inadequate time to safely transfer to another hospital prior to delivery; 2) that a transfer may pose a threat to the health and safety of the patient or fetus; or 3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

1.7. **Incident**. Any occurrence that is not routine in a health care facility. These situations may include, but are not limited to, the following:

a) any unusual occurrence;

b) a happening which could have or did result in an injury to a Beneficiary; or

c) a condition, situation, procedure, etc., which could or did result in an injury to a Beneficiary, including any happening of an untoward (unusual) nature to a Beneficiary.

Incidents shall not be limited to quality of care issues.

1.8. **Dental Director**. A Practitioner or his/her designee who has been designated by SCION to monitor and implement the provision of Covered Services to Beneficiaries.

1.9. **Medically Necessary**. Covered Services which are determined by a Payer to be required by a Beneficiary of such Payer and which are all of the following:

a) rendered for the treatment or diagnosis of an injury or disease;

b) appropriate for and consistent with the symptoms, diagnosis, and treatment of a Beneficiary's condition, disease, ailment or injury and otherwise in accordance with standards of good dental practice within the community;

c) not furnished primarily for the convenience of such Beneficiary, such Beneficiary's family or the Practitioner; and

d) furnished at the most appropriate level that may be provided safely and effectively to the Beneficiary.

1.10. **Normal Business Hours**. Monday through Friday, 9:00 a.m. to 5:00 p.m., EST, excluding government holidays.

1.11. **Participating Provider**. A Practitioner that has entered into an agreement with a Payer or with SCION, or on whose behalf a contract has been entered into with a Payer or with SCION, for the provision of Covered Services to Beneficiaries.

1.12. **Payer**. One or all (as applicable) of the Payers including SCION (or any affiliate of any such Payer) who have entered into an agreement with SCION to arrange for and/or manage the provision of Covered Services to Beneficiaries as set forth on a Plan Addendum and may include health maintenance organizations, preferred provider organizations, indemnity plans, workers compensation plans, self-insured plans, employer groups, local, state, federal government bodies or agencies, prepaid health clinics, Beneficiaries of discount card organizations, and any and all other third party payers who may offer, underwrite and/or administer health benefits. The Plan Addendum shall be deemed a part of this Agreement and, notwithstanding anything to the contrary in this Agreement, the Plan Addendum may be amended from time to time by SCION upon written notice to PROVIDER.

1.13. **Practitioner**. A dentist duly licensed in the state in which he/she practices dentistry and is rendering patient services as or for a PROVIDER. Practitioner shall include any dentist employed by, an independent contractor of, or subcontractor to a PROVIDER and may include PROVIDER if a Practitioner.

1.14. **Provider Services**. Any and all professional services customarily provided in the community by a Practitioner practicing or providing services in the specialty / field / business of PROVIDER which are Covered Services, rendered in a manner consistent with all provisions of this Agreement and SCION and the Payer's utilization management and quality improvement (UM/QI) protocols and the applicable Benefit Contract, and with respect to which PROVIDER has been credentialed in accordance with the terms of this Agreement, except as otherwise set forth in a subsequent Attachment or Plan Addendum.

Section 2 Obligations of SCION

2.1. **Beneficiary Eligibility**. Payer may at its discretion provide to each Beneficiary an identification card that Beneficiary will be expected to present when seeking Covered Services from PROVIDER. SCION shall establish procedures to assist PROVIDER in verifying whether an individual presenting to a PROVIDER is a Beneficiary and PROVIDER shall comply with such verification procedures. SCION and Payer cannot guarantee the eligibility status of any individual. Payers make final eligibility determinations in their sole discretion. SCION shall be permitted to recover payments made to PROVIDER pursuant to this Agreement for such individuals retroactive to the date of ineligibility and shall have no liability to PROVIDER for any services rendered on or after the date of ineligibility. PROVIDER shall be permitted to seek payment from such individuals for whom services were provided on or after the date on which the individual became ineligible.

2.2. **Administrative Requirements and Procedures**. SCION shall make available to PROVIDER administrative requirements and procedures in the areas of prior authorization of services, record keeping, reporting and other administrative duties of PROVIDER under this Agreement. PROVIDER agrees to abide by these administrative requirements and procedures.

2.3. **Compensation**. For all Provider Services for which PROVIDER is responsible hereunder, PROVIDER shall be compensated in accordance with a Plan Addendum as set forth in **Section 5.1** of this Agreement, and all other applicable provisions of this Agreement. Compensation to PROVIDER shall be in accordance with and subject to SCION authorization and claims payment interpretive requirements which PROVIDER agrees to and accepts. A SCION authorization shall be in writing from SCION. SCION may from time to time furnish PROVIDER with PROVIDER bulletins/updates containing requirements for compensation under this Agreement. A prior payment from SCION to PROVIDER under circumstances where PROVIDER was not entitled to compensation under the terms and conditions of this Agreement shall not be deemed a waiver of any subsequent right not to compensate PROVIDER. If a PROVIDER provides any Covered Service that is not a Provider Service or not specified in any Plan Addenda or any non-Covered Service, PROVIDER shall not be entitled to any compensation for such services, except as provided in **Section 3.1**. PROVIDER shall accept such compensation and any applicable co-payments and/or deductibles or self-pay discounted payments (collectively "Co-payments") as payment in full for all services provided by PROVIDER except as otherwise provided by this Agreement. Unless specified otherwise, such Co-Payments shall be included as part of the compensation. Notwithstanding anything to the contrary herein, SCION shall not be obligated to compensate PROVIDER to the extent Payers have not compensated SCION with respect to such period of time or for such Covered Services.

2.4. **SCION- Non-Liability**. Payer shall have the full and final responsibility and liability for payment of all claims for Covered Services. SCION shall not be liable for the payment from its own funds of any claims under a plan. SCION is not the insurer, guarantor or underwriter of the liability of Payer to provide benefits to Beneficiaries. All final claims decisions will be the responsibility of Payer. Notwithstanding the foregoing, if for whatever reason PROVIDER is not entitled to compensation under the terms and conditions of this Agreement, Payer shall likewise not be responsible to PROVIDER. Notwithstanding anything to the contrary in this Agreement, in the event PROVIDER has any issue under this Agreement, payment or otherwise, it shall be a condition precedent for PROVIDER to seek recovery from SCION pursuant to this Agreement including appellate levels or otherwise before proceeding in any manner against a Payer, or a Beneficiary, unless otherwise specifically authorized in writing by SCION.

2.5. **SCION Representative**. SCION will designate a representative who will be available during Normal Business Hours to respond to inquiries from PROVIDER.

Section 3 Obligations of PROVIDER

3.1. **Health Services, Authorizations and Referrals**. PROVIDER agrees to provide or arrange for the provision of those Covered Services consistent with SCION's (or a Payer's, if applicable) utilization management and quality improvement program ("UM/QI Program") and SCION's Provider Manual as delivered to PROVIDER and modified from time to time. PROVIDER also agrees to provide such records and other information as may be required or requested under such UM/QI Program. PROVIDER shall provide Covered Services, which except in the case of Emergencies, have been authorized according to SCION's UM/QI Program, including any referral and authorization procedures, as established by SCION and modified from time to time, and to which compensation shall be subject. The issuance of a referral or authorization is not a guarantee of eligibility or payment. A Beneficiary's medical record must substantiate the provision of Covered Services which record may be requested by SCION for such purpose. PROVIDER agrees, when applicable, (1) to refer Beneficiaries, when medically appropriate and except in Emergencies, only to other Participating Providers and only after receiving proper authorization as required by SCION; and (2) to comply with such other referral, prior authorization, pre-certification or pre-admission requirements as established by SCION. In the event PROVIDER shall provide a Beneficiary non-Covered Services, PROVIDER shall, prior to the provision of such non-Covered Services, inform Beneficiary in writing:

a) of the service(s) to be provided;

b) that SCION or the applicable Payer will not pay or be financially liable for said services; and

c) that Beneficiary will be financially liable for such services.

In the event that Beneficiary is not so informed, neither Beneficiary, nor Payer shall be financially liable to PROVIDER for those services. PROVIDER shall not bill Beneficiaries for services that are determined by a Payer or SCION, in their sole discretion, not to be Medically Necessary unless PROVIDER has informed Beneficiary in advance that the services are not Medically Necessary and Beneficiary has agreed in writing to be financially liable for those specific services. PROVIDER agrees to provide Covered Services in accordance with terms and conditions specified in a Plan Addendum.

3.2. **Provision of Services and Professional Requirements**.

a) PROVIDER shall make necessary and appropriate arrangements to ensure the availability of Provider Services to Beneficiaries on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to ensure coverage of Beneficiaries after hours or when PROVIDER is otherwise absent. PROVIDER agrees that scheduling of appointments shall be done in a timely manner, as specifically defined in SCION's Provider Manual or as otherwise required by applicable law. PROVIDER shall ascertain and ensure that each Practitioner will cooperate with and accept the findings of SCION's peer review procedures as they relate to services provided to Beneficiaries and that such Practitioner will seek authorization from the Dental Director prior to all hospitalizations, except for Emergencies or as otherwise provided in the UM/QI Program. For services rendered by Practitioner on behalf of PROVIDER, PROVIDER shall be responsible to make suitable arrangements with the Practitioner regarding the amount and manner in which said Practitioner will be reimbursed or otherwise compensated, provided, however, that PROVIDER shall ensure that the Practitioner will not, under any circumstances, bill Beneficiaries (except Co-payments) or a Payer or SCION for Covered Services. PROVIDER shall be liable for paying Practitioner and PROVIDER hereby agrees to indemnify and hold harmless Beneficiaries, SCION, DHCFP, CMS and the applicable Payer against charges for

Covered Services rendered by Practitioner. It is understood that SCION reserves the right to make payment (directly or through the applicable Payer) to any Practitioner for which a valid invoice, or portion thereof, is outstanding for more than thirty (30) days. SCION will provide notice of its intention to make payment of such claims but SCION need not wait the above thirty (30) day period where PROVIDER has engaged in a pattern of late payments to Practitioner in the past, as reasonably determined by SCION. SCION or Payer may deduct any such payments plus a reasonable administrative fee from any amounts otherwise due PROVIDER pursuant to this Agreement.

b) All services performed hereunder shall be consistent with the standards of dental care in the community and such services shall, at a minimum, be performed in accordance with the customary rules of ethics and conduct promulgated by the American Dental Association. At no time shall PROVIDER refuse or fail to provide Medically Necessary Covered Services to Beneficiaries.

c) PROVIDER shall utilize such additional allied health and other qualified licensed or certified personnel as are available and appropriate for effective and efficient delivery of health services, consistent with SCION policies. PROVIDER shall have an ongoing responsibility to ensure that PROVIDER'S employees, agents, servants and independent contractors meet, at all times during the term of this Agreement, all legal qualifications, including appropriate licensure and continuing education and that they are members in good standing of their profession.

d) PROVIDER shall participate in any programs including continuing education as SCION or a Payer may require, as well as such programs that may be required by state regulatory authorities.

e) PROVIDER shall notify SCION within one (1) business day of his/her/its becoming aware of: (i) loss or limit of his/her/its DEA permit; (ii) loss or restriction of his/her/its license to provide health care services in any state as well as any actions taken by the state, any accrediting entity, or any other regulatory body that would materially impair the ability of PROVIDER to provide and/or arrange for health services to Beneficiaries; (iii) fine or other penalty, or loss or suspension of his/her/its participation in the Medicaid Programs; (iv) any adverse action by a governmental body, court or other forum having jurisdiction over PROVIDER; (v) occurrence of an Incident at his/her/its facility involving a Beneficiary and shall report such on the Incident Report form as provided by the applicable Payer; (vi) conviction of a felony; or (vii) receipt of any state or federal government inquiry regarding PROVIDER which relates in any way to PROVIDER's authority or ability to perform its obligations pursuant to this Agreement. For Nevada programs, PROVIDER shall also provide SCION and Payer with a copy of any and all Code 15 Reports filed with DHCFP pursuant to Nevada law, involving any Beneficiaries. Receipt of the notices required by this Section shall not constitute an assumption of liability on the part of such Payer or SCION.

f) PROVIDER and all health care Practitioners employed by and/or associated with PROVIDER for the term of this Agreement, shall meet all credentialing and re-credentialing requirements as may be established by SCION or a Payer, if applicable, from time to time.

g) PROVIDER agrees and warrants that it is in compliance with all applicable local, state and federal laws relating to the provision of dental services, including the Federal Clinical Laboratory Improvement Act and other acts, as applicable.

h) PROVIDER acknowledges SCION's and each Payer's obligation and right to report to and access the National Practitioner Data Bank as it relates to PROVIDER. PROVIDER agrees to assist SCION and Payers in accessing and reporting to the Data Bank, including making inquiries to the Data Bank on behalf of SCION and a Payer, if requested to do so by SCION or a Payer.

i) PROVIDER agrees to implement applicable and reasonable procedures necessary for external accreditation of each Payer and/or SCION by URAC or any other similar organization selected by such Payer and/or SCION.

j) PROVIDER shall comply with any and all applicable state, federal and other laws and regulations governing contracting providers and Practitioners of health care service plans and relating to the subject matter of this Agreement.

3.3. **Claims**. PROVIDER shall, within six (6) months of the date of service for outpatient services, or such other period if allowed or required by the applicable Payer plan ("Claims Submission Period"), submit a bill to Payer or SCION in a billing form acceptable to Payer or SCION (i.e. ADA claim form) along with any applicable authorization/referral documentation as instructed by SCION or other applicable documentary support, for all services rendered in a manner consistent with the terms of the Agreement. PROVIDER will also comply with SCION's Provider Manual as furnished to PROVIDER and modified from time to time. SCION may from time to time furnish PROVIDER with PROVIDER bulletins/updates containing requirements for claims submission and payment under this Agreement. If PROVIDER has not billed Payer or SCION for services rendered within the Claims Submission Period, PROVIDER's claim for compensation with respect to such services shall be deemed waived. Payer or SCION shall pay PROVIDER for Covered Services, less applicable Co-payments, in accordance with the terms of the relevant Attachment or Plan Addendum. PROVIDER agrees to accept the compensation paid by Payer or SCION as payment in full for all Covered Services, except for applicable Co-payments. In the event a claim for compensation is pended, contested or denied for any reason, PROVIDER shall resubmit such claim along with any applicable documentation to Payer or SCION consistent with the terms of the Agreement within the time period provided by applicable law after receipt by PROVIDER of notice that such claim is pended, contested or denied for any reason. If PROVIDER has not re-billed or re-submitted the applicable documentation to Payer or SCION for services rendered within such time period, PROVIDER's claim for compensation with respect to such services shall be deemed waived.

3.4. **No Discrimination Against Beneficiaries; Acceptance of Beneficiaries; Protection of Beneficiaries; Compliance with Civil Rights Laws**.

a) PROVIDER shall observe, protect and promote the rights of Beneficiaries as patients without regard to race, ethnicity, religion, gender, color, national origin, age, sexual orientation, genetic information, place of residence, economic status, health status or health care needs, benefit plan or source of payment of such Beneficiaries, including individuals who have or are currently receiving care from PROVIDER for whom payment is being made on a self-pay basis or through another third-party payer program.

b) PROVIDER may not impose any limitations on the acceptance of Beneficiaries from a product line of a Payer for care or treatment that it does not impose on other patients with respect to the same product line. PROVIDER may not request, demand, require or seek directly or indirectly the transfer, discharge or removal of any Beneficiary for reasons of Beneficiary's need for, or utilization of, Medically Necessary Covered Services, except in accordance with the procedures established for such action.

c) PROVIDER agrees to abide by the non-discrimination and affirmative action requirements of Executive Order 11246, title VI of the Civil Rights Act of 1964, as amended, the Vietnam Era Veterans Readjustment Assistance Act of 1974, Sections 503 and 504 of the Re-habilitation Act of 1973, as amended by the Age Discrimination Act of 1975, as amended, the implementing rules and regulations of the Office of Federal Contract Compliance Programs, U.S. Department of Labor, as found in the Code of Federal Regulations, Title 41, Chapter 60, and any other laws applicable to PROVIDER.

3.5. **Charges to Beneficiaries**. Each Payer shall require Beneficiaries to pay applicable Co-payments for certain Covered Services at the time services are rendered. In addition, Beneficiaries shall be financially liable to PROVIDER for Non-Covered Services or self-pay discounted services provided by PROVIDER pursuant to **Section 3.1**. PROVIDER shall indemnify and hold SCION, the applicable Payer and Beneficiaries harmless from any costs, including legal fees, relating to improper billing practices or efforts which breach the terms of this Agreement.

3.6. **Records and Reports**.

a) PROVIDER shall maintain such records and provide such medical, financial and administrative information to SCION as may be necessary for compliance by SCION and Payers with state and federal law, as well as for program management purposes. The Beneficiary's medical record must substantiate the services provided. Records shall be maintained for a period of not less than ten (10) years from the termination of this Agreement and be retained further if records are under review or audit until such review or audit is complete. SCION, the applicable Payer, URAC, state and federal officials shall have access during Normal Business Hours, upon demand, to the books and medical records of PROVIDER relating to the health care services provided to Beneficiaries and to Co-payments received by PROVIDER from Beneficiaries and SCION shall have the right to copy such books and medical records, either with the written consent of Beneficiaries which consent as contained in the applicable Payer's enrollment form is hereby deemed satisfactory by PROVIDER for such purposes, or as otherwise provided by applicable law. In the event appropriate state, federal or other governmental officials conduct an examination of the Covered Services rendered under this Agreement, PROVIDER shall submit any required books and records to facilitate such examination. SCION, each Payer, URAC, state and federal officials shall also have the right to inspect, during Normal Business Hours, PROVIDER's facilities pursuant to SCION's quality improvement and peer review procedures and state and federal mandated procedures. PROVIDER shall comply with any requirements or directives issued by Payers, URAC or government authorities as a result of such evaluation inspection or audit of SCION or PROVIDER. The obligations under this **Section 3.6(a)** shall survive the termination of this Agreement without regard for the cause of such termination.

b) PROVIDER shall maintain a medical record for each Beneficiary in accordance with the requirements established by SCION, consistent with applicable state and federal laws. Medical records of Beneficiaries will include but not be limited to reports from referral Practitioners, discharge summaries, records of Emergency care received by such Beneficiary and such other information as SCION may reasonably request.

c) In the event that SCION requests copies of medical records from PROVIDER for any reason whatsoever, including but not limited to a request from a Payer for any purpose related to conduct or administration of a health plan, such records shall be copied and delivered to SCION at PROVIDER's expense.

d) PROVIDER shall establish and maintain procedures and safeguards so that no information pertaining to Beneficiaries contained in PROVIDER's records or obtained from the Nevada Office of the Insurance Commissioner, CMS or DHCFP in carrying out the terms of this Agreement shall be used by PROVIDER or PROVIDER's agents, officers or employees other than for purposes directly connected with the administration of the Beneficiary's Payer, or except as provided in Section 1106 of the Social Security Act, as amended, and the regulations promulgated thereunder.

e) Dental records of Beneficiaries shall be treated as confidential so as to comply with all applicable state and federal laws and regulations regarding the confidentiality of patient

records, including without limitation, Title 45, Code of Federal Regulations, Section 250.50 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Where required by applicable law, PROVIDER will obtain specific written authorization from a Beneficiary prior to releasing such Beneficiary's medical records. PROVIDER represents and warrants that PROVIDER will comply with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), and all rules and regulations promulgated thereunder, as a covered entity under such laws, including but not limited to all confidentiality and disclosure requirements and compliance with the business associate provisions thereto.

3.7. **Beneficiary Grievances**. PROVIDER agrees to cooperate with SCION and the applicable Payer in resolving any Beneficiary grievances related to the provision of health services hereunder. PROVIDER agrees to participate in grievance procedures, as SCION and such Payer from time to time may establish, and comply with all final determinations rendered.

3.8. **Insurance**.

a) PROVIDER agrees to maintain in force such policies of general and professional liability insurance, as shall be necessary, to insure PROVIDER and their employees against any claim or claims for damages arising by reason of personal injuries or death occasioned, directly or indirectly, in connection with the performance of any service by PROVIDER or as otherwise required by applicable laws or regulations. The amounts, type and extent of such professional liability insurance coverage shall be subject to the approval of SCION. If PROVIDER is a licensed Practitioner or Practitioner Group, amounts shall not be less than $1,000,000 per occurrence, $1,000,000 per policy period or as otherwise required by applicable laws or regulations. If PROVIDER is other than a licensed Practitioner or Practitioner Group, amounts shall not be less than $1,000,000 per occurrence, $3,000,000 per policy period or as otherwise required by applicable laws or regulations. In addition, all PROVIDERS shall obtain and maintain general liability insurance in amounts no less than $1,000,000 per occurrence combined single limit or as otherwise required by applicable laws or regulations. PROVIDER shall immediately notify SCION and Payer of any material changes in insurance coverage and shall provide certificates of insurance to SCION and Payer upon request. SCION and PROVIDER shall each obtain worker's compensation insurance to cover all of its respective employees as required by applicable state law. All insurance shall be placed with carriers approved by the State in which PROVIDER provides his/her/its services and with a rating of no less than B+ as determined by A.M. Best Companies. PROVIDER further agrees that SCION shall be given thirty (30) days prior written notice of any material changes, cancellation or termination of PROVIDER's insurance policies. In the event of such cancellation and/or termination, SCION may terminate this Agreement effective immediately upon PROVIDER's receipt of written notice from SCION. In the event PROVIDER procures a "claims made" policy as distinguished from an occurrence policy, PROVIDER shall procure prior to termination of such insurance, and thereafter maintain, (i) a replacement policy or policies, in the same coverage amounts specified above, with retroactive date(s) no later than the effective date of this Agreement; and/or (ii) purchase unlimited "tail" insurance coverage in the same coverage amounts specified herein, effective on the date of termination of such "claims made" policy, so that continuous general and professional liability insurance coverage in the above amounts is provided with no gaps in coverage, relative to the acts and omissions of PROVIDER in connection with this Agreement, regardless of whether a claim is asserted during the term of this Agreement or thereafter. PROVIDER shall provide a certificate of insurance for any coverage required hereunder to SCION or any Payer, upon request.

b) PROVIDER agrees to notify SCION immediately whenever a Beneficiary files a claim or a notice of intent to commence legal action against PROVIDER. Upon request by SCION, PROVIDER

agrees to provide full details of the nature, circumstances and disposition of such claims to SCION or its legal representative.

c) The parties agree to adhere to and be bound by the common law and statutory principles of indemnification and contribution as they exist in the applicable jurisdiction.

3.9. **Indemnification and Hold Harmless**. PROVIDER agrees to indemnify and hold harmless SCION, Payer and their respective officers, directors and employees and DHCFP and CMS from any and all debts, claims, damages, costs, causes of action, expenses or liabilities, including reasonable attorneys' fees (at trial and all appellate levels) and court costs, to the extent proximately caused by or which may arise out of and/or be incurred in connection with, any negligent act or omission or other wrongful conduct by PROVIDER or any employee or agent of PROVIDER arising from this Agreement and any act or matter arising from or related to any balance billing of Beneficiaries prohibited by this Agreement. This Section shall survive the termination of this Agreement for any reason, including insolvency.

3.10. **Administration**.

a) PROVIDER agrees to cooperate, participate in and comply with Payer's or SCION's UM/QI Program, including peer review and/or Practitioner or Beneficiary grievance programs, if and when applicable, external audit systems and administrative programs as may be established by SCION. PROVIDER shall comply with all final determinations rendered pursuant to the UM/QI Program. The UM/QI Program may include, but not be limited to, service authorizations, specialist referrals and provider profiling based on claim encounter data. Each party agrees to immediately date stamp with the date received any written complaints and to notify the other party within one (1) business day whenever a Beneficiary files an informal or formal complaint as set forth in SCION's and the applicable Payer's grievance procedure, as provided to PROVIDER by SCION from time to time, and to refer Beneficiaries who have complaints to Payer's beneficiary services department. Each party shall cooperate with the other party in the investigation of any such complaint.

b) PROVIDER agrees that SCION and/or Payers may use PROVIDER's name, address and telephone number, type of practice, hospital affiliations, as may be applicable, and an indication of PROVIDER's willingness to accept additional Beneficiaries in order to carry out the terms of this Agreement and in the usual course of advertising, marketing and promotion, including, but not limited to, Participating Provider rosters or directories. PROVIDER may use the name of SCION and/or Payers to indicate it is a contracting provider, subject to SCION's written approval, which shall not be unnecessarily withheld. PROVIDER shall provide immediate written notice to SCION of any changes in such information.

c) PROVIDER will cooperate to the fullest extent possible to allow SCION to evaluate possible subrogation claims and to coordinate benefits in accordance with the National Association of Insurance Commissioners' (NAIC) guidelines. In the event PROVIDER provides Covered Services to a Beneficiary, PROVIDER, at his/her sole cost and expense, will cooperate to the fullest extent possible to:

1. Determine whether the Beneficiary has dental services coverage in addition to the applicable Payer;

2. Determine the Beneficiary's primary and secondary payer, in accordance with NAIC's guidelines;

3. Secure reimbursement from primary payer; and

4. Report coordination of benefits (COB) revenues received to SCION in a format determined by SCION.

If, under applicable industry standards for coordination of benefits, Payer is other than the primary carrier, and PROVIDER'S bill to primary carrier(s) was not computed on the basis specified in this Agreement, then any further reimbursement to PROVIDER from Payer or SCION will not exceed an amount which, when added to amounts charged to the primary carrier(s), equals the amount specified in this Agreement, less applicable co-payments and deductibles.

d) PROVIDER agrees to assist and work with the Dental Director in implementing the UM/QI Program and resolving other issues related to the delivery of health services that may arise from time to time.

3.11. **Cooperation and Relationship with Payer**. PROVIDER understands that each Payer will place certain obligations upon SCION regarding the quality of care received by its Beneficiaries and that Payers in certain instances will have the right to oversee and review the quality of care administered to their Beneficiaries. PROVIDER agrees to cooperate with each Payer in the review of the quality of care administered to its Beneficiaries. Notwithstanding any provision or anything to the contrary in this Agreement, the Agreement makes reference to determinations by Payer, contracts with Payer, policies/programs/procedures of Payer or otherwise, however the applicability of any of these matters involving any Payer shall be as determined at the sole and absolute discretion of SCION and any such reference in this Agreement shall not relieve Provider's duties or obligations or impair SCION's rights under this Agreement.

3.12. **Risk Management**. PROVIDER shall participate in SCION's and/or a Payer's risk management program by allowing access to his/her respective facilities for scheduled reviews and audits. Additionally, PROVIDER shall notify SCION's and/or such Payer's risk management department in writing within two (2) calendar days of occurrence of any and all Incidents including, without limitation, the occurrence of Incidents which are: (i) required by applicable law or regulation to be reported to a Payer or any applicable governmental authority, or (ii) reasonably likely to result in a claim for damages or services. Thereafter, SCION's and the Payer's risk management departments shall coordinate all investigative efforts and, if necessary, PROVIDER shall assist in such efforts.

3.13. **Representation of PROVIDER**. SCION shall represent PROVIDER in matters with each Payer pertaining to the provision of Covered Services under this Agreement, and this Agreement constitutes PROVIDER'S written consent for such representation by SCION. Such representation shall not constitute in any way an assumption of liability by SCION for PROVIDER'S acts or omissions.

3.14. **Equipment and Facilities Used by PROVIDER**. PROVIDER agrees that all facilities, equipment, goods and supplies used by PROVIDER to provide Covered Services to Beneficiaries will be available, properly serviced and maintained, otherwise appropriate for providing any Covered Services to Beneficiaries pursuant to this Agreement and comply with facility standards established by SCION, Payer, URAC, Nevada Office of Insurance Regulation, CMS or DHCFP. In addition, PROVIDER shall assure the availability of appropriate ambulatory care facilities required for the provision of PROVIDER's services to Beneficiaries, which shall include the availability of PROVIDER's current facility(ies), or any other facility used by PROVIDER to provide Covered Services to Beneficiaries pursuant to this Agreement.

3.15. **Display of Name/Materials at PROVIDER Facilities**. PROVIDER shall allow SCION or Payer(s) to display in PROVIDER's facilities materials identifying PROVIDER as a participating provider of SCION and Payer.

Section 4 Term and Termination

4.1. **Term**. When executed by both parties, this Agreement shall become effective as of the latest date set forth in the signature block hereof and shall continue in effect for a period of one (1) year from that date. Thereafter, the Agreement shall be automatically renewed for periods of one (1) year unless terminated as provided below.

4.2. **Termination**.

a) This Agreement may be terminated by either party at any time by written notice given at least sixty (60) days in advance of such termination. This Agreement may also be terminated by SCION effective immediately upon written notice if PROVIDER violates **Sections 3.2(a), (b), (e), (g), (h), (k), 3.6, 3.8, 3.10(a), 3.11, 3.12 or 5.11** hereof or if, in SCION's reasonable opinion, continuation of this Agreement will negatively affect Beneficiaries' care. SCION may also terminate this Agreement immediately in the event of an occurrence under **Sections 3.2(e) (ii) through (v) and (vii) and (viii)**, regardless of whether notice is provided or not. Either party may terminate this Agreement with at least thirty (30) days prior written notice to the other party upon the failure of the other Party, as specifically set forth in such notice, to perform, keep or fulfill any covenants, undertakings, obligations or conditions set forth in this Agreement. Such termination will not become effective if the default is cured within the thirty (30) day notice period. In the event such default is not capable of being cured within that period, the party shall be given a reasonable time to cure so long as that party begins to cure the default within the thirty (30) day period. In addition, SCION may terminate PROVIDER from participation with a certain Payer under this Agreement with the balance of the Agreement remaining in full force and effect. PROVIDER may immediately terminate any Practitioner in part or whole from participating under this Agreement in the event such Practitioner fails to adhere to the terms and conditions of this Agreement or as otherwise requested by a Payer, however the termination of such provider from participation shall not impact the full force and effect of this Agreement.

b) PROVIDER agrees that, pursuant to the underlying agreement between SCION and each Payer, a Payer may, with or without cause, terminate or obligate SCION to terminate PROVIDER's participation on a Payer or Plan-specific basis. In such event of termination, PROVIDER expressly agrees to hold SCION and such Payer harmless from any liability or damage arising from, relating to or resulting from SCION's compliance with its obligations under the underlying agreement with such Payer to terminate PROVIDER's provision of services to such Payer's Beneficiaries in connection with such underlying agreement. This provision shall survive the termination of this Agreement. Such termination shall have no effect on Provider's participation under this Agreement.

c) Upon termination and for a reasonable period of time thereafter, PROVIDER shall cooperate with SCION in making other arrangements for the health care of Beneficiaries affected by such termination. In the event PROVIDER is a specialty Practitioner and without diminishing any other duties and obligations on PROVIDER as otherwise set forth herein, once PROVIDER or any Practitioner associated with PROVIDER becomes unavailable to treat an Affected Beneficiary, whether by termination or otherwise, PROVIDER agrees to notify the Affected Beneficiary prior to the unavailability or termination. An Affected Beneficiary shall be a Beneficiary who has been under the ongoing care of the PROVIDER.

Section 5 Miscellaneous

5.1. **Modification of this Agreement**. Subject to the provisions hereafter, this Agreement may be amended or modified in writing as mutually agreed upon by the parties. In addition, SCION may modify this Agreement upon thirty (30) days written notice to PROVIDER. Failure of PROVIDER to object to such modification in writing during the thirty (30) day notice period shall constitute acceptance of such modification. This Agreement shall automatically be amended to comply with the requirements of state, federal or other applicable law. SCION may also amend this Agreement by Plan Addendum. A Plan Addendum is an addendum to this Agreement, which may set forth the Provider Services and/or reimbursement for such Provider Services for any particular Payer or health plan of a Payer. PROVIDER will execute the Addendum or PROVIDER will not be permitted to render Provider Services for that Payer.

5.2. **Interpretation**. The validity, enforceability and interpretation of any of the clauses of this Agreement shall be determined and governed by applicable law as well as applicable federal laws. In the event of any conflict between this Agreement and a contract entered into between SCION and a Payer or between a Payer and

a) a state for prepaid Medicaid Beneficiaries,

b) CMS for prepaid Medicare Beneficiaries, and/or

c) any governmental entity with respect to a government health care or benefit program (the "Government Contracts") for which PROVIDER is providing services, the Government Contracts shall govern.

PROVIDER agrees to be subject to all requirements that may be imposed on SCION and PROVIDER by a Payer under the underlying agreement between such Payer and SCION. In the event of any conflict between this Agreement and the underlying agreement between a Payer and SCION for which PROVIDER is providing services, the underlying agreement shall govern. The parties agree that jurisdiction for any legal action regarding this Agreement shall be in the state or federal courts in Wisconsin. Beneficiaries shall not be third-party beneficiaries to this Agreement. All the terms and conditions in this Agreement have been bargained for and agreed to between the parties. Each party has had the opportunity for independent legal counsel and representation and this Agreement shall not be construed or interpreted against one party or the other notwithstanding the original drafter of this Agreement.

5.3. **Severability**. The illegality, unenforceability or ineffectiveness of any provision of this Agreement shall not affect the legality, enforceability or effectiveness or any other provision of this Agreement.

5.4. **Waiver**. The waiver of any breach of any term, covenant or condition of this Agreement, shall not be deemed a waiver of any subsequent breach of the same or any other term, covenant or condition.

5.5. **Assignment**. This Agreement, being intended to secure the services of PROVIDER shall not be assigned, sublet, delegated or transferred by PROVIDER without the prior written consent of SCION. In addition, PROVIDER agrees that PROVIDER shall render services in accordance with the terms and conditions of this Agreement to any Beneficiaries connected with any SCION affiliated entity, client, subsidiary or other entity under common control or ownership with SCION or otherwise contracted with SCION.

5.6. **Notice**. Any notice required to be given pursuant to the terms and provisions hereof shall be sent by certified mail, return receipt requested, postage prepaid, or by overnight mail service such as Federal Express, to SCION at: Scion Dental, 10201 N. Port Washington Road, Mequon, WI 53092,

Attn.: Chief Executive Officer; to SCION at: _____ and to PROVIDER at his/her/its place of business. Either party may change the address for notice by notifying the other party in writing of the new address. Notwithstanding the above, an amendment required by law, or amendments or Plan Addendum notice required by **Section 5.1** of the Agreement and any notices related thereto may be sent via regular mail, facsimile, electronic transmission (i.e., email), or may be posted on SCION's website with notice to Provider of such posting.

5.7. **Relationship of Parties**.

a) None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the above nor any of their respective employees shall be construed to be the agent, employer or representative of the other nor will any of the above have an expressed or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

b) Nothing contained in this Agreement shall be construed to require PROVIDER to: (i) recommend any procedure or course of treatment which a PROVIDER deems professionally unacceptable; or (ii) recommend that SCION or a Payer deny benefits for any procedure or course of treatment.

c) SCION agrees that it shall not intervene in any way or manner with the rendition of dental services by PROVIDER, it being understood and agreed that the traditional relationship between Practitioner and patients will be maintained. Thus, PROVIDER agrees that denial of authorization by SCION or a Payer for a particular course of dental treatment shall not relieve PROVIDER from providing or recommending such care to Beneficiaries as they deem to be appropriate nor shall such benefit determination be considered to be a medical determination by SCION or Payer. PROVIDER agrees to inform Beneficiaries of their right to appeal an adverse utilization review or coverage determination pursuant to SCION's and the applicable Payer's grievance procedures.

d) Nothing in this Agreement shall be construed to require SCION or any Payer to assign any minimum or maximum number of Beneficiaries to PROVIDER or to prohibit SCION or such Payer from adding or transferring Beneficiaries.

5.8. Nothing herein shall be construed as authorizing or permitting PROVIDER to abandon any Beneficiary.

5.9. **Headings**. The headings in this Agreement are inserted merely for the purpose of convenience and do not limit, define or extend the specific terms so designated.

5.10. **Agreements with Employees and Independent Contractors**. Notwithstanding any interpretation of this Agreement to the contrary, PROVIDER agrees that all of the provisions of this Agreement, unless clearly inapplicable, shall apply with equal force to PROVIDER's employees or independent contractors and PROVIDER agrees to assure such compliance. PROVIDER agrees, and shall require its employees and independent contractors who are providing Provider Services to Beneficiaries to agree that in the event of any inconsistency, omission or misinterpretation in the contract entered into by PROVIDER and the employee or independent contractor, the terms of this Agreement shall control, notwithstanding any review and/or approval of those agreements by SCION. At SCION's request, PROVIDER shall provide SCION with copies of all forms of agreements entered into to render services to each Payer's Beneficiaries pursuant to this Agreement.

5.11. **PROVIDER Subcontracts and Professional Corporations or Partnerships**. Notwithstanding any interpretation of this Agreement to the contrary, PROVIDER shall require that all of the provisions of

this Agreement, unless clearly inapplicable, shall be incorporated in its subcontracts and agrees to require such compliance. PROVIDER agrees, and shall require its Practitioners to agree, that in the event of any inconsistency, between the terms and conditions of a subcontract and the terms and conditions of this Agreement, the terms and conditions of this Agreement shall control, notwithstanding any review and/or approval of those contracts by SCION. In the event that SCION has hereby entered into or if PROVIDER enters into a subcontract with a provider that is a professional corporation, professional association or partnership rather than an individual Practitioner, PROVIDER shall require by written provision in such subcontracts that all of the terms set forth herein applicable to PROVIDER shall also apply with equal force to both the professional corporation, professional association or partnership and the Practitioners associated with such entity. Any Practitioner by performing services under this Agreement agrees to be bound to all the provisions of this Agreement. All the individual Practitioners providing services through PROVIDER hereunder, are set forth on the Provider Information Form provided to PROVIDER, which shall be updated by PROVIDER as changes occur and as Practitioners are added or deleted.

5.12. **Confidential and Proprietary Information**. PROVIDER recognizes that this Agreement and all material provided to PROVIDER by SCION or a Payer, including Beneficiary lists, is confidential and not the property of PROVIDER. PROVIDER shall not use such information for any purpose other than to accomplish the purposes of this Agreement. PROVIDER shall not disclose or release this Agreement or such material to any third-party without the prior written consent of SCION or the applicable Payer. This specifically includes, but is not limited to, use of any of the above-referenced materials, directly or indirectly, to further the business purposes of any other organization or business including, but not limited to, PROVIDER, Payer's or other alternative health care delivery systems or other entities in the business of SCION or such Payer. Upon notice of the termination of this Agreement, PROVIDER agrees to return all such materials, including all copies, whether authorized or not, to SCION. For purposes of this Section, information shall not be considered proprietary if (i) such information is required to be disclosed pursuant to law, provided, however, that SCION and the applicable Payer are provided reasonable advance notice of such disclosure, or (ii) such information is generally available to the public other than through a violation of this Section by PROVIDER. This provision shall survive the termination or expiration of any term or provision of this Agreement. In addition, PROVIDER shall not solicit Beneficiaries, directly or indirectly, to enroll in any other insurance or health coverage or alternative health care delivery system other than the one such Beneficiaries are currently enrolled in. "Solicitation" or "soliciting", as used herein, shall mean conduct by an officer, director, agent, or employee of PROVIDER during the term of this Agreement and for a period of one (1) year after the effective date of termination of this Agreement, which may be reasonably interpreted as designed to persuade Beneficiaries, employer groups, employees or Practitioners to discontinue their relationship with SCION and/or such Payer or to continue to receive health care services from PROVIDER, other than as a Beneficiary of such Payer, or to encourage Beneficiaries, employer groups, employees or Practitioners to participate in any other prepaid health service plan. This provision shall survive the termination or expiration of any term or provision of this Agreement with respect to such Payer for a period of one (1) year from the effective date of termination except where such termination occurred following an event permitting SCION to terminate such Payer under the agreement between SCION and such Payer. The parties agree that any violation of this Section by PROVIDER will result in irreparable injury to SCION and Payer. Therefore, in addition to any remedies otherwise available to SCION and such Payer and notwithstanding **Section 5.12** below, SCION and such Payer are hereby entitled to an injunction enjoining and restraining PROVIDER and any related individuals or parties from violating this Section. If it is determined that the scope of the provisions of this Section are too extensive to be enforceable by court, then they shall be modified

to be whatever is determined by a court to be reasonable in order to obtain enforcement and the parties agree to accept such determination subject to any appeals.

5.13. **Arbitration**. Except for the remedies as provided in **Section 5.10**, any dispute, controversy, request for an accounting, disagreement over payment, allegation of breach, or claim arising out of, or relating to, this Agreement that cannot be settled through direct discussions shall be settled by arbitration administered by the American Arbitration Association (AAA) in accordance with its Commercial Arbitration Rules, except those parts that are different from this Agreement, in which case the Agreement shall govern. Any order, judgment or decision of the arbitrator may be entered in a court of competent jurisdiction. The cost of any arbitration shall be borne equally by the parties and the parties shall each bear their respective attorneys' and related fees. The arbitrator shall be selected using the following roster process: The AAA administrator will provide each party with a list of ten proposed arbitrators who are generally familiar with the subject matter involved in the dispute. Each side will be given ten days to strike any names deemed unacceptable, number the remaining names in order of preference, and return the list to the AAA. Within a week of receipt of both parties' list, the AAA will invite an arbitrator to serve from among those names remaining on the list, in the designated order of mutual preference. Notwithstanding the rules of the AAA or any provision in this Agreement, the arbitrator shall not be permitted to decide any matters involving other persons not a specific party to this specific Agreement. Pre-hearing discovery will be limited to only an exchange of relevant documents and no more than four four-hour depositions by each party. The arbitrator shall resolve any discovery disputes, recognizing the parties' mutual desire for a prompt resolution of the underlying issue. The site of arbitration hearing shall be at the corporate offices of SCION in Mequon, Wisconsin as applicable. The arbitration hearing shall start and conclude on consecutive hearing days. The arbitrator will have no authority to award punitive damages or any other damages not measured by the prevailing party's actual damages, and may not, in any event, make any ruling, finding, or award that does not conform to the terms and conditions of the Agreement. The arbitration decision shall be in writing and shall specify the factual and legal bases for the decision. Neither party nor the arbitrator may disclose the existence, content, or results of any arbitration or documents or testimony given as part of any arbitration without the prior written consent of both parties. This section is a material provision that has been bargained for and agreed to specifically by the parties and this Section shall survive the termination of this Agreement for any reason, including insolvency by SCION.

5.14. **Class Action**. PROVIDER may not at any time, under any circumstance, permit PROVIDER to be included as a member of a class for any purpose including requesting an accounting of any Pool, compensation or compensation methodology used by SCION and/or pursuing a claim for damages resulting from a breach of this Agreement by SCION. This is a material provision that has been bargained for and agreed to specifically by the parties. This Section shall survive the termination of this Agreement for any reason, including insolvency by SCION.

5.15. **Entire Agreement**. This Agreement (including all Attachments or Addenda annexed hereto and incorporated material referenced herein) contains all the terms and conditions agreed upon by the parties and supersedes all other agreements of the parties, oral or otherwise, regarding the subject matter hereof.

Signature page follows.

Section 6 Signatures | Provider Services Agreement

IN WITNESS WHEREOF, this Agreement is executed as of this ____ day of _____, 2011.

Scion Dental of Nevada, LLC	**PROVIDER**
Signature	*Signature*
Monica Y. Clement	
Name	*Print Name*
Director of Provider Services	
Title	*Title*
Date	*Provider NPI*
Myclement@ScionDental.com	
Email Address	*Date*
ProviderServices@ScionDental.com	
Office Contact Email Address	*Business entity name as listed on W-9*
877-378-5296	
Provider Services Telephone Number	*office email*

SCION DENTAL OF NEVADA, LLC

Amendment and Plan Addendum to Provider Services Agreement

This Amendment and Plan Addendum ("Amendment and Plan Addendum") is entered into by and between Scion Dental of NEVADA, LLC ("SCION") and %PROVIDER_BUSINESS_NAME% "PROVIDER").

WHEREAS the parties have entered into a Provider Services Agreement (the "Agreement").

IT IS MUTUALLY AGREED:

6.1. As set forth in the Agreement, this Amendment and Plan Addendum is incorporated and made part of the Agreement to include the following:

> **PLAN CONTRACT:** AMERIGROUP Nevada, Inc. ("AMERIGROUP" and also referred to as "Payer" and defined in **Section 1.12** of the Agreement) – are certain of those Medicaid Beneficiaries enrolled in Payer's Plan for whom SCION has an Agreement to provide Covered Services in the State of Nevada,,
>
> **PRODUCT TYPES:** HMO (Medicaid)
>
> **COVERED SERVICES:** Those dental services to which Beneficiaries are entitled under the terms of the applicable Benefit Contract as determined by Payer. PROVIDER will comply with SCION's utilization management and quality improvement program.

6.2. With respect to Covered Services rendered to Beneficiaries under this PLAN CONTRACT, PROVIDER shall render services in a manner consistent with the terms of this Agreement and according to the rate set forth in **Attachment A** attached hereto and made a part hereof (together with **Attachment B** and **Exhibit 1**).

6.3. In the event PROVIDER shall have contracted with SCION under this Amendment and Plan Addendum and also directly with Payer for subject business covered by this Amendment and Plan Addendum, this Amendment and Plan Addendum shall be effective and supersede any such contract between PROVIDER and Payer for subject business covered by this Amendment and Plan Addendum.

6.4. SCION may not modify this Agreement in any way that would adversely affect AMERIGROUP's rights hereunder without the written consent of AMERIGROUP.

6.5. The parties agree that AMERIGROUP is a third party beneficiary of this Agreement. Neither party to this Agreement shall dispute AMERIGROUP's standing to enforce its interests in SCION's or PROVIDER's performance of this Agreement.

6.6. In the event of non renewal or termination of the AMERIGROUP Participating Provider Network Agreement by and between SCION and AMERIGROUP ("AMERIGROUP Agreement"); or as otherwise agreed to by AMERIGROUP and SCION, PROVIDER agrees to immediately enter into a Provider Services Agreement with AMERIGROUP which is substantially the same as this Agreement, at which point PROVIDER will have separate, but substantially similar agreements with SCION and AMERIGROUP.

6.7. Either party can terminate this Amendment and Plan Addendum upon sixty (60) days written notice to the other party in advance of such termination. The termination of this Amendment and Plan Addendum shall not otherwise terminate the Agreement unless specifically set forth in any notice.

6.8. The effective date of the Amendment and Plan Addendum shall be %CONTRACT_MONTH_NAME% %CONTRACT_DAY_OF_MONTH%, %CONTRACT_YEAR%.

6.9. Capitalized terms not otherwise defined herein are defined as set forth in the Agreement.

6.10. It is the intent of the parties that this Amendment and Plan Addendum be incorporated into the Agreement and that both be read as one agreement. To the extent that the terms of this Amendment and Plan Addendum and the terms of the Agreement are inconsistent, the terms of this Amendment and Plan Addendum shall supersede and control the terms of the Agreement and any prior amendments.

Signature page follows.

Signatures | Addendum

IN WITNESS WHEREOF, this Agreement is executed as of this ____ day of _____, 2011.

Scion Dental of Nevada, LLC	**PROVIDER**
Signature	*Signature*
Monica Y. Clement	
Name	*Print Name*
Director of Provider Services	
Title	*Title*
Date	*Provider NPI*
Myclement@ScionDental.com	
Email Address	*Date*
ProviderServices@ScionDental.com	
Office Contact Email Address	*Business entity name as listed on W-9*
877-378-5296	
Provider Services Telephone Number	*office email*

Attachment A | Amendment and Plan Addendum
Compensation

1. **General**. Except as otherwise allowed by this Agreement, SCION shall reimburse provider according to the fees listed in **Exhibit 1** to this Amendment and Plan Addendum and adjusted for timely filing as provided for in Attachment B. At anytime during the term of this Amendment and Plan Addendum, SCION may, at its sole and absolute discretion and without prior notice to provider, elect to create a Pool at the beginning of any month in lieu of reimbursing PROVIDER according to the fees listed in Exhibit 1to this Amendment and Plan Addendum. In the event SCION elects to create a Pool, for each Pool, SCION will compensate PROVIDER for performing a Covered Service to a Beneficiary under the Benefit Contract creating such Pool by paying PROVIDER the Amount Payable for such Covered Service from the Distributable Cash in such Pool, subject to SCION's claims authorization and payment requirements. The amount payable to PROVIDER from a Pool for the same service may differ from month to month and may be lower than the fees listed in **Exhibit 1** to this Amendment and Plan Addendum. Pool reimbursement is illustrated in Attachment C. SCION will make any payments due to PROVIDER two times each month for all Amounts Payable for unpaid claims submitted prior to a date determined by SCION that is prior to the date each such payment is processed. Notwithstanding any other provision of this Amendment and Plan Addendum, SCION shall have no obligation to compensate a PROVIDER for any such Covered Service if the Payer under the Benefit Contract has not provided funding for such Pool or if, for any other reason, such Pool has no Distributable Cash.

2. **Adjustments**. For each Pool in any calendar year, SCION may, in its sole and absolute discretion and without any obligation to do so, make an annual reallocation adjustment (addition or subtraction) to each Participating Pool Provider. Such reallocation adjustment for a Pool may result (or approximate with reasonable accuracy) in each Participating Pool Provider receiving equal Amounts Payable for each or certain types of Covered Service rendered to Beneficiaries under the Benefit Contract creating such Pool. SCION shall have the right to (a) set off such amounts as are reasonably necessary to implement such reallocation adjustment from future Amounts Payable to any Participating Pool Providers who receive a reduction pursuant to the reallocation adjustment or (b) directly recover such reallocation adjustment from such Participating Pool Providers (with each Participating Pool Provider paying such adjustment amount within 30 days of SCION's notice).

SCION will make payments to those Participating Pool Providers who are subject to a positive reallocation adjustment as payments are recovered from other Participating Pool Providers without any disagreement.

3. **Remaining Balance**. If there is a Pool Cash Balance in any Pool at a time when SCION reasonably concludes that no additional claims for Covered Services will be submitted by any provider, SCION shall pay PROVIDER a percentage of such Pool Cash Balance determined by dividing (a) PROVIDER's aggregate Amounts Payable from such Pool by (b) the aggregate Amounts Payable to all Participating Pool Providers from such Pool.

4. **Payment in Full**. PROVIDER shall accept the compensation determined under this Amendment and Plan Addendum for any Covered Service as payment in full for such Covered Service and further acknowledges and agrees that PROVIDER may not receive the same compensation for the same services at all times under this arrangement.

5. **Acknowledgment**. PROVIDER acknowledges and agrees that: (a) this Amendment and Plan Addendum and all Attachments/Exhibits thereto have been bargained for at arm's-length between the parties and represents a material inducement for SCION to enter into this arrangement; and (b) any and all provisions of this Amendment and Plan Addendum, including, without limitation, the differences in payments that may result based on the timeliness of claims submissions by providers and the date of service, are a material part of the compensation model agreed to between the parties and necessary to establish a system of administration of claims and compensation for such claims which is intended to attain a level of consistency in payment amounts acceptable to all providers participating under such compensation model, however no level of compensation can be assured by SCION hereunder.

Apart from the compensation model which is explained hereunder and the compensation thereto, the compensation model set forth in this **Attachment A**, **Attachment B** and **Exhibit 1** provides for SCION to make certain measurements, calculations, estimates, assumptions and other decisions. In all such cases, such measurements, calculations, estimates, assumptions and other decisions made by SCION shall be at the sole and absolute discretion of SCION and PROVIDER acknowledges and agrees to accept the same as final and conclusive.

6. **Definitions**. In addition to the capitalized terms defined elsewhere in the Agreement, the capitalized terms shall have the meanings set forth on **Attachment B** attached hereto and made a part hereof.

Attachment B | Amendment and Plan Addendum
Definitions

In addition to the capitalized terms defined elsewhere in the Agreement, the following capitalized terms shall have the following meanings:

6.11. **Adjusted Service Value** for any Covered Service means

a) the fee provided for such Covered Service on **Exhibit 1** attached hereto and made a part hereof multiplied by

b) one of the following factors: (i) 1.00 if the claim for the Covered Service was received by SCION within 90 days of the date on which PROVIDER performed the Covered Service; (ii) 0.50 if the claim for the Covered Service was received by SCION more than 90 days after but within six months of the date on which PROVIDER performed the Covered Service; or (iii) 0.00 if the claim for the Covered Service was received by SCION more than six months after the date on which PROVIDER performed the Covered Service.

6.12. **Amount Payable** for any Covered Service means the amount determined by the difference of

a) the Total Compensation Amount for such Covered Service and

b) PROVIDER's total available reimbursement from patient copayments, coinsurance, deductibles and primary insurance payments, if applicable, for such Covered Service (regardless of whether or not such payments are actually collected by PROVIDER).

6.13. **Distributable Cash** for any Pool at any time means the Pool Cash Balance at the time of measurement minus:

a) Claims payable (processed but not yet paid) for all Covered Services rendered by Out-of-Network Providers to Beneficiaries under the Benefit Contract creating such Pool;

b) Claims payable (processed but not yet paid) for all Covered Services rendered by Non-Pool Participating Providers to Beneficiaries under the Benefit Contract creating such Pool;

c) SCION's estimate, as of the time of measurement, of incurred but not yet reported claim liabilities as of the last day of such month for Covered Services rendered by Out-of-Network Providers to Beneficiaries under the Benefit Contract creating such Pool;

d) SCION's estimate, as of the time of measurement, of incurred but not yet reported claim liabilities as of the last day of such month for Covered Services rendered by Non-Pool Participating Providers to Beneficiaries under the Benefit Contract creating such Pool;

e) Claims payable (received but not yet paid) for Covered Services rendered by Participating Pool Providers to Beneficiaries under the Benefit Contract creating such Pool as of the last day of the month prior to the month in which the measurement occurs;

f) SCION's estimate, as of the time of measurement, of incurred but not yet reported claim liabilities for Covered Services rendered by Participating Pool Providers to Beneficiaries under the Benefit Contract creating such Pool as of the last day of the month prior to the month in which the measurement occurs.

6.14. **Monthly Percentage** for any Pool for any month means the percentage determined by SCION during such month by dividing (i) the Distributable Cash calculated by SCION for such month by (ii) SCION's estimate of the total Amounts Payable for all Covered Services to be provided during such month by all Participating Pool Providers to Beneficiaries under the Benefit Contract creating such Pool; provided, however, that in no event shall the Monthly Percentage for any Pool exceed 110%.

6.15. **Non-Pool Participating Provider** for any Pool means all Participating Providers who receive compensation for Covered Services to Beneficiaries under the Benefit Contract creating such Pool by any method other than the method set forth on **Attachment A**, including, without limitation, by the other methods of guaranteed fee arrangements, member or other capitation payments, and case fees per episode of care.

6.16. **Out-of-Network Providers** for any Pool means all providers of Covered Services to Beneficiaries under the Benefit Contract creating such Pool who are not subject to contractual arrangements with SCION related to their compensation from such Pool.

6.17. **Participating Pool Providers** for any Pool means all Participating Providers, including, without limitation, PROVIDER, who receive compensation for Covered Services rendered to Beneficiaries under the Benefit Contract creating such Pool determined in accordance with **Attachment A**.

6.18. **Pool** means the reimbursement pool managed by SCION for a Benefit Contract as determined by SCION. A pool will consist of deposits into the Pool in an amount determined by multiplying the Pool Allotment Percentage by the amount that SCION receives from the Payer in connection with such Benefit Contract, after first deducting a contract management fee equal to $0.45 per covered member per month. SCION will retain as compensation for any and all SCION's services, and PROVIDER shall have no right to or claim against and waives any rights or claims to, the remainder of such amounts received from the Payer over the Pool amounts.

6.19. **Pool Allotment Percentage** for any Pool means the percentage of the aggregate payments that SCION receives from a Payer in connection with a Benefit Contract, after first deducting the contract management fee, and that will be deposited in the Pool for such Benefit Contract as determined, from time to time, by negotiation between SCION and such Payer, or SCION. PROVIDER acknowledges and agrees that SCION and such Payer, or SCION, may change the Pool Allotment Percentage from time to time effective upon notice to PROVIDER. SCION shall notify PROVIDER of the Pool Allotment Percentage for each Benefit Contract upon determination of such Pool Allotment Percentage. The initial Pool Allotment Percentage shall be 95%.

6.20. The **Pool Cash Balance** for any Pool at any time means

a) actual cash in the Pool at such time minus

b) the aggregate cost through such time of any performance bond or letter of credit required to secure SCION's performance under its contracts.

6.21. **Service Month** for any Covered Service means the month in which such Covered Service was performed.

6.22. **Total Compensation Amount** for any Covered Service rendered to a Beneficiary under a Benefit Contract creating a Pool means (i) the Adjusted Service Value for such Covered Service multiplied by (ii) such Pool's Monthly Percentage for the Service Month for such Covered Service.

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

5.1.1	
Company name:	Voiance Language Services, LLC
Ownership (sole proprietor, partnership, etc.):	Private company. Wholly owned subsidiary of CyraCom International, Inc.
State of incorporation:	Arizona
Date of incorporation:	March 23, 2010
# of years in business:	15 years Parent: CyraCom International, Inc. Subsidiaries: Voiance Language Services, LLC; CyraCom, LLC
List of top officers:	▪ Jeremy Woan, Chairman and CEO ▪ Susan Sweeney, CFO ▪ Todd Torman, VP, Sales
Location of company headquarters:	5780 N. Swan Rd. Tucson, AZ 85718
Location(s) of the company offices: Location(s) of the office that will provide the services described in this RFP:	5780 North Swan Rd. Tucson, AZ 85718 **Tucson Contact Center** 2801 E. Elvira Rd. Tucson, AZ 85718 **Phoenix Contact Center** 14415 S. 50th St. Phoenix, AZ **Las Cruces Contact Center** 2303 Divot Dr. Las Cruces, NM
Number of employees locally with the expertise to support the requirements identified in this RFP:	0
Number of employees nationally with the expertise to support the requirements in this RFP:	7
Location(s) from which employees will be assigned for this project:	7251 W. Lake Mead Blvd., Ste. 104 Las Vegas, NV 89128

5.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

Voiance understands it must register as appropriate with the State of Nevada Secretary of State's Office.

5.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Is "Legal Entity Name" the same name as vendor is doing business as?

If "No", provide explanation.

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

State of Nevada License: NV20091196291
Yes, the legal entity name is the same as the name under which Voiance is doing business.

5.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

Voiance understands this requirement. Please see Appendix 5.1.4 for a copy of Voiance's required license.

5.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

If "Yes", complete the following for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

A. Name of State Agency?

B. State Agency Contact name? Date when services were performed?

C. Type of Duties Performed?

D. Total Dollar Value of the contract?

No

5.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

No

5.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP must also be disclosed. Does any of the above apply to your company? If "Yes", please provide the following information. Table can be duplicated for each issue being identified. Please answer regarding:

A. Date of Alleged Contract failure or breach?

B. Description of failure or breach or litigation including the products or services involved?

C. Amount in Controversy?

D. Resolution or current status of dispute?

E. Has the matter involved a court case?

F. Status of litigation?

None

5.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 1988. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E. [See table on page 180.] Any exceptions to the insurance requirements must be identified on Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP. In order for any exceptions to the insurance

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

requirements to be considered they must be documented in detail in Attachment B. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission. Upon contract award, the successful vendor must provide the Certificate of Insurance identifying the coverages as specified in Attachment E, Insurance Schedule for RFP 1988.

Yes, Voiance complies and possesses the required insurance as stipulated in Attachment E.

5.1.9 Company background/ history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

5.1.9.1 Corporate Background

A. Provide a general description of the primary business of your organization and its client base. Include the length of time vendor has been providing services described in this RFP to the public and/or private sector.

CyraCom International, Inc. is the parent company of Voiance Language Services, LLC and CyraCom, LLC with operations managed at the parent company level. Voiance provides a suite of language services solutions including telephone interpretation, translation and localization, on-site interpretation, and video interpreting services. Voiance meticulously screens and assesses its US-based interpreters before delivery of interpretation services. Voiance's dedicated team of QA Specialists regularly monitors interpreters to ensure accurate interpretation, professional conduct, and customer service skills.

Voiance's US-based contact centers use the best-in-design, layout, and technology infrastructure enabling it to control its service levels and deliver quality interpretation services to clients.

Voiance Language Services provides a portfolio of language services solutions including 24/7 over-the-phone interpretation in more than 200 languages, multimedia translation services, and language assessment services. The company is governed by its parent, CyraCom International, Inc. which has been providing language services for more than 15 years. With ISO 9001:2008 certified processes, onshore contact centers, and advanced telecommunications infrastructure, the company delivers high quality language services to its clients in the areas of healthcare, insurance, government, financial services, and general business.

B. Provide a brief history and current company ownership including the ultimate parent organization and major shareholders/principals.

CyraCom International, Inc. is the parent company of Voiance Language Services, LLC and CyraCom, LLC with operations managed at the parent company level. CyraCom International formed in 1995 under the name Kevmark Industries. In that same year, Kevmark patented the first dual-handset telephone, revolutionizing the language services and teleservices industries. In 1998, Kevmark changed its name to CyraCom International. The company operates as a private corporation with private shareholder ownership.

C. Is your firm a resident of Nevada or a resident of another state? If so, please list the state of residence. Does your resident state apply a preference, which is not afforded to bidders or vendors who are residents in the state of Nevada? This information may be utilized in determining whether an inverse preference applies pursuant to Nevada Revised Statutes.

Voiance stipulates that Arizona does not provide a preference.

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

D. The location of disaster recovery back-up site.

Denver, CO

E. The name, address and telephone number of the Vendor's point of contact for a contract resulting from this RFP.

Steven Cook, Manager, Business Development
Voiance Language Services
5780 N. Swan Rd.
Tucson, AZ 85718
(866) 742-9080 ext. 1776
(520) 745-9022 fax

F. The size of organization in assets, revenue and people.

Revenue: $40 million
Employees: More than 800

G. The organizational chart of your senior management by function including key personnel.

See Voiance Attachment 5.1.9.1 for Voiance's organizational chart.

H. The areas of specialization.

Provision of language interpretation and translation services.

I. The company's main product/service lines and annual revenues for each product/service line in 2010 and 2011.

- Over-the-phone interpretation (OPI)
- Document translation (DT)
- Video remote interpretation (VRI)
- On-site interpretation
- Language proficiency and interpreter skills assessment

J. The corporate philosophy and mission statement.

Voiance's definition of a mutually successful partnership is one where the vendor meets or exceeds performance criteria that directly impact the quality of care provided to the member or customer. Voiance's philosophy operates from the fundamental premise that a genuine partnership with Amerigroup Nevada is one that provides the necessary tools to ensure Voiance is meeting service quality and customer support goals.

K. A description of any plans for future growth and development of your organization.

Voiance monitors its clients' demand for language services access daily to ensure the availability of quick and efficient access. Its operational and workforce management efforts afford it the opportunity to analyze current trends and anticipate future market trends on state, regional, and national levels. In

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

addition, Voiance's client partnerships afford the opportunity to understand clients' challenges, and either proposes an immediate solution or collectively develops a new project scope of work for future beta testing and implementation.

L Please identify any recent market expansion and/or business line addition by your organization. Describe the implementation approach and methodology you employed for the market expansion and/or additional business line identified. For example, what kind of planning and project management techniques, what resources and organization, etc.?

Voiance manages its ongoing relationships with current clients to support their anticipated expansion into new or existing markets. It plans such expansions well in advance to understand the required market demographics and the client's service operations that will support the expansion. A market expansion typically commences nine or more months in advance, and includes monthly and quarterly planning discussions to ensure clarity of language service demands and the deployment of appropriate resources to set up, test, and implement the required service access.

5.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

15 years. Voiance Language Services, a subsidiary of CyraCom International, provides 24/7 over-the-phone interpretation in more than 200 languages, and multimedia translation services. With ISO 9001:2008 certified processes, onshore contact centers, and advanced telecommunications infrastructure, Voiance delivers high quality language services to its clients.

5.1.10.1 Experience

A. Explain in detail the experience your organization has in providing the services requested in this RFP, including specific experience with the following:

1. Managing a network of Medicaid Providers;

Not applicable

2. Managed care programs for Medicaid recipients;

Not applicable

3.Administering Medicaid utilization and case management programs;

Not applicable

4. Medicaid claims processing and adjudication

Not applicable

5. Project management; and

- Not applicable

6. Qualifications of key personnel.

Not applicable

B. Describe your experience with performance incentives based on targeted health outcome standards. In addition, identify specific performance measures that would provide the most meaningful measure

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

of health care service delivery performance.

Not applicable

C. Describe where you have invested in the improvement of services, treatment protocols, and development of best practices.

- Not applicable

D. Describe the experience your organization has had working with state government and/or experience in specifically related services.

Voiance has many years' experience supporting state governments and clients responsible for supporting health, Medicaid/Medicare, social service, and behavioral health-related programs.

Voiance's business operations and account management teams are familiar with the business and service operations of such organizations, along with the regulatory and reporting requirements that support them. Most state governments operate under a master agreement that governs general service delivery, with separate departments managing their own service programs that often require different vendor access methods or market implementations.

E. Provide the names, resumes, and any additional pertinent information regarding key personnel responsible for performance of any contract resulting from this RFP. In addition, specify the specific responsibilities of each of these individuals in relation to the requirements set forth herein. This information must be included in vendor's technical response to the RFP.

See Voiance Attachment 5.1.10.1. for resumes.

F. Provide the names of any additional full-time staff and project supervisors with contract responsibilities in the following area:

1. Information Systems
2. Utilization/Case Management
3. Claims Payment
4. Quality Improvement and Reporting (i.e. HEDIS, CMS)
5. Health education
6. Data / coding
7. Contract negotiations, Network recruiters
8. Encounter data
9. Other staff as needed

1. Alex Montanez, Manager Information Systems
2. Not Applicable
3. Not Applicable
4. Stephen Gerhart, Manager of Interpretation Quality and Development
5. Not applicable
6. Not applicable

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

7. Not applicable

8. Not applicable

9. Best Ihegborow, Director of Interpreter Center Management

G. Provide copies of any current licenses or certifications, including your license to operate as an HMO in Nevada.

Not applicable to this service

H. List any bilingual staff, the area to which they are assigned and the languages spoken.

Voiance's contact centers and interpreter network consist of more than 1,650 interpreters that service more than 200 languages and dialects.

I. List any associations or organizations to which the organization belongs.

- American Hospital Association
- National Council On Interpreting in Healthcare
- American Teleservices Association
- American Translators Association; Institute For Diversity

5.1.11 Plan of Operation: The following are items that will facilitate the evaluation of the Vendor's ability to provide the different components required for the operation of a DHCFP contracted HMO. In each response, a comprehensive description detailing how the requirement will be implemented and maintained must be provided. In addition, descriptions of services which the Vendor believes may be beneficial in implementing and/or maintaining this program shall be included.

5.1.11.1 Medical Services

A. Describe how you will determine the need to provide services beyond those required in Section 4.2.2, Vendor Covered Services.

Not applicable

B. Describe the guidelines and procedures you will use to determine the medical necessity of service authorization requests. Include your process for medical review of claims.

Not applicable

C. Do you have a process for monitoring and evaluating these guidelines and procedures? If so, please explain.

Not applicable

D. Describe your procedure for providing, monitoring and coordinating out-of-network services to enrolled recipients.

Not applicable

E. Describe the role and responsibilities of your case managers.

Not applicable

Voiance Language Services, LLC
Over-the-Phone Interpretation in over 200 languages, and multimedia translation services
F. Describe your plan to coordinate and communicate with DHCFP's DO care coordination staff on behalf of high risk pregnant women.
Not applicable
G. Describe the policies and procedures you have in place to assess enrollees identified as Children with Special Health Care Needs (CSHCN). How will a treatment plan for CSHCN be developed?
Not applicable
H. Describe the network you have in place to provide mental health and rehabilitative services to Severely Emotionally Disturbed (SED) children and Seriously Mentally Ill (SMI) adults.
Not applicable
I. Provide your policies and procedures for emergency and post stabilization services.
Not applicable
5.1.11.2 Enrollment Provide your policy and procedure for transitioning a recipient from or to FFS or another Vendor's plan.
Not applicable
5.1.11.3 Recipient Services A. Provide a sample copy of your current or proposed enrollee handbook and identification card you may issue to enrolled recipients.
Not applicable
B. Describe your process for assignment or auto assignment of enrolled recipients to a PCP or PCS, including your process for changing a PCP or PCS.
Not applicable
5.1.11.4 Network A. What steps will you take to develop and maintain a network that ensures the ability to provide the managed care benefits required in this RFP to enrolled recipients in the required service areas of urban Clark and Washoe counties?
Not applicable
B. Provide a sample of all base network provider contracts.
Not applicable
C. What is your plan to involve essential community providers, such as the Federally Qualified Health Centers, in your network?
Not applicable
D. How will you monitor and evaluate performance and correct deficiencies relative to Section 4.5.5.1 through 4.5.5.9, Access and Availability?

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

Not applicable

E. How will you monitor contracted network provider's activities to ensure they comply with your requirements and those set forth in Section 4.5.3, Network Management? Describe your plan of action to ensure positive provider relations. Include in your response information regarding contracting; compensation; policy and procedures; disputes; and, communications.

Not applicable

F. Do you anticipate offering any physician incentive plan(s)? If so, provide a summary of the plan(s) you anticipate offering. If you currently have a physician incentive plan, so indicate and provide a summary.

Not applicable

G. Do you currently have or intend to have sole source subcontracts for any of the benefits services? If so, please identify the services and the sole source subcontracts you currently have or intend to have.

Not applicable

H. The National Provider Identifier (NPI) is the standard unique health identifier for health care providers. Health plans must use the NPIs of any health care provider or subpart to identify the health care provider or subpart in standard transactions by the 5/23/07 compliance date. How will your health plan prepare for use of NPIs to identify providers on standard transactions in order to be in compliance by the deadline of 5/23/07?

Not applicable

5.1.11.5 Quality Assurance

A. Provide a description of your Internal Quality Assurance Plan and how you will comply with quality standards in Section 4.8 of this RFP.

Voiance's organization became the first telephone interpretation company in the US to achieve ISO 9001:2008 certification. This quality management systems' certification forms the framework of the organization's guidelines and benchmarks to safeguard superior quality assurance for language interpreter services.

B. In adherence with the State's Quality Assessment and Performance Improvement Strategy and Work Plan in RFP Section 4.9, how will you monitor and measure quality improvement of the care delivered to enrolled recipients?

Not applicable

C. In relation to HEDIS Measure Diversity of Medicaid Membership, will the vendor please describe their systems capability to collect and report race, ethnicity, and language over and above what is given to them by the DHCFP?

Not applicable

5.1.11.6 Fiscal Requirements

A. How will you ensure timely payment of claims in accordance with state and federal statutes and

Voiance Language Services, LLC
Over-the-Phone Interpretation in over 200 languages, and multimedia translation services
regulations?
Not applicable
B. Describe your claims payment performance using the most recent available annual period as the time frame of reference. What is your payment aging profile for clean and non-clean claims? What is your percent of claims pended? What is your denial rate? What is your rate of claims resubmission?
Not applicable
1. Provide a recent set of unedited month-end management reports from your claims system. At a minimum, samples should include aging report, clean claim payment rate, denial rate and pended.
Not applicable
C. Describe your plan to identify and report suspected provider and recipient fraud.
Not applicable
D. Describe and submit your policies and procedures for determining and collecting patient liability.
Not applicable
5.1.11.7 Grievances, Appeals and Fair Hearings A. Explain your process for ensuring the due process rights of enrolled recipients with regard to grievances, appeals and access to state fair hearings are followed.
Not applicable
B. Do you have performance standards for the frequency of enrolled recipient grievances and appeals and provider disputes? If so, what are your standards and what have been your performance outcomes?
Not applicable
5.1.11.8 Operational Requirements Provide an organizational chart depicting each functional unit of your organization associated with the proposed contract, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with major subcontractors. Identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the proposed contract and lines of authority within the corporate structure.
See Voiance Attachment 5.1.11.8 for Voiance's organizational chart.
5.1.11.9 Implementation A. If you currently do not have an established network, what time frame and approach will you use to build a network?
Not applicable
B. Provide a Gantt Chart detailing the implementation process and proposed timeline for all program requirements.
Not applicable

Voiance Language Services, LLC

Over-the-Phone Interpretation in over 200 languages, and multimedia translation services

5.1.11.10 Reporting

The Vendor has been requested throughout the RFP to provide various reports. All reporting requirements can be found in this RFP and in Attachment I Forms and Reporting Guide. Review these reporting requirements and acknowledge

Voiance will provide details and information needed to support Amerigroup Nevada reporting to the State.

5.1.11.11 Information Systems and Technical Requirements

Based upon the information provided in this RFP and available in the Vendors' library, provide your acknowledgement of your ability to provide compatible interfaces with existing and proposed information systems.

Voiance acknowledges the ability to provide compatible interfaces with existing and proposed information systems.

5.1.11.12 HIPAA Compliance

A. Describe your status, resources, and approach to HIPAA compliance.

Quality assurance plays a major component in Voiance operations. Voiance is the first OPI provider to obtain ISO 9001:2008 Systems Management quality certification and recent external audits recertified the organization for compliance. Voiance conducts reference checks on all its interpreters and evaluators in accordance with Joint Commission requirements. In 2012, Voiance successfully completed two CMS-level audits, including the review of its HIPAA training and awareness processes, as well as Privacy and Confidentiality for large healthcare provider customers. CMS auditing that Voiance completes background checks on all hired interpreters.

B. Describe your experience in processing HIPAA-compliant provider claims and in submitting HIPAA-compliant encounters to States.

Not applicable

5.1.12 Financial information and documentation to be included in Part III, Confidential Financial of vendor's response in accordance with Section 10.5, Part III – Confidential Financial.

5.1.12.1 Dun and Bradstreet Number

10582544

5.1.12.2 Federal Tax Identification Number

37-1571267

5.1.12.3 The last two (2) years and current year interim:

A. Profit and Loss Statement

B. Balance Statement

See Voiance Attachment 5.1.12.3.

5.3 BUSINESS REFERENCES

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Voiance directly to the Purchasing Division.

Table 5.3-1. Voiance Language Services Reference 1

Reference #:	1		
Company Name:	Voiance		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Over-the-phone Interpretation		
Primary Contact Information			
Name:	Connie Patton Allstate Insurance Company		
Street Address:	401 McCullough Drive		
City, State, Zip	Charlotte, NC 28262		
Phone, including area code:	(704) 547-8076		
Facsimile, including area code:	--		
Email address:	oscpat1@allstate.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Over-the-phone interpretation services in support of Allstate customer information center operations.		
Original Project/Contract Start Date:	4/01/2009		
Original Project/Contract End Date:	3/31/2010		
Original Project/Contract Value:	$200,000		
Final Project/Contract Date:	Ongoing		
Was project/contract completed in time originally allotted, and if not, why not?	Ongoing; still under contract.		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Ongoing; project working within budget.		

Table 5.3-2. Voiance Language Services Reference 2

Reference #:	2		
Company Name:	Voiance		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Over-the-phone Interpretation		
Primary Contact Information			
Name:	Vicki Roth Esurance		
Street Address:	P.O. Box 5250		
City, State, Zip	Sioux Falls, SD 57117		
Phone, including area code:	(605) 782-2846		
Facsimile, including area code:	--		
Email address:	vroth@central.esurance.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Over-the-phone interpretation services in support of customer support and claims processing operations.		
Original Project/Contract Start Date:	3/01/2012		
Original Project/Contract End Date:	Present		
Original Project/Contract Value:	$150,000		
Final Project/Contract Date:	Ongoing		
Was project/contract completed in time originally allotted, and if not, why not?	Ongoing; still under contract.		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Ongoing; project working within budget.		

Table 5.3-3. Voiance Language Services Reference 3

Reference #:	3		
Company Name:	Voiance		
Identify role company will have for this RFP project (Check appropriate role below):			
	VENDOR	***X***	***SUBCONTRACTOR***
Project Name:	Over-the-phone Interpretation		
Primary Contact Information			
Name:	Dean Simon HSBC		
Street Address:	2200 E. Benson Road		
City, State, Zip	Sioux Falls, SD 57104		
Phone, including area code:	(847) 582-2669		
Facsimile, including area code:	--		
Email address:	dean.simon@capitalone.com		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Over-the-phone interpretation services in support of customer service operations for banking, credit, and insurance lines of business.		
Original Project/Contract Start Date:	11/01/2009		
Original Project/Contract End Date:	04/31/2012		
Original Project/Contract Value:	$1,000,000		
Final Project/Contract Date:	04/31/2012		
Was project/contract completed in time originally allotted, and if not, why not?	Yes, project was completed on-time.		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	Yes, project was completed within budget.		

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ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with the terms and conditions specified in this Request for Proposal.

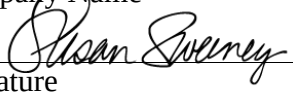
YES XXX I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

In order for any exceptions and/or assumptions to be considered they **MUST** be documented in detail in the tables below. The State will not accept additional exceptions and/or assumptions if submitted after the proposal submission deadline. Vendors must be specific. Nonspecific exceptions or assumptions may not be considered. If the exception or assumption requires a change in the terms or wording of the contract, the scope of work, or any incorporated documents, vendors must provide the specific language that is being proposed in the tables below.

Voiance Language Services

Company Name



Signature

Susan Sweeney

Print Name

11/2/2012

Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)

ASSUMPTION SUMMARY FORM

RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)

This document must be submitted in Tab V of vendor's technical proposal

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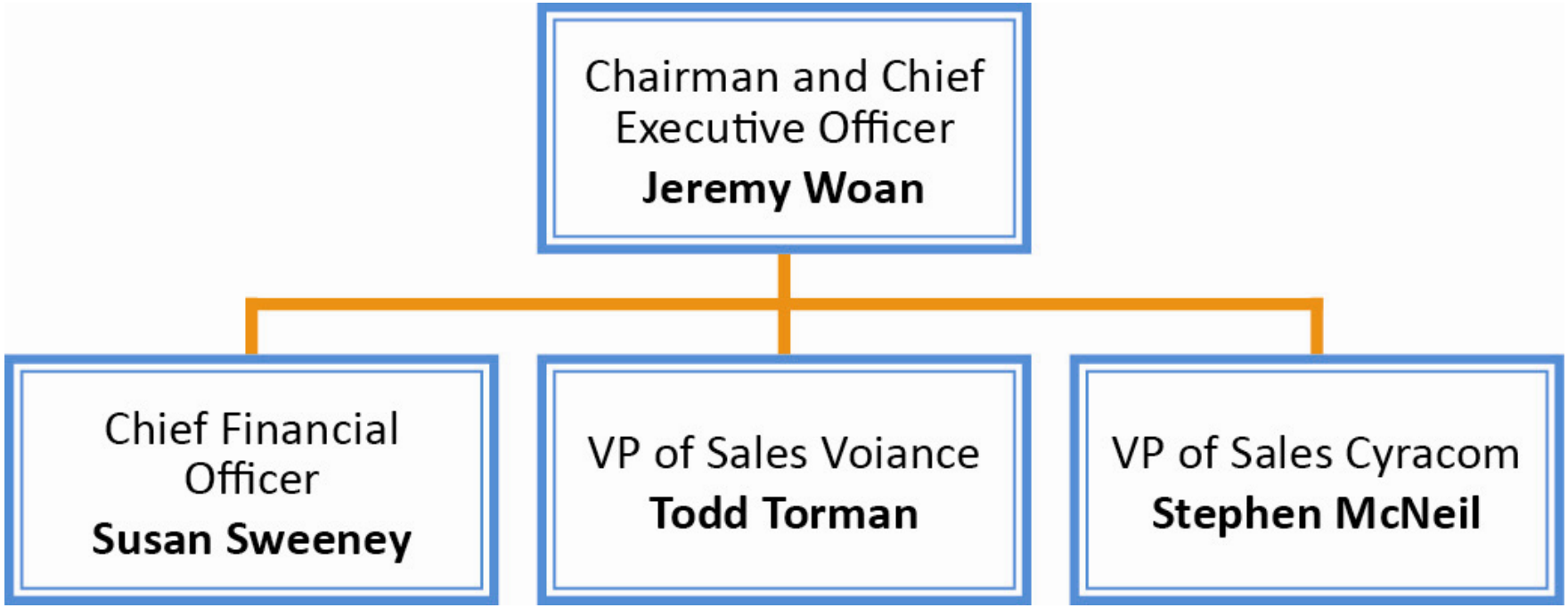
Voiance Organizational Chart



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VOIANCE PROPOSED STAFF RESUMES

Jeremy Woan

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Voiance Language Services (CyraCom International)		
☐ **Contractor**		√ **Subcontractor**	
Name:	Jeremy Woan	☐ **Key Personnel**	
Classification:	Chairman and CEO	**# of Years in Classification:**	15
Brief Summary: of Experience:	For over ten years, Jeremy Woan has successfully invested in and worked with a wide range of transatlantic and U.S. technology and service companies.		
# of Years with Firm:	2		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information: ***MMYYYY to Present:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:***	01.2008 – Present **CyraCom International (Voiance)** 5780 N. Swan Road, Tucson, AZ 85718 800-713-4950 jwoan@cyracom.com *Chairman & CEO*
Required Information: ***MMYYYY to MMYYYY:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:***	01.1997 – 12.2007 **The Bampton Group** San Francisco, CA 650-238-5105 info1@bampton.com *Chairman-* *Venture capital investment*

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:***	Cambridge University Cambridge, United Kingdom United Kingdom Graduate Degree, Law and International Law

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Susan Sweeney

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Voiance Language Services (CyraCom International)		
☐ **Contractor**		√ **Subcontractor**	
Name:	Susan Sweeney	☐ **Key Personnel**	
Classification:	Chief Financial Officer	**# of Years in Classification:**	20
Brief Summary: of Experience:	Susan has over 20 years of experience in Finance and Accounting; she comes from a background of public accounting and senior level finance positions.		
# of Years with Firm:	5		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Client Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	10.2007 – Present **CyraCom International (Voiance)** 5780 N. Swan Road, Tucson, AZ 85718 800-713-4950 ssweeney@cyracom.com *Chief Financial Officer* • Oversight and management of all corporate finance operations
Required Information: ***MMYYYY to MMYYYY:*** ***Client Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	01.2006 – 04.2007 **First Script Network Services, Inc.** 155 North Rosemont Boulevard, Tucson, AZ 85711 520-202-1290 *Vice President of Finance* • Responsible for finance and facilities operations • Developed procedures and internal controls for accounting, billings, and collections
Required Information: ***MMYYYY to MMYYYY:*** ***Client Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:***	08.2002 – 01.2006 **Beaudry RV Company**

Details and Duration of Contract/Project:	3200 E Irvington Rd, Tucson, AZ 85714 520-889-6000 *Assistant Controller* • Implemented internal controls and procedures resulting in reduced audit fieldwork • Supervised accounting staff in areas of A/P, A/R, Fixed Assets and Warranty

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Southern New Hampshire University Manchester New Hampshire Bachelor's Degree

Todd Torman

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	Voiance Language Services (CyraCom International)		
☐ **Contractor**		√ **Subcontractor**	
Name:	Todd Torman		☐ **Key Personnel**
Classification:	Vice President, Sales	**# of Years in Classification:**	2
Brief Summary: of Experience:	Todd Torman is a proven leader whose career has spanned more than 22 years of progressively increasing management experience encompassing sales and marketing, product management, strategic planning, budgeting, operations, fiscal accountability and supervision.		
# of Years with Firm:	2		

RELEVANT PROFESSIONAL EXPERIENCE

Required Information: ***MMYYYY to Present:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	03.2010 – Present **Voiance Language Services (CyraCom International)** 5780 N. Swan Road, Tucson, AZ 85718 866-742-9080 ttorman@voiance.com *Vice President, Sales* • Provides leadership, vision and direction for worldwide Sales and Account Management teams. • Controls expenses, world-wide pricing models, contract negotiations, new business development and overall profit margin for the business unit.
Required Information: ***MMYYYY to MMYYYY:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	06.1998 – 01.2010 **Qwest Communications Corporation** 1801 California Street, Denver, CO 80202 303-992-1400 ttorman@qwest.com *Director, Enterprise Sales* • Provided leadership, vision, and direction for the Arizona and New Mexico enterprise sales team. • Responsible for territory expansion, controlled expenses, regional pricing/offers, contract negotiations and overall profit margin for the territory.
Required Information: ***MMYYYY to MMYYYY:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:***	01.1988 – 06.1998 **GTE Communications Corporation** 600 Hidden Ridge Irving, TX 75038 (972) 718-5600

Role in Contract/Project: ***Details and Duration of Contract/Project:***	*Director of Indirect Distribution Sales (and) Manager of Strategic Planning* • Established a channel strategy by market through Value Added Resellers and Wholesalers. • Built a business plan justifying each market to enter and hired, trained and motivated channel sales managers to run each market.

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	Purdue University West Lafayette Indiana BS – Industrial Management

SECRETARY OF STATE

STATE OF NEVADA

NEVADA STATE BUSINESS LICENSE

CYRACOM INTERNATIONAL, INC.

Nevada Business Identification # NV20091196291

Expiration Date: August 31, 2013

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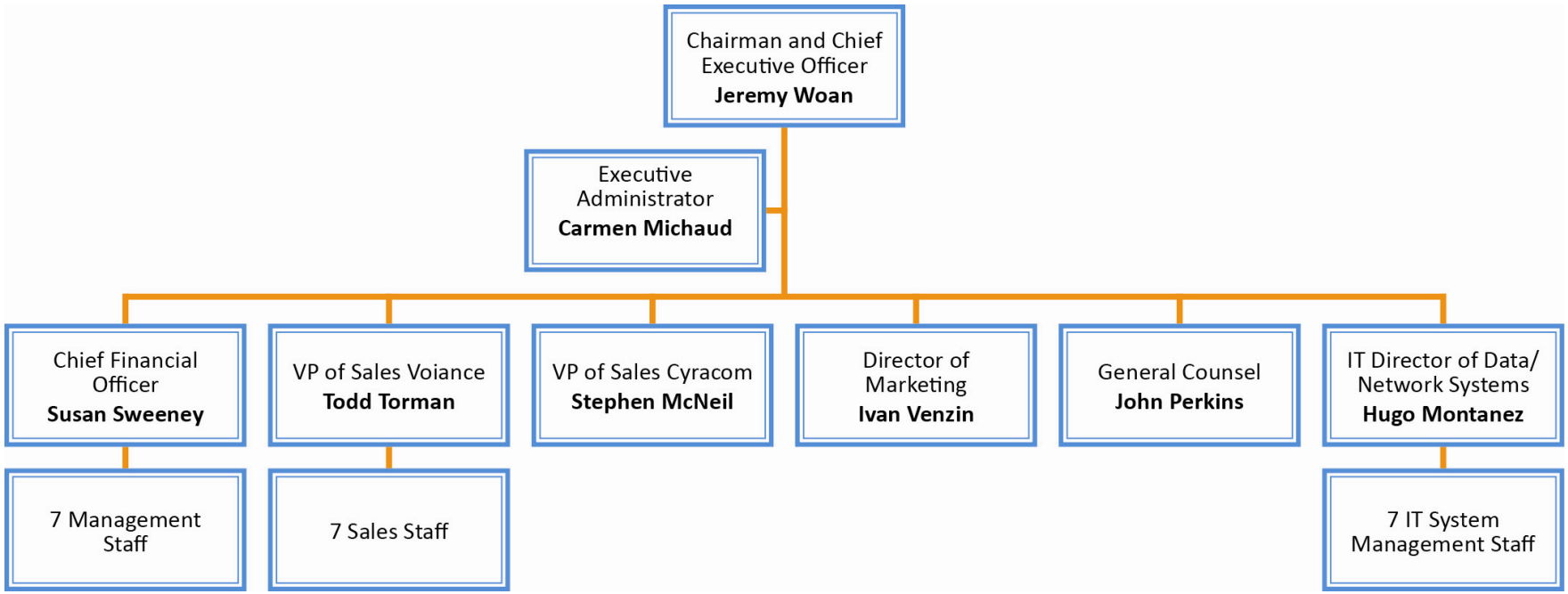
Voiance Organizational Chart by Functional Area



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5.3 REFERENCES

5.3.1	Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last three (3) years.
5.3.2	Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor: The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

The following tables provide information on the four business references that have submitted Reference Questionnaires regarding Amerigroup Nevada, Inc., directly to the Purchasing Division.

Table 5.3-1. Texas Health and Human Services Commission

Reference #:	1		
Company Name:	Amerigroup Nevada, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	HHSC Managed Care Contract		
Primary Contact Information			
Name:	Lisa Neal Manager, Health Plan Management Texas Health and Human Services Commission		
Street Address:	11209 Metric Boulevard, Building H		
City, State, Zip	Austin, TX 78758		
Phone, including area code:	(512) 491-1313		
Facsimile, including area code:	--		
Email address:	Lisa.Neal@hhsc.state.tx.us		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the	Providing comprehensive Medicaid managed care services		

project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	for families, children, seniors, and individuals with disabilities for more than 600,000 members in 230 counties.
Original Project/Contract Start Date:	9/1/2011
Original Project/Contract End Date:	8/31/2015
Original Project/Contract Value:	$1,550,685,776
Final Project/Contract Date:	N/A – contract currently effective
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective

Table 5.3-2. Tennessee Department of Finance and Administration, Bureau of TennCare

Reference #:	2		
Company Name:	Amerigroup Nevada, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	TennCare		
Primary Contact Information			
Name:	Darin J. Gordon Executive Director Tennessee Department of Finance and Administration Bureau of TennCare		
Street Address:	310 Great Circle Road		
City, State, Zip	Nashville, TN 37243		
Phone, including area code:	(615) 507-6443		
Facsimile, including area code:	(615) 741-0882		
Email address:	darin.j.gordon@tn.gov		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the project/contract and description of	Participating at-risk managed care organization in the State's Medicaid managed care program. Responsible for care		

services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	coordination activities and the provision of Medicaid covered services, including long term care and support services, through a contracted network of providers in the Middle Grand Region of the state. Total membership is currently 205,000 members in 39 counties in the middle Tennessee region.
Original Project/Contract Start Date:	4/1/07
Original Project/Contract End Date:	12/31/14
Original Project/Contract Value:	$896,910,240
Final Project/Contract Date:	N/A – contract currently effective
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective

Table 5.3-3. Georgia Department of Community Health

Reference #:	3		
Company Name:	Amerigroup Nevada, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Georgia Families and PeachCare for Kids		
Primary Contact Information			
Name:	Jerry Dubberly Chief, Medicaid Division Georgia Department of Community Health		
Street Address:	2 Peachtree Street, NW 40th Floor		
City, State, Zip	Atlanta, Georgia 30303		
Phone, including area code:	(404) 651.8681		
Facsimile, including area code:	(866) 283-0128		
Email address:	jdubberly@dch.ga.gov		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			
Brief description of the	Participating at-risk managed care organization in the State's		

project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Medicaid and CHIP (PeachCare for Kids) managed care program (Georgia Families). Responsible for care coordination activities and the provision of Medicaid and CHIP covered services through a contracted network of providers in multiple service areas across the state. Includes care coordination activities and family planning services for the Planning for Healthy Babies (P4HB) 1115 Demonstration program. We currently serve 290,000 Georgians in across all counties.
Original Project/Contract Start Date:	6/1/06
Original Project/Contract End Date:	6/30/13
Original Project/Contract Value:	$729,289,205
Final Project/Contract Date:	N/A – contract currently effective
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective

Table 5.3-4. Florida Healthy Kids Corporation

Reference #:	4		
Company Name:	Amerigroup Nevada, Inc.		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	Florida Healthy Kids		
Primary Contact Information			
Name:	Rich Robletto Florida Healthy Kids Corporation		
Street Address:	661 East Jefferson Street, 2nd Floor		
City, State, Zip	Tallahassee, FL 32301		
Phone, including area code:	(850) 701-6111		
Facsimile, including area code:	(866) 867-0054		
Email address:	robletor@healthykids.org		
Alternate Contact Information			
Name:	N/A		
Street Address:	N/A		
City, State, Zip	N/A		
Phone, including area code:	N/A		
Facsimile, including area code:	N/A		
Email address:	N/A		
Project Information			

Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	Participating at-risk managed care organization in the Florida Healthy Kids (CHIP) program. Responsible for care coordination activities and the provision of CHIP covered services through a contracted network of providers in multiple service areas across the state.
Original Project/Contract Start Date:	1/1/03
Original Project/Contract End Date:	9/30/13
Original Project/Contract Value:	$92,665,468
Final Project/Contract Date:	N/A – contract currently effective
Was project/contract completed in time originally allotted, and if not, why not?	N/A – contract currently effective
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	N/A – contract currently effective

5.3.3	Vendors must also submit Attachment F, Reference Questionnaire to the business references that are identified in Section 5.3.2.
5.3.4	The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.
5.3.5	It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in Section 9, RFP Timeline for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.
5.3.6	The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

Reference Questionnaires have been provided to each of the business references identified in Section 5.3.2. We instructed each business reference to complete the Reference Questionnaire and submit directly to the Purchasing Division before 4:30 PM Pacific Time on November 14, 2012.

Our subcontractors have also adhered to 5.3 reference requirements.

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